DRUG & ALCOHOL FINDINGS *Matrix cell*

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Drug Treatment Matrix cell B1: Practitioners; Reducing harm

S Quasi-randomisation reveals methadone counsellor as an 'active ingredient' in reducing illegal drug use (1988). Effectively random allocation of patients to different counsellors at the same service revealed that one had patients who across all measures did consistently poorly while another more organised and proactive counsellor generated on average patients who rarely used illegal drugs despite lower doses of methadone. Reduced illegal drug use (in particular, fewer injections) and engagement with treatment are associated with reduced harm. For discussion click here and scroll down to highlighted heading in bite's *Issues* section.

K Trust is the key to extending harm reduction among injectors (Finnish National Public Health Institute and Department of Infectious Disease Epidemiology and Control, 2008). Study of Finnish needle exchanges and health counselling centres which substantially informed the principles adopted in European guidance below. Built up during day-to-day contact between staff and a marginalised, stigmatised, and wary caseload, "Trust seemed the most significant single factor in the success of health counselling." For discussion click here and scroll down to highlighted heading in bite's *Highlighted study* section.

K Feeling accepted and safe promotes service access (2011). Users of Canadian needle exchanges saw them as safe places free of stigma, discrimination and judgments about drug use, and therefore places where they could access services such as counselling, nursing care, HIV, hepatitis C and sexually transmitted infection testing and information, welfare services and support, and housing. One of the Canadian studies which informed the emphasis on trust in a review which underpinned NICE guidance on needle exchange. For discussion click here and scroll down to highlighted heading in bite's *Highlighted study* section.

K Counsellors differ in how well they retain methadone patients (1999). US study started off investigating methadone dose but found that when tailored to the individual it made no difference. What did make a big difference to retention and illegal substance use (the two were related) was which counsellor the patient had (essentially at random) been assigned to. Retention on methadone is (see cell A1) strongly related to harm reduction. This study was one of three featured in this Effectiveness Bank analysis (1999). For discussion click here and scroll down to highlighted heading in bite's *Issues* section.

K Constructive responses from counsellors help keep methadone patients in treatment (1998). US patients stayed longer when their problems were constructively responded to by their counsellors such as by offering a dose increase or extra services. Retention on methadone is (see cell A1) strongly related to harm reduction. This study was one of three featured in this Effectiveness Bank analysis (1999). For related discussion click here and scroll down to highlighted heading in bite's *Issues* section.

K See cell **B3** for other methadone maintenance studies.

R Extending harm reduction is built on trust (2013). Extensive UK review updated in 2013 which underpinned NICE guidance on needle exchange found evidence from Canada that "trusting relationships" between injectors and exchange staff "appears to be key to facilitating engagement in additional harm reduction services". For related discussion click here and scroll down to highlighted heading in bite's *Where should I start?* section.

R See cell **B3** for methadone maintenance reviews.

G European guidance on preventing infectious diseases among injectors (European Centre for Disease Prevention and Control and European Monitoring Centre for Drugs and Drug Addiction, 2011). Includes desired values and attitudes of services and staff, based partly on research from Finland listed above. For related discussion click here and scroll down to highlighted heading in bite's *Where should I start?* section.

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What is this cell about? As described more fully in cell A1, about reducing the harms experienced by the user as a result of their drug use, without necessarily reducing use or seeking to overcome dependence. Common interventions include needle exchanges and substituting a legally prescribed drug of the same type for the original (and usually illegally obtained) substance, also considered as a treatment for addiction in row 3. This cell is however not about the content of the intervention (for which see cell A1), but whether its impact depends on the interpersonal style and other features of the practitioner relating to the client or conducting

the intervention – a much less commonly researched topic.

Where should I start? European guidance exemplifies the contrast between what to staff, users and experts is the patent centrality of the 'right' attitudes among harm reduction service staff, and the lack of research confirming these attitudes make the expected difference. Where outcome evaluations were lacking, it drew instead on expert advice, best practice, and documented user preferences. Largely on this basis, after consultation with experts and people involved in harm reduction across Europe, the report's authors concluded that, "Obtaining the trust of the clients of the services is essential for the prevention of infectious diseases".

Take a look at the core values section starting page 9 of the document, page 14 of the PDF file. There you will see that the "prevention principles" on which the document is based themselves demand and rest on the ability and willingness of staff to centre their work on the needs, perspectives, and vulnerabilities of what to the broader society are among its most despised and shunned members. So key are these attributes that without them, no matter what the scientific and logical basis for interventions, they would be "difficult to apply effectively".

> *Obtaining the trust of the clients of the services is essential*

What are these attributes? In essence, adopting a client perspective and earning the trust of the clients. In more detail, maintaining a user-friendly atmosphere, "which means clients are addressed with dignity and a true willingness to help, whatever their appearance or social status [and] client wishes are respected." In turn that means "actively listening to the clients and responding to changing needs", and a pragmatic willingness to embrace objectives which to others may seem unacceptably short of ideal outcomes. In its turn that entails an ability to "refrain from ideological or moral judgment … it is not helpful to judge or criticise [clients' drug] use itself from a moral or ideological point of view. Instead, the choices users make should be respected even if they are not agreed with."

Yet while non-judgmentally respecting their clients' choices, these same staff are also expected to use the communication routes they have built to encourage them (primarily through addiction treatment) to consider relinquishing injection and dependent substance use – a difficult balancing act requiring exceptional relationship-builders and above all trust. If we had to unpack what 'trust' means in this context, perhaps it is confidence on the part of the user that advice is being given for their own benefit and to further their own ambitions, not to satisfy the worker's agenda with regard to the rights and wrongs of illegal drug use or that of the wider society. Is that how you would see it too? Given the centrality of trust, getting that clear would seem an important subject for discussion and debate among staff and service users. More on trust below in the context of needle exchange in particular.

Highlighted study "Needle exchange as a safe haven in an unsafe" world was the title of our *Highlighted study* from Canada based mainly on interviews with users of four needle exchanges, but also with staff. Unusually, the analysis in the paper focused on "the *meaning* of needle exchange services from the perspectives of those who access such services" (emphasis added). Its conclusions on relationships between staff and injectors are quoted below.

> "In all four locations, participants reported being discriminated against and not listened to by health-care providers because they had been labelled as injection drug users. In contrast, study participants reported positive experiences when accessing needle exchange services. They described coming to the exchanges as "supportive", "comfortable" and "safe" … Overwhelmingly, clients … described the exchange as a safe place free of stigma, discrimination and judgments about drug use. Particularly important was that all of the sites were viewed as places where they could access services in a safe environment free of discrimination … [C]lients and staff at all sites reported that respect for people and a lack of judgment of drug use were key to facilitating the development of trust and linkages to other services … such as nursing care, assistance with welfare and disability applications, assistance with income tax, and housing."

It is perhaps relevant that these conclusions emerged from the comments of a highly excluded and disadvantaged set of injectors, but one not atypical of similar populations in the UK. Over half said they were homeless or living in unstable housing. Just 13 of the 33 had graduated from high school. Commonly they told stories of trauma, abuse and physical pain that had affected their lives and influenced their drug use. Most said drug use was a way of numbing pain, both physical and emotional. Six knew they were infected with HIV

and 16 with hepatitis C.

With histories and current circumstances like these, aggravated by the stigma of being a drug injector, trust was a key factor in persuading them to enter and re-enter a health facility and make use of its services, opening themselves up to information and influences which could help them cope with their multiple problems.

It was this Canadian research above all that underpinned the conclusion of a review conducted for the UK's health intervention assessors, which concluded that extending harm reduction beyond needle exchange to treatment entry and other services depends on the trust established between the user and the needle exchange.

Though the focus here is on staff-user relationships, from the study also emerged the importance of the organisational context within which these relationships are developed. During the study a fixed-site needle exchange closed and its users were diverted to a mobile service run from a van. Here clients just wanted to exchange and move on. Brief interactions with outreach staff at the van "did not facilitate the development of trusting relationships nor provide the same opportunities for access to referrals not only to nursing and counselling services, but to income and housing supports". In the UK we have similar concerns over the erosion of ancillary services and treatment referral as specialist needle exchanges are replaced by pharmacy-based services: "If someone goes into a chemist they give 10 needles in and get 10 needles back, but there's no interaction," said the director of Addaction Scotland in September 2017.

Regarding trust, messages similar to those from Canada emerged from a study of needle exchanges in Finland, where "Trust seemed the most significant single factor in the success of health counselling. In all of the interviews, the importance of trust was emphasised, as was how that trust was being built and maintained in the day-to-day work." Trust was not only the foundation of the core needle exchange service but also meant its users were more open to seeking and accepting further help.

Issues to consider and discuss

▸ **Sometimes the most important things cannot (easily) be proven** The relative neglect of practitioner/relationship factors in harm reduction research is probably a function of the focus on interventions, and of the difficulty of conducting such research. It is easier and less ethically dubious to randomly assign clients to different interventions, than it is to deliberately assign some to judgemental, inflexible and hostile practitioners, and others to more user-friendly staff, just to see what happens. So while there are good reasons to believe practitioner/relationship factors are crucial to achieving harm reduction outcomes, no study has yet demonstrated this conclusively. As illustrated by the lack of 'real-world' randomised trials of parachutes versus an inactive 'placebo', some things which are lifesavingly fundamental are not susceptible to this form of proof.

Instead, for methadone maintenance we have studies (▸ below) showing that some counsellors hold on to patients longer and help them control their substance use much better than others, and that being proactive, well organised and constructive are part of the reason. The other link in the chain is that reduced illegal drug use (in particular, fewer injections) and better engagement and retention in treatment are associated with reduced harm. Fit these links together, and it *should* mean that the patients of counsellors who relate to patients in certain ways will be better protected against overdose and disease than others.

Similarly for needle exchanges, we know (see *Highlighted study* above) that users value the acceptance and caring they receive at these services, a contrast to the rejection and stigma they often feel from non-specialist services. It makes them want to use and come back to the service and means they are more open to seeking and accepting further help. The upshot should be to increase the coverage of needle exchanges by increasing attendance, and with it the number of sets of sterile injecting equipment the user obtains in relation to the number of times they inject, and also to divert more users into treatment, reducing the number of times they inject. Both are associated with reduced risk of harm – again, forming links in a chain starting with appropriate staff-user relationships which *should* end in reduced harm.

But "should" is not proof this has happened. It is not uncommon, for example, for patients to stay longer in treatment due to various reasons, yet for this to bear little relationship to reductions in substance use. But of all the major treatment modalities, this is least true for methadone programmes, which usually act much like a light switch – rapid impact on substance use when switched on, rapid reversal when switched off, meaning

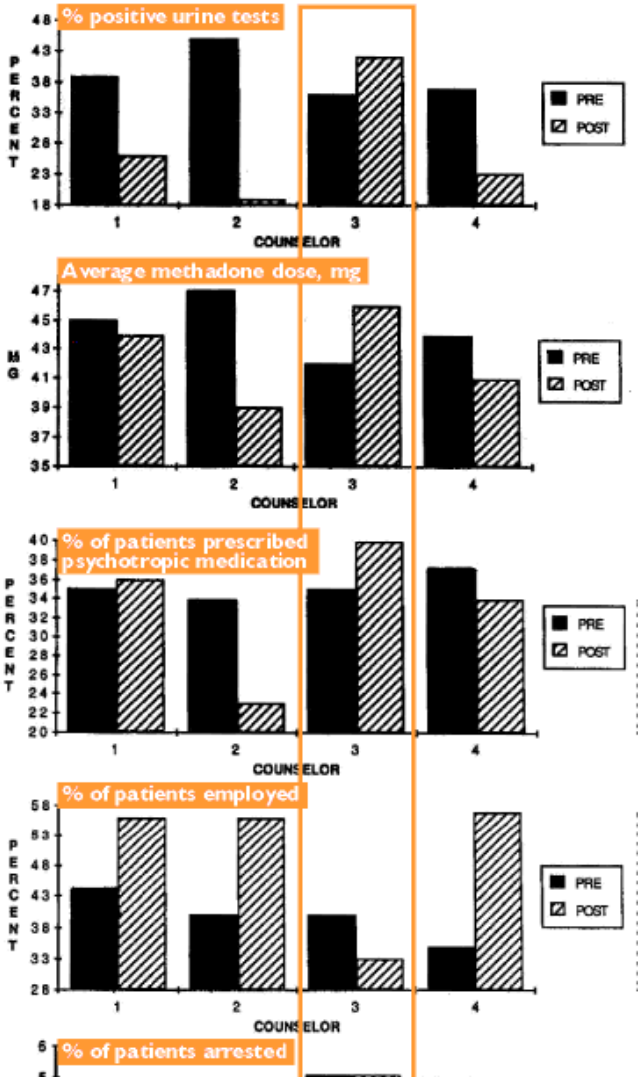
that improved retention is associated with harm reduction. Similarly, needle exchanges cannot have much of an impact on disease-transmission if they are not used and not regularly returned to, and that impact must increase with greater usage if that equates with coming closer to using a fresh set of equipment each time. The evidence for this chain is not substantial, but it does exist. Less clear is whether in practice the extra services needle exchange clients might access in an atmosphere of trust do any more to (for example) intercept disease transmission than the basic needle exchange service.

Does being 'bad' matter more than being 'good'? In the context of the treatment of problem drinking, we have argued that doing the 'wrong' thing matters more than doing lots of the 'right' things, because by the time a treatment-seeking patient knocks on a service's door, already much of the work has been done: "Once would-be patients approach, knock on and seek to pass through those doors, it would seem important to avoid obstructing the process started by the patient by, for example, confrontationally provoking resistance or being judgemental." If that is true of drinkers, it is likely to be yet more true of users of illegal drugs.

We can look for evidence in a seminal US study from Philadelphia, where a methadone clinic was the site of one of those invaluable accidents which permit obscured influences to come to light. It started with the sudden and almost concurrent resignation of two counsellors at a methadone service. In a rush, their caseloads were reassigned effectively at random to remaining counsellors, offering the opportunity to see whether the four who got at least a dozen new patients altered the trajectory of their progress from the six months before to the six months after.

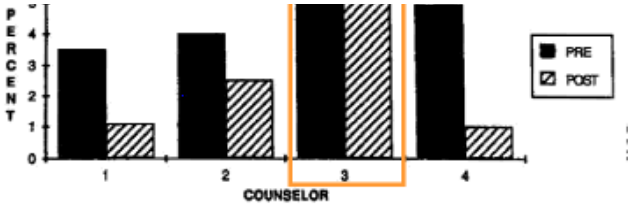
Before the transfer, each of the four sets of patients who ended up with the four counsellors had been spread across the two counsellors who had left, diluting the impact of the individual counsellors. Clinic records showed that before the transfer each set was doing about equally well. After the transfer, by definition each set was in the hands of a single counsellor, and the changes were substantial.

Here we focus on the patients allocated to counsellor three, who stood out from their colleagues for the wrong reasons: see the charts right extracted from the original paper; counsellor three is highlighted. Despite increases in methadone doses and in the proportion prescribed other medications, patients transferred to this counsellor worsened in their compliance with methadone treatment and/or illegal drug use. What harms they suffered as a result are not documented, but more illegal drug use (in particular, more injections) and poorer engagement with treatment are associated with harms to health.



On this and other measures, counsellor three's performance was consistently worse than that of their colleagues. Fewer of their patients were employed, while this proportion rose substantially among the other patients, and no further progress was made in reducing the proportion arrested, while this uniformly fell among patients of the other counsellors.

In contrast, over a six-month period the most effective counsellor (number two) was able to bring patients to the point where their non-prescribed drug use was virtually zero and employment significantly improved, while at the same time substantially reducing doses of methadone and the proportion prescribed ancillary medications.



Differences between patients or in the qualifications of the counsellors did not account for the findings, which were also reflected in their prior caseloads. Instead, the answer seemed to lie at least partly in how they worked with their patients. Compared to more successful colleagues, counsellor three's case notes indicated "far less organisation in the treatment plans and far less detail in the treatment notes. There was little indication of consistency in enforcement of programme rules (eg, take-home regulations, loitering, etc) and very little documentation of the use of programme resources for their caseloads (eg, employment counsellor, nurse, etc). Perhaps most striking was the general lack of documentation surrounding changes in methadone dose and prescription of ancillary medications. Finally, the indications were that [their] patients … were seen less frequently than the patients of the other counsellors."

In contrast, all the more effective counsellors took a well organised and diligent approach to care planning, documentation and clinic rules – an indication perhaps that good organisation is a fundamental platform for everything else, including relationship-building, and/or that caring about your patients also entails caring enough to be well organised. The stand-out counsellor built on this platform, anticipating patient problems and discussing strategies to deal with them in advance, focusing counselling on the development of new behaviours and new ways of thinking. He or she was not only administratively diligent, but actively problem-solving and therapeutic. The authors speculated (the most they could do given the design of the study) that this enabled them to reduce illegal drug use and achieve better outcomes with less medication.

This was one small study, but the proposition that methadone counsellors alter the prospects of their patients was confirmed by another larger US study involving 265 patients and 13 counsellors, which was also able to take advantage of quasi-random patient allocation. In this study, it was counsellor 12 who registered the worst performance, half their patients' urine tests revealing illegal opiate use and nearly two-thirds cocaine. Of those with appreciable numbers of patients, counsellor two provided the starkest contrast; just 20% of their patients' tests revealed illegal opiate use and 24% cocaine. As in Philadelphia, most of the counsellors were about as good as each other; it was the few poorer ones who stood out.

A third US study gives further clues to what it is about some counsellors which mean their patients stay protected by methadone maintenance for longer. After dose and other factors had been taken into account, rather than punitive responses or neglect, retention was strongly related to what the authors classified as "constructive" responses to the patient's problems, including referral for extra counselling and increasing methadone doses. These findings are reminiscent of those in Philadelphia, but we can have more confidence in them because the system used to classify the content of the case notes had been decided in advance of the data being collected. For more related studies see cell B3.

Thanks for their comments on this entry to Stephen Magura of Western Michigan University in the USA. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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