Harm Reduction in All Directions: Supporting the Workforce

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CENTER FOR COMMUNITY-ENGAGED DRUG EDUCATION, EPIDEMIOLOGY, AND RESEARCH

UNIVERSITY of WASHINGTON

Zoom logistics

- Zoom webinar, not meeting
- Only hosts and presenters can share their screen and audio
- Enter questions into the chat and Q&A
- Be curious and respectful

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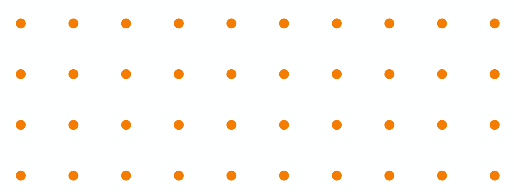
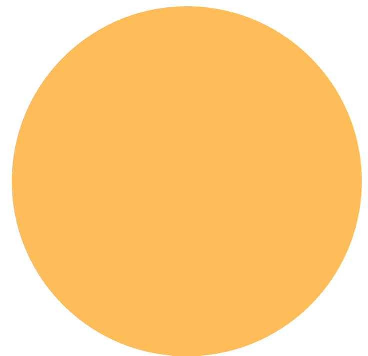


While substantive resources have been invested in the SUD care continuum to address the opioid crisis, little has been invested in the substance use workforce.

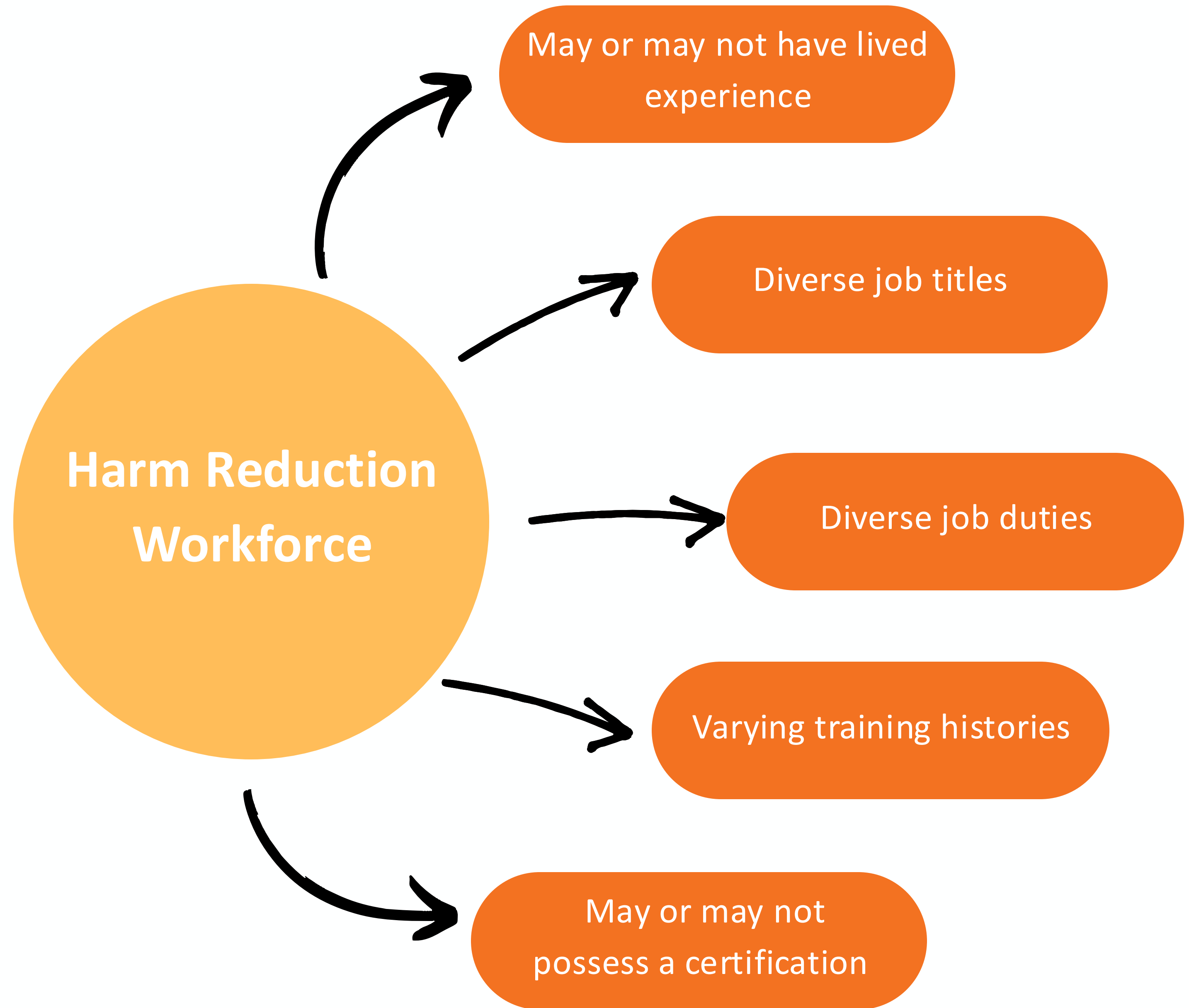
And the number of SUD professionals has not kept pace with the demand for services.



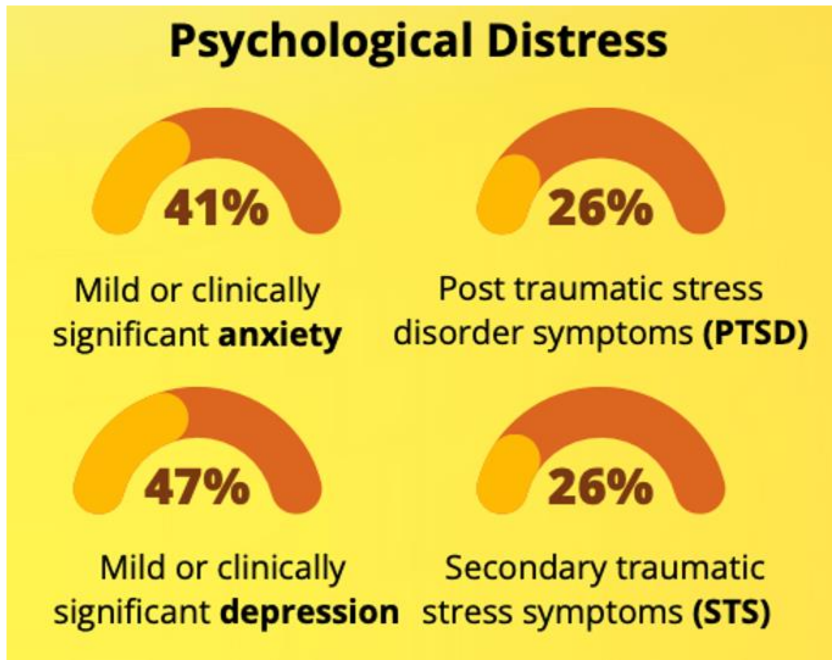
Harm Reduction Workers

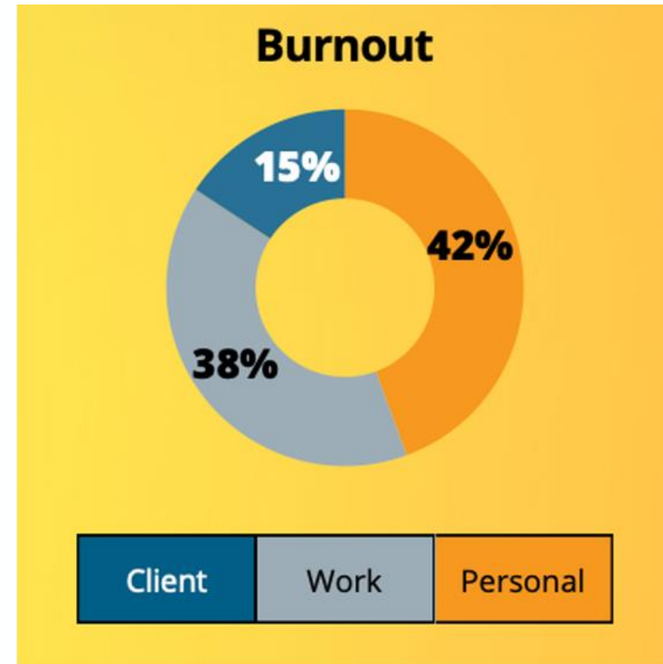
- Street outreach
- Overdose prevention
- HR supply distribution
- Psychosocial support
- Linkage to resources

The Harm Reduction Workforce is occupationally diverse.

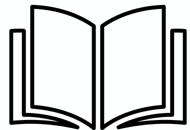


Harm Reductionists have high levels of psychological distress & burnout



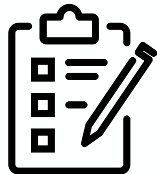


We wanted to also understand the drivers of occupational stress and burnout

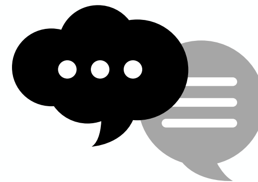


Literature review

In-depth interviews

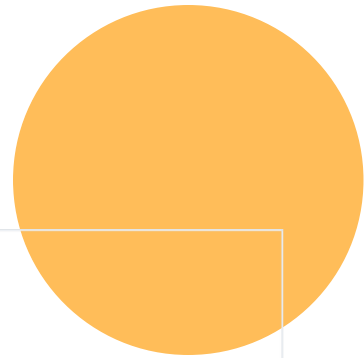


Surveys



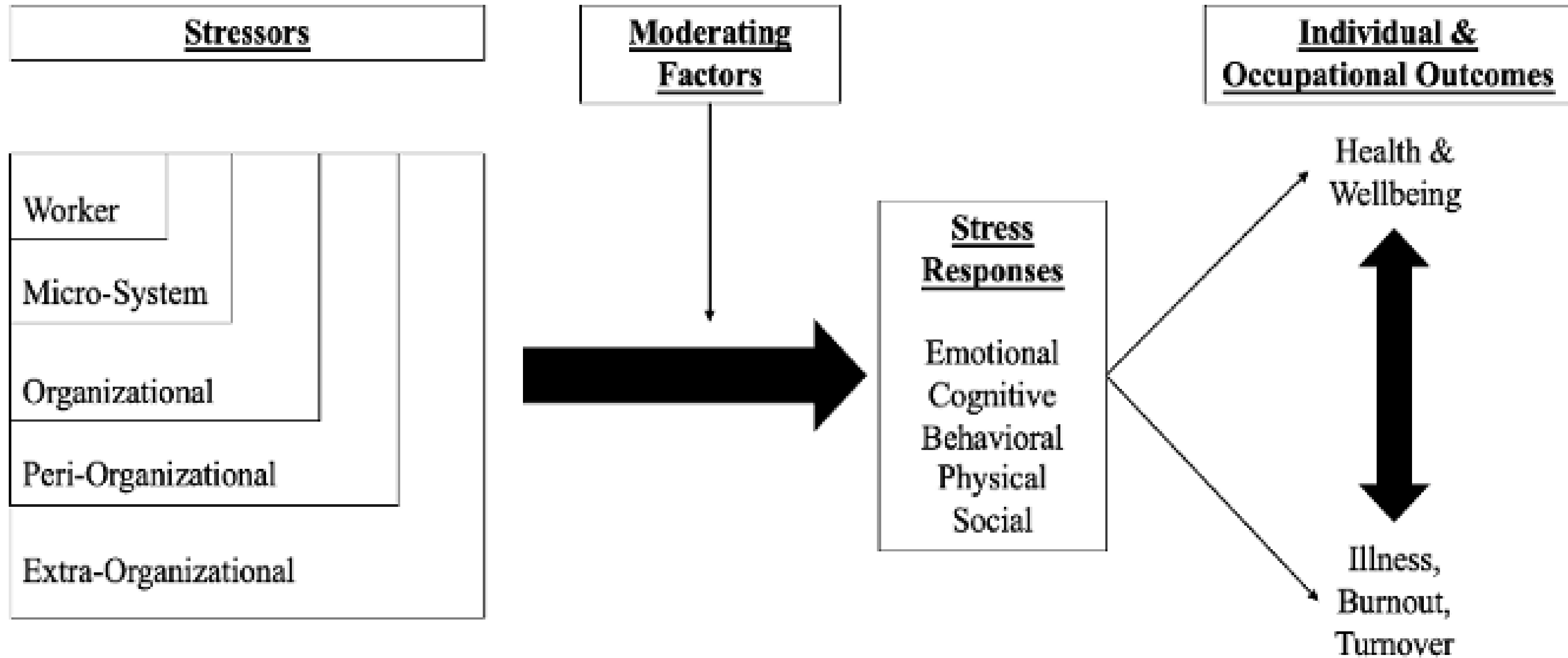
Informal conversations with community-based partners

Occupational Stressors



opposition scarcity
prejudice policies focus community
insufficient health underappreciated
boundaries living lived
stigma secondary conflict workload enforcement
illegal life experience limited understaffed
relational job labor
numbers personal trauma intense funding
interpersonal overlap organizational
insecurity support safety emotional resources
discrimination professional hazards environment
ideology law pay turnover criminalization
supplies abstinence-only

The Revised Ecological Model of Occupational Stress



Individual-level Stressors

Emotional strain, compassion fatigue

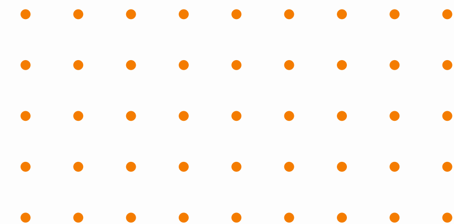
Challenges maintaining boundaries

Moral injury

Lived experience pressures

Secondary & vicarious trauma

Recovery-related challenges



High workload

Limited coworker support

Trauma exposure in the field

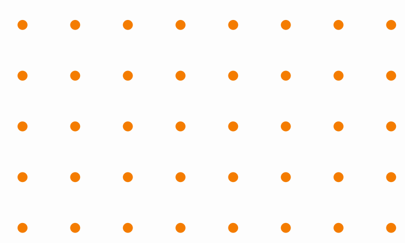
Unsafe or unpredictable work environments

Role ambiguity

Client aggression/conflict

Lack of control over daily work

Health & safety hazards



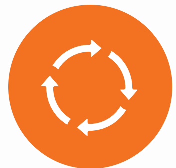
Organizational Stressors

Inadequate training

Expectation of unpaid labor

Job pressure

Administrative burdens


Under staffing, turnover

Insufficient compensation & benefits, pay inequities

Unsupportive leadership

Tokenism

Peri-Organizational Stressors

HR supply shortages

Community opposition toward HR

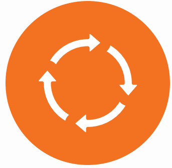
Funding scarecity

Workforce shortages

Stigma & hostility toward PWUD

Competition among orgs

Law enforcement presence & practices


Changes in drug supply

Punitive drug policies, criminalization

Gaps in healthcare & social safety nets

Structural vulnerabilites

Restrictive legal & political environments

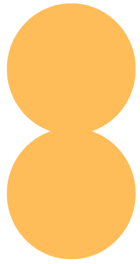
Abstinence-only ideology

Lack of recognition of HRWs as essential

Individual worker	• Lived/living experience with drug use and recovery • Secondary trauma • Intense workload • Emotional labor • Relational boundaries • Overlap of personal and professional lives • Health and safety hazards
Interpersonal	• Interpersonal conflict with co-workers or colleagues in the field • Limited supervisor support • Lack of appreciation from management
Organizational	• Understaffed • Job insecurity • Insufficient pay • Focus on the number of clients reached • Turnover of executive leadership • Changes in organizational policies
Community	• Stigma, prejudice, and discrimination toward PWUD • Scarcity of harm reduction and ancillary resources • Short-term, cyclical nature of funding environment • Local law enforcement
Socio-structural	• Illegal status of harm reduction • Community opposition toward harm reduction • Criminalization of people who use drugs • Intersectional issues • Abstinence-only ideology

What resonates?

What's missing?



THANK YOU!

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Harm Reduction in All Directions

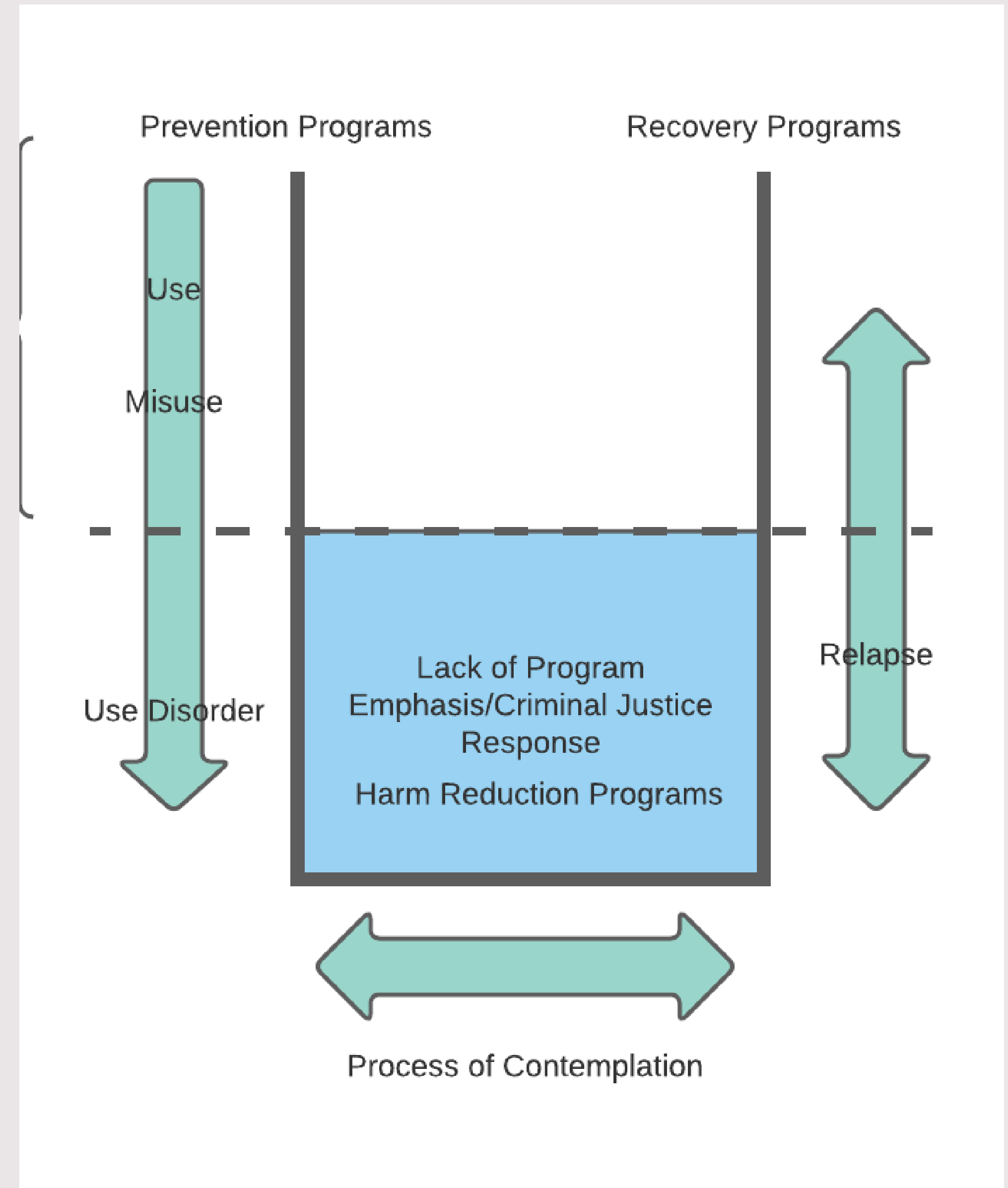
ADAI Webinar: Supporting the Workforce

Everett Maroon, MPH, Executive Director, Blue Mountain Heart to Heart

March 31, 2026

Where the Work Happens

- In the last decade and more, public funding around opioid crisis response has prioritized prevention programs and recovery programs, with health insurance as the mechanism for much of the treatment space.
- This has de-prioritized people who use substances and who may not be interested in reducing or stopping their use.
- These are often the same people who due to stigma, also don't access traditional health care providers.



Models of Care in Rural Areas for Stigmatized Populations

- Medication-Assisted Treatment Models
- Behavioral Therapy Models
- Harm Reduction Models
- Care Delivery Models
- Peer-Based Recovery Support Models
- Prevention Models
- Mobile Health Models

Source: https://www.ruralhealthinfo.org/toolkits/substance-abuse/2/program-models

What Harm Reduction Does

1. It prevents the spread of blood borne pathogens. Not just HIV, but including HIV and hepatitis C, among others.
2. It reduces morbidity among people who inject drugs by providing clean needles and other supplies like alcohol wipes and Epsom salts. We see fewer infections—cellulitis, MRSA, for example—fewer amputations, fewer incidents of vein collapse, less tissue damage.
3. It reduces mortality associated with opioid overdose in part because exchangers learn to test their dope, because they tend to use less once they are in these programs, and because increasingly SSPs give out naloxone to reverse overdose.
4. It increases the likelihood that the exchanger will get into recovery and attempt sobriety.

SEP Best Practices List.xlsx

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	A	B
1		
2	**Service Activities – Best Practice**	**Description**
25	1.4.4 Safe syringe disposal	
26	1.4.5 Encouraging return of used syringes	
27	1.4.6 Promotion of secondary exchange	
28	**1.5** Provision of IDU Materials (no limit, one for each syringe provided)	
29	1.5.1 Sharps Containers	Provide when syringes are distribut
30	1.5.2 Alcohol wipes	Prevent HIV-related (and maybe H
31	1.5.3 Cookers (single use)	To discourage re-use: can transmit
32	1.5.4 Antibiotic Ointment Packets	
33	1.5.5 Tourniquets	Prevent risks associated with re-use
34	1.5.6 Cotton filter bags (pore width 0.22 µm)	Can transmit HCV and cause deep
35	1.5.7 Epsom salt bags	
36	1.5.8 Bandages	
37	1.5.9 Water (~2 mL)	Can transmit HCV (less important
38	1.5.10 Saline	
39	1.5.11 Acidifiers (citric acid or ascorbic acid)	Prevent use of lemon juice and vin
40	1.5.11 Gloves	
41	1.5.12 Glass stems, mouth pieces, and brass screens	To prevent possiblility of transmiss
42	1.5.13 Don't provide bleach and disinfecting materials	Haven't been shown to protect agai
43		
44	*2. SEP Staff/Client Interaction*	
45	**2.1** Greeting	
46	2.1.1 Nonverbal cues	(such as...)
47	2.1.2 Signage	
48	**2.2** Trust building	
49	2.2.1 Non-judgemental service delivery	Don't pass judgement on client cho
50	2.2.2 Client advocacy with police	
51	2.2.3 Informal counseling	Attentive interaction – "actively an
52	2.2.4 Friendly conversation	
53	2.2.5 Combatting stigma	(what does this entail?)
54	**2.3** Exchanger Anonymity	
55	2.3.1 Privacy of site/facilities	
56	2.3.2 Bags for transport of items from SEP site	
57	2.3.3 Confidential identifiers for each exchanger	
58	2.3.4 Assurance that client information will not be shared by SEP worker	

How Harm Reduction Works

- **Harm reduction is a set of practical strategies and ideas aimed at reducing the negative consequences associated with drug use.**
- **These strategies are translated into practices at the program level, and based on the body of evidence that identifies which practices work well ("best practices") and which do not.**
- **Harm reduction strategies work best when predicated on an individual community's needs and population.**

BMHTH's Approach to SSPs

1. Warm Greeting—de-medicalize what is essentially a medical supplies transaction
2. Needs-Based Exchange, with limit (500)—focus on choice of supplies
3. Friendly Data Collection—capture as much as participants are comfortable, every encounter
4. Be Ready to Explain—the whys and hows behind each item
5. Staff and Exchanger Safety—touch syringes as little as possible, use precautions, PPE, bloodborne pathogen protocols
6. Ask about Other Needs—injection-related materials, health of body, need for referrals, antibody tests, vaccines, mental health, etc.
7. Naloxone Determination—for themselves or those they know
8. Genuine Goodbye—finish with a request to see us again
9. Follow-up after Encounter—connect to care coordinator, clinic team, as appropriate

Syringe Services Program

- Co-location with supplemental services:
- Wound care clinic
- Low-Barrier buprenorphine
- Contingency management
- Vaccination program (shingles, tetanus, hepatitis B, influenza, COVID-19)
- Naloxone/overdose reversal program
- Plan B
- Nicotine cessation kits
- Safer smoking kits
- Drug checking service
- Limited food pantry
- 8,000+ people served annually
- 3 fixed sites, 1 mobile SSP, 1 mobile clinic

Considerations for Harm Reduction Workers

- Staff may receive vicarious trauma from participants
- Staff may also have lived experience
- Staff may be financially fragile
- Staff may rely on volunteer help
- Staff may face hostility from the community
- Staff may be more subject to program cuts than other employees

Supporting Staff

- Strong employer-sponsored health insurance
  - Ensuring recovery treatment, mental health sessions, acupuncture, physical therapy, and therapeutic massage coverage
  - Extensions of coverage made by BMHTH general fund
- Generous time off, 160 hours of PTO, plus 11 holidays
- Peer coaching program
  - Monthly meetups with assigned colleague to read books, discuss goals, provide fresh ideas
  - $25 monthly incentive for participating staff
  - Initial training on active listening and coaching

If Staff Relapse

- Health events do not necessitate punitive responses
  - Relapses that do not involve work (clients, colleagues, facilities) are not actionable
- All individuals seeking treatment for SUD are covered by ADA protections
- HR should refer to accommodations protections; supervisors should listen and support

More Considerations

- Harm reduction staff are often the first representatives of your organization people meet
- Harm reduction work is skilled labor and should be compensated as such
- Work environments that are unsafe demean staff and participants
- Ensure open communication to identify challenges early

Final Reminders

- We are not saviors, fixers, or heroes. We help people remember their own value, and we walk with them on their journey.
- The work relies on us but is not about us.
- Everyone deserves to be safe and happy.
- Harm reduction tactics are all around us if we look for them!

Contact

- Everett Maroon, MPH
- Executive Director
- Blue Mountain Heart to Heart
- e.maroon@bmh2h.org
- 509-529-4744

Questions?

Resources

- Guide to Developing and Managing Syringe Access Programs, Harm Reduction Coalition
- Addressing staff burnout and community grief in harm reduction settings, AIDS United
- Coping with Overdose Fatalities: Tools for Public Health Workers, Massachusetts Dept of Public Health
- Hacks for Harm Reduction Policies, Procedures, and Programs, and Hacks for Preventing Escalation, Harm Reduction TA Center