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Fear and Stigma in San Francisco: How Harm Reduction Workers Navigate Burnout, Policing, and Local Resistance Amid the Opioid Crisis

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Abstract

This paper illuminates the street-level experiences of harm reduction workers in San Francisco and their strategies for building trust with people who inject drugs (PWID), a heavily stigmatized population. Existing literature addresses topics like stigma, substance use, and outreach work; however, few studies focus on the harm reduction workforce, and those that do often originate from international settings where harm reduction is more prevalent. In this paper, through 15 semi-structured interviews with outreach workers and health professionals, I find that respondents face political resistance, police tensions, and burnout. To navigate these barriers, workers utilize strategies like lived experience, signaling, and community-based care. Based on these findings, I argue that policymakers should legalize harm reduction practices like supervised injection sites (SIS), allocate funding towards outreach organizations, and implement initiatives to destigmatize substance use. The findings presented here give insight into the harm reduction workforce and the vulnerable populations they serve.

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Introduction

> "**I want to assume that we all love what we do and love harm reduction, but I also want to hold that it's very difficult**. We reverse overdoses in the neighborhood. When we're off the clock, especially as someone that lives in the neighborhood, **I go home and reverse overdoses outside on my front lawn**…Some people throw rocks at my window when there's an overdose outside."

On a crowded street in San Francisco's Tenderloin district, Alex tells me about his "tough" and "beautiful" job as a case manager in harm reduction, a career where the line between work and personal life often becomes blurred. Next to us, a queue stretches around the corner: individuals waiting for drug use supplies, hepatitis C testing kits, and basic resources like food and blankets. Called syringe services programs (SSPs), these community sites operate across the city to provide access to sterile syringes and injection equipment ("Syringe Services Programs," 2019). In managing this SSP, Alex is no stranger to burnout, stigma, and underfunding. Still, he hopes "to work in harm reduction for the rest of [his] life," finding strength in community support systems and his own lived experience with hepatitis C.

While Alex's experience may seem unusual, it is an everyday reality for many outreach workers and health professionals who practice harm reduction, a public health approach focused on minimizing harm from drug use ("Harm reduction," 2008). Through semi-structured interviews, this thesis explores the question of how workers practice harm reduction in the Tenderloin, navigate heavily stigmatized work, and incorporate harm reduction principles into their lives. Interviewees include outreach workers, health professionals, and researchers, all of whom have engaged in harm reduction practices in a formal or informal capacity. These outreach services are largely concentrated in the Tenderloin district, a neighborhood that accounts for nearly 20 percent of San Francisco's fatal overdoses (Jung, 2024).

Facing challenges like political pushback, police tensions, and burnout, harm reduction workers must utilize lived experience, street signaling, and community-based care to build trust with people who inject drugs (PWID); these approaches demonstrate how key principles of harm reduction, which include destigmatizing substance use and "meeting people where they are at," manifest at the street level. In this paper, I will engage with literature on occupational burnout in front-line responders, public stigma associated with substance use, pressure from policymakers, and criminal justice approaches. The findings section will first present the idea that harm reduction is versatile and its practices can take many forms at the street level. Beyond distributing supplies, outreach workers find that harm reduction can represent a collective movement, broader philosophy, and way of life on the streets. Next, I will examine the pervasive stigma and fear surrounding PWID. Conversations reveal that stigma materializes in San Francisco politics and healthcare systems, creating gaps in care that harm reduction workers must bridge. Furthermore, given the criminalization of substance use and the legalization of harm reduction, workers must navigate tense relationships between law enforcement and PWID. As these barriers arise, outreach workers often experience burnout in their roles and must find the motivation to keep going.

The second half of the findings section will present worker strategies for building trust and fostering community among a heavily stigmatized population. Many outreach workers draw on their lived experience with addiction and treatment to empathize with PWID. This shared understanding allows outreach workers to build trust and gain credibility, a crucial component of life on the streets. In addition to utilizing lived experience, workers establish trust by showing dedication, delivering reliable services, and being present. These strategies can be as straightforward as treating PWID with compassion or listening to their stories. Furthermore,

respondents can build trust by addressing individual needs and meeting people where they are at both philosophically and physically. For health professionals, this means practicing community-based care and visiting patients in their place of residence.

This paper will conclude with short-term and long-term policy proposals for supporting the harm reduction workforce and addressing the opioid crisis at large. In the short term, I recommend legalizing pilot programs for supervised injection sites (SIS), which are legally sanctioned injection facilities that provide safe spaces for people to use illegal drugs (Levengood, 2021). Importantly, these harm reduction programs should be rolled out slowly, staffed well, and implemented with a close supervision of PWID. To prevent burnout among outreach workers, I propose allocating more funding towards harm reduction programs and tracking outcomes through qualitative measures like the case study method. In the long term, I recommend policies aimed at destigmatizing substance use and addressing the opioid crisis at large. Recommendations include increasing education in public school systems and medical institutions, amplifying the voices of outreach workers in policymaking, and confronting root causes of health, such as homelessness, mental health, and economic insecurity.

Ultimately, this paper illuminates the street-level experiences of harm reduction workers, a group that is in the public eye now more than ever. Very little research exists on harm reduction workers, especially in the United States where stigma, healthcare, and politics are often at odds. National policymakers look to San Francisco as a leader in drug policy and a pioneer in harm reduction (McDede, 2022). However, the city's harm reduction programs have been met with political scrutiny as overdose rates reach record highs and crime impacts residents (Martinez, 2024). In this escalating climate, conversations with workers at the street level are more crucial than ever for informing the future of harm reduction and dismantling the opioid crisis.

Background

The Opioid Crisis

Fentanyl overdose is the leading cause of death for adults under age 45 in the United States ("DEA Administrator"). Since 1999, the opioid epidemic has claimed the lives of more than 750,000 people nationwide (Ciccarone, 2021). San Francisco recently broke its record for fatal overdose rates, with total overdose deaths at 806 in 2023, up from 647 in 2022 and surpassing the city's previous record of 726 in 2020 (Martinez, 2024).To understand the consequences of this opioid crisis, it is important to contextualize its history. In 1996, Purdue Pharma introduced the powerful painkiller OxyContin to the public. The drug became widely prescribed for managing pain, and through aggressive marketing and promotion, sales skyrocketed from $48 million in 1996 to almost $1.1 billion in 2000 (Van Zee, 2009). Soon after, other highly addictive opioids like Percocet grew in popularity. By 2002, morphine, fentanyl, and oxycodone prescriptions had increased by 73 percent, 226 percent, and 402 percent respectively, marking the first wave of the opioid crisis with hundreds of thousands of deaths to follow ("When did the Opioid," 2020). The second wave of the opioid crisis began in 2010 when heroin use became popular among individuals who were already addicted to opioids. Users shifted their focus to heroin because the drug was a cheap low-purity solution that was much more accessible than prescribed medication (Mars, 2014). Heroin-related overdoses skyrocketed, and by 2015, they had surpassed opioid deaths. In 2013, a third wave related to synthetic opioids like fentanyl devastated the United States. Fentanyl, which is illicitly manufactured in China, is 50 times more potent than heroin and can be deadly in small doses ("Fentanyl Facts," 2024).

The United States is currently in the fourth wave of the opioid crisis. From 2019 to 2020, synthetic opioid-related overdoses increased by 53 percent, and overall opioid-related overdose

deaths increased by 34 percent (Ciccarone, 2021). This has largely been driven by the lethal combined use of stimulants like fentanyl, cocaine, and methamphetamine. While the current wave appears to be closely entwined with the third wave, where co-use of opioids was already prevalent, the reasons for the fourth wave's dramatic increase in stimulant mortality are still unclear (Ciccarone, 2021). Given that the opioid crisis is one of the most significant health challenges in the United States today, it is up to policymakers, health professionals, and outreach workers to navigate the path forward.

Harm Reduction

I. Definition

Harm reduction encompasses a set of practical strategies aimed at reducing negative outcomes from drug use ("Principles of Harm Reduction"). Designed for specific needs at the individual and community level, these services aim to "meet people where they're at" and break down contexts such as homelessness, mental health, and incarceration ("Principles of Harm Reduction"). Principles of harm reduction include accepting drug use and attempting to minimize its harmful effects, emphasizing individual well-being rather than abstinence, approaching substance use without judgment, and addressing social determinants of health.

Three prevalent harm reduction practices include naloxone, syringe services programs (SSP), and supervised injection sites (SIS). Naloxone, known by its brand name Narcan, is a medication that rapidly reduces the effects of opioids, such as heroin or fentanyl (Ciccarone, 2019). Naloxone is ideal for opioid overdose treatment because it can be administered by anyone, including bystanders without medical training ("Stop Opioid Overdose," 2023). The medication has become widespread since 2015, when Narcan nasal spray became the first

naloxone product approved by the FDA for use without a prescription (“FDA Approves,” 2023). SSPs distribute drug use equipment like new syringes and collect used needles for safe disposal (“Harm Reduction,” 2022). In addition to providing new syringes, programs offer services like treatment referrals, overdose education, and testing for needle-based infections (Des Jarlais, 2017). Finally, SISs are legally sanctioned spaces for people to use illegal drugs that involve oversight from a healthcare professional or a peer with personal experience (Levengood, 2021). More than 100 SISs operate in 66 cities around the world, largely in Western Europe, Australia, and Canada, though little to none operate in the US (Wolfson-Stofko, 2018). SISs were only implemented in the US recently, with the first government-authorized sites opening in New York in 2021 (Szalavitz, 2023).

Harm reduction programs were nationalized at the state and local levels in response to the HIV/AIDS epidemic in the late 20th century. HIV has long been linked with substance use, and studies indicate that individuals with HIV face a greater risk of drug overdose compared to those without the virus (UCSF Dept. of Psychiatry, 2024). San Francisco has been a leader in implementing harm reduction; the city’s first SSP, Prevention Point, was founded illegally in 1988 by volunteers passionate about preventing the spread of HIV/AIDS (“History of Health”). The city officially legalized SSPs in 1992, when Mayor Frank Jordan declared a state of emergency and allocated $138,000 in funding to Prevention Point. Today, SSPs are funded by state and local governments nationally. According to a report by North American Syringe Exchange Network (NASEN), the United States has 402 SSPs across 43 states, Washington D.C., and Puerto Rico (“Sterile Syringe,” 2022).

Before harm reduction, the field of substance use treatment in the 20th century was largely dominated by the concept of complete abstinence (McKeganey, 2011). Abstinence-based

practices include the 12-Step Model, which is rooted in the belief that recovery can only be achieved through complete abstinence and moral forgiveness (Paquette, 2022). While abstinence remains the most prevalent form of addiction treatment in the United States, the approach may dissuade PWID from seeking out help (Paquette, 2022). The 2022 National Survey on Drug Use and Health found that the most prevalent reasons PWID are not in treatment are because they are not ready to start treatment, they are not ready to stop using drugs, and they thought they could stop use on their own ("2022 National Survey," 2022). Since most PWID do not utilize abstinence-based treatment, a large population of PWID goes untreated. In these cases, non-abstinence approaches like harm reduction can be effective in minimizing harm. Furthermore, researchers have advocated for a potential combination of abstinence and harm reduction approaches (McKeganey, 2011).

II. Politics

With President Joe Biden becoming the first United States president to support harm reduction as part of his drug policy, harm reduction concepts have permeated into the mainstream (McDede, 2022). In San Francisco, heightened public scrutiny has made harm reduction a political target. Colorful murals that read "The layoffs don't appear to have hit the drug dealers" and "Hey, City Hall, where's the harm reduction plan for our kids?" popped up in alleyways, bus stops, and sidewalks.[1] Coalitions of business and property owners protested against paying taxes and demanded stricter policing for crime (Vang, 2022). Under pressure for reelection, Mayor London Breed announced plans to crack down on drug use and noted that "force is going to have to be a part" of the city's response (Moench, 2023). In March 2024,

[1] Protests were part of the "That's Fentalife!" ad campaign by TogetherSF Action, a coalition that believes harm reduction is misguided and enables drug use (Bishari, 2023).

Breed received approval from voters to require drug screenings and ease restrictions on law enforcement, a plan that reflects a lean towards more conservative policies (Gardiner, 2024b). This stands in sharp contrast to Breed's previous endorsement of harm reduction. In December 2021, she declared an official State of Emergency in the Tenderloin and launched the Tenderloin Linkage Center (TLC), which provided resources like meals, housing, and substance use treatment to over 400 visitors every day ("Mayor London," 2021). While the TLC was not marketed as an SIS, 333 overdoses were reversed at the center (Suen, 2023). It was shut down after 11 months in operation, once the public health emergency was declared to be over. A year earlier, California Governor Newsom vetoed legislation that would have allowed SIS pilot programs in California's cities (Cowan, 2022). In his letter, Newsom voiced concern about "a world of unintended consequences" should SISs be implemented without care (Cowan, 2022). Given heated politics in San Francisco, the future of harm reduction policies and the role of harm reduction workers remains uncertain.

Literature Review

Stigma and Substance Use

A growing body of literature on the stigma associated with drug use identifies PWID as a highly discriminated and marginalized population. Researchers claim that the greatest barrier to drug treatment for PWID is stigma, which can be exacerbated by people who are HIV-positive or from underrepresented backgrounds (UCSF Dept. of Psychiatry, 2024). While stigma is often associated with external sources like employers, friends, and healthcare providers, PWID may also internalize stigma from themselves (Crapanzano, 2018). Dealing with stigma can adversely affect the mental and physical health of PWID through exposure to chronic stress, alienation, and

withdrawal from social support (Ahern, 2007). In healthcare systems, stigma from clinicians can lead to suboptimal healthcare (Van Boekel, 2013). Stigmatizing experiences can also foster an overwhelming distrust of medical providers (Rehman, 2024). Furthermore, structural forms of stigma can manifest in restrictive physical spaces, financial limitations, and a lack of mental health resources (Rehman, 2024). These barriers impact how medical professionals make decisions for PWID and can result in inappropriate pain and withdrawal management. Though stigma is sometimes framed as a public health tool that discourages substance use, research has found that public stigma is not actually effective in preventing use (Palamar, 2013).

To reduce stigma, outreach organizations may hire peers, or people with lived experience. Peer programs are based on the idea that clients are more likely to share personal matters or seek support from people with similar experiences, who are often more understanding than authorities ("Peer Support Programs"). These programs have been found to reduce the likelihood of relapse and extend treatment. Research on peer recovery support services has found that peers can reduce substance use and SUD relapse rates, improve relationships with treatment providers, and increase treatment retention and satisfaction (Eddie, 2019). While not all harm reduction programs are peer programs, many harm reduction workers are peers in that they have lived experience of drug use (PWLE) (Austin, 2021). The benefits of peers working in harm reduction include countering stigma, building community-based trust, and preventing overdose deaths (Austin, 2021). In a study on SSPs in New York, PWID described the mostly peer staff at SSPs as more non-judgmental, understanding, and accommodating than professional medical staff, which made them feel more comfortable connecting to care at SSPs (Muncan, 2020). For peers, working in prevention outreach can improve health outcomes and give them a sense of meaning and purpose in life (Dickson-Gómez, 2004; Wood, 2003).

Burnout Among Outreach Workers

In psychiatry, burnout is defined as a psychological syndrome characterized by prolonged exposure to stressors at work (Maslach, 2016). Symptoms of burnout include overwhelming exhaustion, feelings of detachment from the job, and a sense of ineffectiveness and lack of accomplishment (Maslach, 2016). Burnout is a known occupational hazard in people-oriented professions, such as social work and healthcare, that deal with high-stress and traumatic situations. Research has found front-line workers who support PWID have a higher risk of experiencing burnout (Jawa, 2022). In harm reduction, outreach workers cite burnout from long-term exposure to stigma, workplace discrimination, low wages, worker shortages, and the stress of dealing with overdose deaths (Austin, 2016; Unachukwu, 2023). In addition to poor mental health, workers may suffer decreased productivity and absenteeism (Amer, 2022). As burnout impacts care and health outcomes for PWID, discouraged workers fall into a cycle of cynicism.

Politics

Research has identified political support and funding as one of the greatest challenges to the implementation of harm reduction initiatives (Greer, 2019). Policymakers are incentivized by public perceptions, which can signify pressure for policy change, acceptance of a policy, or credibility of policymakers (Sumnall, 2023). Public moral perceptions can be especially influential for harm reduction, which involves the ethics of banning a harmful behavior or allowing it to continue with reduced harm (Wylie, 2022). Negative public perceptions of harm reduction, driven by low knowledge and high stigma, can adversely impact political support for

the practice (Baker, 2020). Additionally, media representations of drug-related deaths, including age and gender characteristics, have been found to increase public stigma and reduce support for harm reduction (Sumnall, 2023). Still, stigma can look different in various contexts. For instance, research on two communities in Canada found that individuals were more likely to oppose needle distribution and SISs than naloxone and peer navigation programs; researchers hypothesized that the former was associated with 'danger' and linked with criminalized drug use, while the latter was linked to perceptions of 'safety' (Jackson, 2022). While literature discusses the relationship between harm reduction and politics, very few studies address the experiences of outreach workers in confronting these political barriers.

Criminal Justice

Since most PWID live in countries where drug use is highly criminalized, law enforcement is a key contributor to the "risk environment" of PWID (Burris, 2004). The criminal justice approach to substance use includes limiting the supply of drugs by cracking down on drug trafficking, arresting more drug users, and tracking opioid prescriptions (Plough, 2019). Despite enormous expenditures on the criminalization of drug dealers, "there is little evidence that enforcement efforts have been successful" (National Research Council, 2014, p. 154). Incarceration has been found to increase a prisoner's risk of HIV, HCV, and mental health disorders, and policing of substance use can increase community-level violence (Karberg, 2005; Park, 2019). Research has found that states with higher drug crime incarceration do not necessarily lead to fewer overdose deaths, since arrest triggers withdrawal and conviction can lead to houselessness (Kawasaki, 2019). At the street level, PWID often have negative

encounters with the police that can result in syringe confiscation and physical assault (Baker, 2020).

Tensions between PWID and law enforcement can have adverse implications for harm reduction efforts. The threat of law enforcement inhibits the utilization and expansion of SSPs because PWID avoid areas with police presence (Bluthenthal, 1997). In a national survey of harm reduction program managers, 43 percent reported monthly client harassment, 31 percent reported monthly confiscation of clients' syringes, 12 percent reported monthly client arrest to or from the SSP, and 26 percent reported uninvited police appearances at program sites every six months (Beletsky, 2011). Police encounters with PWID often include syringe confiscation or arrest, and violent run-ins with law enforcement are associated with disruptions in harm reduction (Park, 2019). This demonstrates that PWID and the police are constantly at odds, leaving harm reduction workers to navigate strategies for delivering care.

Gaps in the Literature

Despite a growing body of literature on PWID and their experiences with stigma, minimal research focuses on San Francisco's harm reduction workforce and strategies for overcoming challenges such as burnout, politics, and police presence. Furthermore, much of the existing literature on harm reduction comes from studies conducted in international settings like Canada and Australia, where harm reduction is more widespread and socially accepted. For instance, Canada has 39 operating SISs, with the first being legalized in 2003 (Wood, 2006; "Canadian Supervised," 2023). By contrast, the United States did not implement the first two SISs until 2021 (Szalavitz, 2023). In itself, the lack of research conducted on harm reduction workers in the United States speaks to the stigma and fear associated with the profession.

Additionally, it may imply that findings from countries like Canada, where there is a thriving harm reduction community, cannot be directly translated to the United States. This paper aims to bridge the research gap on the harm reduction workforce and understand why harm reduction has yet to be studied and implemented more broadly in the United States.

Setting

The majority of the outreach work discussed in this paper is focused in San Francisco's Tenderloin district. Located north of the touristy Market Street, east of the governmental Civic Center, south of the sloping Nob Hill, and west of the bustling Union Square, the Tenderloin district sits in the heart of San Francisco (Robinson, 1995). Home to nearly 35,000 residents, including 60 percent of the city's homeless population, the neighborhood has long faced challenges related to poverty, homelessness, crime, sex work, and substance use (Kehoe). Coupled with an illegal drug trade, street violence, and prostitution, the area has become a "containment zone" for these populations (Miguel, 2022). As of 2018, one-third of residents live below the federal poverty level, only 7 percent own a home, and less than 4 percent of the area is devoted to open space (Kehoe). Despite having 112 retail outlets per square mile, the Tenderloin has no supermarket and looks nothing like adjacent neighborhoods: major hotspots with upscale boutiques and bustling restaurants (Kehoe). In addition, the Tenderloin community has exceptionally poor health outcomes, with the highest chronic disease and illness rates in San Francisco (Kehoe).

Historically, the Tenderloin has been known as one of the remaining areas in which San Francisco's poor can afford to live. During the 1970s, rapid urban growth and rising rents eliminated low-income housing. Displaced residents flocked to the Tenderloin, increasing the

area's concentration of low-income individuals with histories related to drug addiction and crime (Robinson, 1995). When the Tenderloin was later threatened by gentrification, the community fought back with grassroots resistance, forming the first-ever neighborhood-wide political advocacy group. Many social service organizations followed, utilizing organized activism to preserve the community's residents in a battle against rising costs. Their success in advocating for housing conditions is a rare example of a grassroots movement that managed to withstand gentrification (Robinson, 1995). As evidenced by these efforts, the Tenderloin has had a long history of resistance and self-organization, driven largely by its residents and their ability to build community and mobilize groups.

Methods

Participants and Procedure

Data for this study come from 15 semi-structured interviews with outreach workers, health professionals, and researchers, all of whom have practiced harm reduction or harm reduction principles in some capacity. In speaking with these individuals, I aim to explore the experiences of the harm reduction workforce in San Francisco and how they deal with challenges at the street level. Qualitative interviewing allows me to identify themes, sentiments, and experiences unique to individuals. Furthermore, it provides participants with the opportunity to describe the circumstances and contexts in which they operate.

Before each interview, I asked individuals whether they wished to publicize their name, as well as their formal title and organization. Participants who did not consent have been given a pseudonym, and there are no identifiable details published beyond the field they work in or institutional organization. For a more detailed list of participants, see Appendix A.

I. Health Professionals and Researchers

Recruitment practices varied between the different subsects of participants, as I tailored my outreach methods to their professions and communication preferences. I interviewed four researchers and three health professionals, including a nurse, clinician, and clinical pharmacist. Importantly, all health professionals and researchers have practiced harm reduction, whether in their profession or as a volunteer. All but two of these seven individuals were from the University of California, San Francisco (UCSF). Their professional emails were accessible through UCSF online directories. As researchers and academics themselves, individuals were often responsive to my outreach and willing to refer me to other experts within UCSF. Interviews were conducted virtually over the phone or via Zoom.

Interviews were open-ended and loosely followed the interview guide (provided in Appendix B). These conversations focused broadly on defining harm reduction, contextualizing politics in San Francisco, and potential solutions for caring for PWID. Interviews also contain respondents' motivations for treating substance use, opinions on policy efficacy, and experiences with community outreach or volunteer work. The conversation could cover a range of topics, depending on the participants' preferences or areas of expertise. Since many health professionals and researchers also practiced outreach, topics about street-level experiences would often overlap with outreach workers. Interviews ranged from 30 to 60 minutes, with an average duration of 45 minutes.

II. Outreach Workers

I interviewed eight participants at harm reduction organizations and abstinence-based treatment programs, largely based in the Tenderloin. However, I did not exclusively recruit

outreach workers from harm reduction organizations. Two participants, Cedric Akbar and Cregg Johnson, are directors at an abstinence-based program called Positive Directions Equals Change (PDEC). While PDEC incorporates some principles of harm reduction in their work (lived experience, meeting people where they are at), they do not implement harm reduction practices like distributing supplies or supporting substance use. I included this range of perspectives to give voice to different stakeholders and unearth potential parallels and disagreements among respondents.

To recruit these workers, I utilized a combination of cold-emailing, snowballing, and in-person visits. From my earlier conversations with health professionals and researchers at UCSF, I was able to connect with local outreach workers through referrals. All interviews were conducted virtually over the phone or via Zoom, except for my in-person conversations with Alex and Harry. I spoke to these two outreach workers when I visited an SSP in the Tenderloin. Interviews ranged from 15 to 68 minutes, with an average duration of 40 minutes. I followed the same interview guide I used with health professionals and researchers (Appendix B). I found that health professionals and researchers often discussed macro issues, while outreach workers offered insights into the day-to-day aspects of their work. As a result, if an individual had more experience in harm reduction than research, I would ask more questions about the Tenderloin than policy. Other common topics among outreach workers included challenges related to law enforcement and strategies for building trust with PWID.

Data Analysis

All participants consented to be recorded during their interviews. After recording, I would transcribe audio with the software Otter.ai and correct errors manually to match the

recording. To code my data, I listened through each recording at least twice and developed a broader coding frame in a Microsoft Excel spreadsheet. I categorized qualitative data by tagging common ideas and thematic analysis, groupings that would ultimately encompass the core themes of my findings section.

Findings

Defining Harm Reduction

I. Practices at the Street Level

Harm reduction practices can take many forms at the street level, from case managers operating at distribution centers like the TLC to ad-hoc groups handing out supplies on the street. Danielle Kabella is an academic at UCSF who regularly conducts outreach in the Tenderloin. Every week, Kabella joins a team of volunteers to put together supply packs and engage with individuals on the street. Hand-outs typically contain consumption supplies, such as naloxone kits, glass pipes, and new syringes, in addition to necessities like food and blankets. Rather than direct services, other outreach workers might centralize in one area, setting up stations on street corners and having people line up for resources. Derek, an outreach coordinator who worked at the TLC, explains that while the temporary drop-in center operated as a centralized safe site for individuals, its functions extended beyond basic services like food and showers. Derek's work involved identifying high-risk individuals on the street, educating them about safe consumption, and linking them to services, such as shelter placement, mental health services, and substance use programs. Although harm reduction can take many forms, outreach workers are almost always engaging with PWID and providing them with supplies, resources, and information.

In medicine, harm reduction can be built into health procedures and patient care. As a nurse and clinician at UCSF, Matt Tierney has worked in substance use treatment for 22 years. By educating clinicians on evidence-based treatment, providing consultations to health providers, and addressing barriers to health access, Tierney aims to improve addiction treatment delivery and reach through education. He explains that, in the nursing profession, "a broad application of harm reduction is needed" and "all nurses at every level beginning at foundational education should know the science of harm reduction." Ethan, a psychiatric clinical pharmacist, spends four days every week treating substance use disorders and mental health at permanent supportive housing sites. In addition to dropping off medications such as buprenorphine,[2] he distributes harm reduction supplies like naloxone, safe injection needles, and smoking materials. Both Tierney and Ethan emphasize integrating harm reduction practices with medical treatment.

II. The Multiplicity of Harm Reduction

For many workers, harm reduction exists beyond its traditional definition as a health intervention; rather, it is a fluid concept that lends itself to numerous interpretations and can be applied to many areas of life. Faye is an outreach worker who has worked in harm reduction for 24 years and conducted research at drop-in centers like the TLC. According to Faye, "harm reduction is misunderstood by the general public" and "it's still pretty mysterious to people." Charles, a professor and clinician, has worked on substance use in San Francisco since 1990. For Charles, all healthcare is harm reduction. Since the term "means many different things to so many different people, it almost loses its definition." By highlighting the perspectives of workers who practice at the street level, this section aims to paint a more nuanced and heterogeneous definition of harm reduction.

[2] Buprenorphine is a synthetic opioid used to treat pain and opioid use disorders ("Buprenorphine," 2024)

Workers emphasize that harm reduction extends beyond the distribution of physical supplies. Brandon, an outreach worker who used to run a syringe program in the Tenderloin, splits the term into "lowercase" and "uppercase." According to Brandon, lowercase harm reduction refers to the "nuts and bolts": tangible resources that can reduce harm like needles, methadone, suboxone, smoking supplies, and glassware. By contrast, uppercase harm reduction represents the philosophical practice of "meeting people where they are at," a common slogan associated with harm reduction. Faye describes harm reduction as a "social movement" that motivates her to keep going. For her, the work is about "connection," "human rights," and "liberation" in the context of social issues that look past substance use on a micro level. Gina has worked in harm reduction for 16 years, predominantly in SSPs and drop-in centers. She finds that many people practice harm reduction in their day-to-day lives, explaining:

> "**Harm reduction is not only a framework but a lifestyle. It's something that a lot of us have been doing for most of our lives**, but didn't have the vocabulary for it…Like, everybody's different, everybody's unique. So everybody's going to require different needs…Obviously, harm reduction relates to drug use or substance use behaviors, but I feel like that is **something that can be used for anything else in your life too.**"

However, critics of harm reduction feel that these ambiguous definitions detract from harm reduction's original purpose. Cedric Akbar, cofounder of the abstinence-based reentry center Positive Directions Equals Change (PDEC), believes that harm reduction in the 1990s effectively reduced the spread of HIV through one-to-one needle exchanges. Today, however, he thinks the broader application of harm reduction enables drug use. Akbar explains that these changes defeat the purpose of treatment programs:

> "**Today, what they calling harm reduction is any damn thing.** They call them passing out needles for free, and having them all on the ground, passing out tin foil, when people are dying in the streets. **That ain't no damn harm reduction, and if that's harm reduction, what harm are you reducing, if we got 800 deaths?** And I'm not to say to blame at all on the harm reduction movement, I mean, there's some other factors that are taking place in there. But that's what I was always fighting against."

Despite disagreeing with the practice, Akbar explains that PDEC implements harm reduction principles, just defined differently. Like other outreach workers, Akbar emphasizes the importance of building community, "showing care and love for an individual," and recognizing that "you can't treat everybody across the board the same." However, he doesn't see this as a harm reduction framework. To him, these strategies, philosophies, and practices are just "common sense" and "being a human being." Whether these broader strategies are considered harm reduction or not, outreach workers at the street level often link their work to personal philosophies and frameworks.

Acknowledging Stigma

Outreach workers identify stigma and fear as major barriers for PWID in receiving adequate care. Ivy, an academic, describes the stigma against PWID as "discrimination" and "oppression" that has become widely accepted in the United States. Alex draws similar comparisons, claiming that stigma is "the leading cause of overdose deaths." While stigma poses a threat to harm reduction and PWID, it would be challenging for workers to eliminate these prejudices and stereotypes in a short timeframe. Reducing public stigma is an ambitious, time-intensive task that requires education, legislative reform, and increased interactions between groups (Roe, 2014). Amid an urgent opioid crisis, outreach workers must recognize that stigma is likely to persist, at least in the short term, and seek ways to work around it. Recognizing stigma allows harm reduction workers to understand their clients and identify strategies to deal with these challenges. This section will address two areas of stigma: first, within politics, and second, within healthcare systems.

I. Politics: "At a Breaking Point"

Respondents have observed fear and public stigma against PWID materializing in San Francisco politics. With 2024 being an election year, substance use has emerged as a central focus of ambitious policy agendas, as seen in national headlines such as "San Francisco voters pivot right on drugs, policing" and "Big blue cities are embracing conservative anti-crime measures" (Gardiner, 2024a; Demko, 2024). According to respondents, politicians are largely appealing to right-leaning San Francisco residents with NIMBY mentalities. NIMBY, or "Not In My Back Yard," refers to the behavior of individuals who recognize that something needs to be done somewhere, but who do not want it to be done where they live ("NIMBYism"). Gina emphasizes that there is a strong NIMBY presence in San Francisco, with the city being home to "some of the most aggravating NIMBYs that you will ever encounter." Ivy has noticed "ring-wing people" posting videos of PWID in the Tenderloin and saying, "Look at the scourge. This is what's destroying our city." Amid rising tensions and finger-pointing, Charles emphasizes that fear underlies politics:

> "**Fear gets people elected. And fear is a much more powerful driver of policy than love.** So if you are trying to address the harm of the world, and you want to get elected, the simple answer is to restrict people's freedoms and to threaten prison."

Political barriers are a major concern for harm reduction workers, who depend on public funding and legislative support. Gina thinks the city is reaching a "breaking point." If tensions continue to run high, she does not discount the possibility that "things are gonna get really violent," or that harm reduction organizations will have to "go back underground and stabilize." Ivy expresses a similar sentiment, explaining that harm reduction practices have come "under attack" and outreach workers are on the "back foot." She finds that public health and politics are intersecting in a "dramatic way" in San Francisco, to a point where "harm reduction has become a literally a word that is…stigmatized." Derek believes that policy poses the greatest challenge to

harm reduction, more so than money. Morgan Philbin, an associate professor at UCSF, echoes this sentiment by arguing that "the biggest challenge even before funding" is "making the programs legal." Similarly, Alex explains:

> "A lot of organizations are ready and have the money and say we'll do this. Some of them are like, 'We'll buy a space tomorrow.' But it's the [bureaucracy]. And again, maybe that's the tie between all of our conversations. **Sometimes the money is there. The laws have been checked, everything's there. But it comes down to stigma.** And if there's enough stigma, bureaucrats can stop anything."

As harm reduction faces pressure in San Francisco, the misaligned incentives between policymakers, residents, and harm reduction workers have become increasingly apparent. Recognizing the political landscape is crucial for understanding the experiences of workers at the street level, who must navigate these challenges every day.

II. Healthcare Systems: "Structural Determinants of Health"

Respondents find that stigma against PWID can exist in hospitals and healthcare systems, making it difficult for PWID to receive treatment and trust outreach workers. Ethan notices that stigma often deters clients from seeking help at clinics and pharmacies. He explains that in waiting rooms, PWID can feel judged by other patients who may not be there for the same reasons, such as primary care patients. According to Ethan, many PWID want treatment; however, if they are in withdrawal, they may feel uncomfortable waiting in long lines or interacting with front desk staff. Gina emphasizes that PWID often have to dress a certain way when interacting with pharmacists, who may have "stereotypes" and "prejudices" about them. Given negative encounters with healthcare systems, PWID may initially find it challenging to trust outreach workers. Alex recounts an experience working with a patient with hepatitis C who hid his diagnosis because he "didn't have enough trust with [Alex] yet." Though Alex never pushed him to share, the patient eventually admitted that he had sat on a needle. Alex describes:

> "I think this all speaks to the extreme stigma. I mean, I see people who are revived from overdoses. **And they'll say, 'Oh, I never. It was just weed. I just smoked weed.' And I'm like, 'That's fine. You don't have to tell me.' And after we build a relationship for a while, they'll say, 'There's so much stigma'**…And I'm like, 'That's fine. I'm glad that you trust me. But also I don't care if you never told me.'"

In addition to stigma, interviews reveal that structural barriers to healthcare often prevent PWID from accessing treatment. Tierney finds that systems-centered care, the opposite of person-centered care, is becoming far more entrenched in the United States. According to Tierney, electronic health records and standardized billing practices are structures demanding "Where can the patient meet you?" rather than asking "Where can you meet the patient?" In an environment where healthcare access is dependent on systems rather than individuals, Tierney explains that "many people become ill and succumb to their illnesses" because "the structures in which they live promoted the illness to begin with." He refers to social determinants of health[3] as "structural determinants of health," since structures restrict patient access within a model of system-centered care. Tierney elaborates:

> "**We're a for-profit health system, which to me is one of the biggest oxymorons ever.** It's always going to cost money to help promote health, it's always going to cost money to treat illness….**Providing patient-centered care is what makes the most sense in the current nonsensical environment.** How can we get to people who need our help?"

By understanding the barriers PWID face in healthcare systems, outreach workers can be better equipped to treat clients and develop effective methods of care.

Navigating Law Enforcement

With recent drug crackdowns and increased arrests, it is crucial for outreach workers to navigate policing at the street level. Outreach workers find that PWID often have negative encounters with law enforcement. Guydish emphasizes that when PWID congregate in one area,

[3] A common term that refers to non-medical factors that influence health outcomes ("Social determinants").

"they always have a fear of arrest [and] a fear that they will be identified." Akbar observes tensions between PWID and the police, saying that "black people are afraid still to this day." He explains that "nobody trusts" the police because "when the police come, somebody's leaving, and they ain't coming back." Research has found that PWID fear the police and thus police presence is associated with PWID avoiding harm reduction services, such as methadone clinics, SSPs, and SISs (Sarang, 2010; Park, 2019; Baker, 2020). This dynamic often makes it difficult for outreach workers to practice harm reduction. Kabella describes their experiences with the police as "mixed." Before moving to San Francisco, Kabella worked in Phoenix. They found that while some police officers were open to learning about harm reduction and administering naloxone, others would "use intimidation tactics," "linger around," and "constantly harass" both PWID and outreach workers. These methods would drive PWID away from harm reduction resources.

Amid tensions between PWID and the police, outreach workers on the street must maneuver their relationships with law enforcement. Before moving to the Bay Area, Gina worked in harm reduction in the south. Since harm reduction practices were much more "conservative," Gina had to be "very secretive" by hiding supplies in black bags and wearing her health badge to avoid police run-ins. In San Francisco, where workers distribute resources openly, she finds the police interfere far less. Dynamics between the police and outreach workers have changed significantly since harm reduction was first introduced in San Francisco. Joseph Guydish is a professor at UCSF who volunteered at San Francisco's earliest SSP in 1986 and has worked in substance use treatment for 30 years since. He emphasizes that, before harm reduction became endorsed and widely accepted, outreach workers just had to "trust that the police wouldn't interfere." He recalls an instance during the HIV/AIDS epidemic when law

enforcement confiscated used needles, which he later had to retrieve from the police department. Guydish describes the distinction between trust and tolerance, explaining:

> "Sometimes police tactics are just a break up just to disrupt an activity just to make it harder. So we did have, as I said, tolerance by the Department of Public Health and the police. **I don't know if I would actually call that trust…I had a sense that it was tolerated, not trusted.** Now, later on, it did become trusted because as I mentioned, it became a part of the city's response to drug use and to the risk of AIDS."

Additionally, many respondents believe that criminal justice systems like incarceration put PWID at a higher risk for overdose: a gap that workers must bridge with outreach services. Research has shown that, since imprisonment decreases substance use and tolerance, drug offenders are three to eight times more likely to experience an overdose death in the first two weeks after prison than in the following 10 weeks (Merrall, 2010). As a former heroin addict who had been arrested on multiple accounts, Akbar experienced this withdrawal firsthand. Upon his release from prison on a Friday afternoon, he flew to Southern California for treatment. By the time he landed in the evening, the center was closed. When workers told Akbar to come back Monday, he said, "You're gonna have to call the police because if I leave, I know what I'm gonna do." Ethan emphasizes the need for safe pipelines to treatment upon release. He elaborates:

> "**We're setting people up for failure, releasing them from jail at 10:30 at night** or whatever time they end up getting processed**.** No pharmacy is open. No clinic is open. They don't have their medications. Obviously, they're going to start to go into withdrawal. **They're going to be sick. And the first thing that they're going to do is they need to find a way to manage that**…They don't have a tolerance built up anymore."

Respondents agree that PWID do not trust law enforcement, presenting a complex situation that outreach workers must handle cautiously. Given the unique circumstances of substance use being illegal and many harm reduction programs being legal, workers must carefully navigate their relationships with both PWID and law enforcement.

Enduring Burnout

Faced with prolonged exposure to stigma, including opposition from policymakers, local communities, and law enforcement, outreach workers often face burnout in their roles. This is exacerbated by the fact that many harm reduction workers are not only first responders to overdoses, but also PWLE themselves who may have past trauma, leaving them at a heightened risk for experiencing trauma and occupational stress (Schoenberger, 2024). Derek finds that being "on the ground" every day with the "most acute clients" is a demanding task. He constantly has to be vigilant of his surroundings, which can be "exhausting mentally, physically, and spiritually." Furthermore, as a person of color, Derek finds it difficult to grapple with the fact that many of his clients are also "marginalized people of color that are suffering." He elaborates:

> "That day-to-day of being immersed into that community, it's challenging. **You really got to have the heart, the mind. You have to have the emotional endurance to be able to do that work because you are encountering some of the most challenging situations that any person can be in.** You have the open air drug sales. The open air drug use. You have all sorts of unsanitary spaces out there. You have the violence."

Alex emphasizes that "there is a lot of trauma in this work," though he has found that "the biggest form of burnout isn't from the day-to-day things," but rather the "hopelessness from above." By the latter, he refers to a lack of systematic support from policymakers, expressing that while "vicarious trauma is horrible and all [his] friends are dying," ultimately "the burnout is that the government isn't helping." According to Alex, the average turnover rate for outreach organizations is approximately two years, although it varies significantly; some individuals may leave after a few months, and others may dedicate their whole lives. At the same time, Alex finds that the challenging nature of harm reduction attracts dedicated individuals, explaining:

> "**This is tough work. I think that's why it attracts the kind of people that it attracts.** Maybe that's why there's so much of this community element. Maybe we're the folks [who are already] reversing overdoses in our community. **Maybe we're the ones who are already talking about vicarious trauma,** the ones who are already having these conversations about HIV and grief in our community."

Despite experiencing burnout and encountering political barriers, Gina remains devoted to the harm reduction movement. She moved to San Francisco to a break from harm reduction, though she was soon "sucked back in." While Gina describes burnout as an "ebb and flow," she feels a "moral responsibility" to keep practicing harm reduction. When the mayor pushes new policies or diverts funding streams to treatment-based programs, Gina finds the "the rigor to continue" because "this movement is effective." She thinks that the motivation of helping people and saving lives is what keeps harm reduction alive. In the face of burnout from occupational stress, political uncertainty, and vicarious trauma, outreach workers must find the strength to continue their work in harm reduction.

Building Trust and Fostering Community

As a heavily stigmatized population that faces constant discrimination, barriers to healthcare, and negative police encounters, PWID often experience mistrust and fear. To bridge gaps in care, outreach workers must find ways of building trust with PWID. Once this relationship is established, it becomes much easier to connect PWID to supplies, support, and care, whether it be shelter placement or mental health programs. In the Ted Talk "Everything you think you know about addiction is wrong," Johann Hari argues that the opposite of addiction is not sobriety, but connection (TED, 2015). Conversations at the street level affirm this sentiment. Cregg Johnson, who founded PDEC with Akbar and has worked in abstinence-based treatment for over 30 years, believes that the core of outreach work comes from the community:

> "It's not about the Department of Public Health. It's not about our political leaders. **It's about community. And when your community know where you're at, that's where your people come from.** [It's like] the old saying about a village raising a child. A village also can save a child."

Outreach workers have developed numerous strategies for building trust and establishing relationships with high-risk individuals. First, outreach workers often come from the communities they serve and thus can empathize with PWID through lived experience. This gives them the credibility and community buy-in necessary to develop trust among PWID. Second, outreach workers utilize street-level strategies such as following up with PWID, treating them with compassion, and delivering consistent services. Third, outreach workers and health professionals meet individuals where they are at, both philosophically and physically.

I. Applying Lived Experience

To establish credible relationships and empathize at an individual level, outreach workers often draw on their own lived experience with substance use. Many outreach workers either have personal experience with substance use or have been raised in environments where substance use was prevalent. Faye grew up in the Bay Area with a family history of alcohol use and mental illness. She started using speed at the age of 13 and began volunteering at a needle exchange when one of her friends started using heroin. Harry, an outreach worker, similarly became involved in harm reduction "because [he] grew up around drugs and drug users." While not all harm reduction organizations are peer programs, outreach workers often describe shared backgrounds as an advantage on the streets. Alex finds that hiring PWLE can be "powerful" because clients can find shared understanding with street-level workers like case managers, social workers, and nurses. When Alex connects with his clients, he has the "privilege" to honor how they feel with "some commonality." He explains:

> "**The beautiful thing about harm reduction is that I can do things that I couldn't do if I was working in a clinical setting**. If I was a therapist, it would be harder for me to self disclose. If I had a client who said, 'I'm really upset. I just found out I'm positive for hepatitis C,' **I have the ability to build trust** in the way that I could say, 'Oh, when I

> was diagnosed with hepatitis C, I actually was on MAVYRET and it went really well. It wasn't a death sentence, it's not the same as it was years ago.'"

Furthermore, many outreach workers are closely integrated with the communities they serve, allowing them to foster strong relationships with PWID. Akbar used heroin for 20 years and at one point had "cases in every county in the Bay Area." After completing rehabilitation, Akbar has dedicated the past 30 years to working with PWID and the black community in San Francisco. Like Alex, he explains that his own lived experience makes him more sympathetic to others in similar positions, saying "I love heroin addicts. I always did like them because I understood them a lot more." Akbar feels strong ownership over his tight-knit community in San Francisco, emphasizing that "you just don't walk into something you don't know nothing about it. It takes another person with that experience to do it." Since members of the community know Akbar as "the person that helped people," his work life becomes closed entwined with his personal life. For instance, Akbar might listen to someone's life story at the grocery story or invite people for a drive after a funeral. Johnson echoes this sentiment, emphasizing that they are constantly working with their community and collaborating with churches, schools, the police, and social workers. He explains, "We listen to everybody, and if they know that there's a place they can send their folks, they'll go, and they send them to us." Having lived experience and a deep connection with the community makes it easier for outreach workers to understand their clients, ultimately enabling PWID to access the care they require.

II. Signaling on the Street

While it can be beneficial for outreach workers to have lived experience, harm reduction strategies for building trust extend far beyond shared circumstances. On the street, outreach workers demonstrate dedication, consistency, and compassion towards PWID to signal that they

are trustworthy. First, PWID often recognize harm reduction as an inherently risky profession, which gives outreach workers credibility on the street. Before harm reduction programs were legalized in San Francisco, many volunteer groups took direct action without funding or permission from the city. Guydish recounts his experiences conducting street outreach at an underground SSP during the HIV/AIDS epidemic. He found that PWID often appreciated their efforts to help despite facing stigma and the risk of arrest, which established an understanding between the two groups:

> "They knew that we were taking some risks because **here we were, handing out needles, which was technically illegal**…**And we were there all the time.** And you get to know people, and they get to know you, and they get to know the service and what it's like. And so then they come and then they tell their friends, so **that trust was quite important. Maybe the most important thing**."

Furthermore, outreach organizations build trust by delivering reliable services and demonstrating accountability. For Derek, forming a relationship on the street is like building trust with anyone else; it demands "honesty," "transparency," and "consistency." This means constantly following up with clients and revisiting care plans. Guydish emphasizes that, when he was volunteering at an SSP, they were always there at the day and time scheduled. Importantly, the services were "anonymous," "friendly," and "reliable." Kabella explains that building trust is just "having a consistent place to go to that we can meet people every week."

By showing compassion and treating PWID as humans, respondents can build trust with a heavily stigmatized population. Akbar explains that it is "hard to talk to people if you don't know them, or allow them to be who they are." As a result, he tries to "treat people how [he] was raised." For instance, if Akbar sees a "brother" walking down the street, he gives them a ride. On the street, Brandon approaches PWID with a relaxed demeanor and open body language, paying special attention to asking questions and managing expectations. He emphasizes that PWID are susceptible to fear and stigma, which makes them skilled at discerning other people's intentions.

He notes that, for them, "it's a survival tactic to be able to read people quickly [and ask questions like] 'Is this person going to harm me? Is this person a cop?'" Brandon elaborates:

> "**People can feel your current energetically.** That's something that I've been teaching people that I supervise…just have a relaxed, open demeanor with people. **They'll pick up on it before you even say word one.** And then be careful about what you say. That it's respectful, and that you're honoring the autonomy of the person you're talking to. **Don't ever try to push an agenda on people, it doesn't work, and it actually creates the very problem that you're trying to avoid.**"

In addition to individual strategies at the street level, compassion and humanity can be built into harm reduction programs. Faye, who conducted research and interviewed PWID at the TLC, found that the drop-in center fostered feelings of safety and humanity. According to Faye, many PWID felt that the TLC provided "privacy" and "respite from the street." They could be safe in the event of an overdose and did not have to worry about children walking by, being arrested, or getting asked to move along. Faye noted that the TLC made "people [feel] like they were treated like a person, instead of a problem, which is how people often feel on the streets of San Francisco." Besides programs and supplies, the TLC also provided music, karaoke, and an art group, which Faye thought were "really valuable" in making PWID feel welcome. These measures can be effective in fostering strong communities and destigmatizing substance use.

III. "Meeting People Where They're At"

Respondents can build trust by "meeting people where they're at," a common principle of harm reduction that can materialize in different ways. One strategy for this approach involves tailoring interventions to individuals and recognizing that substance use can look different depending on the situation; as a result, there is no one-size-fits-all solution that should be universally applied. For Kabella, listening to a client's needs and being attuned to their method of use is important to building community. Kabella emphasizes the importance of not

"infringing" on people's space and letting clients go at their own pace. Since different people need different things, outreach workers cannot "push" supplies like naloxone on an individual who might want something else, like a new syringe. Johnson believes that this idea can be applied to substance use treatment. Rather than forcing someone to follow harm reduction or abstinence, clients should be allowed to choose for themselves. Johnson explains:

> "**Our position is that we need harm reduction must as much as we need abstinence**...**It shouldn't be that we're all here having a philosophical argument about which approach is right.** We should make that available to the individual, instead of making that decision for them. That's the issue that we're having right now, with people in African American communities. **'Everybody's telling us what we need, and they're not listening to what we want.'**"

Alex finds that addressing individual situations requires patience and establishing trust can take time. He once spent several months relationship building before the client even agreed to begin hepatitis C treatment. In the end, "none of that was wasted time, because ultimately, he got his hepatitis cured." Depending on the individual, Alex observes that timelines can be even longer, highlighting that treatment often becomes "nonlinear" if the person is reinfected or needs to pause treatment.

For many health professionals, addressing individual needs also involves physically meeting people where they are, or community-based care. By lowering barriers to access, workers are able to treat PWID in a safe, comfortable environment. Substance use is known to disproportionately affect vulnerable populations like unhoused people, and as a result, individuals who need care the most often lack the means to access it (Regis, 2020). Research has found that care at home, in which health professionals visit a patient's home rather than having them come in for treatment, yields greater customer satisfaction and similar health outcomes to inpatient care, at a similar or lower cost (Shepperd, 2009). Tierney believes that care at home should be applied to harm reduction practices and substance use treatment. During the

HIV/AIDS epidemic, Tierney would deliver primary healthcare services by going into the tents of PWID living in Golden Gate Park. These marginalized individuals often lacked sufficient financial and housing security. Today, he is involved in the Care at Home Program at UCSF, which treats individuals who have basic mobility issues and cannot come into systems of care by either going to homes in-person or making remote visits. He explains:

> "How can we get to people who need our help? **Care at home makes a great deal of sense.** The old doctors' home visits, those make a great deal of sense. **But a lot of people have invested in hospitals**, and equipment, and they want to return on their investment."

Like Tierney, Ethan practices meeting people where they are by providing care at their site of residence. He finds that PWID often struggle with logistical tasks like navigating clinic schedules, making appointments, and picking up supplies from pharmacies, where many face stigma. At methadone clinics, clients are required to follow strict regulations, including drug screens and counseling. Furthermore, clinics are typically located in areas with highly concentrated drug use, a stressful environment for individuals who are trying to avoid drugs. Ethan finds that delivering medications eliminates many of these barriers. In addition to dropping off supplies, Ethan consistently meets with patients to assess the progress of the plan and make any necessary adjustments. He explains that visits can be as brief as 5-10 minutes and as long as 30-60 minutes, depending on the individual's needs. To provide healthcare access to vulnerable populations who lack trust in and access to traditional healthcare systems, health professionals can practice care at home.

Like the nature of harm reduction itself, harm reduction principles are adaptable and can be interpreted in a number of ways. Addressing individual needs and providing personalized care for PWID enable outreach workers and health professionals to cultivate trust within a heavily stigmatized and underserved population.

Policy Recommendations

This section contains several policy recommendations for reducing stigma, supporting the harm reduction workforce, and addressing the opioid crisis at large. Short-term solutions include legalizing SISs and increasing funding for harm reduction organizations. In the long term, I propose destigmatizing substance use by educating the public and amplifying the voices of outreach workers in policymaking processes. Finally, I note that policymakers should take a holistic view of the opioid crisis by confronting root causes of substance use, including homelessness, mass incarceration, and economic insecurity.

Short-Term Solutions

I. Legalizing Supervised Injection Sites

To reduce overdose deaths in San Francisco with evidence-based treatment, policymakers should legalize SISs by rolling out pilot programs and closely tracking outcomes. The intervention has already been tested in San Francisco, with research on the TLC revealing that staff managed to reverse 100 percent of the 333 overdoses that occurred in the center's 46 weeks of operation (Suen, 2023). International studies have shown that SISs effectively promote safe and accessible injections, enhance access to healthcare, and reduce overdose rates without increasing drug use in the areas they occupy (Potier, 2014; Marshall, 2011; Stoltz, 2007; Kerr, 2006). Similarly, a study in New York found no significant increases in recorded crimes or 911 calls in the neighborhoods where the SISs are located (Chalfin, 2023). The science shows that SISs are effective in reducing overdose deaths.

Against widespread fentanyl use, SISs emerge as an effective, short-term solution for mitigating the crisis. Policies should be adjusted to reflect changes in opioids and usage patterns,

and fentanyl's high potency has lethal implications for users ("Fentanyl Facts," 2024). For Charles, "[policymakers] haven't been successful in being flexible, or being aware of the drivers and the way that people use." He explains that individuals often use fentanyl alone, rendering naloxone useless. By contrast, people typically use heroin in pairs or groups, which means they can administer naloxone in the event of an overdose. Furthermore, Charles emphasizes that fentanyl is often laced with cocaine, amphetamines, and other stimulants. In users who do not built up a fentanyl tolerance, the risk for death can be extremely high. He believes that the most effective way to address these issues is establishing SISs where PWID can be monitored for overdoses, at least until researchers can find a longer term solution.

In terms of SIS implementation, policymakers should pilot small, decentralized sites that contain high levels of PWID supervision. This would allow each SIS to cater to the needs of individuals. Derek views the TLC as a "wonderful attempt" that was "the beginning of the blueprints of how we do things now." However, he notes that since the TLC was open to all unhoused individuals, people with different needs would utilize its services. This became an issue for visitors who did not participate in substance use and wished to avoid rooms where supervised injection was taking place. Derek believes that with "mini TLCs all over the city," organizations could "design them accordingly" so that a site in the Tenderloin might look different from one in the Sunset District. Furthermore, Derek emphasizes the importance of establishing connections with visitors and giving them enough time to practice safely. Since the TLC was only open from 8 a.m. to 7 p.m., PWID would come and go within a day; by the next week, many forgot about the services they were connected to. As a result, Derek recommends turning SISs into 20-bed facilities. Allowing PWID to stay for 72 hours would give them more time to engage in safe practices and get set up with services before returning to the streets.

II. Funding Outreach Work and Measuring Success

By allocating funding to the outreach workforce, policymakers can support program expansion and address burnout and staff turnover. Alex advocates for increased private and public funding towards harm reduction organizations. He explains that funding is not just necessary to pay for supplies, but also to run harm reduction programs such as medicated assisted treatment, HIV and hepatitis C treatment, and housing services. Alex believes that "harm reduction is all these things." Funding not only covers supplies and services but also supports staffing and project management, potentially reducing work-related stress. Alex elaborates:

> "A lot of what I've seen, especially [with] smaller harm reduction programs…it's like, oh shit, **we're just trying to get boxes and supplies to send to smaller organizations**, because they don't even have anything to give to their clients. And it's like, oh my God, **we need the funding, because we can't even pay our staff. So it's funding to just be able to exist.**" (Alex)

While increased funding can yield numerous benefits, it is necessary to recognize that funding can give rise to misaligned incentives between outreach organizations and the government. As a result, policymakers should be careful about how they measure success for harm reduction outcomes. Gina finds that harm reduction in San Francisco is unique because it is "very competitive" and workers "take a lot of ownership over the services they provide." With everyone trying to meet their deliverables and the government demanding outcomes-based quantitative results for funding, she finds that incentives become distorted:

> "**Harm reduction was never supposed to be this big public health endeavor. It was grassroots.** It was like, 'I'm gonna give you supplies without tracking anything, because I don't want to track anything.' And so, when it's being funded by city department, state departments, **all of a sudden, they're like, 'We need numbers.' And it's very results-oriented**." (Gina)

However, without proper tracking and measures of success, funds may not effectively reach the PWID they are meant to support. Directing public funding toward harm reduction can encourage more organizations to brand themselves as harm reduction programs, even if they are

not. Given the multiplicity of harm reduction and its interpretations, this can make it difficult for policymakers to distinguish which programs qualify for funding. Brandon notices that, as more funding started becoming available for harm reduction programs, "nonprofit organizations would change their mission statement to be more harm reduction-y, in hopes of capturing some of those dollars." Akbar, who runs an abstinence-based treatment program, echoes this sentiment. He explains that PDEC receives less funding than harm reduction organizations because "if you want to get a contract with [the Department of Public Health], you had to adopt a harm reduction model." Ultimately, misaligned incentives pose challenges for governments in deciding how to distribute public funding. An audit of California's homelessness programs revealed that despite the allocation of $24 billion in funding, there is no consistent collection of outcome data and a lack of transparency at all levels of these programs ("Audit finds California," 2024).

To reconcile the difficulty of measuring harm reduction outcomes with the need for transparency, policymakers should test qualitative approaches to program evaluation. Studies have shown that nonprofits often struggle under accountability pressures (Liket, 2014). At the same time, research has found that case study method approaches to homelessness are effective in accounting for broader socio-political and economic contexts in addition to quantitative outcomes (Pauly, 2014). By adopting a broader, holistic approach to assessing outcomes, policymakers can evaluate programs while taking away blame from programs and individuals for systemic failures (Pauly, 2014). Furthermore, policymakers need to have open negotiations with nonprofits to clarify evaluation objectives, program designs, and methods for measuring success. Finally, transparency and communication shed light on the outcomes of harm reduction, easing some of the uncertainty about what harm reduction is. It can also highlight areas that require additional funding and ensure that funds reach the PWID they are supposed to.

Long-Term Solutions

Stigma remains at the core of why organizations lack access to funding streams and workers suffer so much burnout. In the long term, policymakers can eliminate these prejudices and stereotypes through targeted education programs and increased PWLE representation in decision making. Education is the most commonly used approach for reducing public stigma and preventing the spread of misinformation (Roe, 2014). Research indicates that education programs targeting mental illness related stigma can significantly alter attitudes and behavioral intentions, with the effect of contact-based education being twice as strong (Roe, 2014). Contact-based education, in which students interact with a person that has a mental illness, has also been found to destigmatize substance use disorders among medical students (Mort, 2021). Similarly, educational interventions in schools about HIV/AIDS and stigma can decrease HIV-related stigma and help normalize HIV (Jacobi, 2020). In addition to courses, panels, and increased exposure to PWID, interventions can be as minor as altering the language used to discuss substance use. Research has found that the difference between referring to an individual as "a substance abuser" versus "having a substance use disorder" may lead people to perceive PWID as a "greater social threat" and "more deserving of punishment" (Kelly, 2010).

At UCSF, Tierney hopes to improve substance use treatment in nursing education. He explains that "prevention is something that nurses have always carried forward at all levels" and as a result, "there's a lot of potential for for input from [his] profession." Education on harm reduction can also translate to advocacy. Tierney urges nurses and other health professionals to write letters to the editor that promote the legalization of harm reduction programs like SISs. By reducing stigma and contradicting stereotypes about PWID, education programs for both the general public and healthcare workers can improve healthcare outcomes (Roe, 2014).

To reduce misconceptions about substance use, it is important to amplify the voices of outreach workers and PWLE in policymaking. Alex emphasizes that hiring policymakers with experience in harm reduction can be powerful not just at the micro level, which includes frontline service and case management, but also the mezzo and macro level as well. He is inspired by Heather Lusk, the Executive Director of the Hawai'i Health & Harm Reduction Center. Lusk holds MSW and LCSW degrees and has advocated for harm reduction-based public health approaches for over 30 years. Under her leadership and perspective, Lusk has grown harm reduction in Hawaii to include a number of policy initiatives, including SSPs, hepatitis C counseling, homeless outreach, and the operation of a medical clinic. Furthermore, many outreach workers are PWLE who have gone through substance use, addiction, and treatment themselves; these valuable insights that would allow them to properly advocate for PWID.

Finally, to destigmatize substance use and connect PWID to the care they need, policymakers must address the social determinants of health that lead people to substance use, such as homelessness, mental health, mass incarceration, and social isolation. For instance, levels of substance use are significantly greater among the homeless population compared to the general population (Kemp, 2006). Faye believes that substance use on the street can help people survive day-to-day. She explains, "If you're living on the street, you're trying to make unsafe living situation feel safe. And drugs can really help." Similarly, Ethan notes that mental health and substance use are "interconnected" and have to be addressed together. Charles, who has worked on housing initiatives in San Francisco, explains:

> "**The biggest need is more. More shelter, more non-hungry children, more permanent housing, more transitional housing**…So that's the number one thing for homeless policy. And then having diverse housing stock that meets the needs of each individual. So some clean and sober housing some place some housing where people can use in the common room, they need all sorts of different types of services that meet the need." (Charles)

To address the opioid epidemic at large, policymakers must take a holistic approach to the social determinants of health that intersect with substance use. Without addressing these root causes, the cycle of addiction will never end.

Conclusion

Faced with a growing fentanyl crisis and record-breaking overdose deaths, San Francisco's harm reduction workforce is determined to connect PWID to the care they need. Conversations at the street level reveal that deep-rooted stigma against PWID can manifest in San Francisco politics, healthcare systems, and criminal justice approaches. To work around these barriers, outreach workers and health professionals utilize interpersonal strategies to establish trust and cultivate community among vulnerable populations. Still, these are only temporary solutions. As politicians divert funding away from harm reduction, outreach workers suffer occupational burnout and PWID lack proper access to care.

Amid this public health crisis, policy emerges as a catalyst for change and a determinant for the future of harm reduction. First, to reduce overdose deaths, policymakers should pilot small, specialized SISs that cater to individual needs. With lessons learned from the TLC center, harm reduction workers would be well-prepared to design and tackle the project. Second, more funding should be allocated towards the harm reduction workforce to support staff and maintain initiatives. However, these funds should be tracked with both quantitative and qualitative measures, such as the case study method; this would ensure that funds are properly accounted for without incentivizing outreach organizations to manipulate statistics or grow overly competitive. Third, in the long term, policymakers should aim to destigmatize substance use through educating the public and amplifying voices of outreach workers. While addressing stigma lowers

barriers for PWID and improves health outcomes, it is not enough. To address the opioid crisis and understand why individuals use, policymakers need to target the root causes of substance use. Approaching substance use in the context of economic insecurity, homelessness, mass incarceration, and mental health will allow policymakers to confront the opioid crisis from all angles.

While this paper aims to illuminate the experiences of harm reduction workers, it is by no means comprehensive. Limitations of the study include the types of participants interviewed. Most outreach workers and health professionals have worked in harm reduction or addiction medicine for over a decade. Given their experience in the field and confidence in discussing it, there was likely voluntary response bias in my sampling of respondents. Additionally, since many respondents have dedicated their lives to harm reduction, they were likely biased in their support of it. Furthermore, contact was mainly achieved through snowballing outreach; respondents might have recommended colleagues with aligned perspectives. Again, this may contribute to biased results. Future studies could sample outreach workers at all levels of experience within organizations to see if their perspectives differ.

In addition, a direct comparison of harm reduction approaches to abstinence-based treatment would be a valuable area for further research. Conversations with outreach workers at abstinence-based organizations like PDEC revealed that rehabilitation and treatment programs have undergone numerous changes in the last few decades. While these findings are out of the scope of this paper, especially since only two respondents from were interviewed, it would be interesting to conduct a full qualitative study with this workforce. This would allow policymakers to compare and contrast the experiences of abstinence-based workers with harm reduction workers, revealing the goals, benefits, and drawbacks of each approach. Findings may

also suggest ways of integrating the two approaches, allowing them to support PWID together instead of separately competing for public funds.

Ultimately, this study reveals that in order to understand the practice of harm reduction, we must learn from the workers who embody it.

Appendix A

Note: University of California San Francisco (UCSF)

*Note: * represents pseudonym*

Health Professionals and Researchers	
Matt Tierney	Clinical Professor, UCSF School of Nursing; Medical Director, Inpatient Substance Use Management at UCSF Health
Morgan Philbin	Associate Professor, UCSF; Associate Director, Benioff Homelessness and Housing Initiative
Danielle Kabella	Opioid Industry Documents Archive (OIDA) Postdoctoral Fellow, UCSF
Joseph Guydish	Professor of Medicine and Health Policy, UCSF
Ivy*	Academic
Charles*	Physician, Academic
Ethan*	Clinical Pharmacist
Outreach Workers	
Alex*	Manager, Outreach Organization
Brandon*	Manager, Outreach Organization
Derek*	Manager, Outreach Organization
Faye*	Manager, Outreach Organization
Gina*	Manager, Outreach Organization
Harry*	Outreach worker
Cedric Akbar	Co-Founder, Executive Director, Positive Directions Equals Change
Cregg Johnson	Co-Founder, Positive Directions Equals Change; Director, TRP Academy

Appendix B

Background:

- Tell me about your work…
    - Follow-up: What led you to this field?
    - Follow-up: Can you elaborate on X experience?
- In your current role, what does your day-to-day look like?
- What are some of the greatest challenges that you face in your work?

Tenderloin:

- For those who work in the Tenderloin…
    - How did you come to work in the Tenderloin?
    - How would you describe the neighborhood?
- For those who do not work in the Tenderloin…
    - What reputation do you think the Tenderloin has?
    - What is your impression of the Tenderloin?
- Do you think initiatives that work in the Tenderloin or San Francisco could be applied in other areas of the country, and vice-versa?

Harm Reduction:

- How do you define harm reduction?
- What do you think of harm reduction initiatives in San Francisco?
    - Follow-up: Have you been involved in any?
    - Follow-up: If so, what was the impact on the community?
- Are there any stigma or public perception challenges around harm reduction initiatives?
    - Follow-up: How do you navigate these challenges?
- How do you build trust with individuals who need treatment?
- How does drug use intersect with other components (i.e. houselessness, gender, race, etc.)?
- What keeps you motivated in your role?

Policy:

- What policies do you want to see from San Francisco policymakers?
    - Follow-up: What has been working, and what hasn't been working?
    - Follow-up: Why do you think it's this way?
- What do you think are challenges to implementing harm reduction policies?
- Is there anything else you'd like to add or any question that I should have asked you?

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