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Policy Volatility and Service System Strain: Ethnographic Insights From Opioid Response Infrastructures in Central and Upstate New York

Structured Abstract

Objectives

To examine how rapid federal policy shifts between 2025 and 2026 affected frontline opioid response infrastructures, focusing on administrative burden, workforce strain, and continuity of care.

Methods

This qualitative ethnographic study draws on archival research and semi-structured interviews conducted between August 2025 and February 2026 in Chenango and Oneida Counties, New York, United States. Twenty-two stakeholders across governmental, nonprofit, and faith-based opioid and homelessness service systems participated. Data included expanded field notes, analytic memos, and policy documents. Inductive–deductive thematic analysis was employed.

Results

Three primary themes emerged: (1) administrative crisis management and time reallocation, (2) moral and institutional burden under policy volatility, and (3) governance disruption and bureaucratic recalibration. Participants described diversion of labor toward compliance restructuring, anticipatory burnout, and operational paralysis caused by policy ambiguity.

Conclusions

Policy instability introduces systemic strain extending beyond funding loss to affect workforce retention, service continuity, and institutional trust.

Public Health Implications

Continuum-of-care systems depend on administrative predictability and workforce stability. Policy volatility risks undermining harm reduction, housing access, and treatment engagement during sustained overdose mortality.

Introduction: The political climate and public conversations in the United States between November 2024 and February 2026 have been shaped by interpretations and fierce debate surrounding anticipated and announced funding and support changes and executive orders issued by Trump's administration. Out of 240 orders signed between January 2025 and February 2026, 18 were directly aimed at changing health care, pharmaceutical industry, and research landscapes and priorities in the United States.[1] More importantly for the discussion that follows, a number of policy changes associated with some of these executive orders experienced rapid reversal due to immediate (and ongoing) backlash.[2] Most of the critiques that emerged in the aftermath of quick and sudden executive orders, and their consequential reversal, have been associated with themes of violation of free speech and the First Amendment.[2] The polarizing orders, and subsequently polarizing and fierce responses, have mirrored ongoing and growing divisions in public opinion.

Concretely, two main political conversations, and associated policies, have affected the terrain of providing care and support for those affected by substance use disorders. First, Executive Order 14151, "Ending Radical and Wasteful Government DEI Programs and Preferencing" (Jan 20, 2025). This order resulted in loss of funding for a number of programs aimed at reducing health disparities within marginalized communities, programs focusing on environmental justice, and affected support for specialized and targeted health initiatives.[3,4]

Second, on July 24, 2025, President Trump issued Executive Order 14321, titled "Ending Crime and Disorder on America's Streets."[5] This order, among many other things, prioritizes treatment over the "Housing First" model, which had been theoretically dominant for a number of years.[6,7] Further, it discourages funding of programs that focus on, or implement, harm reduction tools and strategies.[5] Harm reduction techniques have been shown to reduce immediate overdose risk and related harms[8] and increase the likelihood of individuals affected by OUD (opioid use disorder, hereafter OUD) engaging in recovery programs.[9]

The urgency of these policy shifts must be understood within the broader epidemiologic context of the opioid crisis. In 2023 alone, the United States recorded more than 100,000 drug overdose deaths, with synthetic opioids accounting for the majority of fatalities.[10,11] Overdose mortality has disproportionately affected rural and postindustrial regions, where service infrastructures remain under-resourced and highly dependent on federal and state funding streams.[12]

Harm reduction interventions, including naloxone distribution, syringe service programs, and medication-assisted treatment, have been shown to significantly reduce overdose mortality and infectious disease transmission.[8,13] Syringe service programs alone are associated with approximately a 50% reduction in HIV and hepatitis C transmission risk,[13,14] while naloxone distribution initiatives have been linked to substantial decreases in fatal overdose rates.[8] Participation in harm reduction programs also increases the likelihood of individuals engaging in long-term treatment and recovery services.[9]

Rapid policy shifts and reversals are known to disrupt implementation infrastructures, producing administrative uncertainty, programmatic delays, and workforce strain.[15] Policy volatility can undermine continuity of care, particularly in systems reliant on grant-based funding and regulatory compliance.[15,16]

During 2025 and early 2026, many venues, both academic and public, have focused on the effects of these sudden changes, proclamations, executive orders, and associated policies on the quality of programs addressing the continuum of care, and the impact these programs can have given unstable and precarious funding and support.[4] This research shifts focus from those affected by OUD to closely examine the effects these turbulences have on individuals occupying roles as service providers, project managers, government employees, NGO leaders, and outreach program facilitators. This shift is not an evaluation of importance; rather, it is a pursuit to bridge the gap in ethnographic data evaluating the tangible effects of politics, writ large, on day-to-day work, resources, and labor invested into prevention and harm reduction.

Existing research has documented high levels of burnout, administrative burden, and workforce attrition among public health and social service providers, particularly in the aftermath of COVID-19 and during periods of funding instability.[17,18] Service providers operating within opioid response systems face compounded pressures associated with regulatory shifts, reporting

requirements, and resource scarcity.[15,16] This paper analyzes how macro-political shifts are experienced and operationalized within frontline service infrastructures responsible for opioid response.

Methods: This article uses data collected between August 2025 and February 2026. The study employed a qualitative ethnographic design and involved human subjects research. The project received approval through an exemption determination from the researcher's home institution Institutional Review Board and was reviewed under the protocol entitled "Navigating Care Barriers in the Opioid Epidemic" (approved October 22, 2025).

Research methods included archival and media research (August 2025–February 2026) and semi-structured individual and collective interviews (November 2025–February 2026), and the data used for this paper consist of expanded interview notes, analytic memos, and archival materials. Archival and media research provided necessary contextual background and narrative corroboration.

The themes of conversations with informants focused on their experiences providing a variety of services associated with OUD prevention and harm reduction. Given that many conversations were open-ended, participants had the liberty to lead the discussion. Concrete topics covered through interviews included policy changes, funding shifts, reporting guidelines, service disruptions, and personal and professional workforce strain.

This paper focuses on conversations with 22 individuals and uses data from 15 interviews (14 individual interviews and one group conversation). Contributions within the group interview were documented and coded individually where possible, while the discussion was also analyzed as a collective data source. The average duration of interviews was 90 minutes, and participants were reminded of the voluntary nature of their participation in accordance with IRB guidelines. Participants provided informed consent prior to participation, and all identifying information was removed from transcripts to ensure confidentiality.

All participants were selected based on their roles as stakeholders in opioid response and homelessness service delivery across governmental, nonprofit, and faith-based sectors. Participants included county commissioners, government representatives, opioid program

coordinators, harm reduction practitioners, Catholic Charities staff, and leaders of homeless service coalitions.

Purposive snowball sampling was employed to recruit participants occupying key roles in opioid response governance and service delivery. Initial contacts were identified through institutional affiliations and professional networks, and additional participants were recruited via referral. This approach, widely used in qualitative anthropology and ethnographic public health research, facilitated access to specialized administrative actors who are often difficult to reach through conventional sampling frames.[19]

Given the nature of the project, this method was the most reliable strategy for conducting highly reflexive interviews with individuals possessing extensive experience and the ability to provide comparative and informed evaluations of ongoing changes.

Data were collected in Chenango and Oneida Counties in New York, allowing for layered analysis of discrepancies and differences in services available across both rural and urban spaces.

Interviews were not audio-recorded due to the sensitivity of governance and policy discussions. Detailed contemporaneous notes were taken during each interview and expanded immediately afterward to produce comprehensive narrative records. These expanded notes, alongside analytic memos developed following each conversation, constituted the primary data corpus and were stored on encrypted institutional servers.

Open coding was conducted across interview records to identify emergent analytic categories, which were subsequently grouped into broader thematic domains. Initial codes were compiled into a codebook that was iteratively refined during analysis. Through cross-interview comparison, recurring institutional experiences were identified. Later interviews reinforced rather than expanded thematic content, indicating analytic sufficiency. Inductive–deductive thematic analysis was used to refine the analytic framework and categories.[20]

The study focused on service systems operating in Central and Upstate New York, a region experiencing high opioid overdose burden and evolving harm reduction policy infrastructures.[10,11] Individuals participating in the study are or have been associated with 17 different entities involved in prevention and harm reduction programming. Despite the

researcher's institutional outsider status, participants frequently described interviews as a rare opportunity to reflect openly on governance pressures and service system strain.

Results: Through inductive–deductive thematic analysis, I established three themes relevant to this paper: administrative crisis management and time reallocation; moral and institutional burden under policy volatility; governance disruption and bureaucratic recalibration.[20]

In this section, I analyze each of the major themes with the goal of situating and understanding the relationship between politics, governance, and public health outcomes associated with the opioid crisis. Across all interviews conducted as part of this research, there is a shared sense of worry, anticipation, and uncertainty in relation to the future of different programs and intervention techniques, as well as in relation to economic and professional precarity. There have been several exceptions, where professionals closer to retirement expressed primarily concern over the future of programs and the potential loss of momentum of intervention initiatives they helped build. I address these differences in the final part of this section.

Administrative Crisis Management and Time Reallocation

As many participants, when engaged in conversation about day-to-day changes to their routine and the effects of the aforementioned executive orders, began describing the amount of work and focus required to address these instabilities, I quickly introduced more concrete questions into the interviews:

"Can you describe the routine monthly workload associated with different programs you are working on?"

followed by:

"Has there been any change to that during 2025 and early 2026? Can you compare and describe your experiences?"

Every participant was not only ready to contrast and describe the differences between pre-2025 and 2025–2026 workloads, but also clearly expressed affective sentiments of frustration and a desire to quantify the time or energy invested in responding to funding and support changes.

Several, when prompted to provide additional detail and reflection, offered evaluations of the number of workdays or hours spent navigating precarious shifts. Some placed estimates—based on their own knowledge—on the corresponding salary allocated for "crisis management."

These estimates varied greatly and were shaped by different levels of engagement with various programs, as well as by corresponding familiarity with program costs and budgets. The goal of this paper is not necessarily to produce an exact calculation of hours used to respond to executive orders; rather, it is to qualitatively interpret impressions, sentiments, and the overwhelming sense—shared across professionals and institutions—of how a volatile political climate affects the (dis)continuity of care in the realm of OUD and public health efforts, particularly within administratively burdened service systems.[15]

A very similar sense of time loss emerged across conversations:

"I would spend three weeks preparing the project proposal. With the (terminology) change, I had to spend another three weeks and even more making sure that everything is compliant."

or

"It was two days nonstop. We didn't do anything else. We just had meeting after meeting doing this (organizing strategies)."

Even though an exact number of days spent responding to policy changes cannot be extracted through this research, based on informant statements I estimate that somewhere between 1 and 2 months of 2025—or roughly 8–16% of annual workload—was redirected toward "crisis management." This is a crude estimate and does not account for creative and emotional labor invested in limiting losses, ensuring continuity of care, and reducing precarity across partnering programs.

Moral and Institutional Burden Under Policy Volatility

Interviews were initially designed to last between 45 and 60 minutes, but most extended to approximately 1.5 hours, with one lasting well over 2.5 hours. This expansion reflected emotional and intellectual investment from participants.

When asked about workload, evaluations of added time were intertwined with reflections on stress related to precarity. Most relevantly, participants frequently articulated anticipation that projects and programs they worked on would no longer reach the same groups. They narrated long-term commitments to outreach outcomes, the difficult journeys organizations underwent in establishing trust, and the time it took to "get initiatives going."

Without prompting, most participants expressed pride, ownership, and excitement about program impacts. One long-term coordinator working for a religious charity stated:

"I want to see this (structure of collaboration) replicated."

Some expressed concern about burnout and financial stability:

"I lost my job for two days. I didn't even know I had lost it. Now I look for a job every evening. I go to work, work a lot, and then look for something else."

This individual, an experienced woman in her early 30s, described a once-stable career trajectory that now felt uncertain. She was exploring positions requiring entirely different skill sets, expressing concern that precarity was "spreading" across initiatives due to discontinued funding.

Similarly, another woman in a leadership role stated:

"I know what to do if this disappears (support for the main project). For years I have worked on this side project—it is funded completely privately. It is… wonderful, and I love it. Though, I have been doing this (primary program) since the 90s."

Statements like these signal not only financial anxiety but grief over potential program loss. Participants were deeply invested in the initiatives they built and were eager to provide success examples. Every interview contained multiple success stories contextualizing perceived funding threats.

Responsibility toward coworkers also emerged:

“We got the notice… I got mine at 1 am. And I had to let two people go. By tomorrow at 6 pm, I could keep them. I am encouraging them to apply elsewhere, but I hate to lose them. The thing is… I don't know if I will have funds for them. I might… I might not.”

This participant then spoke at length about the professional and personal value those staff brought. Relationships between service providers and program managers often became intimate—grounded in shared growth, trust, and mutual concern—echoing relational dynamics documented in frontline service bureaucracies.[16]

Governance Disruption and Bureaucratic Recalibration

Across most interviews, confusion emerged as a central theme. Instability and precarity were compounded by an inability to respond in a timely manner due to lack of information and policy clarity.

One program manager stated:

“You know, they told us that we have to state how we want to proceed. But it took weeks to actually get information on how our decision should be communicated to them.”

Similarly, others noted:

“It is not just the language. It is that we don’t really know what the guidelines are. There is so much uncertainty, vagueness…”

Many described “not knowing what to do.” They attempted to rapidly close out funds, abruptly end programs, and discontinue services that sometimes resumed days later. Interruptions were intensified by ongoing legal disputes:

“You know, we hear there is a lawsuit going on… But what will that help me until it's done? I have to know what is happening now.”

Constraints were shaped by the need to react immediately—and the inability to do so due to bureaucratic opacity, a pattern consistent with administrative burden and street-level governance disruption.[15,16]

Similarities and Differences

The most notable differences in experiences were shaped by perceived employment precarity and professional tenure. Participants with 5–10 years of experience focused on projects currently serving communities and fears of disruption. Those with 10–20+ years emphasized long-term systemic change and concern that recent progress would lose momentum, requiring years to "get back on track."

Discussion: Opioid use disorder is shaped by instability on multiple scales. First, individual experiences change day to day and are deeply interpersonal. Relationships between those diagnosed with OUD and their friends and family often suffer from frequent and temporal turbulence. An individual diagnosed with OUD usually requires a complex and multilayered support system before moving across different intervention tiers and making tangible progress in their recovery journey.[23] Even then, seasonal challenges and personal circumstances can easily disrupt the sensitive balance and trajectory of recovery.[24] Some of these emotional and structural disruptions can lead to fatal outcomes.[25] Thus, uncertainty is embedded in the work of those engaged in harm reduction programs.

Politically charged policy changes during 2025–2026 have introduced a scale of uncertainty unmatched in recent years. My research suggests observed improvements in outcomes associated with available services in recent years; there is now a concern that this trajectory may reverse. Harm reduction and Housing First have been shown to be instrumental for continuous support and are frequently evaluated as powerful strategies that reduce detrimental effects of the opioid crisis.[6,8]

Executive orders affecting funding opportunities, and directly the continuity of care available to those who need it, are introducing instability that many of the professionals I worked with did not previously consider a routine element of program development. This shift—from navigating individual crises and adapting support to accommodate personal needs of someone affected by opioid use disorder—has transformed into multilayered precarity across governmental, institutional, professional, and personal levels.

Most individuals I spoke with shared that funding stability previously meant certainty spanning 2–5 years. Now, many previously regular funds have been revoked; even more detrimental is the perception that remaining funds could disappear at any moment. Further, and even more relevant to the ongoing anxieties my informants expressed, the ideological shift—visible in efforts to change terminology and framing of programs and priorities—threatens already built foundations of opioid harm remediation.[26]

As several participants expressed concern over prescribing trends, they pointed toward a sense that the opioid crisis is not abating. In their view, current circumstances may result in a crisis of significantly larger proportions than previously recorded. Some referenced anecdotal evidence of emerging outbreaks associated with hepatitis infection and growing HIV rates in several communities, speculating that these may be linked to loss of needle exchange programs.[13,14]

These anticipatory fears signal that interlocutors are wary of the future and alert to change within their communities. While this vigilance can be productive in public health contexts, it may also destabilize the foundations of successful OUD intervention and prevention programs. Having sufficient time to evaluate community priorities—and confidence when guiding an individual affected by OUD that services will remain available—are central to all aspects of continuum-of-care programming.[23,27]

However, this study is based on a qualitative sample of service providers operating within a specific regional context in Central and Upstate New York, and findings may not be generalizable to all opioid intervention infrastructures nationally. As participants were recruited through purposive snowball sampling, this research may privilege perspectives of institutionally connected actors while underrepresenting more peripheral or informal service providers.

Public Health Discussion: Public health relies on several interrelated domains of activity. Continuum of Care has been one of the strongest bridging strategies establishing continuous access to health-related services.[27] Most study participants engaged with programs aimed at connecting services available to vulnerable and marginalized populations. For years, they focused on growth, trust, support, and stability as guiding strengths of intervention strategies.

Now, as analyzed above, many perceive a loss of continuity and personal ability to contribute as meaningfully as before.

For some, this has culminated in signs of burnout; for most, it has produced a distinctly new anticipatory concern that they will be forced to pursue different professional trajectories. This burden is not only temporal and emotional for individuals currently employed in public health sectors; it has potential to affect future educational enrollment patterns, hiring strategies, and incentives for professional mobility.[17,18]

Findings suggest that intervention infrastructures reliant on short-term or politically volatile funding streams may benefit from longer stabilization cycles that buffer frontline programs from abrupt policy reversals.[15] Further, targeted retention and employment protections may serve as valuable strengthening strategies for OUD-associated programs and public health projects more broadly.[17]

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