



**“Do More for Less and Get Blamed for It”:
*What Harm Reduction Workers Bring to their
Jobs and their Community***

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Introduction

Harm reduction and nonprofit supportive housing are often argued to be the solution to the overlapping crises of opioid overdose, mental health, and homelessness (Ivsins et al., 2022; Kerman et al., 2021; Pollack et al., 2021). Though the harm reduction approach has been widely debated and researched, a frequently overlooked aspect of this approach lies in the harm reduction workforce, their skills, and knowledge. This summer, a team in the UBC School of Social Work undertook a study involving 30 online and in-person interviews with frontline workers and managers working from a harm reduction model in supportive housing in Vancouver's downtown eastside (DTES). The research explored the knowledge and skills of harm reduction workers, and what changes they would recommend to strengthen this work. The findings, reported below, showed a wide array of finely honed skills, knowledge and practices aimed at ensuring that harm reduction services are provided with dignity and care for those facing the challenges of homelessness, mental illness and addiction.

In many cities, people who use drugs and their allies have shifted the public and policy discourse on drug use from one of criminalization to a view of addictions as a health issue, and a response to trauma requiring medical and community-engaged psychosocial treatments and supports. Traumas underlying addictions include chronic pain; violence in the home and the street; homophobia and transphobia; and the ongoing violence of racism, poverty and colonialism. The longer people remain on the street or engaged with unregulated drug use, the increased exposure they have to further trauma. Shifting even part of their lives to safer practices tends to have benefits for many other aspects of their lives, and the lives of their loved ones and communities. Rather than a single strategy, harm reduction includes integrated practice approaches, policies, services, and programmes (Akiba et al., 2025; Claborn et al., 2023; Jordan, 2023).

Harm reduction focuses on removing or reducing anything that might deter people from accessing or using services and supports (Ivsins et al., 2022; Russell et al., 2025). It stands in contrast to conventional, transactional approaches in which people must meet criteria before being eligible for services. These criteria generally include being clean and sober, or under the care of a mental health specialist, and committing to recovery before being permitted access to services. A significant number of people cannot consistently meet these criteria, particularly when they are homeless and repeatedly facing street-involved traumas. Harm reduction accepts that many people may never entirely stop using psychoactive substances. However, there are ways to improve health outcomes, reduce risks and fold people into productive lives, while simultaneously respecting human rights and shifting power to oppressed and vulnerabilized communities (Kerman et al., 2021). This approach has been adopted by many organizations in the DTES and is an integral part of the federal government's "Housing First" policy that argues that people must first be housed, their lives stabilized at the

pace and in the ways that they can trust, before starting to talk about recovery and treatment (Government of Canada, 2022; Kerman et al., 2021).

Similar to personal support workers, community mental health workers, and disability workers, are generally viewed as quasi-professional or non-professional care workers (Pfau-Effinger & Theobald, 2025; Ware et al., 2024). Also, similar to these other care workers in the DTES, harm reduction workers provide care and supports to meet the immediate and longer-term emotional-psycho-social and physical needs. However, as the findings below show, harm reduction workers also bring additional value to the work in the form of skills and knowledge, helping to save and stabilize lives so that people can live with dignity, and contribute to society as they are able.

Methods

Between May and July 2026, 30 qualitative interviews were undertaken with 16 managers and 14 frontline harm reduction and mental health workers in the DTES. The median time workers had been employed in the sector for 7.7 years (range 1 to 28 years). Twenty-one had university degrees (16 undergraduate, 4 graduate, 1 PhD student), 3 had one or more college diplomas (and one had 3 years of university as well), 6 had completed high school and learned many of their skills working in non-traditional settings such as bars, pubs, or all-night fast-food outlets. Sixteen were male, 12 female and 2 non-binary. Research participants were recruited initially through a small convenience sample (5 participants were known to the researchers through the researchers' volunteer work in the DTES or through UBC connections), followed by snowball sampling (Alston et al., 2026; Crabtree & Miller, 2023) in which interviewees were asked to share our contact details with individuals that they thought might be interested in being interviewed. Interviews used an interview guide, were audio recorded and transcribed, and lasted between 45 minutes to 90 minutes (average 60 minutes). We reached saturation (Carey, 2017) at 28 interviews but continued two additional interviews to confirm saturation, for a total of 30. Transcripts were transcribed verbatim. Data were analyzed using a constant comparison method (Crabtree & Miller, 2023) in which each of the three researchers read the transcripts of two interviews multiple times until patterns surfaced and preliminary codes could be identified. Codes were then discussed among the team, followed by coding two further transcripts each, followed by discussion and refinement of codes, until final codes were confirmed. Ethics approval was provided by UBC Behavioral Research Ethics Board. Limitations to this study include the size and type of sample (convenience and snowball sample), as well as its qualitative method which precludes generalizability but aims to produce rich insights which may be applicable in other contexts.

Findings

This section analyzes the strongest themes in our preliminary analysis, namely: 1) prerequisite skills, 2) specific skills for harm reduction work, and 3) the tension between “book learning” and skills acquired on the job and with those with lived

experience, and 4) one thing the workers would change if they had the resources and power. Quotes are included as examples to highlight the themes but extensive data exists to confirm findings.

1. Baseline Skills

Prerequisite or baseline skills are those that other care professionals and care workers employed in allied services for people experiencing addictions and homelessness also hold, though without specialization in harm reduction. Examples include social workers in general health care services, or counsellors and community workers in services focusing on sobriety and abstinence. As will be analyzed further below, harm reduction workers hold these high-level skills, as well as skills specific to a harm reduction approach. General baseline, prerequisite skills were argued to encompass, “Just empathy, simple empathy, and a non-judgmental approach. Trauma-informed as well (I).” Listening was also seen as an essential skill, “being a really good listener. Active listening is so important because there are so many things that get lost in the nuances. If there is a situation where someone is just coming to me because they need space to vent, approaching them with the right care is so vital to a lot of the work that we do (L).” One manager added the following as prerequisite skills, “being genuine and having integrity in the way that you speak, and being yourself, is something that's very important, because if you're acting or playing a character, the community will see right through that and you lose all credibility (M).” A long-time frontline worker noted that, “The ability to apologize is very important too, because people make mistakes, but when you can respond to somebody with integrity and give them a heartfelt apology, that's very important (H).”

Building relationships and rapport with service users was also seen as a key prerequisite: “I think that the more that you built relationship with your clients, you start to understand what their needs are. You start to meet them where they're at, so that you can build that trust, and so you can get in that little door with them and help them. If you don't show those skills, I find that you're not going to figure out what kind of trauma they've had and how you can help them. So, I think that's just huge to just build that trust and then you understand what kind of skills you need to help them with (F).” Reflexivity was also seen as a critical harm reduction skill, as one worker noted, sometimes “you will fail. There's nothing but reflection to be done in those moments. Like, how did this work? Why did it not work? A lot of it, I think, is learned through practice (L).” Another worker added, “You end up being a really good problem solver because there's a lot of problems that are coming to you. And as a soft skill, problem solving is essential to our work because it's involved in so many aspects of it. You see a challenge and you come up to it and you try to face it (L).”

The importance of fostering relationships and rapport with clients is underscored in this story from a frontline worker:

“Sometimes building that relationship, when somebody comes in and you can see that they're not doing well and might not want to burden you with it. But, when you've built

that relationship and you have their trust even if they're saying no, you might be able to reframe it a little bit and just say, 'Okay, I can see right now, hey, you came in and you're looking worse than you have on other days and it seems like you're pretty down. What's going on?' You might be able to just re-ask what's going on in a different way, and even with that persistence, they're not going to push away because you've built that relationship. They're not necessarily get escalated because even when they've already told you 'no, go away'. They might be more willing to then open up just for that little push that shows that I still care (N)."

Humour was also seen as a general prerequisite, "we have to have a sense of humour here too, because that's how you survive (I)." A manager agreed:

"...Humour and playfulness. That's something that's incredibly important in this work. I often notice escalation and frustration flow in spirals. And as they're spiraling along, if you can find a way to derail someone's argument, maybe move them from that emotional side of their brain to that logical side of their brain, one of the best ways to do that is humour. You're just going to knock them off kilter a little bit, make them kind of hit that reset button in their surroundings and what's going on. And you kind of have to do that to get the joke sometimes (M)."

The same manager also told us that "Critical thinking is obviously really important (M)." Another manager agreed, "Another thing is critical thinking skills of dealing with problems that arise because there are always problems that arise, and there's never 'a code of this is what you do for this problem.' There are always unique problems and problem-solving is creative. But often I think showing up as yourself goes hand in hand as well (A)." One frontline worker added a cultural perspective, "A lot of critical thinking and education, including culturally appropriate practice, even though I am not Indigenous. I would say that I do rely a lot on knowledge to connect with Indigenous providers (I)."

Advocacy for clients was viewed as an important prerequisite: "Advocacy skills would be another one. Advocating with different organizations or housing or different supports to be able to for them to access then housing, health care, income support (K)." A long-time frontline worker emphasized self-care as a central skill:

"You have to take care of yourself and feel like you, you can plant your feet on the ground and you can hold yourself steady enough to be steady with the people you're working with. Right? So, I think that's where it's rooting yourself, but allowing yourself to be flexible. Right? And open. (H)."

2. Value-Added Harm Reduction Skills

Harm reduction skills can be seen to be an additional, higher level of skills and knowledge, and hence adding more value to the baseline skills analyzed above, and to the community the workers support. Overall, harm reduction was argued to be "a beautiful philosophy, which is we take care of people wherever they're at, and we give them opportunities to seek a different way of being. But the idea that people have to get

better is not on. We don't force it (E).” Harm reduction work was seen to require extensive patience, “letting people move at the pace of trust (F),” and the ability to accept that even though change may never happen, people still deserve support and respect. For some, this involves “Adjusting the notion of a good life to fit each client. You have to always meet people where they are (I).”

Specific baseline skills emphasized similar skill sets as for other care workers, but with the added-value of awareness of harm reduction philosophy and services, as one worker put it, “having empathy, compassion, awareness of harm reduction services, [and] the socioeconomic factors that impact the population we serve (B).” A frontline worker argued that the needed skill set is, “all about making sure people are safe, respected, and valued. They know that it's like, ‘I understand you have this addiction, and we're going to work with you to make sure that you have a standard of living’ (L).”

Many research participants focused on skills needed to work in the complex environment of harm reduction services:

“I would say de-escalation skills are huge. We meet people at very, very difficult times in their life. People being escalated for a variety of reasons, maybe it's mental health, maybe it's substances, maybe it's just the reality of being homeless. Being told for the hundredth time that there's no housing, a lot of times it's very understandable, but folks are not exactly in the best mental space. Things can go pretty fast from 0 to 100. So, if you can spot that and be able to take it down a notch and calm people down in a way that still makes them feel validated and preserves their dignity is really important (E).”

Another worker agreed, twinning empathy with de-escalation, “a lot of times people show anger but underneath it was grief (I).” A very senior worker added, “A big part of the care that we provide for people is just being able to come into like really elevated situations and just talk them down and get them back to feeling emotionally regulated (C)”. According to one manager, “Basically, we aren’t afraid of people, you can’t work down here if you are afraid of people. We always think we can work people whatever they are facing (Q)”. Other participants agreed with one noting, “an important skill is being able to face your own social discomfort and figure out how to best support someone anyway (H).”

One worker captured the thoughts of many of our research participants when she noted, “We don’t discharge to the street, even if someone is having a very hard time and is unable to cope in our environment, we find them somewhere else to live until they are ready to try with us again (Q)”. One manager told us that a baseline skill for work in his service was that workers had to “like chaotic environments, want to work in chaotic environments, [and] that have a huge sense of pride in the purpose of the work that we do (M).”

Harm reduction was also seen to be “the smallest possible step that we could take in this moment that would help you feel a little bit more comfortable, a little bit more safe, or even a little bit more willing to reach out again if you need it. I think that that is really

what this work [harm reduction] is all about (J).” Another worker added, “I think the underlying values are that we just want to respect people and make sure they know that they're respected and valued as members of society (L).”

The skill of building strong empathetic relationships with clients also took a particular form in harm reduction work:

“Harm reduction for me means like creating a supportive environment where people feel heard and respected, and reduce the risks related to things like substance abuse. And I've definitely seen it played out at work when somebody we knew was a user, felt safe enough to let staff know that, ‘hey, I'm using in my room’ so later we can do a safety check where we go to the room, and knock to check that they're not overdosing because they got bad drugs or they did more they usually do (K).”

The same shelter worker also spoke about the critical importance of creating non-judgmental relationships:

“This woman came to tell us ‘I'm about to have an overdose, I just did drugs.’ And she just sat down there and waited for us to help her. That's harm reduction. They don't feel judged; they seek help. Because if we had a different approach, they wouldn't feel safe to tell us, they'd be worried about losing their bed, about us getting the law involved (K).”

The skill of setting boundaries was also seen as an important component of compassionate harm reduction work:

“I think when you're living unhoused for a really long time, you learn these survival skills where you tend to test boundaries of staff to see like how much you can get away with or how much you can get. And I get it. I would do the same if I was unhoused. But then when you're an employer or a staff and you're working here, it's like being able to set those boundaries, professional boundaries, keeps everybody safer (K).”

A senior worker provided the following insights in regards to setting boundaries in harm reduction. She noted that service users “taught me really important lessons about what was and was not part of my job. What I could and could not control, and how I can still show up for somebody even if I'm not able to fix their problem or if nothing I say is going to change their situation (J).”

3. Tensions Between Book Learning and Lived Experience

The majority of the participants had post-secondary education (college and/or university), and while they valued their post-secondary education, they attributed their key learnings and skills to learning on the job, often from people with lived and living experience of homelessness, addictions, mental health, and poverty. As a manager of a fast-paced, frontline service noted, “The knowledge sharing from the community, when the community likes you, is some of the most impactful and important training that anyone will receive (M).” He continued:

“I am learning every single day through the fascinating knowledge of both the community and the individuals that I work with who have that lived experience component. An individual who holds down a successful job and meets all the requirements of their employment, while also having gone through mental health issues, the prison system, and addiction, is someone who has a shocking amount of knowledge to share, but also that resiliency (M).”

A frontline worker added, “learning from coworkers [with lived experience] is extremely important, ...because they’ve walked that walk before. They’ve been that path. So, they’re going to have a lot of insight that they can pass on to you, more than you can get from a training video or a notebook in a course at [university redacted] (S).”

Workers also argued that they learned more skills from the community and the clients than from formal education:

“I would say that the skills that I learned were actually on the streets and from my clients. The most important skill is the way I ask questions. If people like the way I ask questions, I can be effective. Because this is not like academic. Sometimes you have to like use very simple language to get to people because they have brain injury. They have mental health. They have substance use. So, I feel that formal education, like from school, was not as helpful (I).”

Some research participants argued that they learned many of their harm reduction skills in hospitality jobs, “I got my skills from working in a pub, which is actually a safe consumption site if you think about it. Similar challenges, similar problems (M).”

Confirming learning by doing, a frontline worker agreed that customer interaction in service work was a great training ground for harm reduction work:

“The biggest, most used and most valuable learning and skill that I actually got was not from my formal training. It was because I worked for six years at McDonald’s..., closing shift or night shift and it was at the bottom of a sky train station. So, I picked up loads of very useful skills and transferable skills just from doing that job (S).”

Research participants also argued that their skills and knowledge were often developed through observation, “So how do you learn it? It’s through experience, either with the community or by seeing other people succeed. It’s through experience. You don’t read skills like that from a book. You can watch somebody (M).” Another worker added, “You’ll see somebody be very successful in a very challenging situation and think, ‘Okay, that person did good. What skills were they putting to use? How are they approaching this?’ Was [it because of] their tone, and what were they saying? And so, observation is very important (N).” Other participants agreed but pointed out that they also learned by doing, “I think that book study itself, it isn’t enough until you’re actually in the field when you can actually get in there and do the help that you need to [do] (F)”. Another worker added:

“The overall skills of the job you kind of need to already have, but you learn as you go. You learn little tricks, like how to get clients in with a certain service faster if you talk to this person, or you fill out this form instead of that form or something like that. You learn these little things, but nobody can tell you all of them, really (E).”

4. One Change

Research participants were also asked what they might change in their work if they had the power and resources. Increased resources and safe supply were the main areas for change. One worker summed it up for most participants when she argued, “Safe supply would solve a lot of issues for everyone working across the sector, and everyone working in healthcare in general (C).” Another worker added, “increasing safe supply would be huge. The number of people we lose just because the drug supply is contaminated is unnecessary. It makes our job much harder when we have to watch that happen (E).” Resources were also seen as pivotal for service users. As one manager put it, “we need more funding for residents because if the residents are doing well, my job is a breeze (V).”

Hiring and retaining staff was also a change workers would like to see:

“Hiring more staff would be a big one. My team, when fully staffed, is only four people and we cover basically from the Granville Strip to the end of the Downtown Eastside, which is our catchment area. So, it’s a huge space that we’re meant to cover, do outreach walks, house people, and all of that, and there’s only four of us. It’s crazy. And most of the time we’re only three (E).”

A senior manager added, in terms of one change she would make, “get more of staff and pay them better. It’s exhausting holding up the world every day (W).” Another manager wryly observed that harm reduction workers regularly get asked to “do more with less, and then get blamed for it [when something goes wrong] (G).”

Research participants agreed that wages had to improve and pointed out that frequently highly skilled staff cannot afford to stay in the job due to the cost of living. As one manager put it:

“I hate to hear when really skilled compassionate people who are great at this job and an asset to the community are priced out of doing this work because they can’t afford to live here. And that’s a real loss. Because it’s not for their own volition that they like choose to leave. It’s that they can no longer afford to do this work. And that’s hard (B).”

Managers and workers spoke of the importance of increasing supports the resilience and work of harm reduction employees, “I think that anything that we can do to build resilience and celebrate strengths before it gets to that [breaking] point, the longer and more fulfilling this career will be (J).” Training was seen as part of supports for staff, particularly “robust training in mental health supports (V).” Other research participants wished there were resources to participate in “conferences in Europe where harm reduction is more advanced, and we can build our knowledge out a bit more (O).”

Another participant added, “it would be great to learn from experts around the globe and develop a global shared support systems for all of us in this work (T).”

Conclusions

Table 1 below summarizes the skills analyzed above. Y indicates yes, N indicates no, ~ indicates sometimes, and ? indicates unknown.

Table 1		
Summary of Skills Applied by Care and Harm Reduction Workers		
Skill	Baseline for All Care Workers	Value-Added Harm Reduction Workers
Empathy & Compassion	Y	Y
Non-Judgmental	Y	Y
Trauma-Informed	Y	Y
Problem-Solving	Y	Y
Active Listening	Y	Y
Being Genuine	Y	Y
Having Integrity in How One Speaks	Y	Y
The Ability to Apologize	Y	Y
Building Relationships	Y	Y
Building Trust	Y	Y
Humour	Y	Y
Critical Thinking	Y	Y
Culturally Appropriate Indigenous Practices	Y	Y
Reflexivity	Y	Y
Self-Care	Y	Y
Requiring That People Stabilize Before Receiving Service	~	N
Meeting People Where They Are	~	Y
Familiarity with Other Harm Reduction Services	~	Y
Extensive Patience	~	Y
De-escalation	~	Y
Comfortable in Chaotic Environments	?	Y
Discharge to the Street	Y	N
Trusted to Provide Overdose Support	~	Y
Show Up for People Even if You Cannot Fix their Problem or Change Their Situation	~	Y

The table and the underlying data show that the harm reduction participants drew on an extensive, unique and significant skill set, including those held by other care workers but with additional, valuable skills and knowledge. Most of these highly skilled workers reported gaining some of their knowledge and skills from post-secondary education, while others also drew on lessons gained in hospitality work. However, they all emphasized that they learned the majority of their skills from each other and from the wisdom that came from lived and living experience of the community they serve. Grounded in the community, these skills were constantly refined in the face of rapidly changing crises and a community struggling to take care of each other in the context of toxic drug supply, poverty, addictions, and mental health challenges. Though critics of the harm reduction approach largely overlook the dedicated and skilled workers providing complex care to deeply disadvantaged populations, these care workers are pivotal to the success of this important and deeply humanistic approach to addictions and mental health challenges in our communities.

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