Enhancing Capacity to Provide Services for People Who Use Substances

A Needs and Assets Assessment

CANADIAN AIDS SOCIETY
SOCIÉTÉ CANADIENNE DU SIDA

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TABLE OF CONTENTS

The Project Team 2

Acknowledgements 3

Executive Summary 4

Section 1: Background 7

- Introduction 9
- Phrases & Key Concepts 9
- Study Rationale, Goal & Objectives 11
- Methods 12

Section 2: Needs and Assets Assessment Survey 15

- Overview 17
- Characteristics of Participating Organizations 17
- Profile of Services 18
- Profile of Policies 21
- What Works Well 24
- Challenges 25
- Service Improvements 26
- Capacity Enhancement 29

Section 3: Key Informant Interviews 31

- Overview 33
- What Works Well 33
- Challenges 40
- Capacity Enhancement 46

Section 4: Discussion 51

Section 5: Resource Guide 55

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EXECUTIVE SUMMARY

This report provides findings from a community-based, multi-phased assessment of the needs and assets of Canadian AIDS Society (CAS) member organizations with respect to providing services for people who use substances. The assessment sought to identify, *from the perspective of service providers*, what proved effective and what proved challenging within Canadian AIDS service organizations (ASOs). The current research is a follow-up to a study undertaken by CAS and The Canadian Harm Reduction Network entitled *Learning from Each Other: Enhancing Community-Based Harm Reduction Programs and Practices in Canada*, which explored harm reduction services from the perspective of service users. It is our hope that current study findings will enrich the practice of harm reduction in Canada by sharing the successes and lessons of experienced practitioners in the field. As well, we endeavour to use the perspectives gathered here to shape CAS' work in support of its member organizations thereby enhancing their capacity to provide services to people who use substances.

The project involved the following components: 1) a National Advisory Committee, composed of individuals from across Canada who have experience with the provision of services for people who use substances and/or personal experience with substance use (this group provided direction and input into all aspects of the research process); 2) an on-line survey of CAS member organizations about their needs and assets with respect to providing services for people who use substances; and 3) key informant interviews conducted with service providers from selected CAS member organizations (these explored strengths and challenges in providing services for people who use substances, and their suggestions for skills building and capacity enhancement opportunities).

Survey Findings

The on-line survey of CAS member organizations showed that the majority of organizations incorporated harm reduction in their service offerings: 89% included harm reduction principles in their mandates; 69% had dedicated staff positions for harm reduction; and 56% were members of a harm reduction network. In terms of peer involvement, 40% of respondents had dedicated volunteer positions within their organizations for people who use substances and 11% had dedicated staff positions for them. Beyond staff and volunteer roles, findings show a range of ways in which peers are involved in the work of ASOs. All respondents indicated that the non-judgmental attitude of staff was a strength in providing services for people who use substances, while 94% cited the provision of a safe and welcoming space as an asset. Prevalent challenges included financial resources limitations (80%) and the capacity to deal with complex mental health issues related to substance use (74%). Improved access to low threshold treatment for people who use substances was the most common service improvement, sought by 41% of respondents. More and improved housing options for people who use substances was the next most common suggestion, provided by 31% of respondents. The most desired additional service was mobile inhalation equipment distribution, cited by 31% of respondents. Finally, survey respondents indicated that training opportunities and/or supportive resources on subjects including harm reduction best practices, reducing drug-related harms, substance use counselling, and overdose prevention would be most useful.

What Works Well in Providing Services for People who Use Substances

First and foremost, key informant interview participants indicated a *harm reduction approach* was fundamental to their success in providing services for people who use substances. This includes a non-judgmental attitude, acceptance of clients' substance use, showing respect for people who use their services, a focus on harms, and the incorporation of harm reduction principles in the organizational culture. As well, a *client-centered approach* characterized by a commitment to starting where the clients are at, adapting services to suit clients' needs, making services more accessible, adopting a holistic approach to service provision, and addressing clients' basic needs, was identified as an asset in their work. *Peer involvement* in service design and delivery was also emphasized by participants as strengthening services for people who use substances. It was credited with improving responsiveness to client needs, expanding service reach, increasing service provider trust through kinship, and empowering clients through role modelling. Moreover, *community engagement*, including the harnessing of community support, the building of community partnerships, and engaging in dialogue with community, enhanced services according to participants. Lastly, in the context of significant resource limitations, participants praised the *resourcefulness* of service providers and organizations in stretching limited budgets.

Challenges in Providing Services for People Who Use Substances

The most frequent obstacles identified by participants in the provision of services for people who use substances were *resource limitations*, including limitations of supplies, human resources, program and service offerings, and funding. As well, participants linked *resistance to harm reduction* with challenging policy environments within which to operate; stigma and discrimination, on the part of health care professionals, service providers, and the community, towards people who use substances; and the inadequacy of community resources to support people who use substances. Some participants noted that *serving diverse populations* of people living with or at risk of HIV/AIDS and overcoming tensions between different client groups complicated service delivery. The exclusion of certain client groups, and gaps in services for specific sub-populations was another key concern. Participants also faced difficulties with respect to *individual capacity to provide services* for people who use substances. Challenges were related to knowledge of client population, maintaining a non-judgmental attitude, negotiating boundaries with clients, and prioritizing self-care.

Service Providers' Capacity Enhancement Priorities

Participants expressed a desire for greater and more accessible *engagement opportunities* for service providers working in harm reduction to facilitate introductions, knowledge exchange, and partnership- and community-building. In particular, participants wanted opportunities to meet face-to-face, along with a national harm reduction conference. As well, participants articulated a commitment to continuous learning and professional development. Specifically, they were interested in *training opportunities and supportive resources* on topics including: substances, working with people who use substances, mental health, safety for staff and clients, and harm reduction policies and practices. Training accessibility and stakeholder involvement were noted as important considerations.

Discussion

The report concludes with a discussion of the research findings, which compares and contrasts them with the findings gathered through *Learning from Each Other*. Many themes from the current research remain consistent with the findings from that report. There was a general consensus among both service users who participated in the *Learning from Each Other* project and the service providers who participated in the current research about key pillars of service for people who use substances. They also had a common understanding of structural barriers to service provision, including resource limitations, and resistance to harm reduction. Service providers were able to shed more light on organizational challenges, including limited capacity to engage in systemic advocacy, lack of coordination among stakeholder groups, and complications arising from serving a diverse clientele. On an individual level, service providers were able to identify areas of their work that were personally challenging, including their knowledge of the client population, maintaining a non-judgmental attitude, negotiating boundaries with clients, and prioritizing self-care. Some distinctions among the perspectives of service users and service providers were also present. The involvement of peers in service delivery and design, and the creation of safe service environments are two such areas where the perspectives of service providers differed from the experience of some service users. Ultimately, this project was undertaken to identify means through which CAS member organizations could be supported in enhancing their capacity to provide services for people who use substances. Support must address a breadth of training and resource needs, recognize and harness existing knowledge within ASOs and be mindful of financial and time constraints.

1: Background

INTRODUCTION

The capacity of community-based AIDS service organizations (ASOs) to respond to the needs of people who use substances is a critical component of HIV prevention, treatment and care efforts. In order to better understand this capacity among ASOs in Canada, the Canadian AIDS Society (CAS) undertook a needs and assets assessment among its member organizations. The assessment sought to identify, from the perspective of service providers, what works well and what is challenging with respect to the provision of services for people who use substances.

This report provides findings from our two-phased assessment: 1) an online needs and assets assessment survey conducted with CAS member organizations across Canada; and 2) key informant interviews conducted with selected service providers working within Canadian ASOs. It is our hope that study findings will enrich the practice of harm reduction in Canada through sharing the successes as well as the lessons of experienced practitioners in the field. As well, we endeavour to use the perspectives gathered here to shape the work of CAS in support of our member organizations, in order to enhance their capacity to provide services to people who use substances. Finally, we wish to celebrate the tremendous efforts of our members across Canada in providing vital harm reduction services to people living with and at-risk of HIV/AIDS. We thank them for the passion and commitment they bring to their work in a challenging field.

PHRASES & KEY CONCEPTS

People Who Use Substances

The phrase "people who use substances" is used throughout this document in reference to a specific community of individuals who access services at ASOs. Within the HIV/AIDS sector in Canada, "people who use injection drugs" or IDUs are more commonly framed as a population of interest, as they are one of eight key populations recognized by the Government of Canada as at risk for HIV[1]. We have purposefully chosen to use more inclusive language for several reasons outlined below.

The term "use", as opposed to "abuse", is purposefully used in this document in order to avoid moralistic judgment with regard to the intake of substances. Substance use can be regarded as ranging along a continuum from low-risk and sometimes beneficial use, through potentially hazardous or harmful use[2]. On the contrary, abuse is a pejorative term that carries negative conations regarding an individual's behaviour, and contributes to stigmatizing attitudes towards the persons themselves[3].

The phrase "people who use" is employed in lieu of "user" of "abuser" in recognition of the inherent humanity of people who use substances. In this way, substance use is positioned as something a person does; it does not singularly define who a person is.

For the purposes of this document, the broader term "substances" is used in place of more narrow terms including "drugs", "illicit drugs" or "injection drugs" to better reflect the reality of people's use. The term "substances" includes illegal drugs, alcohol,

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1 From www.phac-aspc.gc.ca/aids-sida/populations-eng.php

2 Here to Help. *Fact sheet: Understanding substance use*. Available at: www.heretohelp.bc.ca/publications.

3 Kelly, J.F. & Westerhoff, C.M. (in press). Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. *International Journal of Drug Policy.*

solvents, and pharmaceutical drugs that may or may not have been obtained legally. As well, no specific mode of intake is implied by the term "substances" and therefore encompasses injection, ingestion, and/or inhalation. As such, the phrase "people who use substances" is a better reflection of HIV transmission risk beyond injection drug use and encompasses, for example, transmission through sharing crack pipes.[4]

Harm Reduction

The concept of harm reduction refers to an approach to providing services for people who use substances. Harm reduction is both a goal of service delivery and the philosophy that underpins it.

Harm reduction can be defined as:

> *…a pragmatic approach to reduce the harmful consequences of alcohol and [other] drug use or other high-risk activities by incorporating several strategies that cut across the spectrum from safer use to managed use to abstinence. The primary goal of most harm-reduction approaches is to meet individuals "where they are at" and not to ignore or condemn the harmful behaviors but rather to work with the individual or community to minimize the harmful effects of a given behavior*[5].

The concept of harm reduction embraces a number of key principles:[6]

- ***Pragmatism***. A level of substance use is normal in a society. Containment and amelioration of drug-related harms is considered a more feasible option than efforts to eliminate substance use entirely.
- ***Focus on Harms***. The fact or extent of a person's drug use is of secondary importance to the risk of harms resulting from use. Efforts are directed towards mitigating these harms as opposed to decreasing substance use itself.
- ***Humanistic Values***. The rights and inherent dignity of a person who uses substances are respected, regardless of the nature of use, including the right to care, treatment, support, and the right to life.
- ***Hierarchy of Goals***. The objectives of harm reduction programs in a given context are determined based on a hierarchy of goals. Harm reduction begins "where the person is", with the immediate focus on their basic most pressing needs.
- ***Client-centered****:* The knowledge of people with lived experience of substance use is recognized and given credence. Professionals in various service areas and people who use substances are viewed as possessing complementary areas of expertise and work together as partners and in a climate of mutual respect.
- ***Structural Perspective****:* Beyond the health and well-being of an individual, consideration is given to the needs of varying stakeholders including the family, the community of people whose lives are organized around substance use, and the broader community.
- ***Social Justice****:* A person should never be denied access to service merely because they are using a substance, legal or illegal.
- ***Appreciation of Drug Dependency****:* Addiction is a recurring behaviour, permanent or episodic in nature, for which long-term support may be required. While abstinence is not ruled out as a goal, success is measured not in terms of achieving total, unrelenting abstinence, but in terms of positively benefiting health and quality of life for individuals, families and communities.
- ***A Holistic View of Health****:* The concept of health includes emotional, physical, spiritual, mental, social and environmental aspects and determinants of both individual and community well-being.

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[4] DeBeck, K., Kerr, T., Li, K., Fischer, B., Buxton, J., Montaner, J., et al. (2009). Smoking of crack cocaine as a risk factor for HIV infection among people who use injection drugs. *Canadian Medical Association Journal*, 181(9), 585-589.

[5] Marlatt, G.A. & Witkiewitz, K. (2009). Update on harm-reduction policy and intervention research. *Annual Review of Clinical Psychology,* 6(20), 1-20.

[6] Adapted from the document: Canadian AIDS Society & The Canadian Harm Reduction Network (2008). *Learning from each other: Enhancing community-based harm reduction programs and practices in Canada*. Available at: www.cdnaids.ca/web/casmisc.nsf/pages/cas-gen-0150

Canadian AIDS Society Member Organizations

CAS is a national coalition of over 120 community-based AIDS service organizations from across Canada[7]. Member organizations are non-profit organizations which have any of the following as a main objective:

- prevention of the spread of HIV infection;
- provision of assistance and support to people affected by HIV/AIDS and related conditions;
- promotion of health for people affected by HIV/AIDS; and
- work in other domains inherently linked to HIV/AIDS (e.g. anti-poverty, housing and homelessness, settlement, human rights, community health).

STUDY RATIONALE, GOAL & OBJECTIVES

Rationale

The current research is a follow-up to a study undertaken by the Canadian AIDS Society and The Canadian Harm Reduction Network entitled *Learning from Each Other: Enhancing Community-Based Harm Reduction Programs and Practices in Canada*[8]. The *Learning from Each Other* project highlighted innovative harm reduction programs and practices in nine cities across Canada, identified through site visits to community-based organizations. The experiences of people who use harm reduction services were also examined through focus groups conducted at each location.

Findings from the *Learning from Each Other* project revealed that people who use substances want to be involved in harm reduction program development, implementation, delivery and evaluation. They appreciate outreach services and services that had broad and convenient operating hours. They favour community-based, non-judgmental environments to access harm reduction services, and shared that not all health professionals and service providers were welcoming. Focus group participants reported feeling judged, misunderstood, ignored, and unwelcome in their encounters with health professionals and service providers. As such, they felt that health professionals and service providers could be better informed about substance use issues and practices and the associated harms. These findings echoed perspectives gathered from service providers and people with substance use experience at a harm reduction symposium held in March 2007[9].

CAS adheres to community action principles which include harm reduction as it pertains to the prevention of HIV, and its members agree to adopt these community action principles[10]. Based on the results of *Learning from Each Other*, CAS decided to conduct a needs and assets assessment of its member organizations to see where they were at in terms of providing services for people who use substances and to determine how best to support member organizations in enhancing their capacity to offer harm reduction services. Member organizations must be equipped to serve people who use substances, who constitute an important segment of people at high-risk of HIV or who may be living with HIV and in need of support, care and treatment.

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[7] Please visit www.cdnaids.ca/office/membersnew.nsf/members!Openview&language=english for a complete list of Canadian AIDS Society members.

[8] Canadian AIDS Society and The Canadian Harm Reduction Network (2008). *Learning from each other: Enhancing community-based harm reduction programs and practices in Canada*. Available at: www.cdnaids.ca/web/casmisc.nsf/pages/cas-gen-0150

[9] See www.cdnaids.ca/learning_from_each_other for a summary of key messages from the 2007 Harm Reduction Symposium.

[10] Canadian AIDS Society. (2003). *Community action principles*. Available at: www.cdnaids.ca/web/casmisc.nsf/cl/cas-gen-0051

Goal

This project was undertaken to identify means through which CAS could support its member organizations in enhancing their capacity to provide services for people who use substances.

Objectives

In order to effectively gather information about the provision of services for people who use substances within Canadian ASOs, and to reach the above stated goal, the following objectives were identified:

- to explore the assets and needs of ASOs with respect to providing services for people who use substances;
- to understand, from the perspective of service providers, their strengths and challenges when working with people who use substances; and
- to identify service providers' training and/or supportive resource priorities related to working with people who use substances.

METHODS

Overview

An eight month, multi-phase, community-based research project was undertaken between August 2009 and March 2010. The research approach was focused on both capturing the diversity and breadth of experience of ASOs operating in Canada as well as on generating depth of information with regard to the provision of services for people who use substances. Multiple data sources were used to ensure both breadth and depth of information were achieved.

The project involved the following components:

- a National Advisory Committee composed of individuals from across Canada who have experience with the provision of services for people who use substances
- an on-line survey questionnaire, comprised of multiple choice and open-ended questions, conducted with CAS member organizations
- in-depth, semi-structured interviews conducted with front-line service providers, peer workers, and managers/supervisors sampled from Canadian ASOs.

Two CAS Program Consultants shared responsibility for overall project coordination. The project has been made possible through a financial contribution from the Public Health Agency of Canada.

National Advisory Committee

A National Advisory Committee (NAC) guided the development of the research project. The NAC offered direction and input with respect to all aspects of the research process including study methodology, development of consultation materials, interpretation of data, stakeholder communications and recruitment, and dissemination of findings.

The NAC was comprised of ten active members from across Canada. NAC members included: 1) people with lived experience of substance use; 2) representatives from ASOs who work in the area of harm reduction; 3) representatives from community-based harm reduction programs and organizations; and 4) Project Consultants from CAS.

Phase 1: Needs and Assets Assessment Survey

Data Collection

A bilingual, anonymous survey questionnaire was distributed among CAS member organizations via Survey Monkey an online survey creation tool. Responses were sought from a single representative of each agency surveyed. Individual respondents were to be selected by the agencies themselves and could include: 1) peer workers; 2) front-line workers; 3) program staff; 4) managers & supervisors; 5) executive directors; and 6) volunteers. In total, the survey took approximately 20 to 25 minutes to complete.

The survey was comprised primarily of multiple choice questions, with the option to submit short comments in textboxes throughout the questionnaire. This provided participants with flexibility in that they could provide comments with their answers of give suggestions that were not offered within the choices presented. Participants were also given the opportunity to submit longer portions of text, in response to open-ended questions, at selected intervals throughout the survey.

Survey questions explored the following with respect to the provision of services for people who use substances: 1) characteristics of participating organizations; 2) the nature of services provided; 3) organizational policies and practices; 4) knowledge of substance use issues; 5) strengths with regard to the provision of services; 6) challenges experienced in the provision of services; 7) suggestions for service improvements; and 8) needs with regard to capacity enhancement opportunities. For organizations that do not provide direct support services for people who use substances, skip logic was used. In such instances, respondents completed only select portions of the online survey, as well as certain modified questions. Those questions applicable only to providers of direct support services for people who use substances were skipped by non-providers.

Multiple methods were used to recruit survey respondents. A recruitment email and information sheet outlining pertinent details of the needs and assets assessment survey were distributed to all CAS member organizations via a CAS member mailing list. Information regarding the survey also appeared in the October issue of HIVolume, a monthly CAS newsletter distributed via mail to CAS members. Reminders were issued periodically through the above means throughout the window period in which the survey was available on-line. At approximately the midway point of the survey window, a randomly generated selection of CAS member agencies from across Canada were contacted by telephone and informed of the needs and assets assessment survey.

Data Analysis

Descriptive statistics were used to summarize the multiple choice survey data. Tables and graphs were produced from the statistical data as a means of visually representing findings.

Data from both partially completed and completed survey questionnaires were used in the analysis of findings. In cases where an analysis of respondents' IP addresses revealed more than one provider per organization had participated in the online survey, only data from the first respondent per IP address was included in the analysis.

Open-ended responses were analyzed for common themes, in conjunction with gathered key informant interview data, using a narrative thematic approach. The process of analysis is described in detail below in the section pertaining to data analysis of key informant interviews.

Phase 2: Key Informant Interviews

Data Collection

In-depth, semi-structured, one-on-one interviews were conducted with ten service providers from CAS member organizations. Service providers interviewed included front-line workers (5), peer workers (1), and managers/supervisors[11] (4). Interviewees were drawn from ASOs across five Canadian regions, including the Pacific Region[12] (1), the Prairie Region[13] (2), the Ontario Region (4), the Québec Region (2), and the Atlantic Region[14] (1).

Telephone interviews of 45 minutes to an hour were conducted in either French or English by CAS Project Consultants. Interview questions explored: 1) strengths with regard to providing services for people who use substances; 2) challenges experienced in providing services for people who use substances; 3) suggestions for service improvements; and 4) desires with regard to capacity enhancement. Interviews were digitally recorded and transcribed for analysis.

Interview participants were recruited through CAS member agencies strategically targeted for participation. Organizations were selected based on factors including geographical location, the size and remoteness of the communities they serve, and the make-up of their client population. Approval to conduct interviews was sought first from the Executive Directors (EDs) of identified organizations. Willing EDs were then asked to identify an appropriate staff person who was willing and able to participate in an interview. Individual participants were selected from among the following three groups: 1) peer workers; 2) front-line workers; and 3) executive directors and supervisors/managers.

Data Analysis

A narrative thematic approach was used to analyze interview data and open-ended survey responses for common themes. Qualitative data was first reviewed and coded, a process wherein text describing similar concepts or ideas is identified and grouped together. Text corresponding to each of these first-level codes was then organized into broader themes. Inconsistencies among the themes were resolved by discussion and consensus among the project team.

To increase the validity and trustworthiness of the findings, the NAC provided input into overall interpretation of the results. As well, participating key informants were provided the opportunity to review a draft of the interview findings and provide feedback on it.

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[11] Some managers/supervisors interviewed were also actively involved in the provision of front-line services.

[12] Pacific Region: British Columbia, and Yukon

[13] Prairie Region: Saskatchewan, Manitoba, Alberta, Northwest Territories, and Nunavut

[14] Atlantic Region: Nova Scotia, New Brunswick, Prince Edward Island, and Newfoundland and Labrador

2: Needs and Assets Assessment Survey

OVERVIEW

Findings from the needs and assets assessment survey are depicted below in tables and figures. Only a single question was mandatory, so the total number of respondents varies from question to question as indicated by (n = x). In addition, many of the questions allowed respondents to choose more than one response. As a result, the numbers do not add up to one hundred percent. The mandatory question was used to distinguish providers of direct services for people who use substances from non-providers. Where applicable, data gathered from non-providers is reported in conjunction with data gathered from providers of direct services for people who use substances.

CHARACTERISTICS OF PARTICIPATING ORGANIZATIONS

In total, 44 respondents completed the online survey questionnaire on behalf of organizations. Table 1 provides descriptive information about the organizations represented. The majority of respondents were front-line workers (42%) or executive directors (37%) within their respective organizations; not a single respondent identified as a peer worker or volunteer. Almost half (48%) of all respondents were from organizations located in Ontario[15]. Response rates for the other Canadian regions (Pacific, Prairies, Quebec and Atlantic) ranged from 9% to 15%. Three surveys were completed in French.

Table 1: Respondent organization profile (n=43)

STAFF POSITION	NUMBER	PERCENT
Front-line Worker	18	42%
Executive Director	16	37%
Supervisor/Director	5	12%
Other	4	9%
REGION		
Pacific	6	13%
Prairies	4	9%
Ontario	22	48%
Québec	4	9%
Atlantic	7	15%
National	2	4%
SETTING		
Urban	37	80%
Suburban	17	37%
Rural	29	63%
Remote	15	33%

[15] This is largely representative of the national distribution CAS member organizations where 40% of member organizations are located in Ontario.

PROFILE OF SERVICES

Of those surveyed, 36 respondents (83%) indicated their organization provided direct services for people who use substances, while 17% did not (see Figure 1). Figure 2 reports the reasons why some organizations do not provide direct services for people who use substances, including: the organization is not a direct service organization, and services for people who use substances are limited to referrals.

Figure 1

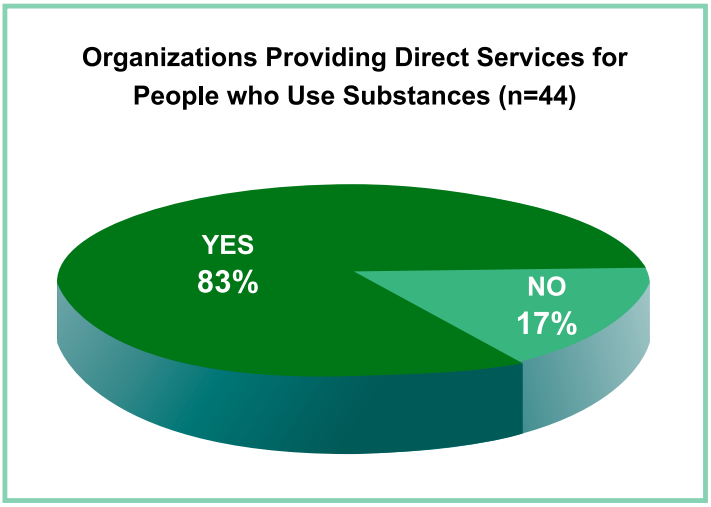
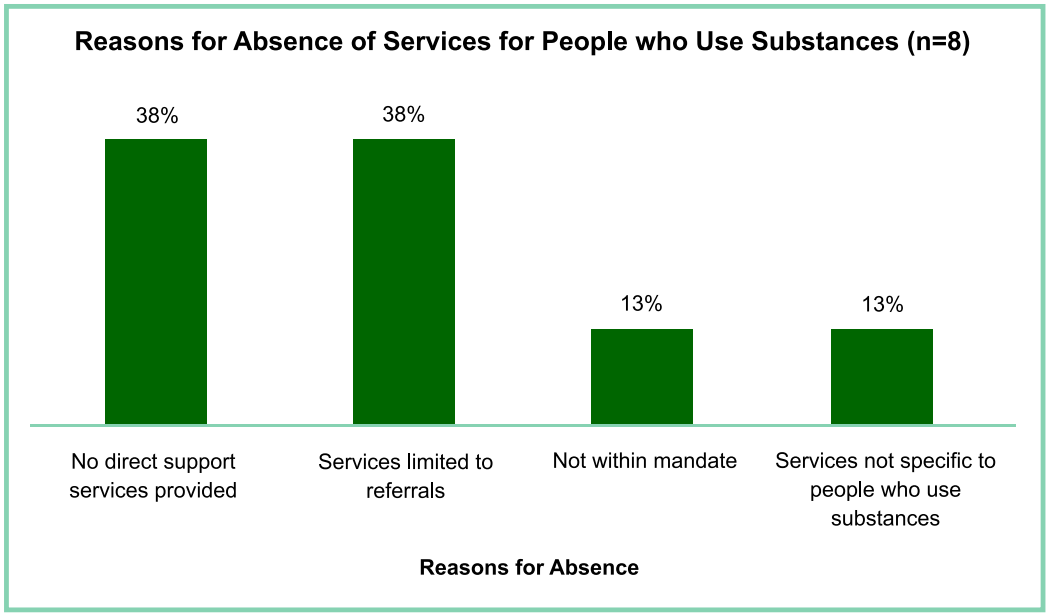
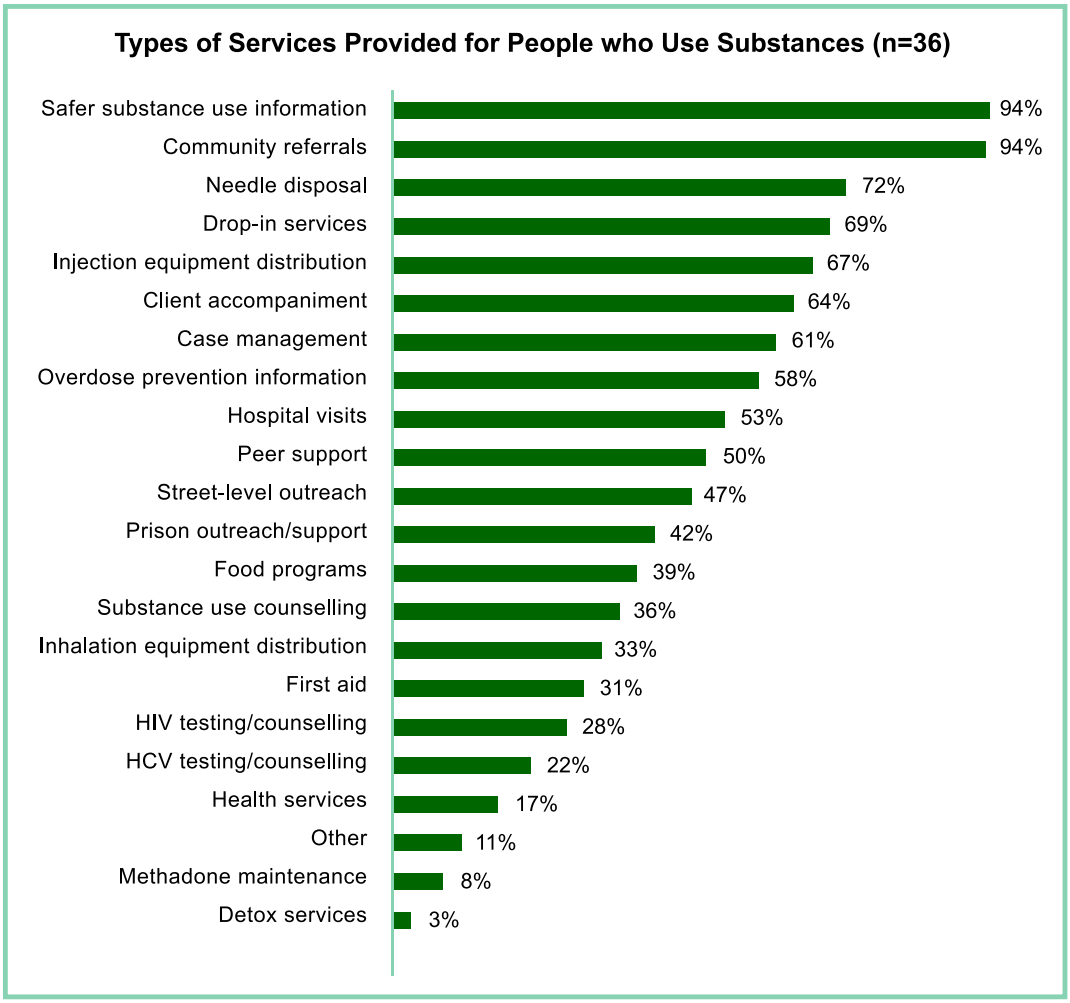


Figure 2



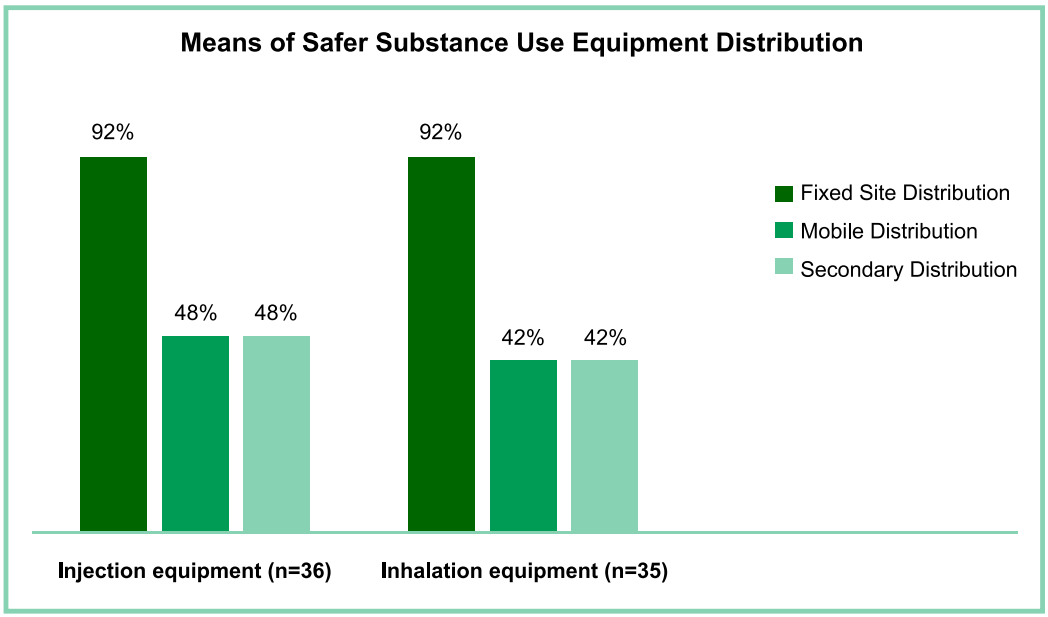
As shown in Figure 3, among those organizations where direct services are provided to people who use substances, the nature and scope of services varied. Most respondents (94%) reported their organization provided safer substance use information, while over two-thirds indicated they provided needle disposal (72%) and drop-in services (69%). Conversely, primary health care, methadone maintenance and detox services were offered most infrequently, provided by 17%, 8% and 3% of respondents' organizations, respectively.

Figure 3



Of the two-thirds (67%) of respondents from organizations where injection equipment is distributed, 92% offered distribution via a fixed site, while just under half (48%) offered both mobile and secondary distribution[16] (see Figure 4). Of the roughly one-third (33%) of respondents from organizations where inhalation equipment is distributed, most (92%) distributed inhalation equipment via fixed site services, while 42% offered both mobile and secondary distribution.

Figure 4

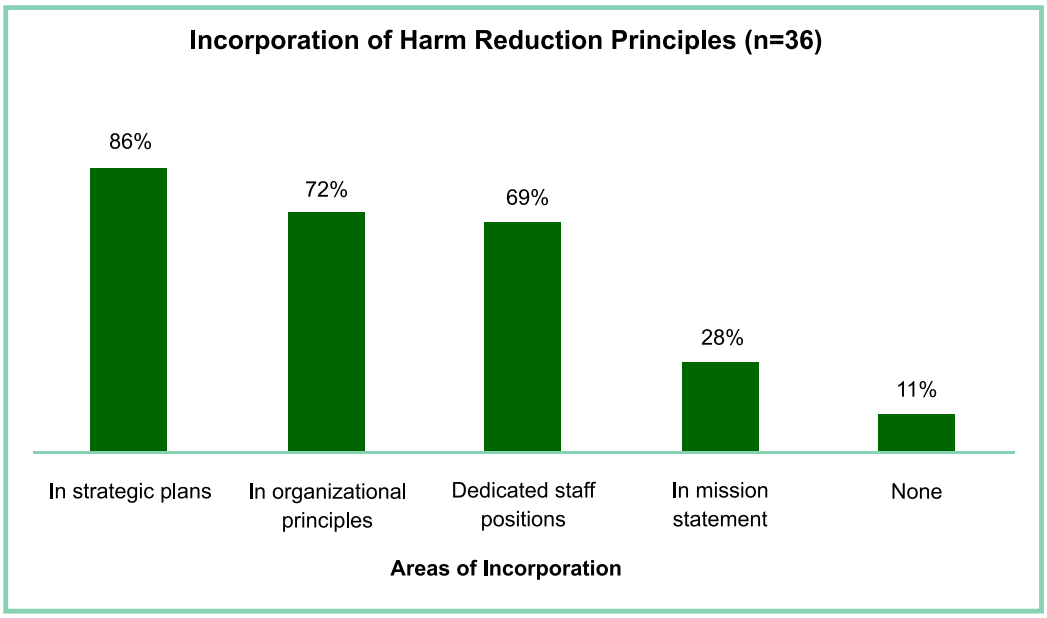


[16] Secondary distribution, also known as peer distribution, involves the informal distribution of safer substance use equipment by a person who uses substances among his/her peers.

PROFILE OF POLICIES

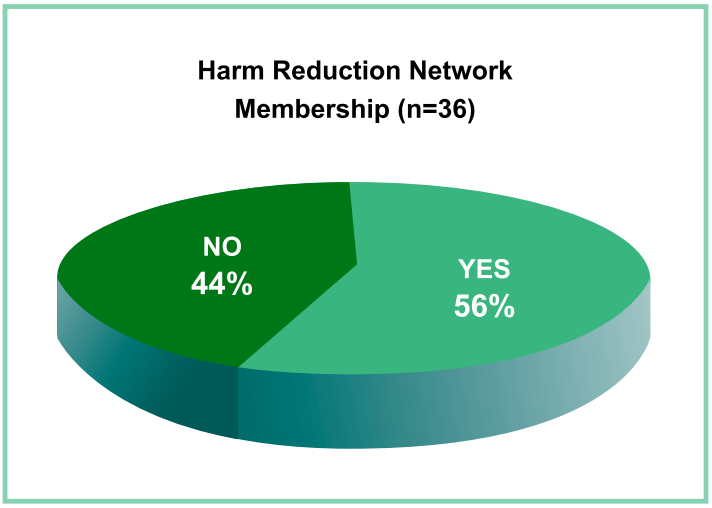
Respondents from organizations that provide direct services for people who use substances were surveyed about how harm reduction principles were included in their organization's mandate. As indicated in Figure 5, harm reduction principles were incorporated through various means, including: in the strategic plan (86%); in the organizational principles (72%); one or more staff positions dedicated to harm reduction (69%); and in the mission statement (28%).

Figure 5



Over half of respondents reported their organization was a member of one or more harm reduction networks (see Figure 6), including various local and regional bodies, The Canadian Harm Reduction Network, international groups, as well as substance-specific networks, such as The Safer Crack Use Coalition and The Crystal Meth Coalition.

Figure 6



As indicated in Figure 7, of those organizations where direct services are provided for people who use substances, two-thirds offer their staff professional development opportunities related to working with people who use substances. Opportunities included attendance at various conferences, in-house training for staff and volunteers, as well as participation in various external workshops and training sessions.

Figure 7

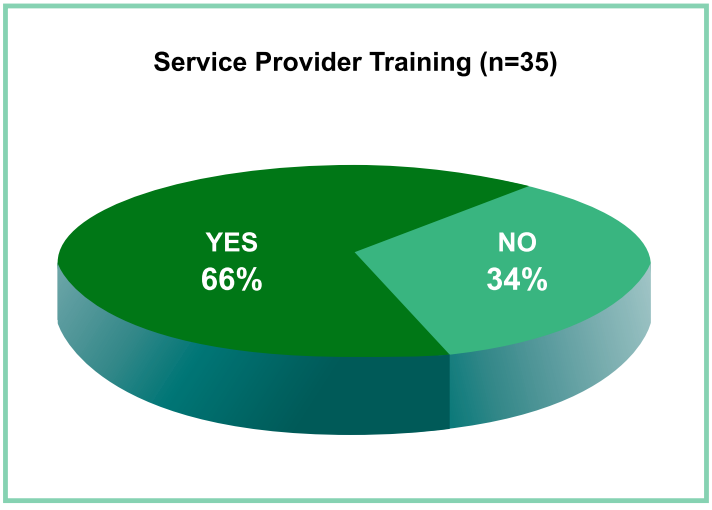
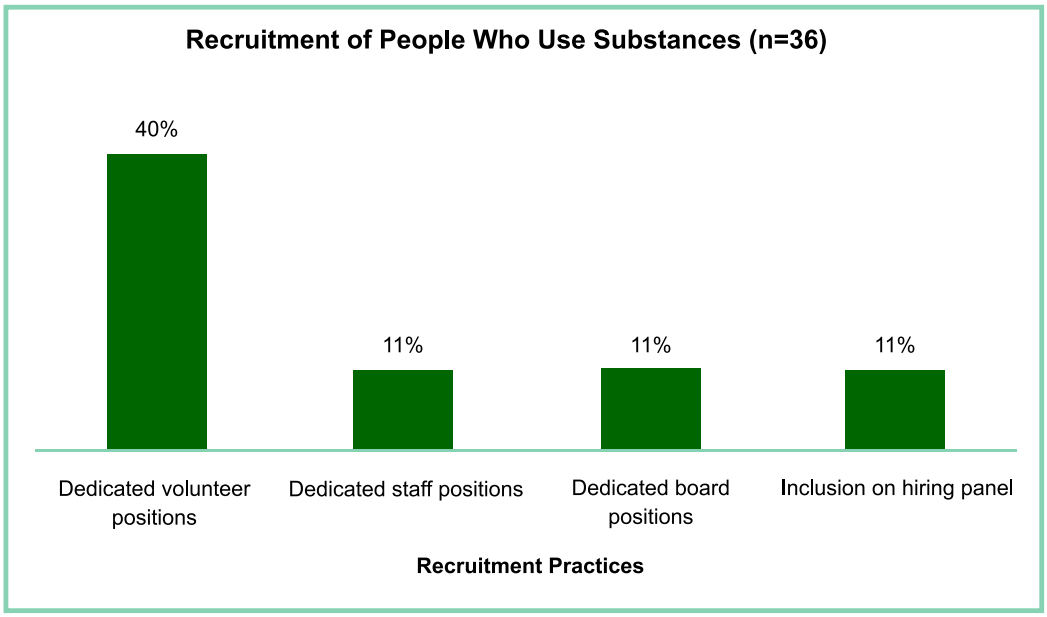


Figure 8 reports recruitment practices aimed at involving people who use substances in the design and delivery of services. Among respondents from organizations where direct services are provided for people who use substances, 40% reported having designated volunteer positions for people who use. Roughly one in ten respondents reported having designated staff, board, and hiring panel positions. To further advance the involvement of people who use substances in service delivery and design, respondents indicated organizations encouraged applications from people who use substances for staff, volunteer and board member positions, gathered feedback through focus groups and advisory committees, and conducted peer engagement programming.

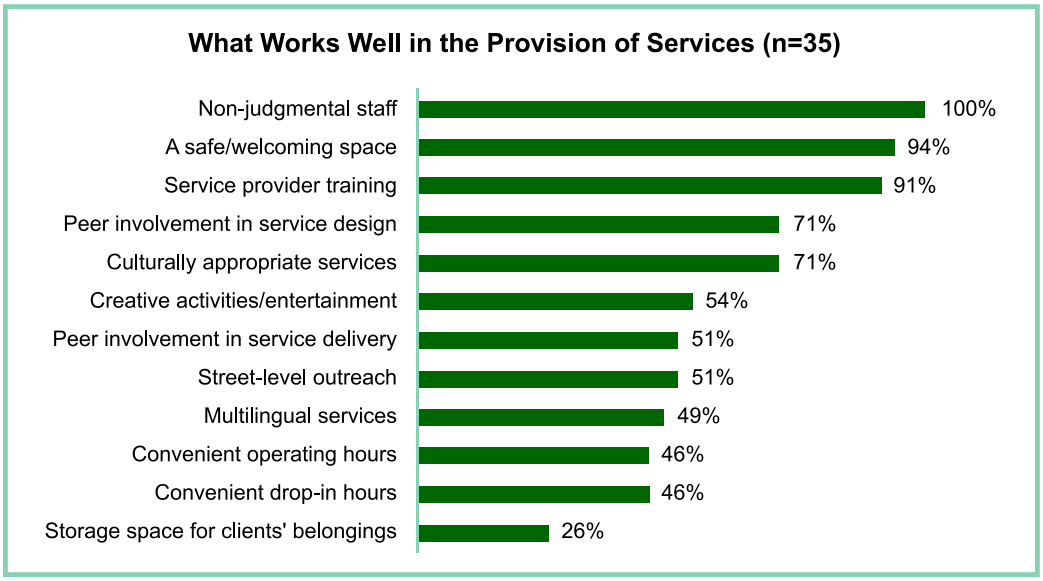
Figure 8



WHAT WORKS WELL

As indicated in Figure 9, when asked what was working well with regard to the provision of direct services for people who use substances, 100% of respondents cited the non-judgmental attitude of their organization's staff. Most respondents also cited the provision of a safe, welcoming space (94%), as well as service provider training on issues related to substance use (91%). Almost three-quarters of respondents reported the provision of culturally appropriate services was working well. A majority of respondents also indicated peer involvement in service design (71%) and peer involvement in service delivery (51%).

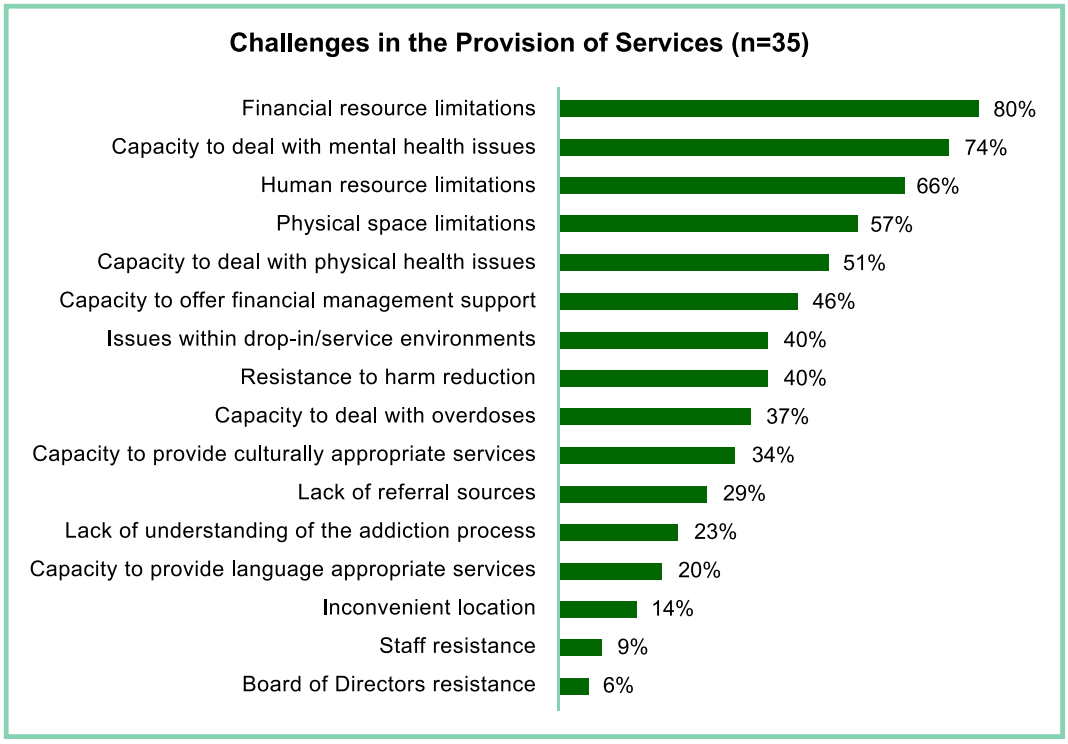
Figure 9



CHALLENGES

Respondents cited various resource limitations as challenges in providing direct services to people who use substances. As indicated in Figure 10, 80% of respondents reported financial resource limitations, 66% reported human resource limitations, and 57% reported space limitations. The capacity to deal with complex mental health and physical health issues related to substance use were also reported by the majority, cited by 74% and 51% of respondents, respectively.

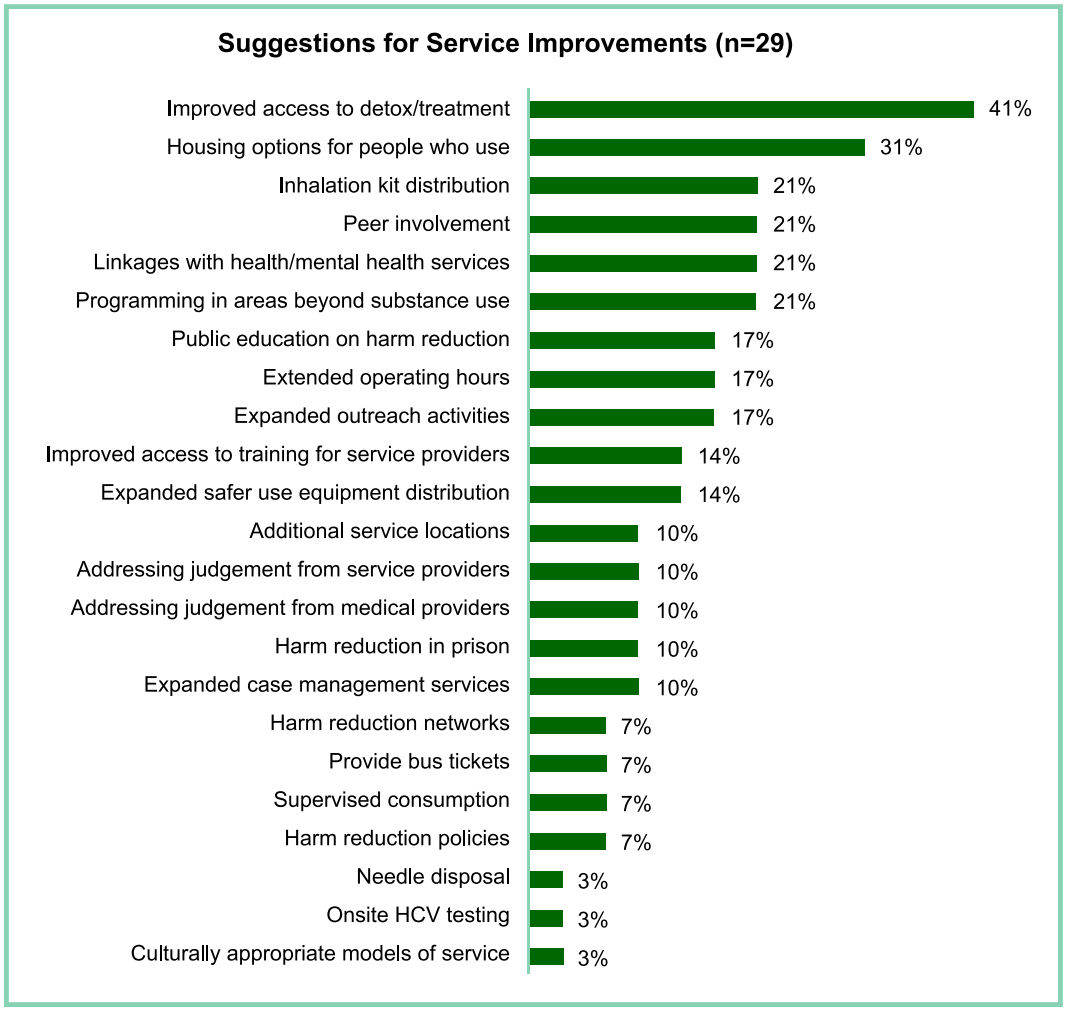
Figure 10



SERVICE IMPROVEMENTS

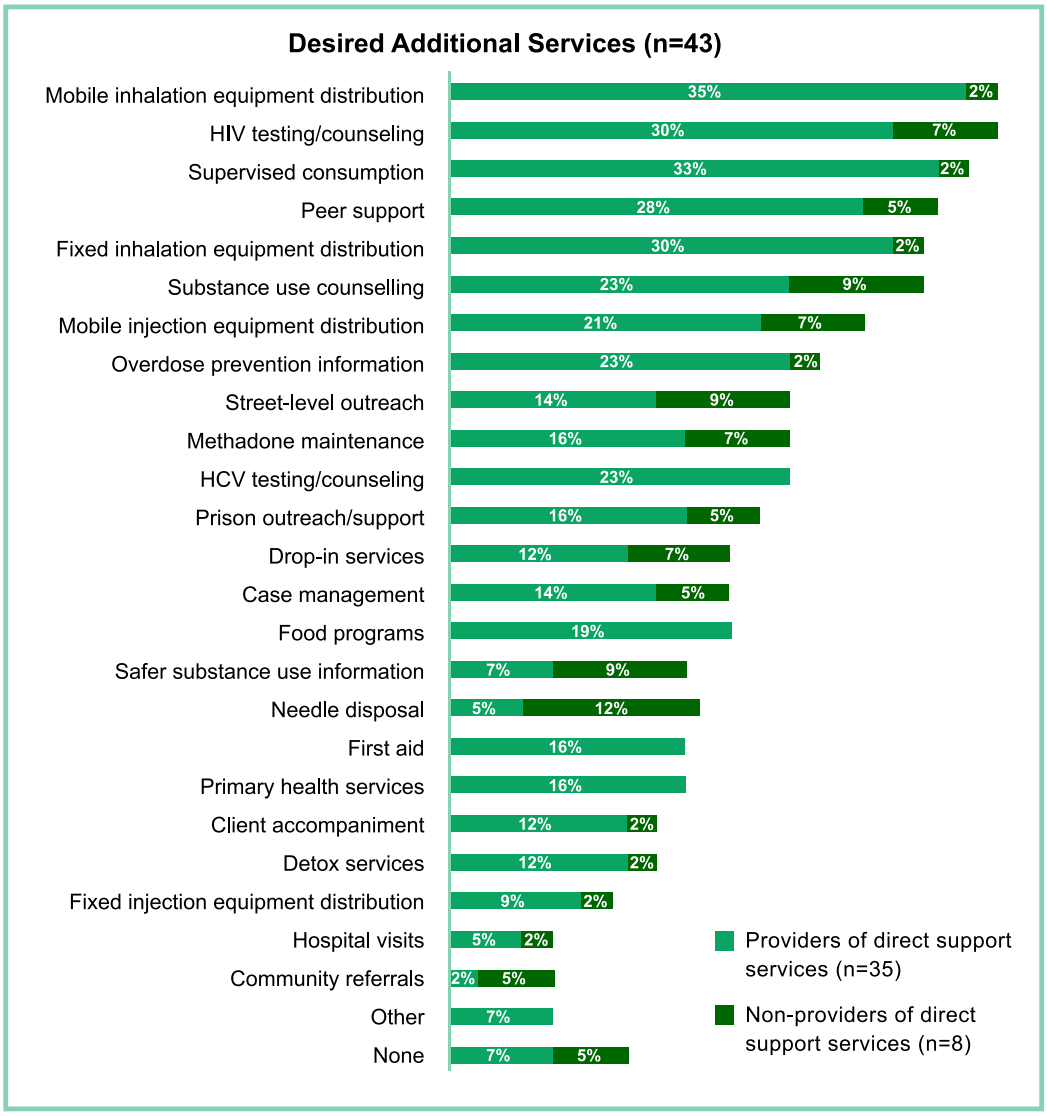
When asked to provide suggestions for service improvements, respondents from those organizations that provide direct services to people who use substances proposed multiple ideas indicated in Figure 11. Improved access to treatment, and in particular low threshold treatment for people who use substances, was the most common response, cited by 41% of respondents. More and improved housing options for people who use substances was the next most common suggestion provided by 31% of respondents. Also appearing frequently, the distribution of safer inhalation equipment, expanded peer involvement in the design and delivery of services, and improved linkages with primary health and community mental health services were each suggested by 21% of respondents.

Figure 11



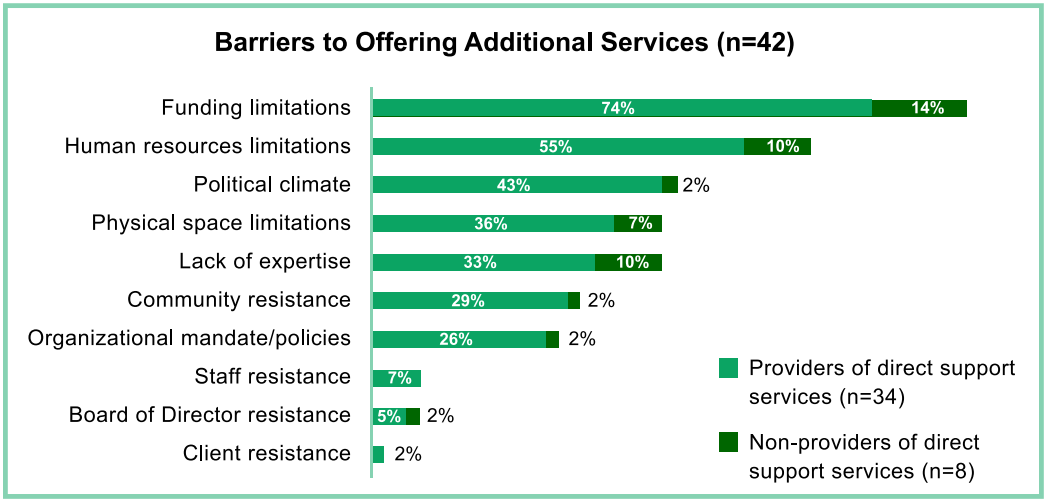
All respondents were surveyed regarding services they would like to offer, but are not currently. Among all respondents surveyed, the most frequently desired additional services included mobile inhalation equipment distribution (37%), HIV testing/counselling (37%), supervised consumption (35%), and peer support (33%). Roughly one in ten respondents (9%) did not wish to offer any additional services (see Figure 12).

Figure 12



Reasons preventing organizations from offering these additional services were collected from all respondents surveyed and are reported in Figure 13. Most often, respondents reported resource limitations, including funding limitations (88%) and human resource limitations (65%), as barriers to offering the desired additional services outlined above.

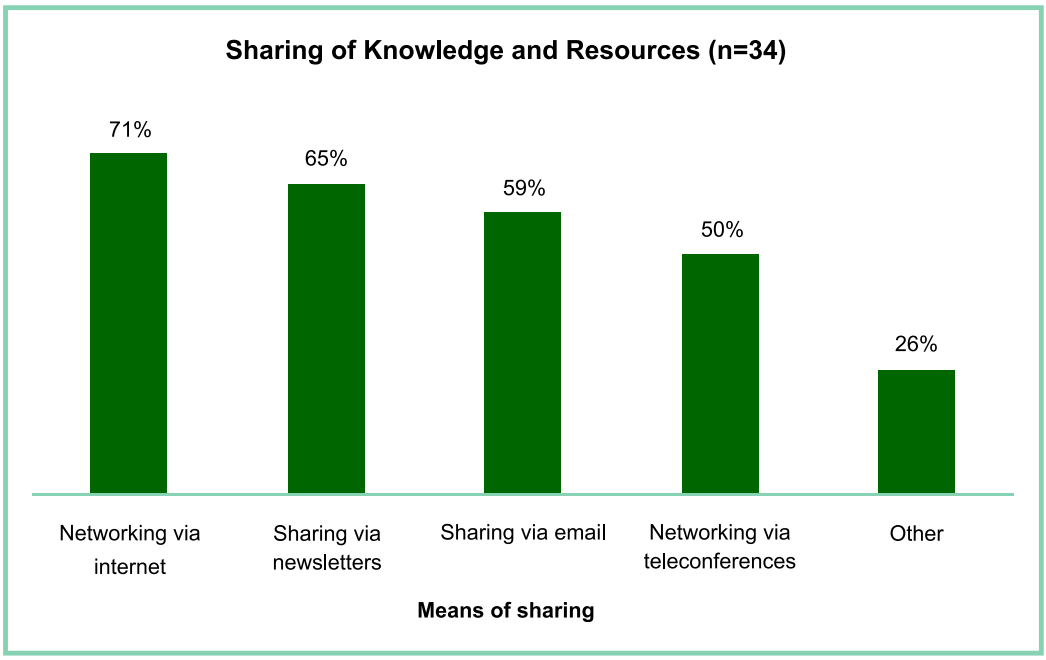
Figure 13



CAPACITY ENHANCEMENT

All respondents were asked how CAS could best share with its members knowledge and resources related to providing services for people who use substances. As indicated in Figure 14, the most frequent response, given by 71% of respondents, was providing networking and support opportunities through the Internet. Almost two-thirds (67%) of respondents indicated their support for sharing success stories through newsletters, while 59% supported the sharing of success stories through email. Other useful means of sharing knowledge and resources identified by respondents include in-person networking opportunities, webinars on directed topics, and conferences for people working in harm reduction.

Figure 14



In order to identify service provider needs with regard to capacity enhancement opportunities, all respondents were asked to rank components of a training opportunity and/or supportive resource in terms of usefulness for their work in support of people who use substances. Scores were then calculated based on ranked responses[17] and reported in Table 2. The most useful components of a training opportunity and/or supportive resource indicated by participants, in order of importance, included harm reduction best practices, reducing drug-related harms, substance use counselling, and overdose prevention. These components ranked highest among respondents in terms of both score and response count.

Table 2: Desired components of a training workshop and/or supportive resource (n=39)

SUBJECT AREAS	RANK					RESPONSE COUNT	TOTAL SCORE
	1	2	3	4	5		
Harm reduction best practices	7	3	3	2	3	18	63
Reducing drug-related harms	8	3	2	2	1	16	63
Substance use counselling	5	1	2	5	0	13	45
Overdose prevention	1	3	4	1	3	12	34
HIV prevention	3	4	0	1	0	8	33
Self care	3	0	1	4	4	12	30
Anti-stigma/discrimination education	0	5	1	2	0	8	27
Anti-oppressive practice	2	2	0	2	2	8	24
Trauma counselling	1	1	0	5	4	11	23
Drug laws/policies	0	1	5	1	2	9	23
HCV prevention	0	3	3	0	1	7	22
Motivational interviewing	1	1	1	2	3	8	19
Addiction processes	0	2	2	2	1	7	19
Stages of change	0	1	2	1	4	8	16
Boundaries and ethics	1	1	2	0	2	6	17
Policy advocacy	3	0	0	0	2	5	17
Financial management	1	2	1	0	1	5	17
Relationship building	0	0	2	2	0	4	10
Grief counselling	0	1	0	2	1	4	9
First aid	1	0	1	0	0	2	8
Working with families	0	0	1	1	1	3	6

[17] Scores were calculated as the sum of the ranks, as follows: 1 = 5 points; 2 = 4 points; 3 = 3 points; 4 = 2 points; 5 = 1 point

3: Key Informant Interviews

OVERVIEW

Important themes that emerged from the key informant interviews are discussed below in relation to three broad areas of enquiry: 1) what works well in providing services for people who use substances; 2) what is challenging in providing services for people who use substances; and 3) service providers' priorities for capacity enhancement opportunities. Quotes are included to illustrate identified themes. While variations of ideas are offered, quotes do not reflect every discussion regarding a given theme. The implications of these findings are discussed further in Section 4.

WHAT WORKS WELL

Canadian ASOs have multiple and diverse assets with respect to the provision of services for people who use substances. Specifically, strengths identified by key informants include: 1) a harm reduction approach to service provision; 2) the client-centered nature of services; 3) the strength of provider-client relationships; 4) peer involvement in service provision; 5) community engagement; and 6) the resourcefulness of ASOs in the context of funding limitations.

Harm Reduction Approach

First and foremost, participants indicated a harm reduction approach was fundamental to their success in providing services for people who use substances.

> *What's working well is that we have, as a staff team, an approach that is harm reduction based.*

A harm reduction approach was described as increasing service accessibility, uptake, and well-being for people who use substances. According to participants, the strength of their harm reduction approach involves a non-judgmental attitude among service providers, acceptance of clients' drug use, showing respect for people who use their services, a focus on harms, and the incorporation of harm reduction principles in the culture of an organization.

Non-judgmental: "We're not here to judge them, and they know that."

Participants identified the non-judgmental attitude of staff as an asset in service delivery. This non-judgmental approach was described as key to making services accessible and to creating a safe space within ASOs for people who use substances.

> *Because we try to be very inclusive and open and non-judgmental in our approach to service delivery, [clients] respond and reflect back to us that they feel welcomed and safe.*

Acceptance of Substance Use: "You can come whether you're high or whether you're not."

Similarly, participants identified acceptance of an individual's substance use as a key factor in service uptake among people who use substances. As one participant stated:

> *One thing that works well and that keeps them coming back here is our acceptance of their drug use and our acceptance of their lifestyle. We're not here to tell people what they should or shouldn't do or penalize them for what they're not doing. We basically support them in their decision, you know, where they're at, at that point in their life. And definitely, I think the harm reduction approach plays a part in that.*

In particular, it was noted that the absence of policies prohibiting service access while under the influence was working well to eliminate commonly-experienced barriers to service access.

> *We work very hard at creating safe and positive relationships with people who use substances so that they are confident that our doors are open to them whether [they are] using or not.*

Valuing Human Beings: "Despite mistakes and addiction, we don't want to feel that we're less than human."

Participants described showing respect for individuals who use substances as a strength of their services. In this way, beyond simply an absence of judgment, service providers are recognizing the inherent dignity and worth of their clients.

> *We're very much an agency that wants people leaving our agency with a sense of worth, and that they have a community that doesn't judge, that they're able to access on a regular basis, that they're valued as a human being.*

Focus on Harms: "We're just trying to promote them doing what it is that they're doing in a more harm-free way."

A focus on harms[18] was identified by participants as a pillar and strength of the harm reduction approach to service provision for people who use substances. This focus on harms was described as essential to demonstrating a non-judgmental attitude and encouraging safer substance use practices.

> *We're not trying to force them to quit anything, we're just trying to promote them doing what it is that they're doing in a more harm free way. And then so that when they do actually get to the point where they decide that this is not the life they want to live anymore, hopefully they don't have hepatitis C or HIV.*

Culture of Harm Reduction: "This is how we operate [,,,] it's not questionable."

Multiple participants described the important role organizational culture plays in a harm reduction approach. For example, a participant described how a culture of harm reduction contributes to the staffing of like-minded service providers:

> *Everybody here's very loving anyways and non-judgmental. Their personalities are geared to this type of vocation. I don't think they'd hire anybody that wasn't, because a person like that couldn't fit in here. They obviously wouldn't gain any trust out on the street doing outreach work.*

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[18] See discussion of harm reduction principles, including a focus on harms, on page 2.

In another instance, an organizational harm reduction policy was described as a means of declaring and preserving the organization's harm reduction ethic:

> *We have an organizational harm reduction policy – that this is how we operate. And it's not questionable […]. If somebody came in and had even a remotely different idea about how the needle exchange should operate, well they wouldn't be there, because we're not going in the other way.*

Client-centered Services

Participants identified a client-centered approach as an asset in their work. This client-centered approach was demonstrated by a commitment to starting where the clients are at, adapting services to suit clients' needs, making services more accessible, adopting a holistic approach to service provision, and addressing clients' basic needs.

Starting Where the Client Is: "[We] are there for them unconditionally at that stage of where they are."

Participants described the basic tenet of client-centered services as a willingness to support people who use substances "where they are at." Key informants described this willingness as a fundamental asset of their work with people who use substances.

> *We really try to just work with a [client] where [they're] at […]. So that might just mean somebody comes in and wants to use the phone or sit on the couch and chill out for half an hour and not actually even talk to anybody. Or someone might come in and ask for help filling out forms for a treatment program – we would do that. So, it really depends on what the [person] needs in the moment and trying to respond in the moment to supporting [them].*

Adaptability/Flexibility: "It goes back to meeting people where they're at and what works best for them."

A willingness to be flexible and adapt services to suit the needs of service users was identified by participants as beneficial to their work. This willingness at both the service design and service delivery levels was described as increasing service accessibility and usefulness.

> *There's a lot of folks who are like 'Well how come we don't have support groups' and that type of thing. You know we've tried support groups in the past and there just hasn't really been a demand for it. We've found that one-on-one counselling or one-on-one sessions has been more effective for a drug user because every Wednesday at two o'clock isn't always that accessible and doesn't really work for someone who's actively using.*

Ease of Service Access: "We make it so easy for people."

Some participants described ease of access as a strength of their services. According to participants factors that improved access to services include: convenient operating hours, convenient service locations, and the availability of outreach services. One respondent described how outreach strengthens services:

> *The importance of outreach is that we're going to where the client is at. There's a lot of clients who choose not to either: a) leave their house just in general, or b) come to the [agency] to be shunned in that whole stereotype where 'If you're walking in, you must have HIV'. And then there's just some individuals that are so consumed in it, it's just best to meet them where they're at.*

It was noted that organizational policies and practices also contributed significantly to service accessibility.

> *We make it so easy for people, like you can come in and have as many needles as you want… It's not like you can only have 10 needles and too bad. That doesn't happen.*

Holistic Approach: "People that work here are never too busy to take a moment to listen, help you out in any way they can."

According to participants, adopting a holistic approach strengthened services, especially in supporting those who have needs beyond HIV prevention. This holistic approach was described as supporting clients however possible.

> *They'll bring you down to the health centre for whatever needs to be done, or sit with you at a clinic because if people are known in the community as being more degenerate you're looked down on […]. And anybody here will take a minute and sit with someone in a hospital emergency room because maybe they have an abscess, a boil, and [they will] not allow that disrespect to go on, stay with that person and support them.*

Notably, supporting clients however possible included undertaking seemingly small tasks that were, nevertheless, appreciated by service users.

> *Some people give me their bags of garbage, like the 3cc wrappers, 1cc wrappers, the waters, the wipes because they don't want them in their garbage. Because, in case the garbage gets ripped, they don't want animals at it and it all over their front yard and then their neighbours might get an idea of what they do.*

Addressing Basic Needs: "Hot food in the winter months…finding money for that is a really good thing."

Addressing basic needs was identified by respondents as integral to HIV prevention, treatment and care, and as a strength in work supporting people who use substances. It was acknowledged that services offered to address basic needs, including food programs and clothing programs, were well-received and appreciated by people who use substances. As one participant illustrated:

> *We all love the hot Friday night soup and donut night. Best soup in [town], comes right to your door in the back of a van. And a lot of these people aren't lucky like me to have a nice home that's warm. All their money goes to where the next hit's coming from. And they need to nourish, they need to get the good stuff in them. And once a week, a hot meal, everyone in this city that uses drugs that's aware of the [organization] waits for that service. That might be their one good meal that week.*

Strength of Provider-Client Relationships

The strength of relationships between service providers and clients was also considered a key asset in working with people who use substances. This strength of relationships, characterized by mutual trust, improved uptake of services.

Human Connection: "It's not just like a quick in and out, they sit and they chat."

Ultimately, the human connection between service providers and service users allowed service providers to become known, and to be recognized and trusted. In this way, building rapport was deemed an asset when encouraging new people to access harm reduction services. It was also seen as strengthening clients' willingness to access the full complement of available services.

They've gotten really comfortable in the office, comfortable to ask if there's anything to eat, if they can have a snack, or where's the water and stuff like that. So, even just seeing that, the trust and confidence, just the change in their attitude, it's not just like a quick in and out, they sit and they chat.

Relationships Built on Trust: "We have very good mutual trust."

Participants identified trust as the foundation of their relationships with clients and as essential to their work in support of people who use substances.

It's the element of trust that's evolved over a long period of time. It's not something that happens instantly... Once they've made that connection with our support services coordinator or our drop-in coordinator, and have those human conversations, and to know that they're not going to be judged in any way. It's really a relationship built on trust.

It was noted that clients are often unable to successfully establish trusting relationships with other service providers or other organizations. ASOs are at times the only connection an individual may have to support services, primarily because they are able to develop trust.

There's a lot of times where we'll be the only individuals really, truly who they trust.

Conversely, respondents described that demonstrating trust in their clients was also critical.

There are no questions asked. If you come in and say 'I need 500 needles,' you would never say 'What do you need 500 needles for? What are you doing with those? Na na na.' So it's a relationship built first with the assumption on our part that they wouldn't be asking for things that they didn't need. So we never would question anybody, never, ever. I mean it just doesn't happen.

Follow-Through: "What is said to you is what is delivered."

Gaining the trust of service users was described as a gradual process. Delivering on promises was integral to the development of a trusting relationship, in particular for those who may not trust mainstream society.

They also see their feedback incorporated within the day-to-day activities. It's not like we're a researching group, which happens quite often, you know, 'Ohhh, we want your input,' and then we never see them again. They actually see those changes implemented in a short period of time.

Peer Involvement in Service Provision

Regardless of its level and nature, participants indicated that peer involvement in the design and delivery of services was an asset. Emphasizing the importance of peer involvement, one participant stated:

If I had to say what's the number one success, it would be the peers. It isn't us, it's the peers.

According to participants, peer involvement strengthens services for people who use substances by improving responsiveness to client needs, expanding service reach, increasing service provider trust through kinship, and empowering clients through role modelling.

Responsiveness to Client Needs: "To make sure that our programming is still relevant and meeting their needs."

An improved ability to understand and respond to client needs was described as an important benefit of peer involvement. Multiple participants drew attention to how service design can profit from the knowledge of people with lived experience of substance use.

We hired a user to actually develop a marketing campaign […] to get the word out on hep C within the community. So he actually brought a bunch of users together and they actually hand-drew images that were going to be in posters, and they decided what kind of messages they wanted to have that would be effective for the community, rather than handing it off to a graphic designer who may not really understand.

Similarly, peer involvement in service delivery was seen to improve responsiveness to client needs.

They're always attached to any hiring that we do…because we want to find staff here who work well with the community, aren't too academic, you know that they'll relate well to. Because the opinion of our [peers] really will speak loudly on how much street cred they're going to get.

Expanded Reach: "That liaison relationship really helps."

Participants described how peer involvement in service design and delivery allowed services to reach people who might not otherwise access services. Peers offer an existing social network through which to reach people who use substances and encourage service uptake.

Mainly it's probably word of mouth, you know, through other users, people who use drugs. So they talk and I think that that's the main word, the main way that it gets out.

Peers also play a role in increasing the capacity to deliver services, for example through secondary distribution of injection equipment.

We absolutely rely on those folks that come in and say I need 500 or 1000 to distribute among their peers. They're the core of our needle exchange program, they really are.

Kinship: "Automatically, there's a feeling of, 'This person understands me.' "

The kinship among peer workers and their peers improved support for people who use substances by facilitating the development of trust between service providers and service users. Describing this kinship, one participant noted:

There's a trust with the peer ambassadors. They know we're not an undercover cop. They know we're not, as they put it, 'Some twenty year old psych major who's reading out of a text book who hasn't got a clue.' Like I've been down in the trenches with them, you know what I mean?

Role Modelling: "I guess they see a change in me."

Peer workers can have an empowering effect on people who use substances, serving as positive role models in multiple ways, including: as community advocates, as skilled workers, as people who have taken steps to minimize their substance use, and as people who have made positive changes in their lives.

I still see the same people that I used to party with, and I guess they see a change in me. And if ever they want to know what I've done to get there or enquire, I'll bring them along the way. And if they stay where they're at, I'll love them that way too.

Compensation for Work: "[We] give them money wherever possible."

Compensating peers for their work was noted as good practice by some participants. It appropriately values the work of peers, increases peer engagement, and provides peers with income. One participant commented:

Their time and their opinions and their work is just as valuable as a paid staff here. Whenever we can reward someone with cash, or bus tickets, or a freezer meal we'll happily do so.

Community Engagement

For some participants, engaging the community as a whole facilitated their work with people who use substances. The absence of community resistance to harm reduction initiatives, the building of community partnerships, and dialogue with community enhanced the provision of harm reduction services.

Community Support: "The community knows… that we're very much needed."

For some participants, an asset to their work with people who use substances has been support from the community. Despite many statements heard to the contrary, select participants reported that the community as a whole had embraced harm reduction efforts. As one participant illustrated:

> *Our whole community has bought into harm reduction. I would have to say that we're incredibly lucky. In the 10 years that I've been here, we have never ever had one bad phone call about our needle exchange. And, in fact, a couple of times a year we'll get phone calls from people who've had a loved one die of cancer or something and they'll say, 'Look, we have these syringes left. Do you think you could use them?'*

Community Partnerships: "If we were trying to do it all alone it would never work."

According to participants, community partnerships strengthen work with people who use substances. Community partnerships were an important means of bringing the voices of people who use substances to the table at relevant policy and service discussions.

> *We're on the homelessness committee, the sex trade committee, the steering committee for the new methadone program. So all of these agencies that would be providing services of some sort, we bring the voice of those people to the table.*

Community Dialogue: "I always go straight back to 'These are your children, these people belong to our community.' "

The forging of community support and partnerships, according to participants, is aided by engaging community in dialogue regarding substance use. Resistance to harm reduction initiatives has been overcome by educating the community about substance use-related issues and the principles of harm reduction.

> *When we say it's for the safety of the community, for the betterment of the community as a whole, that's really what kind of turns people to understanding what harm reduction is. So it's not just getting people high, kind of thing, right.*

Resourcefulness: "They make every dollar count. I can tell you that for sure."

In the context of significant resource limitations, participants praised the creativity and resourcefulness of service providers and organizations in stretching limited budgets.

> *Every penny, I can guarantee you, that comes in here, is used. I've seen [a staff member] walking into an A&P, you know where you give back your grocery bags, well instead of buying bags he goes and grabs recycled bags to put the soups in and the works in. Anyway you can, right.*

As a result of this resourcefulness, maximum resources were directed towards reducing harms and support services.

> *Money spent here is money well spent. It goes to harm reduction. It goes to saving lives. It goes to helping people who are lost find themselves, if that's what they wish, in an atmosphere of unconditional love.*

CHALLENGES

Service providers working in Canadian ASOs encounter considerable challenges, which complicate their work with people who use substances. Key informants described diverse political, social, organizational, and individual challenges in their work, including: 1) resource limitations; 2) resistance to harm reduction; 3) serving diverse populations; and 4) individual service provider capacity.

Resource Limitations

The challenge most frequently identified by participants with respect to their work was resource limitations in the context of a general lack of funding for harm reduction efforts. Simply put by one participant:

> *There is no harm reduction funding available.*

Participants described struggling to meet the service needs of their clients in the context of supply limitations, human resource limitations, program and service limitations, and funding insecurity.

Supply Limitations: "The supplies go quick."

Participants indicated supply limitations hindered their work. They specified that shortages of both safer substance use and safer sex materials act as barriers to meeting the needs of the communities they serve.

> *I've had to tell them to clean things out and use them again, because the budget is spent for this quarter. And that's not because it's been wasted, it's because the supplies go quick.*

As one participant noted, supply limitations are detrimental to HIV prevention work, where organizations are mandated to encourage adherence to safer sex and safer substance use practices.

> *Our mandate is to get out there and encourage as much prevention as we can. But then they're going to limit us about condoms, well that's sort of counterproductive to our program.*

Human Resource Limitations: "[It's] a matter of having the manpower."

Human resource constraints, including lack of staff and/or volunteer capacity, diminished the capacity of ASOs to carry out existing programs and services.

> *We have a lot of projects that are on the go, and services, but it's just a matter of having all the human resources to get them done.*

Human resource limitations were also cited as a barrier to expanding services, with implications for service diversity, accessibility and reach.

> *If funding were not an issue, it would be useful to have staff support or a staff position for an addiction service provider.*

Program & Service Limitations: "We would like to increase all of the services we presently offer."

Limitations to program and services, including frequency, hours of operation, and service reach, were highlighted as key obstacles. Participants indicated they decreased service accessibility and uptake among people who use substances.

We would like to expand our hours. Our budget does not allow for that at this time.

Lack of funding and human resources also limited ASOs' ability to respond to specific program and service needs. In particular, several participants stressed the need in their communities to distribute safer inhalation equipment, and the current lack of resources to do so.

We've got a huge crack problem. It's been ongoing for years, and nobody funds our safer crack program. Now, we're only giving out about 350 kits a month. But, you know, if we looked at a year ago, we we're giving out about 100. It's, like, how are we going to fund these in the long-term?

Funding Insecurity: "It's just not particularly secure."

The tenuous nature of funding was also described by participants as a significant difficulty in working with people who use substances. It often resulted in cutbacks and limited the ability of organizations to provide long-term sustainable services. Participants noted this insecurity could jeopardize client trust and relationships with clients. The limited resources also create a competitive environment among groups doing harm reduction work.

At-risk youth are easy to fund, injection drug users not easy to fund. It is very hard to find regular funding. And I mean, the federal government, you're always a little nervous because it's year to year.

Resistance to Harm Reduction

Resistance to harm reduction was prevalent among many different communities. Signs of resistance include challenging policy environments, stigma and discrimination, on the part of health care professionals, service providers and the general community, towards people who use substances and the inadequacy of community resources to support people who use substances. Lacking resources, some organizations struggled to engage communities in a constructive dialogue about harm reduction in order to address this resistance.

Challenging Policy Environments: "To open our new methadone clinic, we actually had to have a change in provincial policy."

Differing ideologies with respect to harm reduction created challenging policy environments within which to operate, often placing restrictions on the scope and nature of harm reduction efforts. Opposition to safer crack use initiatives was especially evident. The distribution of safer inhalation equipment remains strongly contested and is currently unavailable in many communities, yet is deemed critical to HIV and HCV prevention.

This city is stuck on, 'If you give them crack kits, you're gonna have more crack smokers.' […] They think it's just we're saying 'Ode to crack,' bring it in, it's here. Crack is a reality. And without the crack kits, there's going to be a lot more illnesses pass through this city and a lot more deaths.

Stigma & Discrimination: "There tends to be, among the general population, not a lot of sympathy for people who are street-involved and using substances."

Stigma and discrimination towards people at risk and living with HIV/AIDS, and towards people who use substances is pervasive and impedes the provision of services for people who use substances. According to participants, some people who use substances are deterred from accessing services identified as related to HIV and harm reduction for fear they will be subject to stigma and discrimination. This is particularly the case in smaller communities.

The relatively hidden population we call our residential clients, many are still maintaining their jobs, have their children, etc. They do not access the downtown services for fear of [losing their] anonymity, fear of losing employment and children.

Stigma and discrimination also prevent people who use substances from becoming involved in service delivery. One participant described the difficulty in finding spokespeople willing to go public with their substance use:

A lot of people don't want to [share their experience] too much because they don't want their neighbours, or maybe parts of their family, to know that they were involved in such a thing. Then they're labelled. So people won't talk about it because they're afraid that they'll be judged for what they've done in the past.

Attitudes of Service Providers: "A huge issue, is that many doctors don't have a friggin' clue."

Participants described the stigma and discrimination experienced by their clients at the hands of health care professionals and service providers who have not adopted a harm reduction approach.

We had a young fellow we'd been working with for a while. I said to him one day, 'Do you like your family doc?' 'Oh yeah, I really like him.' And I said, 'Would you be able to bring up the idea around could he maybe get his methadone license?' I basically talked the kid into going and talking to his doctor and his doctor shut right down. 'What I'll do for you is, I'll buy you a ticket to BC and I'll drop you off on Hastings Street and then you can at least die within the next few months and your family won't have to watch.'

Providers not working with a harm reduction framework were described as impediments to service accessibility and uptake. They also sometimes hindered the provision of harm reduction services, as illustrated by one participant:

The question about whether we distribute pipes, I have talked about that before. We are part of a committee with the city, the social services centre, police, street outreach workers, and a school social worker. We had talked about it, but the street outreach workers did not agree with it. They said that instead of finding needles on the ground, they would find pipes. Well, there is no danger with that.

Inadequate Community Resources: "Everything comes back to housing and basic needs."

Participants described a dearth of support services and resources for people who use substances. Specifically, they cited a need for more shelter beds, housing, health care and mental health care, and drug treatment options based on a harm reduction approach.

There is a serious lack of comprehensive prevention and treatment options for people who use drugs in our community. Therefore, the harm reduction programs work, but they need to be supported with the right prevention and treatment programs. It's our biggest concern.

Moreover, existing community resources sometimes discriminate against people who use substances. In the absence of these community resources to refer clients to, participants found it difficult to support clients in meeting their basic needs.

A lot of organizations just send [people who use substances] over to us because they don't want to deal with them. There's actually shelters as well that have shut a lot of our clients out. Our clients are left with really minimal choices on housing, or safety, and such.

Inadequate income supports for people who use substances were also highlighted by participants as a major difficulty.

> *Our income assistance rates need to be brought in line with what would actually allow people even to have a room. [With] two hundred and eighty dollars you can't even rent a room for a month, so of course they're doing illegal stuff. To me, we just all have this awful cycle going.*

Community Dialogue: "People here just don't have an idea of what harm reduction means or what it actually entails."

Many participants understood community resistance to harm reduction efforts to be a product of misinformation and misunderstanding regarding the nature, application, and outcomes of harm reduction services. They described the challenge of engaging their respective communities in a dialogue regarding harm reduction.

> *We're having difficulty getting that conversation going just so they truly understand what's happening in our building, because we provide a lot of services that are based in support, based in prevention, and education.*

In some instances, funding and human resource limitations contribute to this diminished capacity to engage community in a dialogue.

> *We don't always have the resources or the ability to get the word out to the community.*

Advocacy: "Unfortunately, our voice is very small within the conversation."

Participants described difficulties engaging in advocacy to combat resistance to harm reduction efforts. Limited resources and a lack of coordination among stakeholder groups, including other ASOs and service providers in related sectors, render advocacy particularly challenging.

> *I really feel like we're scrambling to have a common goal and a common voice provincially. And to have a larger body advocate on our behalf would just give more weight to the argument.*

Serving Diverse Populations

Participants described the challenge inherent in serving the diverse population of people living with or at risk of HIV/AIDS. Client groups with varying backgrounds, life experiences, and service needs access HIV prevention, treatment, and support from ASOs across Canada. Some participants experienced difficulty overcoming tensions between different client groups, the exclusion of certain client groups, and gaps in services for specific sub-populations.

Tensions: "There can be tensions in a group of people where people are coming from lots of different backgrounds."

Tensions among the diversity of people who access services complicate service provision. A commonly cited tension was between client groups within ASOs that serve multiple communities, including men who have sex with men, people who use substances, women, and people from countries where HIV/AIDS is endemic. Ongoing examples of homophobia, racism, and discrimination were cited by participants. According to participants, these tensions among client groups can be difficult to negotiate.

> *We have an emergency support fund for people living with HIV and I remember a few years ago [a client] calling me and saying, 'You wouldn't let drug users use that fund.' And it's like, 'Well, yeah if they're HIV positive.'*

Tensions also arise between individuals from the same client group. One key informant described an example of stigma and discrimination among people who use substances:

> *We have opiate users, who would only use opiates, who say terrible things about crack users. So it is very interesting, eh? You start noticing all the little nuances and sub-populations.*

Exclusion: "People will say, 'I don't feel comfortable coming [here] anymore.' "

Providing a safe and welcoming space for all clients who access services is particularly difficult when needs vary and tension exists among clients. Participants described circumstances in which particular client groups were uncomfortable accessing services or felt alienated from existing ASOs.

> *We've lost connection with the MSM [men who have sex with men] community because of the demographic that's regularly using our services and because a lot of our work is predominantly anti-poverty work. A lot of the PHAs [people living with HIV/AIDS] within the MSM community don't always feel comfortable coming into our space.*

It was noted that, at times, this exclusion is the result of deliberate policies within organizations, particularly those which bar clients from accessing services while they are under the influence of substances.

> *"We've heard complaints from many of our clients that they had gone to [other ASOs], and they were under the influence, and they were told they weren't welcome there."*

Service Gaps: "We need more resources that will be able to address community-specific issues in regards to substance use and harm reduction."

Resource limitations and a diverse clientele with varying needs, result in service gaps for certain client populations. The most frequently cited gap was with respect to women-specific services, including services for transgender women and women working in the sex industry.

> *Our main concern right now is we want more women-specific services for women who use substances. It's definitely a population that deserves its own space to be able to get together and to have that space to themselves.*

Other client groups experiencing harm reduction service gaps include ethnocultural communities, prisoners, youth, and people who use crack cocaine. Pointing to the service gap for people from ethnocultural communities, one participant noted:

> *We don't really seem to serve a large Black population. I mean you could think maybe there's not a lot of Black people that are using needles and in the sex trade, but I tend not to believe that. So, I think that if there were any area where we would need to get some answers around, it would be that. Any kind of different culture really. [Our city] has a huge multicultural community and most of the people who we serve, especially in the IDU program, are white.*

This service gap has an impact on the effectiveness of harm reduction services. Participants described how traditional harm reduction programming may not address the realities of HIV risk for all client groups.

> *Prevention resources for hepatitis C and HIV and harm reduction messages are primarily focused to communities outside of prison. And so it's not useful for me to send a resource into prison that says, 'Don't reuse your needles' or 'Don't share needles,' because the reality is that they have to.*

Individual Service Provider Capacity

Beyond the structural and organizational challenges cited above, participants also faced difficulties with respect to individual capacity to provide services for people who use substances. These were related to knowledge of client population, maintaining a non-judgmental attitude, negotiating boundaries with clients, and prioritizing self-care.

Knowledge of Client Population: "We could all use more training around providing services for people with substances use issues."

Service providers described an ongoing need in the HIV sector for skills building and training specific to working with people who use substances.

> *You might be working for an organization that provides programs to people living with HIV, but within that population there are many other streams of populations that you'll run into. And so a lot of people aren't equipped with those skills to be able to deal with people with substance use and mental health issues.*

Barriers in accessing training contribute to knowledge gaps. The financial cost of participation, as well as the cost in staff time, make it difficult for service providers to take advantage of available training opportunities.

> *We still are pretty hungry for more information about how we can best meet our clients' needs. And that is a barrier, obviously, because of our limited funding. So we wouldn't be able to necessarily go and take a course. There are some things that are provided to us but a lot of stuff you would have to actually pay for to get that kind of education.*

Maintaining a Non-judgmental Approach: "The reality is that most people have varying degrees of ability to be non-judgmental."

While all participants were committed to a harm reduction approach, some expressed challenges in remaining non-judgmental in practice. As one participant noted, this challenge may be lesser or greater from day-to-day.

> *You can say that we all work from a non-judgmental place, but the reality is that most people have varying degrees of ability to be non-judgmental, and I do actually think that changes day-to-day. One day, I might be feeling really strong and having lots of personal resources to support women who are coming in who are currently using, but maybe the next day I have some kind of trigger that means that I'm not dealing very well with supporting women in that moment.*

According to some participants, the unconditional acceptance of their clients' substance use could take an emotional toll. They described the difficulty of watching their clients using substances that are harmful to their health.

> *My challenge is just being able to say, 'But for the grace of God, they're alive,' and maybe reiterate again, 'That stuff you're putting in your body is hurting you, I can see your skin, maybe think twice the next time, maybe do less,' but still just loving them where they're at.*

Negotiating Boundaries: "I guess it's about saying, 'No,' sometimes."

Participants described negotiating boundaries with clients as a challenge inherent to their work.

> *There's a huge boundary expectation, like knowing your boundaries here at this place, because the clients will push those boundaries with you. And they're trying to survive so, you know, they'll do anything to be able to do so.*

Self-Care: "Our staff are getting tired and burned out."

Some participants struggled to prioritize self-care in the face of heavy workloads and a lack of resources. As a result, burnout was a common occurrence.

> *Because we don't have a lot of staff our staff are getting tired and burned out. And if we don't have enough staff it's because we don't have enough funding.*

One participant noted burnout was compounded by an absence of celebrating successes. In the context of significant resource limitations and competing priorities, service providers and organizations often do not take the time to celebrate their successes.

> *Because everything is so strapped and all the resources are sucked dry, it's really hard to take a moment and breathe and say, 'We're actually doing good work.'*

CAPACITY ENHANCEMENT

During key informant interviews, two major themes regarding capacity enhancement for ASOs and service providers working with people who use substances emerged: 1) the desire for greater and more accessible opportunities to engage with other service providers; and 2) a commitment to continuous learning and a desire for skills building opportunities.

Engagement Opportunities

Participants expressed a desire for greater and more accessible engagement opportunities for organizations and service providers working in harm reduction. Engagement opportunities facilitated service provider introductions, knowledge exchange, and partnership- and community-building. In particular, participants wanted opportunities to meet face-to-face along with a national harm reduction conference.

Service Provider Introductions: "A really unique opportunity for us to meet people."

Opportunities to engage with other service providers were seen to facilitate introductions among those working in the area of harm reduction and related fields. These introductions can help to raise awareness regarding organizations' programs and services, and facilitate communication amongst service providers.

> *Knowing you can call somebody and having that face, it's a lot easier than not knowing which agency is doing what. So, networking where agencies can kind of present to each other what they do and what their programs are and the things that we've found successful. So just like agency introductions maybe.*

Knowledge Exchange: "[To] hear what's going on out there."

Participants described opportunities to engage with other service providers as an important means through which knowledge can be exchanged among ASOs and service providers involved in similar work nationally. Organizations and service providers can share their successes, as well as their lessons learned. Some participant also described these opportunities as facilitating more formalized knowledge transfer activities including training initiatives and resource sharing.

> *It's a big country, and I don't get to often know, you know, geez who's doing a needle exchange in Yellowknife or Kamloops or something. And that's how we get some of our best ideas – it was somebody else's best ideas that we'd heard about.*

Partnership Building: "You complement each other and you learn how you could be working together in a stronger manner."

Participants described how opportunities to engage with other service providers can assist in the creation of working partnerships and facilitate the realization of common goals.

> *The number one thing is to be able to provide an opportunity to hear about what the responses have been nationally and to come together. And that might be an opportunity to be able to form specific committees […] to kind of work on this on an ongoing basis.*

Professional Support: "It makes us aware that there are other people also working on these same things with us"

For some participants, meeting and engaging with their counterparts was also seen as important for service provider well-being. It was viewed as a means of reducing isolation and building community, as well as an avenue for seeking professional support. As one participant noted:

> *Staff who work with people who use are often isolated within their communities and need to be brought together with other like-minded individuals to rejuvenate and be supported.*

In-Person Meetings: "That face-to-face aspect is important."

In particular, participants expressed a desire for more opportunities to meet face-to-face with service providers in the harm reduction field. The human connection created was felt to be a powerful vehicle for building partnerships and exchanging knowledge. Within the context of multiple and competing priorities, such opportunities were also thought to encourage participation where phone or internet communication might fail.

> *I think a lot of it is human connection. It's really about face-to-face. And once you actually have a human being attached to that name or that email, it's way more powerful.*

Harm Reduction Conference: "Where is the national conference?"

A call for a national harm reduction conference was heard from several participants.

> *It would be really great to see a national conference on harm reduction in Canada. We have some regional conferences and international, but where is the national conference?*

While regional and international opportunities, as well as related national conferences (ex. HIV/AIDS-oriented conferences) were highly valued, a need to bring together service providers from across Canada working in the field of harm reduction was expressed.

> *If that happened like even once every couple of years, where nationally you had a chance to chat and say, 'oh my goodness, I didn't even think of those ideas.' Because even provincially, we get those blocks, right. Like were still doing what we're doing constantly. So, just the different bits of input are always helpful.*

Training Opportunities & Resources

Participants articulated a commitment to continuous learning and professional development. Specifically, they were interested in training opportunities and supportive resources on topics including: substances, working with people who use substances, mental health, safety for staff and clients, and organizational policies and practices. Accessibility and stakeholder involvement in training were noted considerations.

Continuous Learning: "Training is always necessary."

Participants expressed a commitment to continuous learning and capacity building.

> *I believe there is a need to be committed to ongoing learning and capacity building.*

With a view to improving services for the clients who access them, they were eager to access available training opportunities and supportive resources related to working with people who use substances.

> *We still are pretty hungry in knowing more information about how we can best meet our clients' needs.*

Substances: "Everything related to substance use… it changes so quickly for drugs"

Some participants called for detailed and up-to-date information regarding substances, substance use, and the physical and psychological effects of using substances.

> *"Up-to-date information (detailed and comprehensive) on the different substances and their physical and psychological effects could be useful for service providers who do not have training in addictions.*

In particular, a desire for information regarding substances that are outside the mainstream was communicated.

> *We have a main idea of the effects of the main drugs that are in town, but we're starting to see a lot of opiates and over-the-counter drugs. I don't feel like those quite get as much of the education base around that. Like heroin isn't really big in [town], but they're injecting a lot of pills and so information about that would be very handy.*

Working with People who Use Substances: "A good knowledge base basically for working with people who use."

Participants described a desire for more substantial or "concrete" skills building opportunities for service providers working with people who use substances. Such skills building initiatives included training regarding specific and measurable skills, knowledge, attitudes and values needed for service providers to effectively perform in their work, and documenting best practices. It was proposed that the development of a supportive resource might help in this regard. One respondent expressed a need for:

> *Concrete training for people that are working in ASOs to discuss what is substance use, and how do we work with people with substance use, and how should we view people that use substances.*

Mental Health: "Because we deal with substance use issues, mental health comes in hand-in-hand."

Multiple participants identified that further mental health training would be beneficial in their work, given the interrelationship between mental health and substance use.

> *We have had the training about what crack is, what crack does, and all of that stuff, but there's also the mental health aspect of it. Because we deal with substance use issues, mental health comes in hand-in-hand. We're wanting to know more information about schizophrenia and bipolar and how to work with that population, even though we're not officially in mental health.*

Safety: "Maybe just really around approaching people, like around safety."

Some participants indicated that capacity building related to safety, including behaviour management and non-violent crisis intervention, would be useful.

> *What are some symptoms to watch out for, or what are some common behaviours attached to particular drug use. Maybe just really around approaching people, like around safety for staff.*

The desire for capacity building around safety also extended to the security of clients and offering a safe space for the diverse clientele that access services at ASOs nationally. One participant expressed this in terms of a need for anti-oppressive practice training:

> *In a group of people that's very diverse, how do you address in the moment when stuff comes up around transphobic remarks or homophobic remarks, or anti-substance using remarks? So that would be a really concrete type of training that would be probably really useful.*

Organizational Policies & Practices: "To introduce people to all the wonderful resources available."

It was communicated that training opportunities and supportive resources on harm reduction and related organizational policies and practices would be of benefit to service providers and ASOs across the country. Specifically, information regarding existing harm reduction initiatives, best practices, as well as front-line resources was suggested. One participant indicated a desire for:

> *[…] things like sample policies, or sample procedures, or sample drop-in rules – those kinds of things, you know. [It] might be interesting to see what other groups do around that.*

Access to Training: "There are resources and training available, it's just making sure that everybody has the opportunity to go to it."

Participants stressed the need for organizations and service providers with few resources and time limitations to be able to access capacity building initiatives. Accessible training opportunities were considered to be either inexpensive or covered by scholarship.

> *If there were ongoing training sessions that were not too expensive, I would definitely send the prevention workers to take them so that their knowledge is up-to-date.*

Location was another important consideration voiced with regard to accessibility, with many participants indicating a desire for local or regional skills building opportunities.

> *I would love to actually see something come to [our area] because we have this changing epidemic here in the province. It is really unique compared to the whole country. I would love to see if you were going to hold something, that instead of it being in Toronto, [it be held] in the epicenter right now. I think that would be really great.*

In-house opportunities were also proposed as a way of increasing training accessibility.

> *Teleconferences, internet forums with directed topics (eg., safer inhalation, harm reduction, primary care, worker self care, working with police, etc.) would be of use.*

Stakeholder Directed Training: "It would have to be championed within the community of people that [...] work with people with substances."

The involvement of people who have experience with, or expertise in, the delivery of services for people who use substances was deemed to be an important consideration for capacity building initiatives. Importance was placed by some respondents on initiatives that were stakeholder directed.

> *Instead of other organizations making assumptions or giving ideas when they're not necessarily dealing with that population [...], I would say definitely that [ASOs] should be able to receive workshops and trainings from people that work with that community on a regular basis. So if an ASO needs that help, they need to definitely have some other organization come in that does do that client support to be able to show them how to do it.*

4: Discussion

The *Enhancing Capacity to Provide Services for People Who Use Substances* project was devised to understand, from the perspective of service providers at CAS member agencies, what proved effective and what proved challenging in their work with people who use substances. As a follow-up to 2008's *Learning from Each Other*, the service provider perspectives presented here will complement those gathered from service users in that report. The findings afford an opportunity to reflect on the similarities and differences in service providers and service users experiences with, and opinions about, harm reduction services. They also offer an occasion to reflect on existing strengths and possible improvements, to enhance the capacity of Canadian ASOs to provide services for people who use substances.

Many themes that emerged from the current research are consistent with the findings from *Learning from Each Other*. There was general consensus among both service users who participated in the *Learning from Each Other* project and the service providers who participated in our current research about key pillars of service for people who use substances. First and foremost, both service users and service providers stressed the importance of operating within a harm reduction framework. This includes embracing harm reduction as both a goal of service delivery and a philosophy that promotes acceptance and respect for the inherent worth and dignity of all people, including those people who use substances. It also includes adopting a client-centered approach, characterized primarily by a commitment to starting "where the client is at". Both service providers and service users also recognized that peer involvement in service delivery and design strengthened harm reduction programming. "Nothing about us without us"[19] was a pervasive theme among service users interviewed, and was echoed by service providers. In addition, community engagement was commonly understood to be critical in countering resistance to harm reduction efforts and in easing the stigma and discrimination directed against people who use substances.

Service providers and service users also had a comparable understanding of structural barriers in providing services to people who use substances. In particular, they shared the opinion that insecure funding and resource limitations have a negative impact on the availability, accessibility, scope and quality of services for people who use substances. Both groups also commonly highlighted the challenge of resistance to harm reduction efforts. Evidence of this resistance was detected through reduced funding for harm reduction programs, presence of stigma towards people who use substances, challenging policy environments for ASOs, and a lack of community resources to support people who use substances. Service providers and users both believed service limitations resulting from these structural barriers, for example the absence of safer inhalation equipment distribution in many communities, undermined HIV prevention and capacity of ASOs to meet the needs of the communities they serve.

While much remains consistent with the findings from the *Learning from Each Other* project, both our key informant interviews and organizational survey highlight some distinctions among the perspectives of service users and service providers with regard to ASOs needs and assets in providing services for people who use substances. First, service providers have, understandably, shed more light on organizational and individual service provider challenges that impact the delivery of services. At an organizational level, service providers noted the sometimes limited capacity to engage in systemic advocacy efforts due to limited resources and a lack of coordination among stakeholder groups. They highlighted a need for a more cohesive national voice with which to counter resistance by providing a clear understanding of harm reduction efforts. Service providers also pointed to complications arising from the responsibility of ASOs to diverse client groups living with or at risk of HIV/AIDS. Tensions among the diverse clientele, including instances of homophobia, racism, sexism, and other forms of discrimination, carry implications for creating safe and welcoming service environments and can contribute to clients feeling alienated from existing services. Moreover, clients' diverse needs, coupled with organizations'

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[19] Canadian HIV/AIDS Legal Network (2005). *"Nothing about us without us": Greater, meaningful involvement of people who use illegal drugs: A public health, ethical, and human rights imperative*. Toronto: Canadian HIV/AIDS Legal Network.

limited resources, have led to service gaps for some client groups, with women, including sex workers and transgender women, being the most commonly cited example. On an individual level, service providers discussed difficulties related to their own capacity to provide services for people who use substances. They identified areas of their work that were personally challenging including their knowledge of the client population, maintaining a non-judgmental attitude, negotiating boundaries with clients, and prioritizing self-care.

In select instances, findings from the current research indicated that the perspective of service providers differed from the experience of people who access harm reduction services. In particular, findings from our current research that outlined peer involvement diverge from the perceptions of service users. On the whole, service providers demonstrated a strong commitment to the greater and meaningful involvement of peers in all aspects of service design and delivery. Key informant interview participants described peer involvement as a strength of their work. Roughly three-quarters of survey respondents cited the involvement of peers in service design as working well, while over half cited their involvement in service delivery as working well. Conversely, findings from the *Learning from Each Other* report indicated that some people accessing harm reduction services experienced systemic barriers within organizations to peer involvement, including strict screening procedures and onerous training periods for volunteering, along with a lack of mentoring, training or support. Service providers' perspectives also differed from some service users' with respect to service environments as a safe space. Providers unanimously described their organizations as safe, welcoming, non-judgmental environments where people who use substances can access service. Survey respondents cited the non-judgmental attitude of staff and the provision of a safe, welcoming space as working well, at a rate of 100% and 94% respectively. Likewise, all of the key informants highlighted a non-judgmental approach and the provision of a safe, welcoming space as a strength of their work with people who use substances. Some service users described a somewhat different reality in the *Learning from Each Other* report. Although service users experienced service environments that were caring, non-judgmental and welcoming, even portraying some service providers as surrogate family, others described instances of feeling marginalized and discriminated against when accessing services. Service providers might consider surveying clients on these areas of divergence in order to gain a clearer assessment of the situation.

Ultimately, this project was undertaken to identify means through which CAS could support its member organizations in enhancing their capacity to provide services for people who use substances. Overall, findings indicate that ASOs have diverse needs in terms of skills building and capacity enhancement opportunities, as well as diverse strengths upon which to build capacity. These diverse needs and assets are reflected in the survey respondents' rankings of components of a training opportunity and/or supportive resource they would find most useful. While certain components such as harm reduction best practices, reducing drug-related harms, substance use counselling, and overdose prevention were more commonly ranked as useful, overall training and supportive resource needs remain broad among CAS member organizations. Perhaps in recognition of the wide-ranging needs and assets of ASOs across the country, a desire for greater opportunities to engage with other service providers in the harm reduction field emerged from the findings. Survey respondents and interview participants alike expressed the desire for more knowledge exchange opportunities and highlighted the importance of learning from each other. Engagement opportunities were also seen to facilitate partnership-building, and as a means of enhancing a coordinated response in working with people who use substances. Accessibility of capacity enhancement initiatives emerged as an important consideration. Organizations with few resources and time limitations are often challenged to access existing skill building opportunities. The importance of accessibility is also reflected in survey respondents' responses to how CAS could best share knowledge and resources with its members. The most frequent response, given by 71% of respondents, was providing networking and support opportunities through the Internet. Support for CAS members who provide services for people who use substances must therefore address the breadth of training and or resource needs, recognize and harness existing knowledge within ASOs and be mindful of financial and time constraints.

5: Resource Guide

The following resource guide is an annotated compilation of Canadian resources that may be useful to organizations providing services for people who use substances. This list is not exhaustive, but points to resources identified through our research. Please note that the Canadian AIDS Society has not conducted a formal evaluation of these resources. We invite you to use them according to your needs and considerations. Where available, links are provided to both English and French versions of the resources.

Harm Reduction Best Practices

Alberta Non-Prescription Needle Use Consortium (2007). *Working With People Who Use Drugs: A Harm Reduction Approach.*

This plain language resource provides advice for service organizations in the writing and implementation of a harm reduction policy. An example policy is provided, along with a set of concerns and responses to help organizations advocate for harm reduction in their communities. Special harm reduction guides for nurses, pharmacists, social workers and/or counsellors, police officers, corrections workers and community leaders are included.

English version (only):
www.hivedmonton.com/resources/NPNU%20HR%20Guide%2007.pdf

Alberta Non-Prescription Needle Use Consortium (2000). *Harm Reduction Information Kit for Professionals Working With At-risk Populations.*

This kit provides information for service providers, health professionals and policy makers on using a harm reduction approach to promote client well-being and safer communities. It contains an overview of harm reduction, information on establishing community-based harm reduction programs, information on developing a harm reduction policy, sample harm reduction policies, a description of the Alberta Non-Prescription Needle Use (NPNU) Consortium, contacts for more information on harm reduction, and a bibliography with recommended web sites, journal articles, books and videos.

English version:
www.harmreductionnetwork.mb.ca/docs/infokit.pdf

French version:
reductiondesmefaits.aitq.com/index.php?option=com_docman&task=doc_view&gid=26&Itemid=37

Association des intervenants en toxicomanie du Québec inc. (n.d.). *La réduction des méfaits liés à l'usage de drogues au Québec.* (Drug-related Harm Reduction in Quebec)

This resource provides a concise explanation of the meaning of, and values reflected by, a harm reduction approach to working with people who use substances. It also offers a history of harm reduction's adoption in Quebec. A myth-busters section helps service providers to dispel misperceptions about harm reduction in their communities.

French version (only):
reductiondesmefaits.aitq.com/index.php?option=com_docman&task=doc_view&gid=141&Itemid=37

BC Harm Reduction Strategies and Services (2008). *Best Practices for British Columbia's Harm Reduction Supply Distribution Program.*

This resource is a provincial government-approved document on best practices for harm reduction. Organizations that serve women, people who use illicit drugs and Aboriginals will find best practices that focus on these three groups. The document also provides recommendations on how police services can contribute to promoting harm reduction in their communities.

English version (only):
www.bccdc.ca/NR/rdonlyres/17E7A2C8-5070-4A29-9971-55210F781B58/0/BestPractices.pdf

Canadian Aboriginal AIDS Network (2007). *Walk with Me Pathways to Health: Harm Reduction Service Delivery Model.*

"Walk with Me" offers a culturally appropriate harm reduction service delivery model for Aboriginal people. It includes four comprehensive, flexible, holistic and culturally appropriate components which focus on the needs of four target groups: Aboriginal women, Aboriginal youth, Aboriginal people who are or have been in prison, and Aboriginal two-spirited men.

English version:
www.caan.ca/pdf/WalkWithMe_en.pdf

French version:
www.caan.ca/pdf/WalkWithMe_fr.pdf

Canadian Aboriginal AIDS Network (2007). *Harm Reduction Implementation Guide.*

This implementation guide is to be used in conjunction with "Walk with Me Pathways to Health: Harm Reduction Service Delivery Model", cited above. It teaches organizations how best to introduce harm reduction approaches specific to their community. The resource outlines a process for assessing a community's readiness to implement harm reduction services and activities, and provides steps to develop an implementation plan to introduce harm reduction approaches based on the level of community preparedness. It has been developed by and for Aboriginal People.

For English and French versions, contact the Canadian Aboriginal AIDS Network at: info@caan.ca

Canadian Aboriginal AIDS Network (2004). *Joining the Circle: Aboriginal Harm Reduction.*

This document provides an in-depth description of how service organizations considering implementing harm reduction programs in Aboriginal communities can establish policies and practices that reflect a harm reduction approach tailored to Aboriginals on reserves or in cities.

English version:
www.caan.ca/english/grfx/resources/fact_sheets/JoiningtheCircle.pdf

French version:
www.caan.ca/french/grfx/resources/fact_sheets/Joining_the_Circle_FR.pdf

Ontario Needle Exchange Coordinating Committee (2006). *Ontario Needle Exchange Programs: Best Practice Recommendations.*

Prepared by the Ontario Needle Exchange Coordinating Committee, representative of the Ontario Needle Exchange Network, this document establishes best practice standards for needle exchange programs in Ontario, and responds to a need for minimum standards for program operations. It synthesizes the scientific literature and provides evidence-based harm reduction practices regarding: needle exchange program delivery models, start-up and effectiveness; exchange, handling and disposal of needles, syringes and other injection-related equipment; distribution of glass stems; education regarding safer injecting, safer sex, and overdose prevention; referrals, counselling and methadone maintenance treatment; primary care; relationships with law enforcement; program evaluation; and other needle exchange program considerations such as methamphetamines, OxyContin, buprenorphine, heroin substitution, and safe injection facilities. Its findings may be highly applicable to services in other provinces and territories.

English version:
www.ohrdp.ca/wp-content/uploads/pdf/Best_Practices_Report.pdf

French version:
reductiondesmefaits.aitq.com/index.php?option=com_docman&task=doc_view&gid=167&Itemid=37

Superior Points Harm Reduction Program (2005). *Harm Reduction Training Protocols for Staff, Volunteers and Community Agencies.*

This training manual is intended to provide direction for staff and volunteers of the Superior Points Harm Reduction Program in Thunder Bay, Ontario, and community agencies providing harm reduction services under contract with the Thunder Bay District Health Unit. Organizations may find it useful to guide the development of their own protocols. The manual provides: an description of harm reduction; an overview of the Superior Points Harm Reduction Program; instructions for the safe handling of sharps; guidelines for needle exchange programs; site-specific logistics for staff and volunteers of fixed needle exchange sites; details on relevant legislation; safer use information for people who use injection drugs, solvents and/or crack cocaine; contacts for other needle exchange programs in Ontario; and additional print and web-based harm reduction resources.

English version (only):
canadianharmreduction.com/readmore/SPHRP+Training+Manual+-+Master+Copy+zip.pdf

HIV/HCV Prevention

Ontario Needle Exchange Network (2007). *Reducing the Risks of Hepatitis C for People Who Use Crack or Crystal Methamphetamine.*

This resource aims to increase understanding of the hepatitis C virus and related transmission risk through crack cocaine and crystal meth use. It educates about the health impacts of using these substances and the signs of overuse and overdose. This guide would be useful for service organizations that support populations affected by hepatitis C and by crystal meth and crack use.

English version (only):
www.toronto.ca/health/cdc/pdf/needlex_crack_user.pdf

Safer Substances Use

CATIE Hepatitis C Program (2008). *Sharp Shooters: Harm Reduction Info for Safer Injection Drug Use.*

This booklet is intended for use by injection drug users who are seeking to reduce their risk of hepatitis C and HIV infection. It provides detailed, accessible information to allow users to identify health problems associated with injection drug use and how they can reduce their risks of exposure. The booklet also includes detailed descriptions – with images – indicating where to safely inject on the body and how to clean needles in the instance where new ones are not available. A specific section addressing the needs of women who use injection drugs is provided.

English version:
www.hepcinfo.ca/resources/media/toolkit/items/1042_CATIE_sharpshooters_V2_e.pdf

French version:
www.infohepatitec.ca/resources/media/toolkit/items/1129_CATIE_je_me_pique_V2_fr_f.pdf

Prisoners' HIV/AIDS Support Action Network (PASAN) (n.d.). *Keeping Fit: A Prisoner's Guide to Syringe Care.*

This short guide provides information on how to keep injection drug materials safest in prison. The guide focuses on how prisoners can use materials that might be available to them to sharpen and maintain their needles, and on how to clean needles that are shared.

English version (only):
www.pasan.org/Publications/Keeping_Fit.pdf

Santé et Services sociaux Québec (n.d.). *One Kit, One Hit.*

This one-page image-based guide promotes the use of clean materials for people who inject drugs, explaining in plain-language how to keep materials as sterile as possible. The guide also includes information on where to get safe materials and numbers to call for health and hepatitis vaccination.

English version:
publications.msss.gouv.qc.ca/acrobat/f/documentation/2008/08-305-01A.pdf

French version:
reductiondesmefaits.aitq.com/index.php?option=com_docman&task=doc_view&gid=53&Itemid=37

Stella (2006). *Dope Guide: Sex Work, Drugs, Alcohol and Other Substances.*

Created in collaboration with sex workers and ex-sex workers, drug users and ex-users, nurses, doctors and lawyers, this guide is for women, transvestites and transsexuals who work in the sex industry, though male sex workers will find plenty of useful information. This guide offers information needed to help sex workers make informed decisions and provides support in their efforts to live and work safely and with dignity, regardless of their relationship to drugs, alcohol and other substances. It discusses the various substances that are currently on the market, and suggests ways to reduce risks associated with their use. It also provides crucial information to avoid getting pregnant, or to give birth to a healthy baby and maintain custody once it's born. It contains information about the law and on rights with regard to drugs. Lastly, it offers helpful information in deciding to make changes regarding substance use or to quit entirely.

English version:
www.chezstella.org/docs/GuideDopeAng.pdf

French version:
www.chezstella.org/docs/GuideDopeFr.pdf

Streetworks (2005). *Uptown, Downtown: The Drug Handbook.*

This bullet-point guide offering advice for people who use drugs includes information on cocaine, crack, crystal meth, heroin, speed, ecstasy and other substances. In addition to general information, this guide provides clear, concise women-specific information, with content relevant to women who are pregnant.

English version (only):
www.streetworks.ca/pdfs/Drug_Book.pdf

Reducing Drug-Related Harms

Point de Repères (2004). *Practice Guide 1: Acute Skin and Soft Tissue Complications Associated with Injection Drug Use.*

Injection-related skin and soft tissue infections are a major health problem for people who use injection drugs, accounting for almost half of their hospitalizations. This guide provides tools to help service providers improve services for people who use injection drugs and support them in their efforts to improve their quality of life. It includes wound identification and management guidelines, a brief description of the most frequent complications (abscesses, cellulitis, phlebitis), a summary of risk factors associated with these infections, and prevention guidelines.

For the English version, contact Point de Repères at: m.gagnon@pointdereperes.com

French version:
reductiondesmefaits.aitq.com/index.ph p?option=com_docman&task=doc_view&gid=80

Prisoners' HIV/AIDS Support Action Network (PASAN) (n.d.). *Be Kind to Your Veins: A Guide to Caring for your Veins While Fixing in Prison.*

This one-page guide provides good explanations for prisoners who inject drugs on how to take care of their veins. Service organizations working with people who inject drugs could also distribute this concise image-based resource in their communities to promote better vein care among their clients.

English version:
www.pasan.org/Publications/Be_Kind_to_Your_Veins.pdf

French version:
www.pasan.org/Publications/Prenez_Soin_de_Vos_Veines.pdf

Overdose Prevention

Point de Repères (n.d.). *Practice Guide 2: Cocaine and Opioid Overdose.*

This document provides information drawn from the literature on cocaine and opioid overdoses, and is likely to be of practical interest to service providers in the field. It includes a series of evidence-based recommendations for social workers and health care professionals. It provides a overview of the unique characteristics of each substance (route of use, drug mixing, circumstances, signs and symptoms, complications, risk factors), as well as a information on preventive interventions.

For the English version, contact Point de Repères at: m.gagnon@pointdereperes.com

French version:
www.btec.fsi.ulaval.ca/fileadmin/btec.fsi/pdf/cahiers_BTEC/cahier-6-overdose.pdf

First Aid

Streetworks (2000). *Street First Aid: 'Cause You Just Never Know'.*

Written by people who live on the streets for people who live on the streets, this first aid guide includes advice on rescue breathing, the signs of shock and hypothermia, how to treat broken bones, gunshot and stab wounds, bites and punches and what to do if someone overdoses. It is ideal for organizations working with clients who live on the streets and want to provide them with sound and relevant first aid advice.

English version (only):
www.streetworks.ca/pdfs/streetfirstaid.pdf

Crack Use

Canadian HIV/AIDS Legal Network (2008). *Distributing Safer Crack Use Kits in Canada.*

This document is a good legal brief for service organizations that distribute safe crack use kits or are considering implementing such a program. The document provides answers to legal questions that might concern such organizations and those that they serve.

English version:
www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1390

French version:
www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1391

Safer Crack Use, Outreach, Research and Education (SCORE) (2008). *Lessons Learned from the Score Project: A Document to Support Outreach and Education Related to Safer Crack Use.*

This report provides key findings related to the SCORE (Safer Crack Outreach, Research, and Education) project, which grew out of the Safer Crack Use Coalition of Vancouver. The project aimed to facilitate a better understanding of the health concerns and service needs of people who use crack. Its main components included kit-making circles in which women constructed safer crack use kits, and kit distribution in which outreach teams distributed safer crack use kits and engaged in a harm reduction discussion with recipients. Insights gained from the SCORE project may be of benefit to others engaged in similar initiatives.

English version (only):
vancouver.ca/fourpillars/documents/SCOREReport_FINAL.pdf

Street Health (2007). *The Crack Users Project: A Manual.*

The Crack Users Project (CUP) is a capacity-building initiative, developed by Street Health and Regent Park Community Health Centre in Toronto, with the goal of reducing the harms associated with the use of crack cocaine among users in downtown Toronto. The project's objectives are to: increase communication with and among marginalized crack users; build capacity among crack users to develop and implement peer-led harm reduction strategies; and to improve access to physical and mental health services for this population. This manual shares lessons learned through the CUP project and provides other organizations working with marginalized populations that use substances with a starting place from which to replicate this project.

English version (only):
www.streethealth.ca/Downloads/CUP-Manual.pdf

The Safer Crack Use Coalition of Toronto (n.d.). *Fact Sheet: Health Issues Affecting Crack Smokers.*

This fact sheet describes health issues that affect crack smokers and includes information on the adverse effects of using crack, crack addiction and diseases that can be transmitted through crack use. A description of The Safer Crack Use Coalition of Toronto is provided for service organizations wishing to become supporters.

English version (only):
www.canadianharmreduction.com/readmore/facts_crack2.pdf

Trip Project (n.d.). *Safer Snorting.*

This brief document explains the risks of hepatitis C transmission when sharing paraphernalia to snort drugs, and provides tips on how to snort drugs more safely.

English version:
www.hepcinfo.ca/resources/media/toolkit/items/safer_snorting_e.pdf

French version:
www.infohepatitec.ca/resources/media/toolkit/items/sniffer_sans_risques_f.pdf

Peer Workers

Canadian HIV/AIDS Legal Network (2005). *"Nothing About Us Without Us." Greater, Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical, and Human Rights Imperative.*

This document examines the importance of, and strategies for, increasing the meaningful involvement of people who use illegal drugs in the response to HIV and hepatitis C. Its goal is to promote respect for the human rights of all people living with or at-risk of HIV/AIDS, and to promote and protect the health of people who use drugs by: increasing knowledge and understanding of the issues related to greater involvement of these populations in Canada's community and government response to HIV/AIDS and HCV; to increase the capacity of non-governmental organizations and governmental stakeholders to involve these populations, more often and more meaningfully, especially in the development of better policy responses to HIV/AIDS and HCV in Canada.

English version:
www.aidslaw.ca/publications/publicationsdocEN.php?ref=85

French version:
www.aidslaw.ca/publications/publicationsdocEN.php?ref=86

Street Health (2006). *Best Practices in Harm Reduction Peer Projects.*

Developed through the Crack Users Project, this resource summarizes current peer practices in harm reduction based on a review of the literature and interviews with practitioners across Canada. It identifies challenges to developing and maintaining peer projects, key factors influencing their success, and recommends best practices for service providers, policy makers and funders. The document also contains a descriptive bibliography of key documents for further reading.

English version (only):
www.streethealth.ca/Downloads/BestPracPeerProj.pdf

Toronto Harm Reduction Task Force (2003). *Peer Manual: A Guide for Peer Workers and Agencies.*

This manual is for people who use substances, peer workers and agency workers. It was conceived and produced by people with substance use experience and harm reduction advocates. It seeks to clarify ideas about peer work, and encourage the further development of harm reduction peer programs. It is a work in progress and the authors invite feedback and suggestions.

English version (only):
www.canadianharmreduction.com/readmore/ichip_peerManual.pdf

Safe Disposal

Clean and Safe Victoria (2008). *Safe Needle Disposal Toolkit.*

This useful booklet clearly illustrates various drug use paraphernalia, including: lancets, blue plastic vials, crack pipes, needle clips, disposal boxes, and sharps containers. It describes the risks associated with used paraphernalia and ways to safely dispose of them, and offers advice on what to do in the case of a needle stick injury.

English version (only):
www.avi.org/images/needletoolkit.pdf

Evaluation

Manitoba Harm Reduction Network (n.d.). *Guidelines for Evaluating Harm Reduction Services.*

This short document provides useful guidelines for agencies, governments or community groups seeking to adopt a harm reduction policy and/or to evaluate and monitor the policy's implementation.

English version (only):
www.harmreductionnetwork.mb.ca/docs/policyevaluationguidelines.pdf

Human Resources

Canadian Centre on Substance Abuse (2010). *Competencies for Canada's Substance Abuse Workforce.*

The "Competencies Project" details the technical and behavioural skills needed by the workers in the substance use field to perform effectively and ensure quality client care. The competencies apply to those working in health promotion, support and outreach, counselling, withdrawal management, clinical supervision, administration and senior management. It is also relevant to allied professionals (e.g., primary health care providers, enforcement officials, Elders, volunteers, and social workers) interacting with individuals who have issues with substance use. The resource includes:

English version:

Preface.
www.ccsa.ca/2010%20CCSA%20Documents/ccsa-011799-2010.pdf

Section 1: Behavioural competencies.
www.ccsa.ca/2010%20CCSA%20Documents/ccsa-011801-2010.pdf

Section 2: Guide to competency-based interviewing.
www.ccsa.ca/2010%20CCSA%20Documents/ccsa-011803-2010.pdf

Section 3: Interview tools.
www.ccsa.ca/2010%20CCSA%20Documents/ccsa-011805-2010.pdf

Section 4: Guide to competency-based performance management.
www.ccsa.ca/2010%20CCSA%20Documents/ccsa-011807-2010.pdf

Section 5: Performance management tools.
www.ccsa.ca/2010%20CCSA%20Documents/ccsa-011809-2010.pdf

Section 6: Technical competencies.
www.ccsa.ca/2007%20CCSA%20Documents/ccsa0115242007.pdf

French version:

Préface.
www.ccsa.ca/2010%20CCSA%20Documents/ccsa-011800-2010.pdf

Section 1: Compétences comportementales.
www.ccsa.ca/2010%20CCSA%20Documents/ccsa-011802-2010.pdf

Section 2: Guide d'entrevue axée sur les compétences.
www.ccsa.ca/2010%20CCSA%20Documents/ccsa-011804-2010.pdf

Section 3: Outils d'entrevue.
www.ccsa.ca/2010%20CCSA%20Documents/ccsa-011806-2010.pdf

Section 4: Guide to gestion du rendement axée sur les compétences.
www.ccsa.ca/2010%20CCSA%20Documents/ccsa-011808-2010.pdf

Section 5: Outils de gestion du rendement.
www.ccsa.ca/2010%20CCSA%20Documents/ccsa-011808-2010.pdf

Section 6: Compétences techniques.
www.ccsa.ca/2007%20CCSA%20Documents/ccsa0115252007.pdf

Training Workshops

Ontario HIV & Substance Use Training Program

The Ontario HIV & Substance Use Training Program (OHSUTP) provides training to substance use, mental health and allied service providers in Ontario to increase knowledge of HIV/AIDS and to promote skills development. The full training takes place over two days and is tailored to the needs of each community. OHSUTP offers services free of charge across the province and is accredited with the Canadian Addiction Counsellors Certification Federation. Please visit the website for more information: www.ohsutp.ca. The training modules may be used freely and include:

English version (only):

Substances 101.
www.ohsutp.ca/uploads/Substances_101.pdf

HIV 201.
www.ohsutp.ca/uploads/HIV_AIDS_201.pdf

HIV & HCV co-infection.
www.ohsutp.ca/uploads/HCV_and_HIV_Coinfection.pdf

Harm reduction.
www.ohsutp.ca/uploads/Harm_Reduction.pdf

Stigma & discrimination.
www.ohsutp.ca/uploads/Stigma_and_Discrimination.pdf

Disclosure & legal issues.
www.ohsutp.ca/uploads/Disclosure_and_Legal_Issues.pdf

Counselling issues.
www.ohsutp.ca/uploads/Disclosure_and_Legal_Issues.pdf

Videos

CATIE Hepatitis C Program (2008). *Hep C: Peer Voices and Safer Choices DVD: Harm Reduction: Safer Injection Demo.* (4.24m).

This video provides practical public health advice on how to prevent the spread of hepatitis C through the use of safer methods of injecting drugs.

English version:

www.hepcinfo.ca/videoplayer_e/safer_injection_e.FLV

French version:

www.infohepatitec.ca/videoplayer_f/injecter_securitaire_f.FLV

CATIE Hepatitis C Program (2008). *Hep C: Peer Voices and Safer Choices DVD: Safer Smoking Demo.* (5.05m).

This video provides practical public health advice on how to prevent the spread of hepatitis C through the use of safer methods of smoking drugs.

English version:

www.hepcinfo.ca/videoplayer_e/safer_smoking_e.flv

French version:

www.infohepatitec.ca/videoplayer_f/fumer_securitaire_f.flv

The Ontario Needle Exchange Coordinating Committee (2006). *The Sleeping Giant: A Day in the Life of a Needle Exchange Program.* (11m).

This video follows the workers from Thunder Bay's Superior Points needle exchange program through a typical day and provides insights on needle exchange programs.

English version (only):

www.ohtn.on.ca/Videos/sleeping%20giant.wmv