Hearing from the Helpers

A podcast from the Northwest ATTC
Hosted by Mitch Doig
https://attcnetwork.org/northwest-helpers

Episode 3: Commitment to Connection with Evan Burke

Mitch Doig:

Welcome back to Hearing from the Helpers. If you were here last episode, you already know why we're here. If you're here for the first time, each episode of the show, you'll hear me, Mitch Doig, talking to somebody about what excites, challenges, and has guided them through their journey as a helper. My hope is that you are someone who is curious about joining the behavioral health field. If you are, this is the general nudge that you need to take that from a curiosity to a plan, because honestly, I had no idea what it meant to help, but I knew I always wanted to do so. I'd use words like psychiatrist, therapists, psychologists, and counselor as a way to say, "I think I could listen to people and help them." Fortunately, I found my way into the field by complete accident and it's been 15 years.

I still have a really big love for this field and I want to see if there's anything that might work to bring more people into it. If this podcast reaches at least one person who has been curious about what becoming a helper is and one of the people I talk to inspires you to start that journey, this is a win. In 2012, I moved to Portland, Oregon and was set to begin work in an opioid treatment program. This program was one of the few in the area providing counseling services, as well as medication for opioid use disorders. Unfortunately, stigma also exists within providers just as much as it does in the rest of our society. I distinctly remember choosing not to share with my colleagues where I was going because of the concern I had for their reactions. I shared this huge change in my life with a coworker one night in my final days work into the only treatment program I had ever known.

He turned to me with the biggest grin and said, "Man, that's where the real work is happening. I'm excited for you." My friend was from San Francisco. He told me that his parents were early patients of the Haight Ashbury Clinics in San Francisco, and to him, programs like the one I was going to work at saved lives, saved the lives of his parents and even played an important part in his own recovery. He shared all of these stories of mutual aid programs assisting in syringe exchanges, wound care, and other services that can drastically improve the quality of life of those who need it. I remember leaving that conversation knowing that what I was leaving to do was important regardless of the perceptions I was worried about before. I enthusiastically told the rest of my colleagues. When met with less than positive reactions, I felt suddenly

empowered to share about the true impact of these services, my reasons for wanting to help, and had hoped one day that they would be on board too.

Since then, in the treatment and recovery community, harm reduction has been increasing in favorability and access has expanded. While it is true that there's still some hesitation to embrace harm reduction, people like today's guests are doing so much to show communities that harm reduction saves lives and improves communities. When I was reaching out to people asking, "Hey. Who do you think I should talk to about harm reduction?" I heard enthusiastically, "Oh, you need to talk to Evan. He's doing great things." Now that I've talked with him, I can definitely agree. Like each guest we've talked to in this series, his career pathway has been unique from his first steps into the world of behavioral health up to his current position at the Idaho Harm Reduction Project. It's incredible to see the ways in which those working with harm reduction embody the practice from the smallest actions, such as word choice, to the biggest goals such as impacting policy itself. Found it incredibly hard to stop talking to him about his work, his ideas, and his life story, and I'm really excited to share it with you today.

Evan Burke:

Get into it, but much of my work experience before actually doing harm reduction professionally was actually on a locked adolescent acute psych unit.

Mitch Doig:

Really?

Evan Burke:

Yeah. Before that, I was actually, for a couple years, on what.... I don't know if there's actually other programs like this, but it was called a CEEP, a Counseling Enriched Education Program. It was almost like an IOP school, but as tucked onto the public school district for kids. It's like a branch of special education specifically for kids with behavioral health diagnoses. I did that as a paraprofessional for a couple years and then worked on adolescent acute psych for four years after that, both on the floor doing fairly similar milieu supervision kind of stuff, but then also ended up moving into other elements of that program as well.

Mitch Doig:

How'd you get into that?

Evan Burke:

Yeah, definitely. Kind of for the money actually too. This was all back in San Francisco, by the way, which is where I'm from. I had been working as an afterschool program leader at an elementary school and was really broke doing just that. It was 30 hours a week, so it's not even benefited kind of thing.

Mitch Doig:

Probably stipend almost in terms of payment.

Evan Burke:

That's right. Really in that pay range for sure. I started working as a para at the school that I was, like the afterschool teacher at, just to stack that and piece together in sufficient employment. Once I was working for the school district, I could see the other jobs that would

pop up at all the schools throughout the school district, which was a million of them. Because talked about retention in fields, retaining people in public school district, but especially people who work in the behavioral health slice of the public school system, is just like a meat grinder. At least in San Francisco, it was. You'd go on and you'd see every school in the district had para jobs open, and some of them paid more than others. I didn't even know what it was, but I was like, "Huh, what's this SOAR thing?" The SOAR program was special ed specifically for kids with behavioral health diagnoses, and a lot of them with pretty intense externalized behaviors in classroom environment.

But I was like, "That's $2 more an hour. $20 an hour sounds pretty good." I started doing that and just really liked it. I enjoyed working with the older kids. I love hanging with the little guys. When I was at elementary school, I was mostly with third through fifth graders. That's a treat, it's super fun and sweet, but I think I was able to just connect on a different level with the more middle to high school range. You just chat a little easier. I think, also, it connected a little more personally to what was, for me, a very difficult time in life. I found it a cool way to be helpful, which I enjoyed that, and enjoyed being helpful in a new way and getting to use different skills. I was there for almost two years, I think.

That program was actually housed in a hospital, technically. It was like a medical center and then there's a behavioral health building, and one floor of the behavioral health building was actually the day program, day treatment counseling program school thing that I worked at. On the floor above that was the inpatient acute unit that I ended up working on. You would have the clinical staff were actually hospital staff therapists, and there was an NP and a psychiatrist. There was a clinical director that was from the hospital behavioral health, and then there was the academic director who was a principal, a special ed principal from the school district. The behavioral health person just plucked me. They poached me from the program and offered me a job that paid a lot more than the school district did and was also just a really cool growth opportunity in just a million ways. It happened to coincide with a time in my life where I had a really significant change in what my capacity would be to be helpful and to be a functional responsible human in the space.

It'll be part of what I talked about in terms of how I ended up doing the work that I do, but I was a drug user for a long time. While working with children in schools and that whole thing, and so I happened to get offered that job in the hospital right after I'd gotten out of the treatment program, and where I'd had some abstinence going, and was starting to get my footing a little bit, and was able to show up on time to work and answer emails, and do all sorts of things that humans can do when they're not basically dysregulated 100% of the time. I was able to really dive into that opportunity and make it something pretty cool.

Mitch Doig:

What was it that appealed workwise? I know you were mentioning this stability you found in your life and all of those things, and I want to come back to it, but what was it that appealed more about the... If there was anything about the job that appealed more about the inpatient unit itself?

Evan Burke:

Yeah. I think there were definitely some things beyond the quality of life improvements that I got as a result of being in that position. I think to speak to your point about underemployment, I think part of what... I came through this experience of experiencing a life of pretty wildly fluctuating periods of low functionality and high functionality and somewhere in between, where I couldn't ever really perform consistently at anything really. I would have periods of pretty high

achievement, whether I get academically or whatever, and then just go off the rails. I think part of what happened is when that stabilized for me in my life and I was still doing this sort of para thing, which was fun, but I think it wasn't sufficiently stimulating, I think, for me anymore. It was enjoyable and I felt helpful, and also I felt... I definitely felt attention and perhaps even opportunities for resentment at times, at feeling like I know I can be effective in this situation, but it's not my role to do so.

Certainly, at the time, feeling also like I see people... When things like de-escalation is something that I've just become a really significant part of all of my work since then, basically, but a situation in which I'm very comfortable and navigating that with someone, and seeing people ramp clients up unnecessarily. I think feeling like, "I really wish I could be the one having this interaction right now, but it's not my role, so I got to step back and watch things get worse." That sounds a little judgmental, but I think that definitely, at the time, I think that's part of how I was feeling, is like, "Man, I can actually starting to notice that I had some capacity for some of these things," and wanting the opportunity to... Noticing that I could be helpful, all of which was a fairly new experience. What the job on the inpatient unit presented was a lot more responsibility and a lot more autonomy, responsibility, and the opportunity to exercise a pretty diverse array of skills and also to gain new ones.

There were things I had to do in that role that much of it I had just never done before or that I was doing and what felt like a much more a higher pressure environment in certain ways in acute psych. A big part of my role, for example, was I was the intake coordinator for the unit. The unit didn't have an intake department, it was just me. What that ended up looking like is a lot of... We would be getting in dozens of patient referrals over the fax. We killed a forest probably at that place, but just 40-page patient charts coming through from emergency departments and crisis stabilization units all over California actually, the whole state. It was like the primary part of my job was actually reviewing those and then presenting them, having conversations with the doctors about the patient's appropriateness for the unit.

That was a huge jump for me in terms of responsibility and also the ability to actually engage my brain critically, and also for my assessment to matter and to have these collaborative conversations with people who I certainly, at that time, felt... I felt an incredible amount of imposter syndrome as well, navigating this wild off the charts, because all of a sudden, I'm having these one-on-ones with physicians, who I could feel it in my body, the difference in our social standing. It was still so internalized for me at that time that I'm social inferior to this person. I have less value in society. But over time, you just have these interactions with them over years where I'm like every day I'm having conversations with the doctors and getting asked my opinion about whether or not what's the acuity of the unit right now? Is this a reasonable admission given this, this, and this? Also, being able to actually think critically and have my perspective valued was pretty cool.

Mitch Doig:

It's fun hearing. I feel like there's going to be a lot of me relating to you over the course of our conversation today. It's cool hearing you say part of what that experience you had as a para was, one, not being challenged enough, but two, the challenge coming from saying, "Hey, we're doing this wrong. We could actually help in a different way and I know the way," but also, again that role clarity. It's this weird thing of not being able to really change the system or change other people's behavior. I've definitely been there, in those moments of if you just keep bombarding somebody with questions, they're going to get more upset. What if we just listened for a little bit? All of those frustrations. Neat hearing once you're put in this position of being

able to be challenged, your opinions start to, one, matter, but also it's interesting. It's engaging and all of those things. I'm just curious, has that imposter syndrome ever gone away?

Evan Burke:

Not really. I don't think it ever will. I do think it's a good thing. As I continue to grow as a human, I continue to seek more opportunities for growth and seek to challenge myself. What that usually ends up meaning is my discomfort manifested imposter syndrome in those situations a lot of the time. It can feel like the natural next thing, like going back to school or accepting a role that has... With the harm reduction project, that puts me in a position of significant leadership at the organization and doing stuff like that, and then all the time thinking, one, I'm having ideas that are good ideas that I think are helpful and will be effective. Also, why would anyone listen to me?

Mitch Doig:

Well, it's funny. Not to be too on the nose with it, but I'm almost hearing you're constantly balancing risk versus reward, and I know that that's a part of harm reduction itself. But you're really like, "Well, I could have this impact. Also, what if I make a mistake?" All of those things an imposter syndrome brings.

Evan Burke:

Definitely.

Mitch Doig:

Could I share something? You might already know this, but one of the things that really bothers me, I'm also somebody that imposter syndrome has been something... Honestly, over the last year, I have a really great supervisor. She's really helped me think a little bit differently about imposter syndrome. But way before I met her, she shared or somebody else had shared a study where people who have imposter syndrome actually tend to do better jobs than people who don't. That popped into my head because you were like, "It'll probably never go away, and I do all of these things." I feel like part of it is that self-critical nature of like, "Oh, I need to do a little bit better." It's that drive that gets you to be the person that's like, "Oh, yeah. I'll take the challenge. I'll start looking at these charts and explaining to a doctor why I think this person will be a good fit for the milieu or maybe need a different care," or so on so forth. I think that that's probably why you're good at what you do too.

Evan Burke:

That's really interesting to hear that. I like that reframe and I think that does dovetail with something maybe I hadn't connected with the imposter syndrome dimension, but something I like to think of as a value, but it's just like a... You can call it just trying to avoid overconfidence, something like that, but just being wary of any sense of certainty in my position, being so sure that I'm right that I start to not engage with other people's ideas. I think that if I'm definitely pretty consistently reminding myself of my fallibility, and so that, I think, maybe the imposter syndrome does help with that, helps me maybe ask more questions and be a little less willing to just charge ahead.

Mitch Doig:

Well, I'm almost hearing you describe humility. You have to be humble in order to do probably what you do, but also to have that... The phrase that comes to mind is beginner's mind, where you're just like, "Nope. I'm in that state of curiosity and learning continually almost."

Evan Burke:

Yeah, I would identify with that, at that.

Mitch Doig:

There's been an interesting thread as I've had these conversations with different people where, and I didn't expect this at the outset and it's caused me to reflect a little bit more on myself, but I've been hearing almost everybody I've talked to mentioned that this is a field where you get constant feedback. You get constant skill growth, and that's not something that I think whenever I pictured what it would be like to have a nine-to-five job, for example, I imagine going and sitting myself at the desk, colorless filter basically over my life of just like, "This is meaningless." But also, that's not what I've heard people describe about behavioral health.

There's these moments of, "Man, I messed up and I get that moment of growth." Or, "I did really, really well and somebody got helped by the benefit," or, "I got offered this position at the floor above," and all of those things. If it's okay to touch on, I know you had mentioned there's obviously this lived experience element to your work now then. How did you end up going into harm reduction? I don't know if that's taking a step back into lived experience mode to get there or what's the best way to tell that story about how did you end up where you are now?

Evan Burke:

Yeah, it definitely would involve the fact that I was a person who was using drugs. It was not something I had been involved with before I at least started trying to adjust my relationship with drugs. What I would say is I was actually not super familiar with. I had heard of syringe exchanges. I'd heard of some of the local organizations around the city that offered those services, but I had not made use of them. But what it really actually how it just started was I had gone through a treatment program and was connected to 12-step communities in San Francisco. I'm taking that recovery approach for a long time.

Mitch Doig:

That recovery approach like abstinence only?

Evan Burke:

Abstinence, yeah. Abstinence-based recovery primarily through... The 12-step community in San Francisco, there's a really strong AA community. AA is all sorts of interesting regional variations and stuff, but in San Francisco, everyone in AA did drugs, it felt like. That worked for me.

Mitch Doig:

As opposed to with there being an NA pathway, you're just saying it's not Alcohol Anonymous. It's just like a 12-step that we are all going to an AA meeting.

Evan Burke:

Exactly, right. I make that distinction because there are places where... Traditionally, there's a reason why NA came into existence. They didn't come out at the same time. It's hard to

imagine. Super common these days, but historically, people who use drugs were not necessarily made to feel super welcome in AA room, and either had to avoid actually speaking specifically about that experience or just not talk about it in order to practice the program in that way. It was tricky. I think, for folks, it sounds like. But that was not my experience. I'd gone through a treatment program. I was doing the meetings thing and stuff as part of a 12-step community in San Francisco. A really big part of that was getting involved in service of all sorts. It's really heavily emphasized in that community.

I think also part of what I experienced by getting involved, as I underwent my recovery and healing process, was also I was a person who I think largely didn't really have a sense of... I had very little insight into my internal emotional experience and I didn't really have a sense of having values. I didn't have a sense of having values and trying to live in alignment with them and stuff like that. It was not something that really was a thing in my life. I think as my brain was starting to rewire itself a little bit, probably, and I was getting it together a bit, and also just had the head space and the time for reflection and stuff, started to learn that, "Oh, there are things that matter to me. What are the things that bring me joy or make me feel more connected? Connection, a thing that matters.

How do I feel more connected? What's a way that, for me, is a meaningful way to share time and space with others, and also to have a sense of value as a human in space?" There's a 12-step community being involved in that, being helpful there, but also I was like, "What does this look like in other areas of my life?" I had way too much time on my hands because I was on a leave of absence from work for a little bit, and so I finished my treatment program, have all this time on my hands, and so I start volunteering actually at Glide memorial, is the organization in San Francisco. It's like a big nonprofit that is associated with a church technically, but it's a really radical non-denominational, but not non-denominational Christian Church in the sense that people usually mean.

It's technically part of the United Methodist Church. It's sort of a faith community, but not really. It's like a radical nonprofit organization. It has shelter beds, pro bono legal services, a harm reduction organization, a meals program. I just started filling my time by volunteering there, but not actually in the harm reduction program initially. It was actually in the meal program a bunch, and then eventually, in the harm reduction program. That's a really long way of saying how I got there.

Mitch Doig:

I'm almost imagining this place being in a typical movie where they were like, imagine church helping the houseless population. That's what I'm picturing this as. It's just everything, like one-stop shop, all of the things that you need to support a community basically.

Evan Burke:

It is, and it doesn't really feel like a faith community. It doesn't feel like a church. There is a church there, but frankly for me, if it had felt like really intense like faith community, I probably wouldn't have worked for me.

Mitch Doig:

Yeah. It was curiosity that got you to make that jump. What's the harm reduction program doing? Or is the meal to the harm reduction part a jump?

Evan Burke:

Yeah. Well, I think actually when I first started volunteering there and I heard about the harm reduction thing, I wanted to do that, but they were pretty discerning about who they would let volunteer actually. I had started volunteering with the kitchen and had only been coming around for a little while, and also hadn't told anyone what my background was. They didn't know that, "I used to buy drugs right around the corner from here." But I can't remember exactly how I ended it playing out. But not long after I started volunteering there in the kitchen, I went and talked to them. I think I heard about what they were doing being around there, and just that they were doing outreach work and were doing Walking Street outreaches and stuff. I just thought that sounded really dope.

As I just learned a little bit more about it, it was really clear to me that this is... This was obviously a lot of clarity. This is a good thing. I think at that time too, it felt really important to me, as someone who's trying to figure out who they are and trying to be a helpful person who doesn't necessarily have a sense of... I didn't necessarily have that image of myself as someone who was that way. It was very helpful to feel clarity around, "Oh, they're definitely doing a good thing." I can just go be there and I'll be doing a good thing. That was enough and that felt really good. Also, just very quickly getting involved there, I was surrounded by people with shared experience. Whether it was the staff there, which was primarily made up of people with lived experience, or just outreach and being out in the community. For probably three hours a week, sometimes six hours a week, just out there on street outreaches, just chatting with folks and handing out supplies and just talking to people in the community.

It's also the opportunity to identify that that was something I'm good at too. I can engage people in the community, and just I can chat with strangers and have nice warm interactions with random people. It feels good and I'm met with good energy. I think it all just felt really good. From a pretty selfish perspective in terms of what it did, it was really about what it did for me initially at that time, but that's how I initially got involved, and I just stayed involved for many years as other parts of my life started to change, but I got super interested in it intellectually as well.

I read a lot about harm reduction and was also... I was at that, even after I got this more serious job and the other parts of my life started to fill in and get a lot busier and to have more responsibilities in other spaces, I never really fell off. That was always like no matter what else was happening, I was at Glide most of the time, twice a week for street outreach for almost five years. It was my favorite thing in my life, regardless of what else is going on.

Mitch Doig:

It sucks that this is going to be an audio-only thing, because it's really fun to see you light up as you talk about... I'm hearing you almost stumble into your like, "Oh my God, this is my calling. It's being with people who have similar experiences. It's connecting with people through my experience. It's being out there." I think it says a lot that your life gets busy and you still spend two days a week doing this. This is my own preconceived notion, and I know San Francisco is probably maybe a different place and setting for this. One of the people in my background is really important to me. He comes from the Bay Area, and he told me that needle exchange started in San Francisco mainly because there was... When needle exchange started, it wasn't legal, number one, but two, you weren't able to go do it as an outreach service. It was people had to bring their syringes in for exchange their syringes in for exchange. And I heard a story of a gentleman coming from, I think the term is shooting gallery, a house where a lot of people are using injectable drugs, with a garbage bag full of syringes on a public bus. And it led to the city being like, nope, it's okay. We'll drive them. Outreach is okay. You can bring syringes wherever you want now. And I think again, what a pragmatic view. And long, roundabout way of saying I

know that typically, or for a while, it's taken a little bit for one, the recovery community but also just our society to really embrace harm reduction. Was there anything that felt odd to you, I guess, stepping into that world as somebody who was seemingly in an early recovery space, did it all click instantly? Was there anything that kind of felt off at first or...

Evan Burke:

I would say that it kind of felt like it clicked right away. I don't know why I would identify that as being the case, but it definitely did, I think. I don't remember really ever having any experience of like, ooh, this stuff is cool, but I don't know about that. And it was everything from the earliest days, you'd be on outreach. I just give this as an example of something that I think that some people would hear and it would give them that reaction. It's like you'd be out on outreach and a young pregnant person would get syringes from us. For me then and still now, from a certain perspective, harm reduction feels really simple. And if you boil it down, you know what? I'm going to kind of reframe this.

Mitch Doig:

Yeah.

Evan Burke:

I feel pretty familiar with the experience of choosing between bad choices. I'm going to choose the least bad thing. That was not a difficult idea for me to connect with then or now. And I think that that is just what my brain connected harm reduction to from the jump, which is just what's the least bad thing here? People click. I know personally, I know just in terms of the literature, people are going to use drugs and they don't stop when people tell them to stop typically. And if that's the case, accepting that as the premise for the work that I'm doing and the reality in which I'm operating, what's the least bad thing here? And so it was not hard for me to just go with that and accept, perfectly happy to think of a world in which this is not as much of an issue, but that's not the world and I'm well aware. And so I think there's a lot of clarity that came with that.

And I think also the feeling of you can't, both from my experience and also just so many people I love who are also people who have used drugs and people who have died because of their experience using drugs. People are going to do what they're going to do. And they generally don't make adjustments because I want them to or because all the people in their life who care about them want them to. And so responding to that reality, I felt like there was so much clarity about, yeah, if someone's going to do this, what's their alternative? And would I ever want them to have to do that? Would I ever want someone to have to reuse a needle when they don't have to? Someone who's carrying a future human life, why would I ever want them to subject themselves to a greater degree of suffering and potential physical harm, whether they're pregnant or not? But obviously you think about that could be... Someone thinks like, oh, a pregnant person using drugs, that can't possibly offer them something that could enable that behavior.

And I think the clarity to understand that that's not what's happening here. What's happening is the behavior is occurring and you can play a small part in the process that hopefully reduces some of the risk and the suffering associated with that person's life in a really small way. And it's a significant thing.

Mitch Doig:

It's one of those things that I think I shared with you in a call before we started today. I had mentioned to you that for me, I really quickly move to try to intellectualize harm reduction. Because I'm like, why are we arguing about death prevention? It's kind of where my brain goes instantly. And I like that you pulled in, there's an emotional part of this though that I think we can't really jump over. At the end of the day, this is about caring and giving just a little bit more choice to something that I don't think people realize, especially, I'm going to add, especially people who haven't maybe had as much contact with what addiction does to a life, how much choice doesn't seem to be there. The story you're telling me, I'm imagining, again, this pregnant person who's getting a clean needle, for example. If they just stop, there's a high probability that the body that they're carrying doesn't come to full, they're not able to deliver that baby.

That's a reality for heroin use. It really is. And granted, you could do some sort of opioid substitution and things of that nature, but also if that's not part of the decision-making tree, why close the door on that person? And I love that you're saying, why don't we just open doors, welcome people into maybe a slightly healthier life if they choose to do so. And it's interesting to me that there tends to be an argument about people saying, well, you're enabling use. And it's like, the use is going to occur whether or not that I'm providing a clean needle is really what you're saying. And I think that there's a lot of beauty to the way you're describing that and a lot of compassion to the way you're describing that. And it makes sense hearing you say now, no, this always made sense to me because I'm familiar choosing between two not so great things. And I think that your way of saying this is a lot nicer than me, for example, just saying, so we're going to argue about death prevention then, because that's where my head goes a lot.

Evan Burke:

I'm with that too though. I hear you on that.

Mitch Doig:

Yeah. Well, I mean there's a value to human life, right? And I think it's one of those things that it's a priceless value. And I think that's the hard thing is I think about the suffering. I don't know about you, but I know you had said that you've seen people die as a result of substance use. I've seen people who have lifelong heart issues as a result of using a needle that had bacteria in it, for example. And that's a preventable thing. And I think that we could argue about the legality of substance use, we could argue about all of those things. And at the same point, humans have been using some sort of substance for thousands and thousands and thousands of years. Maybe the substance has changed and the purpose has changed, but it's interesting, we've gotten to a place where it's like, you did this to yourself, enjoy all the health consequences is kind of our response.

Evan Burke:

Yeah, yeah. I understand that people's views on substance use are informed by their own experience and that the stigmatized perspectives don't arise out of a vacuum.

Mitch Doig:

Yeah.

Evan Burke:

But I do think that the perspective that you've expressed is all too common. And also it's startlingly calloused to me. It feels to me like it cannot withstand the actual experience of

another human being in front of you who is suffering, who you have the power to assist in some small way. And why can't withstand be, I feel like, the common sense arguments that are available in support of harm reduction. I feel like that's an important part of why I do what I do and why I like so much of my work is about talking to people about harm reduction, is I just feel like the arguments against, which are largely the arguments against the value of the lives of drug users, are just not good arguments. I think any arguments against the value of human life are probably not great. They don't have a lot to stand on. It feels to me like an exciting opportunity to have conversations with people who may hold those views because they just feel they're not sustainable. That perspective is not sustainable.

Mitch Doig:

Well, I appreciate too, you mentioning the word that's popping up in blasting red letters is as soon as you said that phrase though, you're like, this doesn't happen in a vacuum. Stigma does not happen in a vacuum, right? And I also think drug use doesn't happen in a vacuum. If we think about reasons people might use a substance, for some people it's recreation, but for some people it's to cover up pain or to get through those things. And I think if we go into the perspective that you could just say, just stop and suddenly that would fix problems. We're forgetting that maybe this is helping people forget an experience. Maybe it's helping provide a little dopamine that's not there. Maybe it's providing something that's just missing in somebody's life. Who knows? I think being houseless isn't easy.

Evan Burke:

Yeah.

Mitch Doig:

If you could do something that makes that a little easier, I get it. And I think that harm reduction provides a way for people to, again, it's not the best of both worlds, but it's a little bit bad of one of those worlds sometimes. And I guess a question that I'm curious about because this is, at least from my standpoint, a misconception that I see a lot of times where people will say harm reduction is kind of the waiting room for recovery. And I have a different view of that, but I'm just curious yours.

Evan Burke:

Yeah. I would also say I have a different view than that. I think that, sorry, excuse me. I think that harm reduction can be a way to facilitate greater agency in the determination of a relationship with drugs for people. And whether that's a greater degree of health while they navigate that, because nothing sets you down like being dangerously ill or just uncomfortable all the time. And in terms of trying to make adjustments in your life that promote greater wellness. And I also think that there's the conception that it's just an all or nothing proposition and that if you're still using drugs, you have experienced no overall increase in the wellness of your life. And that's why I kind of, hear me say wellness a lot. I kind of liked that term wellness, health. These are things that we can gain, piecemeal, that can be built and that people can exercise agency over and can construct lives that facilitate a greater degree of wellness rather than having to be abstinent to be okay, which is a really high bar. And this also is not the right fit for everybody necessarily. It's presumptuous to think that that is the right fit for everyone.

Mitch Doig:

Well, and I imagine too, again, going back to this concept of a life, we're living a value of life. There's this interesting spectrum where it's like, so you only value it if under these circumstances, but it's like maybe if you're not having to spend all day trying to find a substance, find safe ways to use the substance, get the money for the substance, suddenly maybe you can be with your family, do parts of your life that are enjoyable that aren't using substances or something like that. And it has less of an impact on you, the people around you, et cetera, right?

Evan Burke:

Exactly. Yeah, I completely agree with that. Yeah. And that's why I talk about medication assisted therapy a lot. In Idaho, don't talk so much about safe consumption sites necessarily and safe supply, but whether someone is still participating in the street drug supply, but they have access to entirely clean tools and Narcan and a supportive community that's committed to improving the safety of drug use, that life has the opportunity for a little bit more stability. And I'm really glad you brought it to relationships because I do think that's just the dimension that is not given sufficient attention when we talk about whether or not someone is doing okay or whether or not someone is meeting our standard for a person who has moved past substances or something like that, or I just think that if someone is able to be present and participate in the relationships that matters to them in their life and to be a loving accountable person in their life, it's hard for me to think that there should be a whole lot to say about it beyond that.

And that's why I do think about things from the perspective of when you think about harm, if a human is not causing harm as associated with their behavior, if they're very well potentially being a helpful, contributing human to the people around them and to their community, how much can we have to say about what they're up to? That's part of how I think about it as well. I think to be honest, I don't actually spend a lot of time thinking about, or even talking about the dimension of abstinence or addiction or just where people land on the drug consumption spectrum. I have a lot of conversations about the language people use to talk about that experience, but I don't necessarily find in my work conversations that center around the idea of the final destination, the final goal for someone who's engaging with our services to be, because it's something I get asked about a lot. And I don't actually find that to be particularly helpful or fruitful conversation, generally.

Mitch Doig:

When you say that, is it with people who are utilizing the services or is that in general you're like, I don't really get a lot of movement in that space basically?

Evan Burke:

I would say in general. In general. And I don't see the benefit for the people I am seeking to be of service to in having that conversation generally. What I should say is if participants, like our people come in and they want to talk to me about their drug use, I'm always there to be an active and empathic listener. But even then in those conversations, I try to mostly listen. And mostly listen and make sure they're aware of the tools, particularly actual practical tools that I may be able to offer as a representative of the harm reduction project. But I'm not there to be, and I'm not asked to be really ever by our participants to be a recovery counselor or anything like that. And the only input that I'll ever really have for people who are using drugs who talk to me about their drug use is doing the little bit that I can to encourage them to use more loving language when they talk about themselves. Or at least to not use any language that de-emphasizes their humanity and their value.

And so that's really the extent to which I engage with that material. But I should say, just the other night I was getting a harm reduction info session at College of Western Idaho, my community college out here. And definitely I was asked about this topic generally, and so I get asked about it frequently and I gave them kind of basically the answer I just gave you.

Mitch Doig:

It's funny hearing you mention if the people that I'm helping or providing service to talk about their drug use, which tells me too, harm reduction isn't so focused on drug use so much as that it's harms that might exist within an entire person's experience too. And you'd mentioned wellness earlier, and I think in some ways that went over my head where it's just like, we're not only talking about their substance use, we're talking about harms that this person may experience as a part of all of their experiences too.

Evan Burke:

Absolutely. Absolutely. And I think that's part of what harm reduction informed organizations, whether that's syringe service programs or if they are in some sort of recovery program, substance treatment program that is incorporating harm reduction principles into the services they offer. I do think that a really essential part of what harm reduction is about and what actual sort of brick and mortar harm reduction organizations are about is community and is just a space, regardless of what the outside world is offering and what the environment is like, whether we're talking San Francisco or Boise, Idaho, it's a space in which you'll be received with warmth and generosity and you will be communicated with respectfully and honestly and with love. And that is seeking to empower a person to live the healthiest life that they feel like living at that time. And so if that's getting supplies from the syringe service program, awesome. Absolutely. Or if that's kicking it at our office all afternoon because cold outside and we have snacks and computers, that's great.

I think it's just a little incubator of kindness and respect and an environment that is committed to the value of all human lives regardless of the behavior they happen to be engaged in. And there's not a lot of spaces like that, in my experience. And so for people who use drugs and especially people who use drugs, especially people who are experiencing homelessness who just sort of work to the margins, I think they can be pretty important places to have the opportunity to improve wellness in various areas. People come hang out with us, but the outreach came from we don't offer supportive housing services, but we certainly make sure that the folks who do come around, and that the folks who come talk to us are aware of how to get in touch with them and make sure that... An important part of my job is, as I see it, is being connected to... So much of the work I've done in my role with iHeart is just taking the responsibility of understanding the environment that my participants are living in and the service landscape out here, taking the responsibility of understanding that really seriously and making sure that anyone who is playing a role in potentially either offering services or in impacting the wellness of the lives of the participants are people that I want to know.

And are people who I think we ought to be in dialogue with. And so whether that's their awesome partners, our Path Home is a housing first organization out here in Boise that has an outreach team. It works really closely with us, and we do outreach with, they're really obvious, easy partners, right? We can go hit the streets together, it's great. Or it's probation and parole. 75% of the people in the corrections system out here are in there for some sort of drug related offense. And it's a very vulnerable population in a lot of ways, and one that is very easily, they're sequestered and easily forgotten and easily treated with little respect. And that is the thing that we view as unacceptable. And so even though as a harm reduction organization, we

may be prison abolitionists, and fundamentally it's in organizations. I think it's in our mission and values or something like that, that we're fundamentally committed to righting the wrongs of the racially informed drug war.

But also, I spent two hours with the district manager for probation and parole last Friday talking about how we can make sure that everyone who gets out of prison in Idaho has access to Narcan. And that's part of it too.

Mitch Doig:

And I think you're describing pragmatism, we could be abolitionists and also the system that we imagine doesn't exist yet. We do need to partner. We do need to have these conversations and be that voice of change. And this other thing that I'm hearing you describe though is it excites me. Because you're describing all these things that harm reduction is, I think, as a simple kind of way, in a really great approachable way. And one of the ways I always like to describe clinical work, at least my view of it, is my role is to try to remove shame that people carry with them because I think we know shame doesn't actually help behavior change. It actually hurts behavior change. There's a couple of fascinating studies that they've done where if you interview people about their substance use, the amount of shame, body language they show will show how likely it is for them to return to substance use and how severe that return will be.

Shame is a predictor, and you are describing how do we almost decrease the shame that people will have thrown onto them for their substance use, and how do we make sure that they're making decisions for themselves and not because everybody's like, how dare you? But instead, it's like, I don't really want this thing to happen to me anymore. Could I avoid that and could I have more positive experiences by doing this other thing? And it's funny almost hearing you say that harm reduction, this is kind of my way of reading, harm reduction's this internal conversation you're allowing people to have with themselves while you're having all these external conversations about like, "Hey, could you bring your services near where we are because people are coming and having just safe days with us? They're just coming and having a good day, getting coffee, getting snacks, being on the computer," all of those things. And if you could come by with your housing program just so they know you're available, that'd be cool. There's no pressure in either of those directions.

And I think that you're describing pragmatism as a community support element, and I think that's something that a lot of the health system's missing. Compliance doesn't work, but self-adherence really does work. If it's your plan, that might be a pretty good plan.

Evan Burke:

Yep. Yeah. And I would say harm reduction is, certainly in terms of harm reduction, syringe service programs for people who use drugs, I think are grounded in the idea of self-adherence. Really nothing is intended to be prescriptive. And some of this stuff is really top of mind right now given some of the conversations we've been having at work. But I mean, a way that I've been putting it lately when I have conversations with providers and there's other service providers in the community, when I meet with those folks, is just the responsibility of leveraging the resources, both material and in terms of access that we have in order to provide options that a stigmatized community is not likely to be able to comfortably access themselves always. I think that's an important part of it too.

Mitch Doig:

Well, it's hard to, because there is a systems change that has to occur for a lot of things. I know one of the topics that I know is a thing in Idaho, but it's kind of a thing in the entire region that the Northwest ATTC works with is I believe in all four states, fentanyl test strips. Well, actually it's federal. Fentanyl test strips are considered paraphernalia. It's illegal. And also the potential benefit to being able to provide those things is astronomical.

Evan Burke:

Yeah.

Mitch Doig:

And I think it's one of those, and I won't say that this is something you do, I don't know if it is, but I know of organizations that I'm aware of that find ways around those things because it's just like, do we want to sit and wait? And it's sucks that sometimes really well-meaning people have to assume the risk of being able to provide really good services. Even Narcan a couple years back for some places was like, you can't provide Narcan to people.

Evan Burke:

It's not uncontroversial still, I would say, in Idaho. The fentanyl test strips thing is a good example. In Idaho, not that maybe the logistics of this are important for this conversation, but in the context of services, fentanyl test strips for us as a syringe service program actually don't occupy a meaningfully different position than syringes do. It's all paraphernalia that we are allowed to distribute. We distribute fentanyl test strips legally.

Mitch Doig:

Oh, very cool.

Evan Burke:

Yeah, yeah. Now-

Mitch Doig:

They're utility though.

Evan Burke:

Like many other things... Yes, right? And like many other things we offer, as soon as they leave my hand and are into the hand of a presumed drug user, they're paraphernalia. And so it is not uncomplicated. And it also makes what we call secondary distribution really difficult. Because harm reduction, there's not a vast network of syringe service programs in Idaho. There's a few of them. And it's a largely rural state. And so it's pretty important for us to be able to have community partners that may not be a syringe service program, but that are down to have a supply that are well positioned to distribute supplies to people that we know need them. And so fentanyl test strips are a really good example. We have a ton of organizations around the state that do secondary distribution for Narcan. Everyone's cool with that pretty much. Fentanyl test strips though, because of their legal status, even though they are another really powerful tool that give people really important information to reduce their risk of overdose and to make adjustments and their behavior if they want to, organizations will be comfortable distributing Narcan, but not fentanyl test strips. That is a barrier that we definitely run into.

Mitch Doig:

Well, and it's hard too because I think a lot of organizations are faced with risk management at a certain end of the day.

Evan Burke:

Oh, for sure. Yeah.

Mitch Doig:

And I don't know, it's one of those things that, again, I hope we exist in that new world, the new paradigm that you're envisioning someday. And until then, those are the decisions. Something, if it's okay, I want to share just a little anecdote because there was a thing that you had said about if harm reduction is just somebody hanging around our office, getting snacks, staying warm all day, there's a value to that, both to that person, but also I think to the community as a whole.

Evan Burke:

Definitely.

Mitch Doig:

And one of the most impactful moments of my entire career was my clinical supervisor. One of my very first bosses, basically. One night he was at our program way too late. I worked till midnight at this place, and we just, yeah, fun swing shifts. He was hanging out outside in the parking lot and all of our clients are in bed. We'd had this experience where, because this is an abstinence only program, not a harm reduction program. And we'd had an experience where this person who'd accessed our services had come back for the third time. And maybe I think in that week I'd heard one of our clients had passed away, somebody else had a lapse. All of these things had happened. And I remember turning to him and saying, "Are we bad at our job?" And in that moment, he turned, he's like, "Why would you say that?" And I said, "Well," and I explained all the things I just told you.

And he said, "You're really overlooking the fact that for the last 90 days, this person had a warm bed, got three square meals, they've put weight back on that they haven't had on their body in quite some time. They put weight back on, that they haven't had on their body in quite some time. They went back to the doctors. Their family reconnected with them. He said something that really kind of blew me away. He's like, "It's highly possible that that person had never felt success in their entire life, until they completed this program." He's like, "You're overlooking how they feel about their successes. This isn't about you." I'm hearing you, as you're talking about harm reduction today, saying how much this isn't about Evan. I know you had said it's a little selfish because you felt so much connection. You're like, "Oh, this is what's meant for me." But at the end of the day, everything you're doing is for everybody else and for the community. I'm just curious, is that intentional, accidental? Where's that coming from? Because everything you're describing is for the other, almost as a disregard to you. I think that's the interesting thing about harm reduction. It's not cheap, providing a warm place, a computer. All that costs something, and you're still doing it.

Evan Burke:

Yeah. Thank you for sharing that anecdote. I really like that. I guess, from a personal perspective, I would say that you could trace it back to my initial experience, maybe, with

getting involved in harm reduction like, "Oh, this feels good. Connection, this is important." That has kind of grown into, I think, a core value for me. Some of it comes down to a personal sense of purpose. It's a little hard to articulate, maybe. I think it's kind of a tricky question.

Pretty front of mind, a lot of the time, I think, in my life, is the intention to be of maximum service to others, but especially to people who do not have enough people thinking that about them, do not have enough people trying their best, at least, which is what I would say I'm doing, trying my best to take a generous, warm, loving perspective towards these people. I would connect it in some ways, too, to my own personal process of healing and growth, in a way. I find that to be pretty consistently motivating. So, yeah. I don't know if this is materializing into anything particularly helpful as an answer, but...

Mitch Doig:

It's funny. I can buy you a little bit of time. Somebody told me this one time. They're like, "You just asked a fish, in water, what it's like to be wet," is really kind of what-

Evan Burke:

Yeah.

Mitch Doig:

... I just did.

Evan Burke:

That's funny. It's a good way to put it. Yeah. It's also weird, too. There's also something very flattering about the question, so-

Mitch Doig:

Wow.

Evan Burke:

... trying not to engage with that, but-

Mitch Doig:

That humble imposter is kind of seeping in a little bit.

Evan Burke:

Oh, yeah. It's definitely flaring a little bit and be like, "Yeah, yeah. Deflect, deflect." Maybe, a way to answer the question is also that I'm not consumed with this all the time. It doesn't keep me up at night. I am also a human who tries to have good work boundaries while also doing a thing, knowing, I think, that not having good work boundaries given this type of work that I want to do, will actually in the long run allow me to be less helpful to the people that I care about and who I want to be of service to.

I think, answering your question of why I am this way, there's a million different things. There's also just the fact that I'm pretty powerfully motivated. Don't think about it every day, but some people who are really dear to me, have died. Whether it's healthy or not, there's a certain amount I think, also, of a way that I can honor them and love them. Maybe, in certain ways I felt like I could have done better when we were all together, to demonstrate a commitment to

making sure that people who have shared our experience, or shared experiences like theirs, are loved. Love is a really cheesy, generic word. What I mean is, have people who are committed to making sure that they have the opportunity to live good lives and are from respect, and are seen and are given time to be people. That's almost visceral. I feel it in my body that that is important.

Mitch Doig:

There's a... I'm trying to remember. Franklin Reality Model. I don't know if you've ever heard this. The diagram, it looks like a window, with a little window pane in it, four quadrants. The idea is that there are four basic human needs. One of those is to be alive, which is the obvious one of those. Food, water, shelter, those are all combined. Third is variety. The last one on that window, and I think that it's what you're describing, is to be important, to feel important and have important people around you, or important things around you. You're kind of like, "I'm here to provide that." Maybe, not you're here to provide that, but that's something that you're doing. You're an important person. You might not feel important. Other people in the community might not have made you feel important. You're important to me. You're important to us, the community. You're still a human. Right?

Evan Burke:

I think I would definitely agree with that. I don't do it perfectly, but I do think that combining that with common sense, evidence-based service interventions, that are effective when utilized, is something that really works for me, it feels like. Maybe to go back, also, I use the word clarity a lot. There's still a part of me, that I'm just more comfortable. I have the experience of being a person. I've grown a lot through this. Once upon a time, didn't have a great sense of self-worth, didn't have a really clear sense of myself as being a good human. Not that I think about whether I'm a good human, or not a good human, anymore. You know what I mean?

I do think that I find something pretty powerful and grounding about just kind of positioning myself somewhere where I know that people are trying to do good work, and where I can see intellectually where something that can be effective is trying to be done. I can just go there and try to do my best, and position myself where my skills and my energy is going to be useful.

It's pretty simple, but it is kind of how I think about it, in certain ways. And, yeah. What I do now, I think this is the thing that works. I see people respond to it emotionally and in terms of their health. I think there's also health. The physical health of the community and society is really important to me. It's a human right that we ought to have access to, obviously, the fruits of society that can improve people's health. Being able to go to a place where people are trying to make that more available to people, who the society at large is not reaching effectively, who I also happen to have a very personal connection to, is how I think about it.

Mitch Doig:

This is something that's kind of kept popping up. You're like, "It's also evidence-based." I think the evidence-based, too, is on the individual, but it's also to the society at large.

Evan Burke:

Yes.

Mitch Doig:

You seem to come at this with a very humanistic kind of person-centered approach. There is this other thing that I think is worth mentioning. It actually saves everybody a lot of money and time, in the end. It's an amazing thing we overlook a lot of times.

Evan Burke:

Absolutely, and I talk about it all the time. And, yeah.

Mitch Doig:

Yeah.

Evan Burke:

That's the thing, too, I wouldn't feel this way about it if it wasn't something that was so effective. I think that's part of what allows for me to feel okay and just throw my weight against this. They're public health and behavioral health interventions that are shown to be overwhelmingly effective. Don't always feel particularly abundant. Yes. Resources are required. The resources are not inconceivable, that are required to make interventions that have a profound impact on the health of the individual, and the community, and the resource burden of the community.

Mitch Doig:

It's funny, too. I think this is the other kind of interesting thing where you can see where the values come from. If you talk about any other aspect of harm reduction that exists already, seat belts, brushing your teeth. I always go to brushing your teeth as one of those examples. We could just be like, "Okay. Everybody stop eating sugar. You need to make sure you're rinsing your mouth after anything goes in your mouth." We could go that approach if we really wanted to. Or, "Twice a day, you put some stuff from a tube onto a brush and rub it on your teeth." The health savings to that, all of those things. And, "Is it annoying?" And also, "Do I forget sometimes?" "Yeah. I make mistakes in that." I see the billboards that remind me to do it.

I think that it exists in a lot of other places. Public health being one of those. A lot of our health practices being those, and they work. I think the fun part is those are approached with a lot less scrutiny, a lot less stigma. There's no stigma around wearing a seatbelt, theoretically. In fact, probably there's stigma around not, if anything at this-

Evan Burke:

Yes.

Mitch Doig:

... point. When you start to normalize behavior as just something humans do, we feel differently about it. We remind people like, "Hey, wear your seatbelt, bud. Don't text while you drive," those simple things.

Evan Burke:

Yeah, yeah.

Mitch Doig:

Really quick. I know we kind of found our way. How did you end up moving from working with youth to harm reduction? I think we took this detour that I've loved, but also my brain started to

be like... Was it just like, "Oh, I'm enjoying doing this thing on my off time, so let's make it my on time?" Or, what happened there?

Evan Burke:

Yeah. It was definitely a certain degree of coincidence, there. I was working on an inpatient hospital unit, mental health, but inpatient hospital unit, during COVID. Nothing at work changed all that much, other than that it got a little harder. It certainly didn't stop. I was not working from home. It was just super, got to be one of those fun people who worked in a hospital during COVID. So, I was doing that and still volunteering in harm reduction. Now that being said, there was this period where we hit kind of early COVID, and I would say, max hysteria around COVID. I shouldn't say hysteria, but max public fear and contraction, and this max strength of public health intervention. So, everything's closed. So, even things like harm reduction outreach services, really that kind of stopped, or were really significantly limited. Obviously, it was pretty early in a pandemic. That's a high risk thing-

Mitch Doig:

Yeah.

Evan Burke:

... to be doing, potentially.

Mitch Doig:

Yeah. The fear, too. I had shared with you before, at the start of our call-

Evan Burke:

Yeah.

Mitch Doig:

... I was working in behavioral health at the start of COVID. I remember-

Evan Burke:

Yes.

Mitch Doig:

... one of the fears we would talk about is like, "Is my contact with one of the people we're helping potentially putting the other people I'm helping at harm?" That's a real fear.

Evan Burke:

Oh, absolutely. Especially when you talk about harm reduction, we're talking about a population that is... Immunocompromised people are overrepresented amongst this population, significantly. Anyway, all that's to say that I was still working in behavioral health with adolescents. For probably, the first, I don't know, almost year of COVID, or something like that, the harm reduction organization was not allowing any volunteers in, and really shut down pretty much all of their outreach services. It's kind of like a period where I wasn't able to be involved in that, which was really a bummer and definitely missed it a lot. It felt kind of different in my life,

not having it, in a way. Some of it's just choices made, in terms of adjustments I wanted to make in my personal and professional life.

I'd been in the same role with behavioral health unit for three plus years, something like that, by 2020, I believe. Combination of the stress of working in the hospital environment and I would say some of the stress that I felt, but also just the way the tone changed in that space. There was not a lot of levity in the hospital environment during COVID. People freaked, and obviously, it was getting kind of hard. I didn't really feel any more like I was growing in that position. I felt a little stagnant. I felt like I was still being helpful, but maybe in certain ways, also, I felt that I had grown and wanted a new opportunity. Also, I'm 30 years old now, which is not old, but it's also not exactly young. I think I was having more of the sense of wanting to either try something different, or have a clearer picture of what the course is going to be from here.

I don't have an advanced degree. I don't have MSW, or something like that. So, I don't have any sort of advanced degrees and certifications that really align with a long-term career path, necessarily. So, I think I also felt a little vulnerable, even, in my position. It's like, "I'm very helpful here. I'm compensated in a way that works for me, here. Also, I don't know if I would actually be able to find exactly this. I don't know the options I have in this space." That is a little nerve wracking, in a way. You want to be able to know that if the job isn't working for you, you're not proud.

A lot of people do experience the feeling of feeling kind of trapped in a job, and it doesn't feel good. That's kind of professional stuff. Also, part of what happened is, because of all of those things, I felt less attached to that job. My partner, who I'm with and who I've lived with out in San Francisco, was from Boise, Idaho. We'd come back here to visit her family, who's all out here, a number of times. We're like a year into COVID. She's a nurse also, also working in a hospital during COVID. I think both of us are feeling like, "Man, I think we're ready to maybe make a change here." San Francisco in the middle of COVID, don't really get to do the cool city things when the whole city is shut down, indefinitely. So, felt like making a change.

We moved from San Francisco to Boise. Actually, before we got to Boise, I was kind of doing some research. I didn't have a job lined up when we moved here. I was fortunate enough to have a little money saved and figure like, "I'm going to allow myself to navigate this slowly. I want to find a good fit and not put myself in a crappy position." So, we move out here.

One of the first things I did, when we decided we were going to move out here, is I tried to see what the deal was with harm reduction out here. It wasn't even, necessarily, actually professionally originally. I was kind of like, "I don't know if I actually want a job, yet. I'm going to try to actually, maybe, relax for just a sec here." So, I reached out to the Idaho Harm Reduction Project. You Google Harm Reduction, Idaho, not a lot of things come up. The Idaho Harm Reduction project does. I emailed them, just asking if they take volunteers and if they need any help. Told them this tiny bit about my experience, that I was familiar with harm reduction and thought it was cool that they're doing what they're doing, and I wanted to be involved. They responded by like, "We'd love to have you volunteer, but actually we have a position that we're hiring for. Would you consider looking at that?" My goodness.

I was like, "Oh, I'll spare you." I mean, "I don't actually really want to work yet, but I can't actually turn this down. This is a cool thing, potentially." I should say actually, also, I had actually looked for jobs in harm reduction in San Francisco before we decided to leave. When I knew I was, maybe, ready to make that change, I started looking for jobs. The only positions available were kind of entry level positions. It would allow me to be helpful and be in a space that I appreciated, but I think would've been setting myself up for another kind of underemployment type-

Mitch Doig:
Going back to the-

Evan Burke:
... situation, or-

Mitch Doig:
... lack of challenge, not being-

Evan Burke:
Exactly.

Mitch Doig:
... able to do the skillset that you know have, kind of thing.

Evan Burke:
Exactly. It would've been in certain ways, not as much of a lateral move, but more of a step down into a space that I knew and loved, but into a role that I think inevitably there would've been some friction, for me, in that role. Yeah. So, I hit up the Idaho Harm Reduction Project. We move out here, and I interview for the job with them. They were gracious enough to give it to me. Yeah. As far as how I decided to make that change, like I said, some of it was just... I love working with adolescents. It tickles me. It is so-

Mitch Doig:
Yes.

Evan Burke:
... fun. Obviously, they're also professionally obnoxious. Honestly, it feels like it keeps me sharp. I feel like I'm funnier when I work with adolescents on a regular basis, so.

Mitch Doig:
I realized, working with teenagers, why dad jokes are a thing. There's-

Evan Burke:
Oh, yeah.

Mitch Doig:
... just something about the style of humor that you can get away with teenagers that I think is exceptional.

Evan Burke:
Oh, it's so fun. Yeah. So, I love that. It's something that I do hope can somehow still be in my life some way, at some point, in my professional path. There's so much joy in that, to me. Also, when you talk about sort of overlapping layers of what I feel personally connected to, I identify with being a person who used drugs, for whom that was an important and difficult experience.

Also, a person who had a pretty miserable adolescence. I know a lot of people do, but it was a formative time for me. So, I enjoy being able to share those spaces and be helpful in those spaces. I feel like I can connect well.

Mitch Doig:

It's cool to kind of hear, almost, that, not to sound too whooie, but stars aligned, almost, for you to land where you are. You're like, "We are ready to make this jump, right as this thing was happening." I wrote this down as soon as you had mentioned, as somebody who experiences imposter syndrome. I'm just going to throw out a wild guess, here, that this also was part of why you were hired for the role you are, is lived experience. I've talked with a few people who, maybe they identify as peers, or people who are using lived experience in their roles. I'm assuming that part of the challenge, for those roles you were looking at in San Francisco, is that they were looking for a degree, or they were looking for some sort of qualification that says, "Ope. You know what you're doing and you can do this," even though you did know what you were doing and you definitely could have done something, not entry level.

I mean, you've been somebody who's been in the workforce for as long as you have. How do you imagine... Actually, what's a better way of putting this? I guess, lived experience has value, and it's-

Evan Burke:

Yeah.

Mitch Doig:

... starting to become more valued. I'm just kind of curious, thoughts on that. It's something that excites me about the field, again, as somebody who does not hold a higher degree, as well, who's constantly almost trying to prove worth. I think that it's an interesting thing where we're suddenly deciding like, "You know who might know something about this? The people who have experienced this and have accessed these services before."

Evan Burke:

Crazy.

Mitch Doig:

Who would've thought?

Evan Burke:

Yeah. Yeah. First off, I also think it's a good thing. I think it's exciting. I'm not super familiar with what the change in the value of lived experience looks like, outside of harm reduction. It would not surprise me, if within harm reduction, given the origins of the movement as it's been taught to me, that that has been kind of foundational in certain ways to harm reduction. It can only be a good thing. As a person with lived experience, I do think it's a tricky thing to navigate, in different ways for different people, speaking for myself. You appreciate that that experience is valued. I don't necessarily always even bring it up. I'm bringing it up for this conversation. It's appropriate. It's useful, but I don't bring it up if it doesn't feel useful. I do think there's the pitfall, in terms of you talk about the challenges of imposter syndrome. There's also the challenge of feeling like you're kind of like... I'm trying to figure out exactly the right way to say it. Basically, that you're kind exploiting your own experience a little bit, or something.

Mitch Doig:
The word was exploitation, is what I was-

Evan Burke:
Yeah. Exploitation.

Mitch Doig:
... going to throw out there, too.

Evan Burke:
You know? It doesn't always feel really good-

Mitch Doig:
Yeah.

Evan Burke:
... trying to find that balance. I think, for me, it feels important to not just be defaulting back to like, "Everything is grounded. I went through this, so it should be this way." It doesn't promote dialogue, always. Also, the reality of being a person with lived experience in a mixed work environment, where not everyone has it, and also people's lived experience is different. I think this is pretty relevant for the conversations you're having. Whether it's mental health or it's harm reduction, working in these mixed environment, where there's always going to be people, probably, with some sort of advanced degrees who took that educational route, the social workers and the master's of public health folk. Those are also people with lived experience, too, sometimes. There is kind of the conception of the non-profit, official experience. You've got a lot of folks, generally, in leadership, who got their master's and have some advanced educational experience, whose position and thoughts and experience is valuable.

Also, the professional dynamic. There may be a dynamic at play, in terms of those people being in positions of leadership over people with lived experience. It's a tricky thing to navigate, sometimes, I think. It's not helpful to have to throw something out as a trump card like, "I went through this, so I know how this should be." Not helpful in an organization to promote effective teamwork and conversation, but you feel it sometimes. You know?

Mitch Doig:
Well-

Evan Burke:
So... Yeah. Go ahead.

Mitch Doig:
No. I was going to say, it's hard, too. I think that you could have that conversation about both ends of this. I think-

Evan Burke:
Oh, yeah.

Mitch Doig:

... that sometimes maybe somebody who has gotten the experience is like, "No. I actually do know the solution." Just as providing advice to the people walking into the Idaho Harm Reduction Project isn't always helpful. It's sometimes just being like, "Here's what we're going to do," not always helpful. I think it goes both directions.

Evan Burke:

Oh, yeah. Definitely-

Mitch Doig:

Well-

Evan Burke:

I'd definitely say so.

Mitch Doig:

I think that's the interesting thing, hearing you talk about, I'm going to say, maybe, emotionally, value wise. You started volunteering in harm reduction like, "Oh, this makes sense." Then, there was this other thing that you did, where you're like, "And, I started to look into it. I started to learn more about it." This is probably my bias, but I think that you're describing that there isn't a moment of arrival for knowing it all. It's a constant state of development that you kind of have to be in. Realistically, there's something else that you had mentioned, as like, "Just because it was one way for you doesn't mean it's the same way for everybody else." You've kept referring to yourself as somebody who used to use drugs. The world of drug use has changed pretty dramatically, probably, since that was not a part of your life anymore. It's a very different landscape, at this point.

Evan Burke:

Oh, absolutely. When I do talk about my experience with folks, especially with participants, I'll probably more readily self-disclose. Talking with folks, my favorite example is, I grew up in the Bay Area, heard of Mac Dre and thizz pills, and stuff like that, or the thizz dance.

Mitch Doig:

Yup.

Evan Burke:

That refers to pressed pills that were widely available in the '90s and 2000s, in the Bay Area. I partook, and you know what's in those pills these days? Fentanyl, a lot of the time.

Mitch Doig:

Yup.

Evan Burke:

That wasn't a thing when I was around. I talk about that a lot, just acknowledging that it is a different world for people who are navigating that. There are some different challenges.

Mitch Doig:

Again, not to keep saying, "What I'm hearing from you," but what I'm hearing from you is at the-

Evan Burke:

I got you.

Mitch Doig:

... end of the day, that strive to learn more, to know that it's [inaudible 01:29:28], it's compassion. It's concern for the other, again. It wasn't the same way, and here's what I've been hearing from everybody else I've been working at, "This is a concern. So, let's try to remove the potential harms, or minimize the potential harms, that this is causing." Not saying that you have to do anything different, but this didn't hurt you much. Right? There was one other thing that I really was curious about that you had mentioned earlier, too. You had said part of your view on why you operate the way you do is because you're like, "I can't let this be all consuming for my life. I can't let it keep me up. And I'm hearing you kind of mention... because you had said it's important for you to be able to continue to do this, it's an act of self-care in a way, self-preservation. What is success to you in your role? Because that's something that I think can be really hard for people to navigate when they first enter human services in general, is knowing what is a good day, I guess, to put it in a really simple way.

Evan Burke:

Yeah, totally. Yeah, I mean, I can say especially working in behavioral health, definitely that can feel like really a moving target. And I would say that there are certain things that are interesting about my role and just what it's like doing what I do in Idaho, that are pretty interesting and relevant to what success can feel like, or what I can allow myself to accept as success in a good day. In certain ways, I feel pretty lucky to be in an environment where harm reduction is kind of a newer thing. And of course, I just wish it wasn't, and everyone just had all the services, and it was perfect, right? But it's not. And so, what that means though, is little victories feel like they happen all the time, and some in tangible ways, it feels like.

And maybe this does speak to the perspective that I take with this though, but for example, my meeting with the district manager of probation and parole last week. I'm going into that meeting open-minded, I'm going in ready to be pleasantly surprised that this person is interested in being an ally, and is potentially open to sharing my view of a possible world. But also, not expecting that, given who I'm going into and who I am going into this meeting. But given that that is the case, my expectations are fairly low for what can come out of this meeting. And so, even... Honestly, to me, out here in the work that I do, people like that taking meetings with me and being willing to spend their time, which they're busy humans... They're busy, they feel like the work they do is important, they probably are also themselves intending to be helpful given the work that they do is focused on interacting with humans.

And so, if I can take all those assumptions and go in there, and they're down to sit and talk with me... This meeting went on for two hours, this was a very pleasant surprise, it was a great meeting. But they're willing to share some of their valuable time with me to talk about something that they may not know about, or they may view fairly negatively, and they're giving me some of their time to talk about it, that feels like an opportunity. And so, I think that, as far as what feels like good days, good days feel like where I have that feeling of opportunity available to do something helpful, or to make a new connection.

And I do think that is applicable in other areas, not when you're just doing an advocacy and community building kind of thing. I do think it's relevant in my individual interactions with participants as well. We're a small team, I do street outreach as well. And so, all those things... Yeah, just being open to those little opportunities that feel exciting and being vigilant for those, I think, is helpful. Because it's easy to also not be, it's easy to go into a meeting like that and be like, "Ugh, this person's probably not going to be very happy to see me. Why? I'm not..." Maybe they took this meeting because they felt like they had to, or they don't actually care, or to give me a piece of their mind.

Mitch Doig:

You kind of sound like, if you go into... It's that expectation setting too, if you go in having some sort of assumption, it might be what you get, but if you kind of go in and be like, "Well, any direction..." The only direction is up, it'll probably go up.

Evan Burke:

That is how it feels. And I also don't think that that's a bad way to view any service interaction in a lot of ways, because it's about my point of entry, right? As far as I'm concerned, where I'm entering is the bottom, even if things are great. Because from where I'm standing, where my role comes into play, it's part of where, maybe to circle back to harm reduction principles, meeting people where they're at. I'm meeting this person, this is where I come onto the scene, right? And it's the same thing with, whether it's like they're already doing drugs, and that's not my... Whether they're doing drugs or not is not my thing, but they are, and so here I am. I have things that they may be interested in utilizing, and my intention to be helpful to them and make them feel seen.

And same thing with a meeting like this, or something like that. I'm assuming this person, maybe they care and like harm reduction, maybe they don't, probably not. And I'm coming in and I'm like, "Here's what I've got. Let's talk. You're a person who wants to be helpful to people, I'm a person who wants to be helpful to people. Surprise, a lot of our people are the same people, so let's talk about this." And so, I think when I take that perspective, I'm rarely disappointed and often pleasantly surprised.

Mitch Doig:

It's neat too, because one of the stories that I always tell people is, you're sometimes even surprised where you're surprised. And it seems really silly, but one of my favorite things that I ever did when I was working with clients is, we'd have people walk in who didn't want to really engage in services, but they wanted... Again, the site maybe respite from the environment or something. And we used to have, there was a company that gives socks to nonprofits called Bombas, which...

Evan Burke:

We have like 10,000 pairs of Bombas at the office right now.

Mitch Doig:

Yes, exactly. So my favorite thing ever to do was to say, "Hey, do you want some socks, bud?" And just the impact that socks can have sometimes, it never got old. The impact of clean underwear for people never got old to me. And I think that just being open to that sometimes is so important. Just being open to the idea that there might be this thing that we take for granted

every single day, you are somebody who embraces harm reduction every day, you think about it probably even in the way you make decisions. And this person maybe never has to consider the fact that NARCAN being available in the lobby could save one life someday. It'll go missing, maybe somebody will steal it, and then it saves somebody's life? Cool, cool. That little thing could have such a huge impact and I think those are those tiny kind of... Like you said, there's victories all over the place.

Evan Burke:

Yeah, yeah. And I like what you said, I love what you said about the gloves or underwear and stuff like that. I think one, relatable experience, I know exactly what you're talking about. And two, I do think that when you're... and it's applicable to probably all work, but when you're doing community-based work, when you're doing behavioral health work, those little wins are also often very joyful, silly little moments.

Mitch Doig:

Yeah.

Evan Burke:

That stuff is also an opportunity, that is moments of connection, that is moments to make someone feel seen, and also to be silly, and to have just a simple unambiguously nice little moment. I understand that the work that I do, or the work that people do in the community and stuff is hard, and burn people out, it does. But I also think that if I'm keeping an eye out, and the way I kind of like to put it is I'm moving slow enough to see those things as they come up. And my attitude is just so much better and my sense of like, I don't have a lot of days where I get to the end of it and I'm like, "Oh, hope the next one's not like that." At least not work related, I'm human in life, obviously there's tough days. But work related, I do think I kind of just am able to be continually often just kind of pleased, just pleasantly surprised.

Mitch Doig:

If you look for the rewards in your work, they're there.

Evan Burke:

Yeah.

Mitch Doig:

There's just a couple more things that I wanted to ask. And these are more out of sheer curiosity, because I think you're, one, from a values perspective, I think somebody who is exciting to talk harm reduction with. But two, obviously you're knowledgeable with, so there's the emotional part of this and the mental part of this. And I know we just talked about not setting expectations too high, but I'm curious, what do you have for hopes for the field of harm reduction, whether it's just in Idaho or elsewhere over the next couple of years? And maybe there's a pragmatic what you believe will happen, but also what you do want to see happen.

Evan Burke:

I'm glad you asked this in the context of me just talking about little victories, because my view of the possible future is very ambitious, and definitely... But I also think it's realistic, because I think part of it's why I feel excited about this work and about, from an intellectual and public

health standpoint, it's not that complicated. The implementation is complicated and there are political realities that certainly complicate things, but the actual particulars of the interventions themselves are like... We're already working with a pretty good menu of really effective interventions that can be implemented now, and relative to the cost of other programming, are not particularly crazy compared to the things that we spend money on.

And so, I mean, it's like a little organization like iHARP can... We distributed 750,000 syringes year before last and 600,000 last year, 20,000 boxes of NARCAN. We're a teeny little organization. Tiny, there's like eight employees. If that can happen... I think I just feel a lot of excitement about just how effective these things are, and so, in my mind it's just like the uptake of the ideas. Once people start to implement a little bit more, this future that I have a vision of feels pretty realistic. And so to be more specific, for example... whether we're maybe talking Idaho specifically, but for example, having NARCAN available to... One, this is a very specific example, but having NARCAN available to residents of prison, inside the prison, access to a medication like that, it's not a thing, I actually don't know if it's a thing anywhere currently, but-

Mitch Doig:

And there's no risk to it for it being there too.

Evan Burke:

No risk, right. So it feels like, and I've already been working on this, the answer is no for right now, but that's okay, baby steps. But that would be a big thing, because you think about... We talk about it all the time, talking about the data of drug overdose and stuff like that, the populations or the periods of life that we view as the highest risk moments is, we always talk about people getting out of institutions, psychiatric hospitalizations, residential treatment programs, prisons, experiences where people have reduced access to... Maybe experiencing forced abstinence from opioids, and then they come out, and then that's a really high risk period for overdose, especially fatal overdoses, it's when a lot of them happen for folks, right? It's dangerous and so it seems like... Also, there's overdoses that happen in the prison. Anyway, this is a bit of a digression now, but stuff like that, because what that would speak to me too, it's not just cool that the prisoners have access to a resource that is lifesaving, and is an acknowledgement of their reality, which is that people are using drugs in prison.

And I think that's also what's so important about that and that's when I think the ambitious vision of the future is also one in which we acknowledge what is occurring, and we are on the same page about, we know that there are effective responses to the... we can all--- there is some agreement, some unity around the problems, in a sense. And I say it this way, because I talk to people in Department of Corrections all the time, some people will be like, we can have very open conversations with, and others basically won't acknowledge that drug use happens inside prison, or that sex happens inside prison. I was also trying to get condoms in prison and I can't do that yet. But that's what I mean, having those things in there, one, excellent public health intervention, two, would also be a paradigm shift for that institution.

So in my view, things like that, obviously a big long view would be way less prisons, but... Imagining a future that does not have to change so radically, but would feel different and would have a very meaningful impact in the lives of the people that I'm looking to be of service to. People in prison having NARCAN and condoms, in a prison where the corrections officers, the prison administrators, and the counselors there are all aware and on the same page, and acknowledge the fact that drug use happens, and they care enough to make sure that their residents have access to this thing, they care enough about the lives that they're responsible for, that they provide those lives with the tools to have a better quality of life. And it's a respect,

that's a respect change, that's a greater sense of dignity in an environment where very little is given. And so that's just one example, but it feels like it would be a big change, and also it doesn't feel impossible to me.

So that's one pretty significant one. I also think, this is the harm reduction world, but also kind of harm reduction adjacent, would be nonviolent emergency response, I think is a pretty big deal. And so, I would be a very strong proponent of that. It's not currently something that we are specifically working on, but for example back in San Francisco, they were just kind of getting started. They had a couple of nonviolent response teams going, and the harm reduction organization that I volunteered with was definitely plugged in with those guys, and they would have peers on the rigs that would go out, and so there was a bridge there to the drug user community. And so, I do think something like that, like a nonviolent community response that incorporates a peer and mental health professional, involves no guns at the scene of an agitated individual in the community, would be... And I say that, I know it's not harm reduction specific, but it's so relevant to the drug using community and to houseless, the people-

Mitch Doig:

I was going to say-

Evan Burke:

... experiencing homelessness. Sorry, go ahead.

Mitch Doig:

No, no, no, I was interrupting you. I think that, because describing essentially... I just want to make sure I'm understanding correctly, because I'm thinking about situations that I see happen a little too often, is a situation where maybe there's somebody on a street corner or kind of yelling, talking to somebody who nobody else can see, and somebody calls 9-1-1 and they're like, "Somebody's doing something."

Usually police would respond and you're kind of saying, "It's an act of harm reduction." What if, mental health team, peers? And I think that it's not entirely unlikely that some of those things that we don't see or hear, this person is seeing or hearing as a result of substance use. And it makes a lot of sense to, rather than have somebody show up who again maybe may be well-meaning, but show up... Like, if you have a gun in a holster, that obviously sets a power dynamic that will cause some agitation to occur.

And if this person's fearful, then things happen. And we're talking about a lot of harm reduction at that point. And then maybe again, there's a connection to peers or harm reduction program that's like, "Hey bud, are you testing your substances? Et cetera, et cetera." There's a lot of different pathways this creates for somebody to have more wellness, as you've kind of put it a few times.

Evan Burke:

Exactly. I think that's really well put in and definitely describes what I'm referring to, and what I would hope for in that situation. And I also think that it'd be a very easy thing for there to be bridges between that type of service and a harm reduction organization, and housing and shelter organizations, and stuff like that. And for there to just be a more cohesive network that is able to operate together in that way. And I don't see reasons in the way that reality exists, why that can't be the way that it is, I don't see that why it has to be different than that.

Mitch Doig:

Well, and I think that the other thing that you're not necessarily describing, but I am seeing you describe is theoretically a more cohesive health system is reducing harm. I think that, even as somebody who... I would like to say that I'm a pretty skillful adult, it's hard for me to navigate our health system. Like, me trying to find a doctor, trying to find a dentist, trying to find anything that's in network for decent insurance even, let alone if I had Medicaid for example. That's challenging, and if you had a cohesive health service that could just respond to you and say, "Here's a menu of options." Think of all of the... Not even harm reduction, maybe harm prevention at that point.

Evan Burke:

Yes.

Mitch Doig:

Like, there's not even harms to occur that you need to reduce, they just don't occur in the future.

Evan Burke:

Yeah, absolutely. Absolutely. And what I would throw into that too is more housing first programs kind of thing. That is very relevant to our drug user community and our houseless community. And so, I think I absolutely agree with what you're saying. And so, I do think that that's something that maybe, from my position with an organization like iHARP, that is not a current line of specific advocacy that we are working on right now. But I do think that it is where things can go and that it would improve the lives and go out for a greater degree of wellness for our participants, so we would be in favor of it.

Mitch Doig:

The last question that I think I have for you and who knows, we'll see, but... The last question I do have for you, what would you say to somebody who's maybe on the fence and is like, "Oh, I kind of want to get into the work of harm reduction," or do some sort of help, or whatever it is. I don't know if it's advice or parting words, or whatever you might want to call it, but what would you say to somebody who's just like, "Oh, this sounds like something I would be into?"

Evan Burke:

Yeah, I would say, one, I haven't heard of a harm reduction organization yet that doesn't need volunteers, and that isn't supported by a really awesome network of volunteers. And so, if you're harm reduction curious, go volunteer or just reach out, hit them up on social media, or just show up at a harm reduction organization and ask if there's anything you can do to be helpful. And I think that's a great way to dip your toe in the water, because I do think there are important things that would be helpful to know about yourself if you don't already.

And so, this can be a space... For example, if you haven't worked in an environment where folks may be frequently experiencing challenging mental health situations, if you haven't worked in an environment where... Not that this is the norm at all, but where you may have to frequently respectfully and patiently navigate agitated individuals, then dipping your toe in the water and going and volunteering, and doing something like that...And my experiences with volunteers at harm reduction organizations, this is my experience in San Francisco at Glide, it's what it's like with our organization.

I run our volunteer program here at the harm reduction project, I know others around the country where volunteers come in and are able to really get involved quite a lot. They offer outreach, they're out on outreach with us doing the same thing I am, and so I really think that is a great way to do it. I also think that if you're someone who does not have... Assuming you're someone who maybe doesn't have lived experience and hasn't spent a ton of time in the drug user community, if you don't have a lot of experience with that community, but I think it can also be a great way to learn to respectfully become more familiar, and to explore a curiosity about a work that you think could be meaningful to you in a respectful way, because I do think that-

Mitch Doig:

Not with that exploitative kind of thing you were talking about with lived experience, maybe of having to ask people. It's just like you're there helping actually.

Evan Burke:

Yeah, yeah. And so, I do think that, yeah, I think it can be helpful to have a sense of what you're getting into, and thankfully with something like harm reduction, unlike a lot of professions, you can kind of go check it out quite a bit as a volunteer. Now, what I would say beyond that also, if you already know you're interested and you already have some sense of what harm reduction is, and the work you do, and you're just trying to decide whether to get involved, I think I would just say, if what you're looking for is the opportunity to be involved in something that can be really impactful in people's lives and you're ready to do it while exercising a lot of humility, respect, and acknowledgement that the personal relationships that are at play, and the interpersonal dynamics that play in harm reduction and in being someone who is working with a highly stigmatized community, are really important.

And that relationships are really important, and that the work is really fun and it's joyful, and... For the most part it's fun, it's joyful, it's very playful a lot of the time in terms of just the outreach work and interaction with participants and stuff, lovely. And also, it's really important to respect, and warmth and humility are really important, because fundamental to harm reduction, we're talking about the philosophy that is sort of the premise upon which this work is going to be based, in which the services ought to be grounded in, is the assumption that this is not prescriptive, and that we are making things available for folks to access.

We are agents of empowerment, we are meeting people where they're at, and so we can't be coming in hot with our own ideas about where someone ought to be, where I want the world to be in any given moment. And I think you need to check a lot of that stuff and be ready to just practice humility. I think humility would almost be like... I would say almost the most important value in terms of the direct and participant interactions, but also in terms of even if you're operating at a higher level, if you are working in harm reduction or you're someone who maybe has a degree or something like that, you're coming out of a program and you are going to potentially be able to move straight into a position that's not just an entry level outreach or peer worker position, but you may be moving into a position where you get to make some sort of programmatic decisions.

Humility is as important or if not more, because you're making decisions that are going to impact people's lives. And a really important part of harm reduction as well is that the work be informed, even if you're not a person with lived experience or your organization isn't stacked with people with lived experience making decisions, that the voices of the participants are informing the nature of the services that are offered. Because if they're not, you're defaulting to a prescriptive model. You're saying, "This is what we're offering because we think it's what you

should have." Not, "This is what we are endeavoring to make available because it's what you've said matters to you." And so, it ought to be prepared to be in dialogue and to be flexible.

This kind of still goes along with what my recommendation about volunteering, but I do think if you're interested in... If you have an idea that you're interested in pursuing this type of community-based work, start demonstrating a commitment to that work. Because that is really valued, whether you have lived experience or not, if you've demonstrated a commitment over time, that this is something that matters to you and that you're not... Like, for example, and no judgment on this, I know it could sound like there's some judgment on this, but that you're not just looking for that first job.

Because from a perspective of like... I help do our interviewing for our positions and stuff, and so it is helpful as someone who's, just from a professional efficacy standpoint, if you want to be taken seriously when you're applying to jobs in this field, it matters. It makes a difference. It sets you apart if you're someone who's demonstrated a commitment to care for others. And it doesn't have to be working with people who use drugs, it doesn't have to be exclusively outreach work, but like... it wasn't just something you did for a summer, or something like that. And if you did, that's still great, that's still really good. I just mean that there's real value in having a demonstrated commitment to service, I think.

Mitch Doig:

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