

Research paper

Improving health and social care relationships for harm reduction

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Abstract

This paper explores elements of the relationships that develop between people who use illicit drugs and people who provide services to them. It focuses on expectations people who use drugs and service providers have of health and social care relationships for harm reduction, as well as facilitators and barriers to effective and ineffective interactions, and to what governments might better do to help strengthen interactions. Prior to Canada's inaugural national harm reduction conference, informal discussion groups were organized to source local views regarding policy reform for harm reduction. One component of these discussion groups focused upon improving health and social care relationships for harm reduction. Community-based organizations providing services for harm minimisation were consulted to help develop themes and questions. Discussion groups conducted in French or English were held in 10 cities across Canada. Groups were audio-recorded, transcribed and thematically analysed. Disjuncture between understandings of the nature of health and social care relationships for harm reduction were found. Interpersonal and structural factors functioned both for and against the development of effective interactions. Differences in expectation sets held by illicit drug users and service providers may reflect the fluid experience of boundaries as a population on society's margins moves between harm-causing and harm-reducing behaviours and identities. The research described in this paper targeted those most directly involved in receiving, developing and delivering harm reduction programmes across a very diverse nation. It did so by including representatives of those most directly involved in utilizing and providing services within the research process itself. By incorporating a process that was community-based, user-driven, and which strived to be non-judgmental, the research was able to explore suggestions for improving health and social care relationships for harm reduction proffered by professionals actively providing services, as well as a variety of users, including some isolated or structurally excluded from service access by geography, illiteracy and/or street-involvement.

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Introduction

Targeted health and social care services for illicit drug users which include harm reduction is one of the benchmarks of a continuum of care within many health systems. As harm reduction services continue to develop, new and evolving understandings of the nature and extent of illicit drug use have called for modifications to service provision. One result is that some previously stigmatised and criminalised behaviours and lifestyles have been re-examined and re-considered. In many jurisdictions, both

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government policy makers and service providers have met evolving practice by fine-tuning harm minimising health and social care services to make them more cost effective and more responsive and meaningful to a range of different kinds of drug users. An ongoing goal is often to continue to improve services, and to ensure they meet the needs and requirements of consumers while being responsive to evolving client need and expectation (Laing, 2002).

Of those service providers who deliver health and social care to people who use drugs, some appear to have been more effective than others in affecting such shifts. Many community pharmacists, for example, have successfully introduced ground rules for the services they provide, as have some clinic-based counsellors (Myers, Cockerill, Worthington, Millson, & Rankin, 1998; Matheson, Bond, & Pitcairn, 2002). Less has been documented of the expectations and experiences of street-based and other service providers and the health and social care relationships they develop with illicit drug users. Although there is considerable public and academic debate over the success, efficacy and ultimate value of services for harm minimisation (McKeganey, Morris, Neale, & Robertson, 2004; Reuter & Pollack, 2006) – both in terms of its outcome and its cost – there is some consensus within the literature that making harm reduction services available for a variety of drug dependencies is desirable both for the reduction of drug-related harm as well as drug dependence cessation (McLellan et al., 1996; Hser, Anglin, Grella, Longshore, & Prendergast, 1997; Prendergast & Podus, 2000). Provision, to quote Reuter and Pollack “can justify itself in terms of reductions in harms to individuals and communities” (2006:341). Not only can sensitively delivered services help to reduce the harm associated with an individual’s drug use, they can lead also to broader improvements in health and employment outcomes and reduction in the risk of other harms, like crime and related violence (Grosenick & Hatmaker, 2000). Often, however, minimising harms associated with illicit drug use may necessitate some shift in the ways providers and others envision and understand the use and needs of people and subcultures who either exist below society’s radar or function at its edge. For drug users, as for other marginal groups, the migration between harm-causing and harm-reducing behaviours can require some movement between one social order and identity to another (Park, 1928).

This paper examines experiences within health and social care services as one element of the harm reduction continuum. It explores how a sample of illicit drug users and those who provide services to them experience care, and some of the expectations users and providers have of these working relationships. It examines some similarities in terms of the experiences of these two groups of stakeholders as well as where sets of expectations and experiences may differ. It explores also the kinds of beliefs participants voiced about how governments in general could

help improve health and social care relationships for harm reduction.

In November 2002, Canada held its first nation-wide harm reduction conference in Toronto. This was a gathering of current and former drug users, peer educators and front-line workers to respond to critical and emerging issues through three primary streams: skills building and education, policy development and networking. Within the context of the conference, harm reduction was defined as: “a practical approach to drug use. It recognizes that quitting drugs may not be realistic or desirable for everyone.” (Ages, Allman, & Cowan, 2003).

The event was a long time in the making. As early as 1997, a Canadian national task force on HIV/AIDS and injection drug use had stated that the country was in the midst of a public health crisis concerning HIV and injection drug use, as the virus was continuing to spread in vulnerable populations with little regard for geographical boundaries (Canadian Centre on Substance Abuse and Canadian Public Health Association, 2001). One response to this crisis was envisioned as a national meeting where harm reduction proponents could share harm minimising strategies, education methods and networking skills. As evidence-based decision making has a demonstrated track record as a basis for substance abuse and harm reduction policy (United Nations Office for Drug Control and Crime Prevention, 2002), the funding body and the conference organizers preceded the conference with a community-based national pre-conference needs assessment. Research was to become central component of the conference, in part, because community and governmental stakeholders hoped it could be a mechanism to bring local views forward prior to the event to inform the conference organization and programme, and to help orient discussions on policy reform for harm reduction in Canada (Allman, 2002). Within this context, the research activity functioned as a mechanism to allow conference organizers to understand the full range of potential supports and services required to help guarantee the safety and well-being of attendees – the majority of whom would be illicit drug users or service providers.

Method

Early in the planning stages of the first Canadian national harm reduction conference, current or former illicit drug users with ties to their communities were recruited from across the country to act as peer networkers. Existing communication networks were built upon to recruit 15 individuals. These networkers were frequently the research teams’ point of community contact, undertaking local coordination, promoting research data collection and providing feedback on data collection instruments. Researchers sought to recruit as broad a sample as possible for discussion groups through advertising, the internet and word-of-mouth. Discussion groups were conducted in five regions. Discussion groups were

equally divided between larger metropolises and smaller cities and remote or rural towns. Groups were organized by peer networkers and host agencies and conducted by researchers. Each participant was offered a small honorarium to cover costs associated with attending. Groups lasted approximately 90 minutes, and were conducted in French or English. A discussion guide was developed in consultation with peer networkers and research advisors. Groups were audio-recorded, transcribed and thematically analysed (Babbie, 1999). Data coding was structured on qualitative data handling practice following Ritchie & Lewis (2003). This included initial coding to identify themes, the addition of a second coding layer to identify broader social concepts, and the utilization of a third analytic layer to move from initial concept identification to explanation. Techniques for analysis were further influenced by the grounded theory of Strauss (1987), and the open coding of Strauss & Corbin (1990).

All participants provided informed consent to participate in the research and to have the results disseminated in a variety of ways. The provision of informed consent was an active process achieved by discussing the research and consent process with participants in order to ensure that all understood participation was wholly confidential. To ensure this, no demographic information was collected nor were specifics of actual drugs used or services accessed explored. Further, all dissemination of these research activities avoided attribution to any one data collection region. In order to assist the analysis presented here, names to which quotes are attributed are generated by a random, gender neutral name generator.

The objectives of the discussion groups were to discuss the upcoming conference; to reflect upon local and national networking for drug users and service providers; and to consider the nature of effective health and social care relationships. This paper focuses on the latter objective. To explore this topic, three broad questions were discussed: (i) what makes for good working relationships between people who use drugs and service providers; (ii) what can damage these relationships; and (iii) what could governments do to strengthen these relationships?

Results

In total, 20 discussion groups were held, 10 for current illicit drug users and 10 for service providers and previous illicit drug users. Seventy-four individuals participated in discussion groups for drug users and 60 in groups for service providers and previous users. Attendance ranged from three to 10 individuals. Groups were held in three large metropolitan cities of between one and four million residents, three mid-size cities of between 200,000 and 900,000 residents, and three small, remote cities of between 25,000 and 75,000 residents. Sixteen discussion groups were conducted in English and four in French.

Characteristics of effective relationships

Similar characteristics described by both illicit drug users and service providers

In general, discussions revealed many common experiences and expectations of effective health or social care relationship relationships, and factors that helped facilitate their developments. “Attentive” interaction, that is, the utility of service providers to actively and attentively listen and respond to information shared within health and social care relationships was seen as beneficial. A second valued characteristic commonly described was “direct” interaction, that is, service providers who could be “straight up” or direct within a health and social care interaction. “Confidentiality” was described as an important characteristic, as actors entered service situations with the expectation and hope that service providers would maintain and not disclose information provided. The maintenance of confidentiality was seen as primary and essential to developing “trust,” as was the service provider who was “patient.” Discussants frequently described the advantages of service provision that demonstrated patience across various stages of health and social care interactions, particularly for clients who either had ceased to consume illicit drugs or had reduced harms associated with such use and subsequently relapsed. The wish for “respectful” service provision and “supportive” interaction, regardless of whether the provider might express personal feelings (sympathy or empathy) concerning a client’s circumstances, lifestyle choices or drug use was frequently described. “Non judgmental” service provision was a further characteristic described as beneficial, that is health and social care services that did not pass judgment on substance use, lifestyle choices, or individual or group characteristics.

The most frequently discussed effective component of health and social care relationships would describe a provider as “experiential”, that is a service provider who “had been there; done that;” who had personal experience with drug use. This referred particularly to those who may have successfully managed to migrate from harm-causing to harm-reducing or abstaining activities. Experience was seen as a most important element of these interactions as it allowed service providers to understand where people “were really at.” Being experiential most often meant the service provider had a history of drug use, and had subsequently moved beyond their drug use. Those who had been there and had exited successfully were viewed as particularly able to understand the realities of a life that included illicit drugs, as well as the challenges faced by those attempting to cease or reduce drug-related harm. The very existence of such service providers was contextualised “as an example and an inspiration.”

Variation in descriptions of effective service relationships

Beyond the common characteristics most discussants agreed were instrumental in forging effective health and

social care relationships were a series of diverging characteristics which different sets of participants used to describe effective service relationships for drug-related harm reduction. For illicit drug users, these included service providers who were “experienced” in service provision for harm reduction (as opposed to experiential); who were “known” and “reputable” within drug-using networks and who could be counted on to be “there to listen.” Service providers were favoured if they were “approachable,” “caring,” “sensitive,” “empathetic,” “understanding,” “helpful,” “honest,” “open-minded” and able “to make a person feel at ease.” Participants who used drugs also expressed the benefit of service providers who were “communicative” and presented an “upbeat” attitude; who were neither “patronizing” nor “prejudicial,” and who entered the service relationship with “no perceived expectations.”

Participants within service provision discussion groups tended to envision effective relationships somewhat differently. Within these groups, service provision interactions were seen as beneficial if the person delivering services was “ethical” within their interactions with clients and able to “focus on the client rather than their drug use.” A good service provider was considered one who was “firm” and able to foster “open dialogue” using “common language” and demonstrating “explicit boundaries.” Effective service provision was possible if the person delivering the services was “self-reflective” and “authentic.” That person needed to be “accepting” and to manifest an “ability to bond;” to be “welcoming,” “friendly” and “demonstrative;” to value people “unconditionally” and to be “accessible” and “available.”

Thematic groupings of descriptions

Characteristics described by both categories of participants were able to be grouped into three broad themes, defined here as (i) professional (reflecting a courteous, conscientious, and generally businesslike workplace manner); (ii) affective (relating to, arising from or influencing feelings or emotions); and (iii) affirmative (favouring or supporting a chosen course of action). Whereas agreement between service providers and drug users tended to reflect upon effective professional characteristics, there was less agreement on the affective and affirmative characteristics of good health and social care relationships. Illicit drug users tended to favour affective interaction while service providers tended to favour affirmative interactions. In general, when described by discussion groups for illicit drug users, characteristics of good service provision interaction reflected greater attachment to personal and interpersonal elements, whereas those described by service providers tended to reflect a greater reserve and caution – perhaps an indication of the realities of the work, the incidence of relapse or return to drug use on the part of those abstaining from drug use, and the high rates of burnout among agency co-workers and others. Of note is the belief that the success and efficacy of harm reduction relationships rested almost exclusively on the shoulders of service providers.

Despite probing by facilitators, neither drug users nor service providers focused to any extent on the responsibilities consumers brought to the health and social care interaction, or traits that made a client an effective participant in a care relationship.

What can damage these relationships?

The second structured question within discussion groups focused on what could damage service provision relationships. For drug users, the breaking of trust was a major issue. Service providers who were “suspicious;” who believed “all needs are motivated by drugs;” or who were “unable to see beyond the drug use” were seen as less capable of effectively delivering harm reduction. A lack of “professionalism,” and respect and not recognizing free will and choice were cited as damaging as well. Users stressed that relationships were easily hurt by service providers who attempted to “force their answers or solutions on you,” or by health and social care situations where “things are enforced on you.” Users also identified a tendency for health and social care services in general, and relationships between users and providers in particular, to lack an ability to embrace other, more mainstream approaches to well-being, such as the overall physical and mental health of an individual, and not their drug-use issues alone.

As with users, service providers also identified breaches in trust and confidentiality as actions that could damage service relationships. Providers who were overly curious, gossipy, insincere or voyeuristic could lose the confidence of the client. Unreasonable expectations also could damage, such as: “expectations that people won’t fuck up and won’t relapse;” or seeing “clients as an extension of themselves and their successes.” For service providers, the manner in which they comported themselves and behaved was a recurrent theme. Burnout, restrained body language, and even being overly professional could all have detrimental effects. Environmental factors, such as “busy days like methadone days when one is essentially doing crowd control,” and the difficulties some service consumers had “keeping appointments and being on time” could be counterproductive as well.

What governments could do to strengthen relationships

Participants were asked to reflect upon what governments in general (federal, provincial and local) could do to strengthen relationships between people who use drugs and people who provide services. Consistently this was the theme which elicited the most passionate and articulate response. Indeed, it seemed to be a topic that was frequently discussed within participants’ professional and social networks. Whereas discussion groups with drug users tended to focus

on government action more broadly, service providers were more direct and critical in their response.

Views of illicit drug users

Drug users stressed that governments could take a more active role improving the relationships between drug users and service providers. A common sentiment was that policy and policy makers were simply too far removed from the realities of health and social care service provision:

Government should come out and see what day to day existence is like. (Phoenix)

The government [should] experience what we do, not read statistics in a report. (Kendall)

Many drug users also felt that care relationships could be improved if governments made more services available, therefore allowing service providers more tools with which to help users:

More detox. (Shannon)

Latitude and more authority for service providers to do more for addicts. (Taylor)

Allow more alternative medicines for these services that can actually go in and get to the heart of the matter. We need to legitimize and pay for these medical services. (Jay)

Public education

Discussion groups with drug users spoke to a need to educate the public, not only about drugs, but also about life skills that could be used to help refrain from drug use:

At 18 they kicked me out of my foster home they didn't show me no life skills, they didn't teach me how to fend for myself or nothing. When I got out they said there is the street, fend for yourself. There has got to be stuff [to learn]. Life skills . . . what you learn is survival skills, how to survive on the streets. (Rylee)

I think the Department of Health and the Department of Education have to get together . . . to work with experiential learning . . . they need to teach people who are learning to be teachers, life skills. It should be mandatory and they need to teach life skills in school so that when these kids get out on their own at 14 or 16 they at least know how to make friends and how to choose friends and how to hang on to them and what a commitment is and what responsibility is and I think there is your answer right there. The people who are teaching children have to learn and then they have to teach it in school. Being an addict I am on the outside I feel. I would like to reach people that aren't addicted and

don't have problems and educate them that we are human beings; we are part of society too, but I have always felt outside and not able to talk to straight people. I would like to see more of that, more across-the-board education. (Carson)

Education was a recurrent theme, and drug users frequently discussed the need to educate – and in some cases re-educate or re-train service providers in order to allow for more effective interpersonal interaction:

Have more training for the service providers so that they can bring this to their communities. (Dylan)

Retraining for service providers and special parts of a student's practicum that deal directly with harm reduction. (Tyler)

Views of service providers

In contrast to the suggestions for government policy and action suggested by users, service providers tended to focus more specifically on structural issues, such as education and training, the workplace, government bureaucracy and funding. Providers concurred that a lack of suitable education and training was a deficit. Many recognized service provision within the field of harm minimisation was an evolving expertise, and that the skills required to effectively do the job would require replenishing as a matter of course:

Educate service providers so that they remain progressive in the field. (Ali)

Sponsor a trainer program where one person in a region goes and learns skills and then returns to share them with their peers. (Parker)

Service providers also discussed best practices, and the difficulty identifying, and by extension, utilizing, the most up-to-date information.

I would like to see a best practices document on harm reduction. (Alex)

[The government] might be able to . . . through a best practices document . . . to encourage the provinces or the health agencies within the provinces to work in a more integrated way. (Drew)

Workplace issues

Workplace issues were frequently discussed. These took the form of suggestions for action to improve workplace environments, thus enabling the development of more effective relationships between provider and consumer. These included job security as well as the physical, emotional and

legal safety of individuals who choose to work within the field.

Where is the safety, where is the safety network for people on the front lines? Where I am working we are trying to find that safety network. We are all long-term offenders who have been released working with long-term offenders inside and outside and sometimes you can be in a situation where one of your clients . . . gets busted in your company and you get busted too, you lose your job and get sent back to prison because of the job you are doing and this is something that has happened to people across Canada in the job that I do and this is something the government is going to have to look at. (Reagan)

The respect they give our type of work? Oh, you are a street worker? Are you a social worker? Oh, no, no you're not a social worker. Its like: what education do you need to do that? Oh, you don't need any studies particularly. You know, we hear these kinds of things all the time. We are frontline with these users. I'm not saying we know everything but we have particular knowledge that [governments] certainly are not getting in their offices . . . It is a respect of this kind of work: a recognition of the necessity and importance of frontline work. (Pat)

For many providers, working with drug users was experienced as a demanding job. Many felt governments could do more to support people in the workplace, particularly as the work could be emotionally and psychologically demanding, and could often lead to burnout:

Workloads are too large. (Morgan)

Support for the service provider for whom this work can raise personal issues. (Bev)

Governmental bureaucracy

Service providers also suggested government bureaucracy had a role to play in improving care relationships between users and providers. For example, the large amounts of paperwork required to remain accountable, such as a need for receipts, demands for case management documentation, and the need to constantly re-apply for project funding, could prevent workers from fully focusing on the needs of consumers.

They are always asking for new projects when we know that the old ones are good. (Jamie)

A repeated concern was that governments did not always appreciate the sensitive quality of information service providers were privy to through their interactions with clients. Service providers believed their ability to keep information confidential was integral to the development of trusting harm-reducing relationships, but that often it was precisely this

confidential information which governments required them to report.

Respect confidentiality between service provider and client. (Chase)

Not expect or require sensitive information to be shared. (Alex)

There is a contradiction with Revenue Canada because if we pay peers, we have to provide them with a [tax income statement] and if we issue a [tax income statement] then if they are on disability or are a user . . . it discloses their drug history and it can mess up with their disability. (Dana)

Funding structures

A final theme identified by service providers concerned funding. It was strongly believed that a workplace able to provide more secure and longer-term funding would translate to more effective health and social care relationships for harm reduction. Stable funding was seen as instrumental in reducing staff turnover while facilitating a more consistent focus on client need.

Even long term agencies have to spend every year looking for more funding. (Harley)

Something that the government could do that would make our jobs easier, I think it somehow all relates to long-term, long-standing funding for community-based organizations . . . because we are poorly paid; poorly supported. (Reese)

Counsellor salaries are all short-term contracts. How can these relationships develop without secure funding and long-term counsellors? (Sage)

Discussion

Grosenick & Hatmaker (2000) suggest that for improved human service delivery, investigating the desired characteristics of service providers and other staff is extremely relevant as it is this human capital which ultimately controls the service encounter, and it is the management of this control coupled with clients' perception of this power which are instrumental in creating a context for effective substance abuse treatment. The kinds of characteristics frequently discussed in the literature as helping to ensure quality health and social care interactions include communication, hospitality, courtesy, friendliness, enthusiasm, respect and 'simple niceness' (Scully, 1995; Preston, 1997; Zenger, 1997; Grosenick & Hatmaker, 2000). In turn, service providers and staff have been found to garner respect if they are perceived as humanistic, caring, and sensitive, while at the same time exhibiting the determination that they will and can 'get tough' if required

(Grosenick & Hatmaker, 2000). Clearly, attitudes and motivations illicit drug users hold towards accessing harm reduction services will vary, as will expectations for what these services will or will not be able to offer and provide (Zweben, 2002). Individuals motivated to reduce drug use or to minimise harms associated with use have been found more likely to report care services to be useful. Conversely, those with less motivation have been found to be less favourably oriented or satisfied with available services (Woff, Toumbourou, Herlihy, Hamilton, & Wales, 1996). Logic suggests—and research supports this—that given the choice, illicit drug users prefer to access services that best meet their needs and best respond to their expectations. Furthermore, illicit drug users will tend to avoid—if at all possible—services that are disrespectful, judgemental, negative, hostile, stereotypical or biased against providing that which is actually sought (Reid & Klee, 1999; McLaughlin, McKenna, & Leslie, 2000). Indeed Grosenick & Hatmaker (2000) found four factors seemed to determine the overall success of harm minimisation treatment: staff knowledge and experience, supportiveness, nonthreatening behaviours, and availability. Adams & Drake (2006) found that interactive, shared decision-making provides, not only to the development of information and an understanding of choices available, but can create the context within which client needs and preferences can be heard and responded to. For these reasons, simply making systems for harm minimisation available in a community may not be sufficient without a concentrated attempt to link the characteristics of the harm reduction services provided with the expectations of the drug users who access them. This is because the services targeted at people who use illicit drugs, prejudicial attitudes really can prevent people from accessing effective and humane health and social care, including care that falls within the range of services described as harm-reducing (McLaughlin & Long, 1996). Thus, rational approaches for matching patient expectations with services provision are required (Widman, Platt, Lidz, Mathis, & Metzger, 1997). As Bonner (2003) explains, social programmes and projects intervene not only within intervention contexts, they also have some ability to alter the social capital of people and communities, and help them reason and make choices. However, it is not programmes alone that lead people to change or minimise harm-causing behaviour. Rather, it is frequently programmes in tandem with individual service providers that do so. It is individuals who have some of the greatest potential to generate change in specific contexts through interactions built upon their powers and capacities, and use thereof.

Occupational safety; an ability to meet the expectations of clients through better caseload management and more stable working environments (Myers et al., 1998; Thompson et al., 1998) – these are as essential for services to be useful for drug users, as is recognition of changing demands and expectations placed on providers in a context where the availability of illicit drugs may be erratic, where drugs of choice often evolve, and where increasingly educated individuals, with a greater diversity of service needs, seek new

and novel ways to reduce the harms associated with drug use (Hartnoll, 1992; Zweben, 2002). For these reasons, the boundaries framing harm minimising relationships are often aided by the incorporation of some flexibility, as flexibility can allow a service provider to meet diverse client need and respond to unexpected situations (Strike, O’Grady, Myers, & Millson, 2004). At the same time, flexible boundaries can lead to blurred boundaries, and hence, may contribute to varying and fluid expectations. As Strike et al. (2004) found, limiting roles at the same time as delivering services can lead to environments in which the boundaries of roles become overly ambiguous and potentially problematic.

Anderson & Levy (2003) apply Robert Park’s (1928) concept of the ‘marginal man’ (or marginal person) to the realm of illicit drug use. That is, any drug-using individual, who, at an intermediate point between two distinct cultures, may embody contradictory normative expectations, behaviours and beliefs. Just as the older users considered in the work of Anderson and Levy were seen to move from central to marginal positioning within an illicit drug culture, so too may individuals migrate from self-identities of more harmful drug use to self-identities more amenable to help-seeking and harm minimisation. Improving service provision may require shifting understandings of the potential challenges resulting from such migration. Models of service provision within these contexts may need to pay greater attention to the potential fluidity of social and cultural boundaries experienced as marginal men and women move between harm-causing and harm-reducing behaviours.

It has been suggested that the provision of harm-reducing and minimising services be monitored and evaluated in the same way that the provision of similar services are when provided to less marginalised client groups (Neale, 1998). Clearly the need exists for managed and continuing research on users’ views of service providers as well as service providers’ views on users. Equally clear is the fact that illicit drug users alone cannot “provide the definitive statement about the value of drug service provision.” any more than service providers alone can. McLaughlin et al. (2000) found deficits in the knowledge, skills and values of health care professionals in relation to illicit drug users, indicating, that the kinds of knowledge and the attitudes and expectations held by service providers do play a fundamental role in the experiences drug users have with the services they access: Neale (1998) suggests that drug users will often be at the frontline of service evaluation, and many will know that a good service provider will be knowledgeable about drugs and their use, and will have a non-judgemental, non-stigmatising attitude to drug users.

McKeganey et al. (2004) indicate that generally speaking, within health and social care settings, the consumer perspective has become embedded in virtually every aspect. Yet, within services targeted toward drug users, consumerism or the client-centred approach is perhaps not as fully integrated (Neale, 1998; McKeganey et al., 2004). It may come down to a particular form of client-centred mutu-

ality that favours—not so much a practitioner dominance where providers unilaterally make all decisions—but rather a more balanced approach where decision-making is shared between practitioner and client. The benefits of the latter approach can be argued from theoretical, ethical, economic, epidemiological, and clinical perspectives. (Adams & Drake, 2006).

Findings from 20 discussion groups held with current and former drug users and service providers revealed some common beliefs, experiences and expectations as to the nature of effective health or social care relationship relationships, and how these might be improved. Notable were the ways in which idealised characteristics diverged, along professional, affective and affirmative dimensions. Breaches of trust, a lack of professionalism, and an inability to recognize free choice were seen as particularly damaging. Service providers reported providing health and social care to drug users was often a complex and exhausting activity, with burnout being a common result. The most animated reflections in all discussion groups were reserved for reflections on what governments could do to strengthen relationships between people who use drugs and people who provide services to them. Here, respondents favoured a more active role on the part of governments and policy makers, as this would potentially lead to more and improved services becoming available. The need to educate the public, broadly and realistically about drug use and its prevention was a recurring theme among participants, while models of best practice and other workplace issues including bureaucratic reporting requirements and a lack of occupational security were seen by service providers as limiting the effective delivery of services.

This paper reflects upon a range of observations from illicit drug users and service providers of the situation with respect to the provision of harm reduction services in Canada. However, it does so within the context of several limitations. First, the division of the nation into five pre-determined regions coupled with research budget limitations did not allow an exhaustive reflection of the breadth of views nationally. Second, the nature of the convenience sample and limitations in recruitment may have functioned to inaccurately reflect the full range of realities or opinions. Third, national findings relating to Canada, with its unique proximity to the United States of America's drug wars, may have limited application with regards to other countries and contexts.

This research has led to some reflections on the training received by health and social care service providers working within harm reduction today, and this leads to the question of whether enough is being done to train service professionals to competently function within harm reduction frameworks. In a Scottish sample of service providers, while more than three-quarters had received national clinical guidelines pertaining to drug dependency, less than one-quarter believed these guidelines had influenced their practice. Further, only one-third had received any training regardless of a relatively high involvement with drug users (Matheson, Pitcairn, Bond, van Teijlingen, & Ryan, 2003). The evidence suggests that

a compendium of best practices alone may not suffice, and that other forms of training, capacity and skills building for the provision of harm reduction services may be required. Beyond training issues, this research reflects also an ominous sense of structural and material precariousness within which service professionals provide harm reduction to illicit drug users in Canada. It is among the most disturbing findings of this investigation. Previous research has reported that scarcity of resources within a service setting, and barriers to accessing such resources, can lead to conflicts in expectations between health service users and providers (Bronfman, Castro, Zuniga, Miranda, & Oviedo, 1997a, 1997b). This is one of the recurrent themes that might most warrant future investigation.

Today, many countries experience environments where negative community concerns about needle exchanges, methadone programmes and other drug services help to foster climates antithetical to the provision of harm-reducing activities (Allman, 2005). The irony is that this is occurring at a time when communities, service providers, researchers, and grass-roots policy makers are beginning to truly understand the makings of truly effective harm minimisation (Canadian HIV/AIDS Legal Network, 1999; Health Canada, 2001; Kerr, Douglas, Peace, Pierre, & Wood, 2001; Ogborne, Carter, & Wiebe, 2001; Allman et al., 2006). Within such an environment the first Canadian Harm Reduction Conference developed a civil society-oriented approach to tackling these issues by allowing members of a marginal and traditionally excluded subculture to dialogue with both those providing and allocating services, as well as those forming and setting policies that underpin service availability. The accompanying research activities described here targeted as well, those most directly involved in receiving, developing and delivering harm reduction strategies across a very diverse country, and it did so by including representatives of those most directly involved in utilizing or providing these services. By incorporating a response that was community-based, user-driven, and which strived to be non-judgmental, these research activities pursued a greater understanding of what might be required to improve health and social care relationships for harm reduction. It did this by seeking out the suggestions of professionals actively providing services, as well as illicit drug users, including some isolated or structurally excluded from access to services by geography, illiteracy, and street-involvement.

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