THE CENTER
at Sierra Health Foundation

CDPH
California Department of Public Health

CAPHRI
CALIFORNIA OVERDOSE PREVENTION & HARM REDUCTION INITIATIVE

Medications for Addiction Treatment in California Harm Reduction Programs

INSIGHTS FROM PROGRAM STAFF AND CLIENTS



JUNE 2026

Acknowledgements

The Center at Sierra Health Foundation would like to thank the harm reduction program staff and participants throughout California who shared their perspectives on access to medications for addiction treatment.

Funding for this report, supported by The Center at Sierra Health Foundation, was provided by the California Department of Public Health Office of AIDS, through the California Overdose Prevention and Harm Reduction Initiative.

Table of Contents

Purpose of this Report **2**
Key Context **2**
Theme 1: MAT Models Vary in Harm Reduction Programs **5**
1A. There is a spectrum of MAT models offered through harm reduction programs 5
Theme 2: MAT via Harm Reduction Programs is Effective **6**
2A. MAT services at harm reduction programs support, change, and save lives 6
2B. Harm reduction programs make MAT access more equitable 6
Theme 3: How Harm Reduction Programs do MAT Differently **8**
3A. Harm reduction programs minimize the "leap" of engaging with treatment 8
3B. Harm reduction programs offer trusted and valued non-MAT services 8
3C. Nonclinical harm reduction program settings reduce stigma 9
3D. Harm reduction programs foster connection through shared experience 10
3E. Harm reduction programs thoughtfully address precipitated withdrawal 11
Theme 4: Characteristics of Low-Barrier MAT **13**
4A. Making MAT low-barrier requires numerous considerations 13
Theme 5: MAT Challenges for Harm Reduction Programs **14**
5A. Harm reduction programs strive to support staff with lived experience of drug use 14
5B. The intersection of homelessness and drug use amplifies barriers to MAT 15
5C. Harm reduction programs need more funding and staffing for MAT programs 16
Conclusions and Implications **17**
Appendix: Methods **19**
References **21**

Purpose of this Report

California has invested in medications for addiction treatment (MAT) as a tool to address opioid use disorder and its health impacts, including overdose risk. For MAT to be as effective as possible, all populations must be able to access it, including those less connected to traditional health care systems. Harm reduction programs, which focus on providing essential health services to people who use drugs, play a unique role in expanding MAT to people who might not otherwise access it. This report explores the perspectives of staff and participants from community-based harm reduction programs that offer MAT.

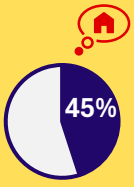
Harm reduction programs provide essential health services and are focused on serving people who use drugs. This report focuses on community-based harm reduction programs (syringe services programs authorized in California) that provide syringe access, naloxone, and safer drug use supplies, while varying in their scope, model, and other health services offered.

Key Context

California is experiencing an ongoing crisis of opioid-related overdose

Mirroring the broader U.S., California is experiencing a crisis of opioid-related fatal overdose, driven in part by an unregulated and changing drug supply. In 2023–2024, approximately 1.6% of California adults had opioid use disorder.[1] In 2024, nearly 5,500 Californians died of opioid-related overdoses—a rate of 12.4 per 100,000 people.[2] Although California's opioid-related death rate is lower than that of the U.S. (23.1 per 100,000 people)[3], the state hosts the highest count of overdose deaths nationally due to its large population size.[4]

Opioid-related overdose death rates in California are pronounced in several groups, including men, American Indian and Alaska Native people, Black and African American people, and white people.[2] While more urban counties tend to host the most overdose deaths due to their larger populations, less populated rural counties—particularly those in the North State and North Coast regions—tend to have the highest overdose death rates.[2] Throughout California, people experiencing homelessness are the group most impacted by overdose deaths. In Los Angeles, which hosts California's largest homeless population, 45% of deaths among people experiencing homelessness in 2023 were due to overdose.[5]



Nearly half of deaths among people experiencing homelessness in Los Angeles were due to drug-related overdose in 2023.[5]

As with most other U.S. states, fatal opioid overdoses in California have been decreasing recently, with a 30% decrease between 2023 and 2024.[2] According to the Centers for Disease Control and Prevention, decreasing drug overdose deaths likely has many contributors, three of

which include widespread, data-driven naloxone distribution, better access to evidence-based treatment for substance use disorders (such as MAT), and investments in overdose prevention and response programs.[6] However, fatal opioid-related overdoses remains an urgent public health issue, with continued investment needed to further reduce preventable overdose deaths.

MAT plays a key role in preventing overdose

MAT includes a set of evidence-based drug therapies that treat opioid use disorder.[7] Methadone and buprenorphine—the most commonly used and well-studied MAT[A]—have consistently demonstrated reductions in opioid-related mortality and morbidity, all-cause mortality, and serious opioid-related acute care, while supporting retention in opioid use disorder treatment.[8-12]



Medications for Addiction Treatment (MAT)—most commonly methadone and buprenorphine—substantially reduce death and harms related to opioid use disorder.

Recently, California has invested in expanding MAT in diverse settings, including non-traditional settings like **community-based harm reduction programs.**

Facilitated by major policy and funding changes, MAT prescribing in California has increased in the past decade, especially for buprenorphine, for which the rate of buprenorphine prescribing has approximately doubled.[2] In addition, the piloting of MAT provision through diverse settings, including hospitals, emergency departments, emergency transport services, carceral settings, residential treatment facilities, mobile facilities, and harm reduction programs, has expanded access to populations unlikely to be reached or engaged via traditional MAT channels (federally certified narcotic treatment programs and high-barrier clinical buprenorphine provision).

Harm reduction programs are well-positioned to expand MAT access

The state of California has specifically invested in MAT offered through harm reduction programs through its Low-Barrier Opioid Treatment project, which intends to increase the availability of opioid treatment for communities not fully served by current health infrastructures. In the most recent round of funding, the state awarded more than $19M to 25 harm reduction programs to implement MAT between 2024–2027.[14]

California has invested approximately $39M into expanding MAT through harm reduction programs:



- State Opioid Response (SOR), Round 2, 8/1/20-3/14/23: **$6.9M**
- SOR, Round 3, 9/30/22-9/29/24: **$13.2M**
- SOR, Round 4, 9/30/24-9/29/27: **$19.3M**

[A] Naltrexone, a less commonly used MAT, was not shown to reduce the risk of all-cause mortality in a 2018 study (Larochelle et al., 2018), though the authors concluded that a small number of patients receiving naltrexone prevented confident conclusions. In a 2019 study of MAT real-world effectiveness (Morgan et al., 2019), naltrexone was not associated with reduced overdose risk.

Harm reduction organizations are well-positioned to support low-barrier MAT expansion because their services are tailored to people who use drugs and reach those disconnected from traditional care settings, including those experiencing homelessness and those who use drugs. A 2025 survey of 1,441 participants at 51 California harm reduction programs found that 81% were experiencing homelessness or housing instability, and 59% had been unsheltered within the past three months.[15] The same study found that 15% of harm reduction program participants had experienced an overdose in the past three months, 58% had witnessed an overdose, and 79% reported using drugs alone.[15] Notably, the study also found that nearly two-thirds (62%) of harm reduction program participants were interested in substance use disorder treatment, including 35% interested in methadone and 25% interested in buprenorphine.[15]

Strengths of Harm Reduction Programs

- ✓ **They are tailored to meet the needs of people who use drugs**. This is different than traditional clinical settings where there may be more stigma and a higher threshold to access care.
- ✓ **They reach many populations who use opioids but are not stably engaged in medical care**. This includes people experiencing homelessness and/or mental health conditions that co-occur with drug use. In other words, harm reduction programs have relationships with people who may not otherwise be exposed to or have access to MAT.
- ✓ **They provide services to a high proportion of people who have experienced and/or witnessed overdose.** Expanded MAT access for people at high risk for overdose and their peers has notable potential to save lives.
- ✓ **Their participants are interested in MAT**. One study showed that more than 1/3 of program participants were interested in methadone, and 1/4 interested in buprenorphine.

Research suggests that harm reduction programs across the country are exploring MAT services, facilitated by the changing policy landscape, such as loosened MAT telehealth regulations resulting from the COVID-19 pandemic.[16-18] Notably, studies comparing harm reduction organizations with syringe services *plus* MAT services to those only providing syringe services or only providing MAT services, suggest that organizations offering syringe services *plus* MAT are most comprehensive and cost-effective.[19,20] However, organizations offering both syringe services and MAT services are less common than those with only syringe services or only MAT.[20]

Learning from existing MAT programs at harm reduction organizations is essential

In 2025, The Center at Sierra Health Foundation collaborated with Facente Consulting to explore the strengths, challenges, and opportunities for California harm reduction programs that provide MAT services. The project engaged 42 harm reduction program staff and 64 harm reduction program participants from 16 unique programs through interviews and focus groups.[B] The rest of this report summarizes the themes that emerged and implications for the future.

[B] See appendix for more detailed methods.

Theme 1: MAT Models Vary in Harm Reduction Programs

1A. There is a spectrum of MAT models offered through harm reduction programs

There is no one-size-fits-all approach to MAT services at harm reduction programs, as each program is tailored to available resources (e.g., funding, staffing) and participant needs. MAT models range from referral and linkage protocols (less resource-intensive) to same-day on-site MAT access (more resource-intensive). Table 1 shows examples of models shared by staff across the 16 interviewed harm reduction programs. Telehealth was the most common model.

Table 1: Some common MAT models employed by interviewed harm reduction programs

	MAT Model	Description of Model	Quote from Program Staff
Less resource-intensive ↑	**Informed Referral**	Many harm reduction programs rely on strong referral networks to provide access to MAT. These programs typically provide a warm hand-off to a known provider to maximize the chance that the participant will access MAT after referral.	"I'm on the cell phone with the addiction medicine doctor. We start with confirming he's there… I say, 'I have a participant here. They want to come over. Can they come?...Then, 'okay, would this time work?'...We also have slips [that] say where we referred, so [participants] have the address, location, and hours."
	Telehealth Onsite	Harm reduction programs support participants in virtually accessing a MAT provider, such as a local physician or a dedicated telehealth provider. The telehealth process takes place within the trusted harm reduction program setting.	"[The MAT] telehealth program… It's the most low-barrier program out here. We can get people signed up and talking to a doctor and receiving their meds all within the course of a few hours."
	Direct Linkage and Co-located Substance Use Navigator (SUN)	SUNs are experts in navigating buprenorphine access and have direct connections to prescribing MAT providers. When SUNs from a MAT provider are co-located at harm reduction programs, they can promptly connect participants to MAT without leaving the harm reduction program, similar to the telehealth approach.	"SUNs can easily get a script filled for somebody because we have access to [the electronic medical record] and laptops at the [harm reduction program]. They get the clearance from the doctors and all the people who make decisions like that…and they don't even have to touch foot into a hospital; they can get a script for somebody at the [harm reduction program]."
↓ More resource-intensive	**Provider On-site**	MAT providers are physically available at harm reduction program drop-in centers or outdoor sites to provide same-day care for participants.	"The MAT services…we have it right there. Step on into the back, into the RV, and here's our navigator [and MAT provider]."

Theme 2: MAT via Harm Reduction Programs is Effective

2A. MAT services at harm reduction programs support, change, and save lives

Harm reduction program staff shared personal anecdotes about their MAT program's effectiveness. They felt that MAT services and the harm reduction structure in which MAT services are nested have been critical to supporting, changing, and saving lives.

> "I have people who call me frequently, who I've never even come face to face with, who tell me how they're only alive because of this program."
>
> *- Harm reduction program staff*

Several staff shared that their MAT services have helped participants move from isolation to connection. Examples included reintegrating with family, giving back to the community (e.g., volunteering), and improving physical and mental well-being.

> "We hear these genuine, true stories from our participants, almost daily… 'If it wasn't for you guys, I wouldn't have my kid back.'…'I'd be in the hospital.'…'I'd be in jail.' To hear those things lets us know that we're doing something right."
>
> *- Harm reduction program staff*

Staff also reflected on the importance of supporting and engaging participants regardless of their drug use patterns or whether they are interested in MAT. As it may take time for a participant to decide to engage with MAT, staff focused on building a trusting relationship, providing desired services that promote wellness and reduce harm, and continuing to make MAT available. Ultimately, this approach can make the difference of whether a participant decides to try MAT when ready.

> "We know that we're giving them the tool they need for when they are ready to take MAT…They may pick it up and not take it for a while, but it's there when they need it. One gentleman is now nine months off fentanyl and meth and doing great. He was a mess but he kept showing up, and he kept getting supplies, and we kept building that trust, and eventually it clicked, and now he's doing great."
>
> *- Harm reduction program staff*

2B. Harm reduction programs make MAT access more equitable

Harm reduction program staff emphasized that their MAT programs reach participants who otherwise would not be introduced to MAT. This includes people distrustful of medical care settings due to previous experiences of discrimination, as well as those likely to be disconnected from traditional medical care models due to their life circumstances, such as people who experience homelessness or mental health conditions.

> "Most people that we work with are not currently connected to medical care. We did a survey last year of our participants and their relationship with medical care…Over 40% wouldn't seek medical care because they felt that they would be stigmatized."
>
> *- Harm reduction program staff*

Some program staff stated that their services have improved MAT access in BIPOC (Black, Indigenous, and People of Color) communities. In particular, BIPOC-led harm reduction programs and those with BIPOC staff have been able to root MAT programming into cultural context. For example, one indigenous-led MAT program uses traditional Medicine Wheel teachings that focus on MAT's intersection with the physical, mental, spiritual, and emotional aspects of the whole person. This approach provides a deeper understanding than a clinician simply telling someone MAT can treat opioid use disorder.

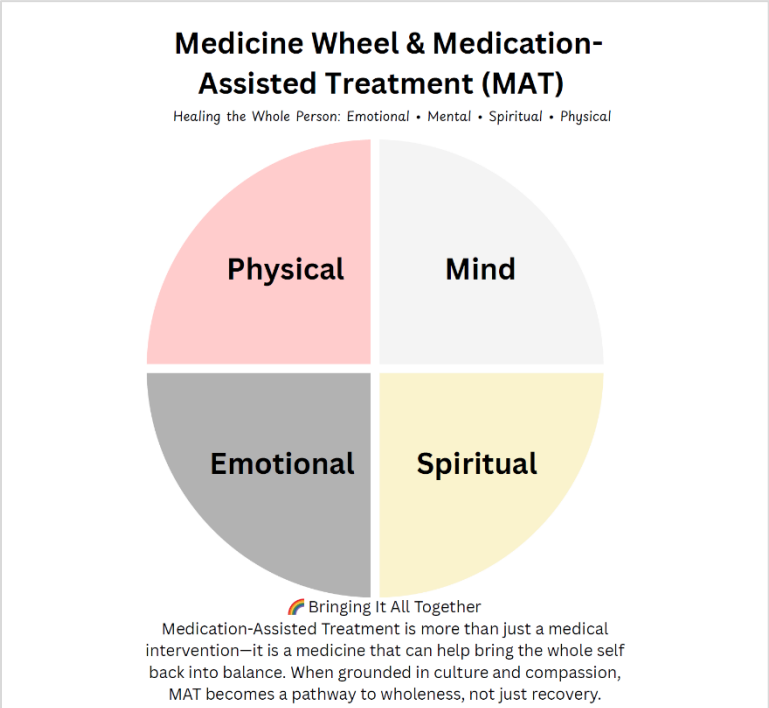


Photo Source: Arlene Brown, Crossroads Recovery Center

As another example, telehealth MAT models were described as expanding MAT access in rural, BIPOC communities (such as Latino communities), where people cannot easily visit a harm reduction program or MAT program without being noticed. In these communities, telehealth provides a more private alternative, requiring no physical doctor visit and resulting in prescriptions that can be picked up at a regular pharmacy.

> "Telehealth allows us to reach out into the rural clinics in the small towns, which are predominantly Latino…They're very small, so everybody knows everybody's business, including the local police. If we [the harm reduction program] start showing up, we're going to stick out like a sore thumb. Instead, folks can call and talk with the doctor. He does the intake, asks them what pharmacy they go to, and sends an electronic prescription."
>
> *- Harm reduction program staff*

Theme 3: How Harm Reduction Programs do MAT Differently

Harm reduction programs are more than just another MAT provider—their unique characteristics lend them a niche in the MAT services ecosystem that is unlikely to be filled by another type of agency. Below are five common characteristics of harm reduction programs that allow them to expand MAT to populations not reached by traditional health systems.

3A. Harm reduction programs minimize the "leap" of engaging with treatment

Harm reduction program staff shared that a key strength of their MAT services is the fact that MAT is offered where potential MAT users already are. As a result, making the leap between visiting a harm reduction program and starting MAT is a small step that does not require participants to seek services elsewhere. Ultimately, the transition to treatment is less intimidating than seeking MAT at a clinic or starting treatment through a residential program, lowering the barrier to entry. Additionally someone can learn about MAT, and its benefits without being in a space to formally seek treatment.

> "A lot of people's interactions with recovery programs involve people making a really dramatic decision to change their use. Obviously accessing any kind of treatment can embody that…but [we can] make it clear that to do so doesn't [mean you] have to step away from accessing the…supports that you already have been [using]."
>
> *- Harm reduction program staff*

3B. Harm reduction programs offer trusted and valued non-MAT services

Harm reduction program staff and participants explained that harm reduction programs are known for being trusted, non-judgmental, and supportive spaces that provide a wide range of valuable and desired services to people who use drugs. The foundation of trust plus the array of harm reduction services—which includes basic needs like food, shelter from the heat or cold, and hygiene; opportunities for social connection; first aid (e.g., wound care); places to use a computer or charge a cell phone; transportation vouchers; lockers to secure belongings; and overdose prevention supplies—are what



"Community Resources" sign from a harm reduction program

draw participants into harm reduction programs over and over.

From this baseline relationship of trust and desired services, harm reduction programs can add on medical services, such as MAT or referrals for medical care, to the menu of supports they provide. In contrast to settings that are MAT-specific—where there may be more pressure to start or adhere to MAT—harm reduction programs offer a low-pressure alternative. At harm reduction programs, participants can learn about MAT while accessing non-MAT services, with the option to start it at any time they wish to do so.

> "We've built trust with them…They're coming to us consistently already… They may not access [MAT] right away…but when they're ready, they know where to come. They don't have to make an appointment. They can just one day, decide, 'hey, I want to change this aspect of my life,' and they can walk up to the table and do that."
>
> *- Harm reduction program staff*

3C. Nonclinical harm reduction program settings reduce stigma

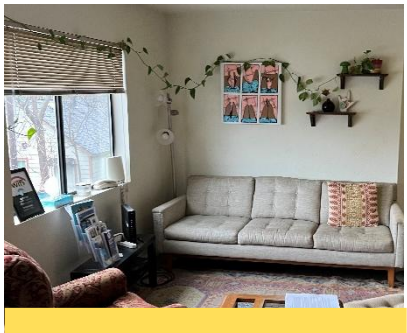
Harm reduction program staff and participants shared that stigma related to drug use is common in medical institutions; in contrast, harm reduction programs represent a nonclinical setting where they expect to be treated well and welcomed back, regardless of their drug use journey, decisions related to MAT, or the way they look. Harm reduction program staff described the relationship with participants as a nonlinear, continuous process—in contrast to the way that clinical settings structure their services around a specific medical outcome or "doing recovery the right way." Staff also emphasized engagement in itself as a measure of success, as a focus on relationships helps participants feel respected, encourages them to collaborate with staff to move toward goals, and ultimately lowers barriers to starting and staying on MAT.

> "They make it really easy to stay on the [MAT] program… you're not afraid. If you do relapse, you know you're not going to lose everything that you worked so hard to get just because of that. It really does help."
>
> *- Harm reduction program participant*

> "[Access to buprenorphine is] in that nonclinical setting. There's not all that pressure, all that associated stigma and trauma associated with being in the clinical setting. We're outside, literally outside, right?…There's a little bit more control people feel."
>
> *- Harm reduction program staff*



Harm reduction program in outdoor setting



Chill space in a harm reduction program

3D. Harm reduction programs foster connection through shared experience

Many harm reduction programs hire staff with lived experience of drug use and/or the conditions that can co-occur with it (e.g., homelessness, incarceration). Program staff noted that this representation is critical to building trust and helping participants feel seen, rather than othered. Moreover, staff with lived experience—especially those who have used MAT—can more deeply understand the nuances of what participants are experiencing and needing. Ultimately, staff with lived experience foster a culture of inclusion and support.

> "It's like walking into a party…you don't know anybody. You're looking for people to connect to…who might have something that you can talk to them…Our folks are walking in the room where nobody gets them and no one's trying to get them, and then all of a sudden they walk into a space like ours, and someone's been locked up for 15 years that's on our team. All of us have been addicted to drugs at some point."
>
> *- Harm reduction program staff*

Harm reduction program staff and participants also emphasized the way that harm reduction programs foster social connection by creating space to chat, laugh, grieve, share food and drink, and connect with others, including those with similar life experiences. Positive interpersonal interactions with harm reduction program staff and participants buffer the isolation associated with drug use, provide another reason for participants to return for harm reduction services, and create stronger accountability and motivation around participant wellness goals, including goals related to MAT.

> "When people access our services, they're greeted by their friends, they talk about the jokes they made last week…People can sit under our little tent…not on the other side of a desk, drinking coffee together while they wait for their appointment. Those little social and interpersonal shifts do an enormous amount to make people want to come back to our program and feel comfortable participating in our program."
>
> *- Harm reduction program staff*

> "Every week I got something to look forward to coming here…and the whole social thing really helps gives me responsibility."
>
> *- Harm reduction program participant*



A harm reduction program's memorial to people lost to overdose

3E. Harm reduction programs thoughtfully address precipitated withdrawal

Fear of precipitated withdrawal—a sudden, severe form of withdrawal that can occur when buprenorphine is started while opioids still linger in the body—is a well-established barrier to buprenorphine use.[21-24]

In this assessment, **precipitated withdrawal was cited by harm reduction program participants as the top barrier to not engaging in MAT**. One participant described it as "the worst experience I've ever add," noting that they would "definitely not be open to trying it again." Moreover, multiple participants felt that their past experiences of precipitated withdrawal had been dismissed or unaddressed by clinicians, with one participant sharing that the doctor "didn't really even care."

> "I tried it a second time, and it was really bad. It made me really sick…and it just it stressed me out so much more…I was still shaking. I couldn't sleep. It was horrible, like a nightmare…So I didn't feel it was useful the second time around at all, and they told me to up my dosage a little bit more and see if that would help. That just made me more sick."
>
> *- Harm reduction program participant*

Mirroring participant concerns, harm reduction program staff noted that many participants have experienced or observed precipitated withdrawal, giving buprenorphine a reputation for making people sick. Staff shared many ways in which they are intentional, thoughtful, and participant-centered in addressing precipitated withdrawal in their MAT services. Strategies included:

> "When they're getting sick, trying to get on these medications, [they say] 'I'm sicker from the medication. I don't want to try that again.' Or, 'I watch my friend go through this…I'm not willing to try this."
>
> *- Harm reduction program staff*

- **Being transparent about MAT trade-offs**. Program staff described being "blunt" about the pros and cons of both methadone and buprenorphine so that participants can make an informed decision. This conversation includes attention to what a participant feels is tolerable and how they anticipate responding to precipitated withdrawal, should it occur.
- **Creating participant-centered MAT induction plans**. Program staff emphasized working with participants to develop a personalized buprenorphine plan based on their previous experiences, current goals and needs, and constraints of safe medication use.
- **Introducing alternative induction protocols.** Some harm reduction programs have rolled out education on "direct-to-inject" buprenorphine as a relatively new alternative

> "We have a good way of being like… 'you're actually the expert here, so you're going to tell me what's worked and what hasn't. Then we're going to creatively come up with ways that work in the confines of medical allowability to make you feel better. We don't follow a strict algorithm or protocol. Everyone gets an individualized approach."
>
> *- Harm reduction program staff*

that has been shown to reduce precipitated withdrawal and general withdrawal symptoms. While access to direct-to-inject buprenorphine is not yet available at harm reduction programs, some are collaborating with emergency departments to connect participants interested in this option.

- **Co-creating language on buprenorphine options.** One harm reduction program shared that they work with participants to develop flyers related to MAT, withdrawal, and the options for starting buprenorphine. This approach makes flyers more participant-centered while also introducing participants to alternative options and approaches.
- **Planning for comfort**. Harm reduction program staff discussed strategies for comfort during withdrawal, such as medications, food, and even collaborations to get participants medical beds or hotel rooms for inductions. By doing so, they create transparency around the possible side effects of MAT while reassuring participants that they will have tools to support them. Staff also are thoughtful in making sure that participants understand their dosing, such as being able to follow their dosing protocol and split doses as needed.

> "How can I help you tolerate something really uncomfortable for an hour? Oftentimes that's like a few extra Clonidine, a few Gabapentin, maybe a milligram of Ativan, maybe something like a sugary treat, or a place where you can honestly, just yell and b*tch at someone. Those are the ways that we are like, 'how can we get you to manage distress?'"
>
> *- Harm reduction program staff*

Notably, harm reduction program staff's serious concern around precipitated withdrawal stands in contrast to a recent statewide assessment of clinical MAT providers and experts. In the previous assessment, most clinicians and experts de-emphasized precipitated withdrawal related to buprenorphine, describing it as a present, yet manageable challenge.[25] This difference in perspective may stem from harm reduction program staff's greater lived experience (i.e., real-world understanding of what it is like to undergo withdrawal), closer relationships with participants (i.e., participants share more of their concerns and fears openly); tendency to engage people with less stable lifestyles that may heighten the challenges of buprenorphine induction or maintenance (e.g., living on the street, mental illness) relative to patients seen by clinical providers, or other factors. Regardless of the reason for this difference in MAT provider perspectives, **the alignment of harm reduction program staff and participants on the significance of buprenorphine-related precipitated withdrawal highlights the strength of harm reduction programs in understanding the experiences and needs of their participants**.

Theme 4: Characteristics of Low-Barrier MAT

4A. Making MAT low-barrier requires numerous considerations

During interviews, harm reduction program staff emphasized the unique, low-barrier nature of their MAT services. Table 2 lists common elements of low-barrier MAT, how they support low-barrier access, and what they look like in practice. One of the elements that was particularly notable and unique was the lengths that programs go to offset pharmacy barriers (row 4).

Table 2. Example elements of low-barrier MAT at harm reduction programs

Element	Why It's Low-Barrier	What It Looks Like
Flexible MAT Access Points	Allows participants to access MAT as soon as they are ready	• Not requiring appointments • Offering evening and weekend hours • Bringing services to people during outreach
Streamlined MAT Enrollment	Reduces participant burden and wait time	• Minimal paperwork/questions (e.g., 1-page form) • No urinalysis
Same-day MAT Access	Participants do not have to come back	• Being seen within 5 – 10 minutes • Receiving medication within a few hours
Offsetting Pharmacy Barriers	Mitigates the common challenge of participants not being able to access MAT through a pharmacy	• Picking up medications for patients who cannot visit the pharmacy (e.g., lack transportation, no ID); delivering medications to patients or the program • Building relationships with pharmacies to educate them about MAT, ensure they stock buprenorphine, and advocate for respect of participants
Consistency in MAT services	Supports clarity, trust, and accountability	• Having a clear schedule for MAT services • Being reliably reachable by phone
Participant-Centered MAT Clinicians	Fosters trust and good experiences, which in turn shapes the reputation of services	• Caring providers who make participants feel heard • Providers knowledgeable about harm reduction • Providers who thought partners with participants on how to move toward their goals • No punitive policies if return to use occurs
Navigation Support	Added support may allow participants to move towards goals and use MAT	• Providing intensive case management • Supporting insurance enrollment • Advocating for respectful health care • Calling to check on MAT participants within a week
Addressing Precipitated Withdrawal	Brings attention to a top MAT concern among participants	• Being transparent about possible side effects • Centering participant concerns • Co-creating individualized MAT induction plans • Providing comfort supports to offset withdrawal
Supporting Holistic Needs	Allows participants to access basic needs and connection, which support ongoing engagement	• Hiring staff with lived experience • Providing nourishment (food, water, coffee) • Supporting hygiene (kits, showers, laundry) • Providing respite from weather (warmth, cooling) • Creating comfortable social spaces (chairs, sofas) • Providing overdose prevention supplies

Theme 5: MAT Challenges for Harm Reduction Programs

5A. Harm reduction programs strive to support staff with lived experience of drug use

While staff with lived experience of drug use—including those who have used MAT—are part of what makes MAT services at harm reduction programs so effective (see section 5), programs are still learning how to best support these staff. Meaningful support requires rethinking standards of professionalism, providing flexibility and work life balance while being clear about expectations, considering what is happening in staff members' personal lives, considering what skills they may need help with (e.g., computer skills), and recognizing that societal stigma may make it difficult for staff members to be honest about their drug use. Three strategies that harm reduction programs are employing to support staff with lived experience include:

- **Providing a spectrum of options for input and employment**. This approach reworks traditional concepts of employment to meet staff where they are, especially if they cannot take on a full-time job. Examples include flexible and adaptable work schedules and roles for staff members and volunteers to ensure that everyone feels comfortable working at the harm reduction program.

> "We provide work programs. It pays people cash to work at whatever level they're ready. They can show up for an hour or they can work all day, depending on how much work they want and what they're able to [do]."
>
> *-Harm reduction program staff*

- **Providing burnout support**. Staff with lived experience of drug use are more likely to experience vicarious trauma from losing people to overdose in both professional and personal spheres. Harm reduction program staff described burnout and trauma as requiring "really serious attention" to prevent further loss of staff and lives. One approach that harm reduction programs are employing is to provide community learning through clinical supervision—a process in which a trained clinician or support person provides group and one-on-one spaces to offer support around triggers, return to use, grief, trauma, or anything else that may come up. Interviewed program staff also emphasized the importance of connection to other people doing the work, both within and across organizations.

> "We're looking into a different type of schedule to give people a day off, which has been really challenging, because we operate every day. We are trying to find ways to prevent people from burning out…Everyone [is] trying to juggle work and their personal life, and those of us with lived experience sometimes come with a lot more needs."
>
> *- Harm reduction program staff*

- **Supporting staff growth and retention.** Harm reduction programs reported investing in staff wellness and skill-building to offset burnout and maintain a strong, experienced workforce. Several staff described strategies to promote staff and provide capacity-building and leadership opportunities. They emphasized that this process usually takes years, not days, requiring ongoing support.

> "We've promoted a lot of people. We've had people come in as participants, then volunteers, who are like, 'I can't get paid on payroll…I was like, 'okay, well, this is how we're going to support your efforts, whether it's incentives or vouchers, stipends, whatever.' Until they're like, 'I'm ready for Uncle Sam, I can get a check now.' I'm like, 'okay, are you looking for full time? Part time?'"
>
> *- Harm reduction program staff*

5B. The intersection of homelessness and drug use amplifies barriers to MAT

Harm reduction program staff frequently discussed how challenging it can be for participants experiencing homelessness to initiate and stay engaged in MAT.

In terms of **initiating MAT**, they noted how scary it can be for participants who live outside to give up a significant coping mechanism. In addition, both participants and staff noted the especially traumatizing nature of undergoing precipitated withdrawal (when starting buprenorphine) in street settings where there are fewer supportive resources (e.g., comfort medications, safe spaces, restrooms, nourishment), compared to controlled, well-resourced medical settings or comfortable private homes. Participants initiating MAT also typically interface with pharmacies, which sometimes deny medication or stigmatize them based on how they look and their prior relationship to the facility.

> "It's really daunting to not only be living outside and dealing with all the oppressive factors that people deal with when they're living outside, but then to think about letting go of, for many of them, their most significant coping mechanism. It's scary for people to take that first step, and…if you still have opiates in your system…the worst withdrawal imaginable."
>
> *- Harm reduction program staff*

> "[At harm reduction programs], you're not going to be denied anything because of the way you look, the way you smell, any of that, which we see a lot with pharmacies…Our clients are told they can't pick up their prescription because they smell bad, or because they've stolen from that store, and those are huge barriers that prevent people from getting the care they need."
>
> *- Harm reduction program staff*

With respect to **staying engaged in MAT**, many people experiencing homelessness do not have reliable access to phones, making it hard to communicate with them, and requiring harm reduction program outreach staff to create alternative forms of stable communication (e.g., consistent schedules, getting to know their neighbors, leaving medications with friends). Even when communication runs smoothly, government sweeps of encampments cause participants to lose their personal belongings

(including phones and medication) and/or make it difficult for staff to find MAT participants. Indeed, a 2025 point-in-time study of 51 California harm reduction programs found that among those participants unsheltered in the past 3 months, 69% had been forcibly displaced by police or government officials, and 54% had had their belongings taken.

> "We blame homeless people for homelessness, we blame drug addicts for addiction, and we don't look at the broader systemic context within which these things are produced. A lot of that results back to trauma, but something gave you that stress, right? So [harm reduction programs have] taken the onus and the burden of solving these huge social problems off of our clients, and we put it on for us to change the systems that have produced [this] with our services."
>
> *- Harm reduction program staff*

Ultimately, a central challenge of MAT services at harm reduction programs is the systemic context that results in opioid use disorder, homelessness, and other overlapping conditions. While programs strive to reach the people who have been most negatively impacted by these systems, the programs cannot alone solve the major upstream social problems that make MAT access so difficult.

5C. Harm reduction programs need more funding and staffing for MAT programs

To sustain and expand life-saving access to MAT, harm reduction program staff repeatedly named funding and staffing as key needs. Those who do not offer MAT directly specifically noted the importance of funding an on-site clinician to make access even more low-barrier. Some also noted that the resources it takes to circumvent pharmacy barriers is extremely challenging on small budgets.

> "It's always funding. We have funding. But we need more people. We need more days in the week. We need more hours in the day. There's such a need out there, and we're doing our best to meet it."
>
> *- Harm reduction program staff*

Harm reduction programs also reported being underrecognized for their important work. One staff member noted that harm reduction programs are often blamed for negative parts of the overdose crisis and overlooked when allocating resources. As a result, harm reduction programs often operate on a shoestring budget that causes burnout and limits what they can do. As national policy changes threaten overdose prevention funding, harm reduction programs have heightened concerns about sufficient MAT funding.

> "We've never been given the respect of people who've solved a public health crisis… If any drug problem gets out of control…its blamed on us. Really we're the water, but we're being called the spark because we don't have the resources to really tackle things…because we haven't been given the respect and resources we deserve."
>
> *- Harm reduction program staff*

Conclusions and Implications

The findings from this report have implications for funders and harm reduction programs. They may guide funders in prioritizing scarce resources to ensure MAT is accessible to those more vulnerable to overdose deaths and drug related harms. They may also support harm reduction programs with tangible strategies to expand MAT access through low-barrier services.

Key take-aways from this qualitative assessment

- **MAT models at harm reduction programs are not one-size fits all, with a range of services, staffing, and budget**. Programs may offer MAT through referral, through the support telehealth, through on-site substance use navigators (SUNs), or onsite.
- **MAT services are perceived as effective by program staff.** They feel that MAT is saving lives and making a difference for their participants. They also feel that their MAT services are reaching people who otherwise would not be engaged in the health care system.
- **Harm reduction programs are effective at MAT delivery because they do MAT differently.** They do so by providing nonjudgmental, participant-centered services that carry less stigma than traditional clinical settings. The lived experience of staff builds trust and authentic connection with MAT clients.
- **"Low-barrier" MAT contains numerous elements.** Examples include minimizing enrollment burden, offering same-day services, facilitating pharmacy services, prioritizing thoughtful discussions about precipitated withdrawal, and providing resources to support basic needs.
- **Harm reduction programs that provide MAT face steep challenges**. These include insufficient funding and staffing, burnout, and the inability to address upstream social factors that influence drug use and MAT engagement, such as the housing crisis and inadequate mental health resources.

Implications of this qualitative assessment

- **Innovative low barrier MAT does not happen without funding, so funders can continue to support harm reduction programs to ensure that MAT is accessible to populations who need it**. Beyond sustaining current funding or initiating new funding, funders can consider the reality that many harm reduction programs are at risk of funding loss under evolving federal conditions. As harm reduction organizations already describe being short-staffed and tight on budget without these federal cuts, expanded resources are likely needed to sustain their MAT services.
- **Harm reduction programs planning to implement MAT services can learn from the insights in this report.** For example, they might identify a model to explore, consider how

their agency can support low-barrier MAT services, and/or mimic strategies that support staff with lived experience. A separate resource has been developed from this report to provide specific guidance to harm reduction programs on MAT services.

Appendix: Methods

Overall Approach



The Center at Sierra Health Foundation hired a public health consulting firm (Facente Consulting) with expertise in qualitative research and community engagement methods, as well as content expertise in harm reduction and MAT to lead this project. Facente Consulting was tasked with engaging California harm reduction program staff and participants affiliated with programs that offer MAT, to ultimately elicit their perspectives on MAT services at harm reduction programs.

Recruitment



With guidance from The Center, Facente Consulting reached out to harm reduction program staff by email to request their participation in an interview. To conduct as many in-person interviews as possible, interview slots were set to occur at the California Syringe Exchange Programs (CASEP) conference (October 2–3, 2025). Facente Consulting also offered a virtual interview option (via Zoom) for any harm reduction program staff who were not attending the CASEP conference. Harm reduction program participants were then recruited with support from the interviewed harm reduction program staff, who outreached to participants using their MAT services and helped them access Zoom for a virtual interview with Facente Consulting.

In addition, Facente Consulting reviewed previously collected data from a 2025 statewide analysis of the MAT landscape led by The Center. The data came from 20 previous interviews with harm reduction program staff, two focus groups with harm reduction program participants who used MAT, and four focus groups with harm reduction program participants who used opioids but were not using MAT.

Instrument Design



Facente Consulting collaborated with The Center to develop interview and focus group guides. Guides for harm reduction program staff focused on understanding how their MAT programs operate, their strengths (with emphasis on specific strategies employed to deliver effective MAT services), and their challenges. Guides for harm reduction program participants explored their perspectives on MAT overall, as well as their experiences accessing MAT or other services through harm reduction programs.

Data Collection



Considering both the new and previously collected data, Facente Consulting ultimately interviewed 42 staff from 16 California harm reduction programs, while interviewing or

leading focus groups with 17 harm reduction program participants who use MAT and 47 harm reduction program participants who use opioids but are not on MAT. Interviews and focus groups were audio-recorded with the consent of those participating.

Data Analysis



Facente Consulting transcribed interview and focus group audio via a third-party transcription platform (Otter.ai) and subsequently cleaned transcripts. Facente Consulting then imported transcripts into a qualitative analysis platform (Dedoose). Two Facente Consulting staff collaboratively developed codebooks (one for harm reduction program staff and one for harm reduction program participants) and refined the codebooks after piloting them with three transcripts. They then coded all transcripts, with the resulting codes reviewed, discussed, and grouped into themes.

References

1. Substance Abuse and Mental Health Services Administration (SAMHSA). National Survey on Drug Use and Health (NSDUH), 2023 - 2024. Accessed June 8, 2026. https://www.samhsa.gov/data/sites/default/files/reports/rpt56986/2024-nsduh-sae-state-tabs1/2024-nsduh-sae-state-tabs-california.pdf
2. California Overdose Surveillance Dashboard. 2024. Accessed June 8, 2026. https://skylab.cdph.ca.gov/ODdash/
3. Kaiser Family Foundation. Opioid Overdose Death Rates and All Drug Overdose Death Rates per 100,000 Population, 2025. Accessed June 8, 2026. https://www.kff.org/mental-health/state-indicator/opioid-overdose-death-rates/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
4. Kaiser Family Foundation. Opioid Overdose Deaths and Opioid Overdose Deaths as a Percent of All Drug Overdose Deaths, 2024. Accessed June 8, 2026. https://www.kff.org/mental-health/state-indicator/opioid-overdose-deaths/?currentTimeframe=0&selectedDistributions=opioid-overdose-deaths&sortModel=%7B%22colId%22:%22Opioid%20Overdose%20Deaths%22,%22sort%22:%22desc%22%7D
5. New Public Health Report Shows Homeless Mortality Rate Plateaued for Second Consecutive Year in 2023 - Report Highlights that Preventative Work Must Continue. 2025. http://publichealth.lacounty.gov/phcommon/public/media/mediapubhpdetail.cfm?prid=4980
6. Centers for Disease Control and Prevention (CDC). CDC Reports Nearly 24% Decline in U.S. Drug Overdose Deaths (2025). Accessed June 8, 2026. https://www.cdc.gov/media/releases/2025/2025-cdc-reports-decline-in-us-drug-overdose-deaths.html
7. Oesterle TS, Thusius NJ, Rummans TA, Gold MS. Medication-Assisted Treatment for Opioid-Use Disorder. Mayo Clinic proceedings. 2019/10/01/ 2019;94(10):2072-2086. doi:https://doi.org/10.1016/j.mayocp.2019.03.029
8. Sordo L, Barrio G, Bravo MJ, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. (1756-1833 (Electronic))

9. Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association With Mortality. Annals of internal medicine. 2018;169(3):137-145. doi:10.7326/m17-3107 %m 29913516

10. Ma J, Bao Y-P, Wang R-J, et al. Effects of medication-assisted treatment on mortality among opioids users: a systematic review and meta-analysis. Molecular Psychiatry. 2019/12/01 2019;24(12):1868-1883. doi:10.1038/s41380-018-0094-5

11. Wakeman SE, Larochelle MR, Ameli O, et al. Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. JAMA Netw Open. Feb 5 2020;3(2):e1920622. doi:10.1001/jamanetworkopen.2019.20622

12. Timko C, Schultz NR, Cucciare MA, Vittorio L, Garrison-Diehn C. Retention in medication-assisted treatment for opiate dependence: A systematic review. Journal of addictive diseases. 2016/01/02 2016;35(1):22-35. doi:10.1080/10550887.2016.1100960

13. California Awards $19.3 Million to Enhance Opioid Treatment. December 17, 2024. https://www.dhcs.ca.gov/formsandpubs/publications/oc/Pages/2024/24-42-Low-Barrier-OUD-Treatment-12-17-24.aspx

14. RTI International, National Harm Reduction Coalition, and California Department of Public Health. California Overdose Prevention & Harm Reduction Initiative: 2025 Point-in-Time Survey. presented at: California Syringe Exchange Programs (CASEP) Conference; 2025

15. Wenger LD, Kral AH, Bluthenthal RN, Morris T, Ongais L, Lambdin BH. Ingenuity and resiliency of syringe service programs on the front lines of the opioid overdose and COVID-19 crises. Transl Res. Aug 2021;234:159-173. doi:10.1016/j.trsl.2021.03.011

16. Del Pozo B. CommunityStat: A Public Health Intervention to Reduce Opioid Overdose Deaths in Burlington, Vermont, 2017-2020. Contemp Drug Probl. Mar 2022;49(1):3-19. doi:10.1177/00914509211052107

17. Castillo M, Conte B, Hinkes S, et al. Implementation of a medical student-run telemedicine program for medications for opioid use disorder during the COVID-19 pandemic. Harm reduction journal. Nov 17 2020;17(1):88. doi:10.1186/s12954-020-00438-4

18. Ijioma SC, Pontinha VM, Holdford DA, Carroll NV. Cost-effectiveness of syringe service programs, medications for opioid use disorder, and combination programs in hepatitis C harm reduction among opioid injection drug users: a public payer perspective using a decision tree. J Manag Care Spec Pharm. Feb 2021;27(2):137-146. doi:10.18553/jmcp.2021.27.2.137

19. Krawczyk N, Allen ST, Schneider KE, et al. Intersecting substance use treatment and harm reduction services: exploring the characteristics and service needs of a community-based sample of people who use drugs. Harm reduction journal. Aug 24 2022;19(1):95. doi:10.1186/s12954-022-00676-8

20. Simpson KA, Bolshakova M, Kirkpatrick MG, et al. Characterizing Opioid Withdrawal Experiences and Consequences Among a Community Sample of People Who Use Opioids. Substance use & misuse. 2024;59(6):886-894. doi:10.1080/10826084.2024.2306221

21. Masson CL, Knight KR, Levine EA, et al. Barriers to Buprenorphine Treatment Among People Experiencing Homelessness: A Qualitative Study from the Provider Perspective. Journal of Urban Health. 2025/04/01 2025;102(2):465-475. doi:10.1007/s11524-025-00967-y

22. Wyse JJ, Eckhardt A, Waller D, et al. Patients' Perspectives on Discontinuing Buprenorphine for the Treatment of Opioid Use Disorder. Journal of addiction medicine. May-Jun 01 2024;18(3):300-305. doi:10.1097/adm.0000000000001292

23. Teruya C, Schwartz RP, Mitchell SG, et al. Patient perspectives on buprenorphine/naloxone: a qualitative study of retention during the starting treatment with agonist replacement therapies (START) study. J Psychoactive Drugs. Nov-Dec 2014;46(5):412-26. doi:10.1080/02791072.2014.921743

24. The Center at Sierra Health Foundation. Exploring the Landscape of Medications for Addiction Treatment (MAT) in California: Findings from a Statewide Assessment." 2025. https://facenteconsulting.com/wp-content/uploads/MAT-in-CA_Landscape-Analysis_2025_FINAL.pdf