CONTACT THAT HEALS:

FRONTLINE WORK IN THE OPIOID CRISIS AND BEYOND

by

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CERTIFICATE OF APPROVAL

I certify that I have read CONTACT THAT HEALS: FRONTLINE WORK IN THE OPIOID CRISIS AND BEYOND by Nancy Marie Mullin, and that in my opinion this work meets the criteria for approving a dissertation submitted in partial fulfillment of the requirements for the Doctor of Psychology in Clinical Psychology at the California Institute of Integral Studies.

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ABSTRACT

It is crucial to investigate factors that may have an immediate impact on the catastrophic rates of fatal overdose in Canada and the United States over recent years, a central aspect of the phenomenon known as the opioid crisis. Supported by research and critical writings from a number of different fields, both in Canada and the United States, this research explores the following question: What is the therapeutic potential in the relational process that occurs between providers and individuals accessing services in harm reduction contexts? "Therapeutic potential" was preliminarily defined by a wide range of potential outcomes, including an experience of demarginalization, consistent or increased engagement in services, an experience of emotional connection with a provider or agency, and a reduction in harm to the individual and to society, the notion broadly encapsulated by the bottom-line agenda of harm reduction approaches. Utilizing a constructivist grounded theory approach, themes identified from a series of intensive interviews with frontline providers point to an underlying relational process by which therapeutic potential may emerge in even brief moments of contact between providers and drug users accessing services in harm reduction settings.

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Sincere thanks to CIIS for being the context through which the ideas presented in this research could be realized, thought about, and grappled with.

DEDICATION

This work is dedicated to those who live their lives at the margins and to those who have lost their lives to overdose. You are important. You are worth fighting for.

To my love, Jeffery Mullin: You keep the flame of our home and our family lit so that I am able to do this work that I care so deeply about. I love you.

To my babies, Wesley and Scarlett: My love for you knows no bounds. You continually inspire me to be better. Part of that is dedicating myself to the ideas outlined in this piece of writing. I am blessed to be your mama.

To my family, both blood and chosen: I would not be here without your love. I would not have accomplished this piece of writing without your love. Thank you for believing in me.

To my Em: Thank you for saving my life. Thank you for allowing me to save yours. Our tether is a constant source of strength.

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CHAPTER 1: INTRODUCTION

A central aspect of the phenomenon known as the opioid crisis has been the catastrophic rates of fatal overdose in Canada and the United States over recent years (Corace et al., 2019; National Institute on Drug Abuse, 2019). It is crucial to investigate factors that may have an immediate impact on these rates. Equally important is a contribution to evolving knowledge about what works in addiction treatment beyond this focus. Widely available and traditionally used models of addiction treatment in North America, namely those centered on abstinence as the primary goal, are proving inadequate in current contexts (Gostin, Hodge, & Noe, 2017; Kolodny et al., 2015; Scholl, Seth, Kariisa, Wilson, & Baldwin, 2019; Stewart, 2019). Research continues to be needed to explore the multitude of factors that may help to mitigate the current crisis. Factors open to investigation range from those emerging from macro-level drug laws and policies to micro-level factors (such as specific treatment modalities and interventions) influenced by state, provincial, county, or city-run policies and services.

The current research focuses in at the micro level and is interested in exploring the therapeutic potential that may exist in the contact, however brief, between providers and those accessing services in harm reduction settings. Supported by research and critical writings from a number of different fields, both in Canada and the United States, it assumes that individuals who tend to access street-level harm reduction services and who are often at greater risk for fatal overdose share a number of common characteristics. These include a significant history of relational trauma that is in most cases compounded by ongoing trauma

in the context of heavy illicit substance use (Denning & Little, 2012; Lee & Petersen, 2009; Rothschild, 2010). Additionally, these individuals often experience a pervasive sense of shame (Denning & Little, 2012; Lee & Petersen, 2009) and feel considerably disconnected from positive social supports (Denning & Little, 2012; Little & Franskoviak, 2010).

With this in mind, the current research asks the following question: What is the therapeutic potential in the relational process that occurs between providers and individuals accessing services in harm reduction contexts? "Therapeutic potential" is defined by the researcher as a relational experience with the capacity to contribute to healing or to enhanced well-being in some way. Healing and enhanced well-being are preliminarily defined by a wide range of potential outcomes, including an experience of demarginalization, consistent or increased engagement in services, an experience of emotional connection with a provider or agency, and a reduction in harm to the individual and to society, the notion broadly encapsulated by the bottom-line agenda of harm reduction approaches.

An articulation of this relational process and the development of a theory from what is discovered will contribute to a growing understanding of factors involved in the delivery of more effective addiction services and reduction in rates of fatal overdose. From the perspective of real-world practice, there is a need for flexible therapeutic intervention strategies that extend beyond the context of inpatient treatment settings and traditional psychotherapy. Effective interventions must meet people directly where they are most likely to access treatment services, often at entry points. Entry points in the form of hospital emergency rooms,

primary care clinics, street-level outreach, needle exchange and safe injection sites, and other harm reduction-related activities and services offer promise for these contexts in terms of engaging groups that are typically underserved. Under consideration here is the practical matter of attracting and retaining an extremely vulnerable group of individuals in services where stakes are often literally life or death. The various aspects of this matter are discussed from a relational perspective.

Delving from practical to theoretical, the fundamentals of this relational process were considered from several angles. It is the position of this researcher that both parts—the practical and the theoretical—are worthy of exploration and articulation. Research was undertaken in both Canada and the United States to account for as much experience in frontline response to the opioid crisis as possible. Conducting research in both countries also acknowledges the researcher's position in connection to these locations as a student and provider.

CHAPTER 2: REVIEW OF THE LITERATURE

The Opioid Crisis in the United States

A report released by the National Safety Council in January 2019 acknowledged that for the first time in the history of the United States, opioid overdose has surpassed motor vehicle crashes as the leading cause of death. According to 2017 data, the probability of people in the United States dying from an opioid overdose is now 1 in 96, with the chance of dying in a vehicle crash 1 in 103. For the former, this figure may even represent an undercount by as much as 35% (Stewart, 2019, para. 2). This undercount is largely attributed to omissions on death certificates and varying standards on how overdose deaths are investigated and reported across different states (Harper, 2018).

Data available from the United States in 2017 suggests that 47,600 deaths resulted from drug overdoses involving opioids that year representing a significant escalation from 18,515 opioid-related deaths in 2007 (Scholl et al., 2019). This also represents a 12.9-fold increase in opioid overdose fatalities in the United States from 2007 to 2017 (National Institute on Drug Abuse, 2019, para. 1). Synthetic opioids, such as fentanyl and carfentanyl, are implicated as the primary driver of the rising rate of opioid-related drug overdose deaths and the primary factor accounting for why this crisis continues to worsen (National Institute on Drug Abuse, 2019; Jones, Einstein, & Compton, 2018; Scholl et al., 2019). Fentanyl represents a particularly serious overdose risk because of how quickly it suppresses respiration. It has been steadily cut into heroin, counterfeit OxyContin, and a wide variety of other illicit substances by suppliers with

distribution in Canada and the United States because of its potency and low production costs (Frank & Pollack, 2017).

In 2017, with roughly more than 600,000 opioid overdose deaths recorded in the United States since the crisis began, 180,000 more were predicted by 2020 (Gostin, Hodge, & Noe, 2017, p. E1). In addition to illicit opioid use, Kolodny et al. (2015) report that the rate of opioid pain reliever (OPR) medication use in the United States increased exponentially between 1999 and 2011 (more than doubling for hydromorphone and increasing 500% for oxycodone). The rate of opioid pain reliever-related overdose deaths nearly quadrupled within the same time frame (p. 560). Kolodny et al. cite the Centers for Disease Control (CDC) and their description of this phenomenon as the "worst drug overdose epidemic in [U.S.] history" (p. 560). In 2014, the agency added opioid overdose prevention to the top five list of public health challenges.

Compton, Jones, and Baldwin (2016) argue that prescription opioids, heroin, and fentanyl are all "elements of a larger epidemic of opioid-related disorders and death" (p. 161) and that "viewing them from a unified perspective is essential to improving public health" (p. 161). Despite a slight decline in drug overdose deaths in the United States observed in 2018 as a result of a dip in opioid pain reliever-related deaths, fatal overdoses involving fentanyl continue to rise (Goodnough, Katz, & Sanger-Katz, 2019).

Strategies for addressing the opioid crisis in the United States at the federal level have remained unclear. Gostin, Hodge, and Noe contended in their article from 2017 that a declaration of a national public health emergency related

to overdose fatalities was essential in order to mobilize resources, including public health authorities. They argued that a declaration was crucial in order to facilitate and fund the innovation of strategies aimed at addressing the escalating rate of fatal opioid overdose. Many of their suggestions for moving forward remained contingent on an emergency declaration from federal government (Gostin et al., 2017).

President Trump did in fact declare the opioid crisis a public health emergency in October 2017 and proposed spending $10 billion on the crisis over the following 2 years (Haberman, Goodnough, & Seelye, 2018). What this declaration has meant specifically for federally funded strategies, however, has remained vague (Gostin et al., 2017; Haberman et al., 2018). Strategies proposed have largely centered on restricting the supply of opioids for nonmedical uses, restricting opioid pain prescriptions, and punishing prescribers. While some action has been taken at the government level to achieve this aim, deaths from opioid overdoses have continued to accelerate (Singer, 2018). The Trump administration has not made a formal proposal regarding new resources or spending to address the crisis, which is typically the starting point for any emergency response (Ehley, 2018). Emphasis ultimately continues to be placed on punitive measures rather than on addressing the cost to human lives.

Koh speaks to the need for humanizing the crisis and argues for the notion that adequately addressing this public health crisis will require the heightened and sustained efforts of a variety of different organizations, agencies, and individuals. He speaks to the reduction of stigma associated with opioid addiction as one

important facet of mobilizing an appropriate national response (Koh, 2017). Compton et al. (2016) likewise stand firm in the position that "the perniciousness of this epidemic requires a multipronged interventional approach that engages all sectors of society" (p. 161).

In a report from the National Institutes of Health (NIH) outlining the research plan of the trans-agency initiative Helping to End Addiction Long-Term, the authors suggest that the numbers and statistics pertaining to the opioid crisis in the United States, while staggering,

> fail to capture the full extent of the damage of the opioid crisis, which reaches across every domain of family and community life—from lost productivity and economic opportunity, to intergenerational and childhood trauma, to extreme strain on community resources, including first responders, emergency rooms, hospitals, and treatment centers. (National Institutes of Health, 2018, "Introduction," para. 1)

The Opioid Crisis in Canada

Canada experienced more than 10,300 opioid-related overdose deaths between January 2016 and September 2018 (Corace et al., 2019), the vast majority of which are attributed to fentanyl (Gatehouse, 2018). Between 2016 and 2017, Canada saw a nearly 40% increase in opioid-related deaths, with the total number of deaths in the first 9 months of 2018 exceeding the total for all of 2016 (Corace et al., 2019, p. 2). In 2017, 11 lives were lost per day in Canada to opioid overdose (Government of Canada, Health Canada, 2019).

In British Columbia, where the opioid crisis has had the most concentrated and devastating impact nationwide, illicit narcotic use is responsible for dragging down the average life expectancy (Lupick, 2018). The government of British Columbia declared overdose deaths a public health emergency in April 2016 and,

as in the United States, deaths there are overwhelmingly linked to illicitly manufactured fentanyl and fentanyl analogues available and sold on the street (Corace et al., 2019). As overdose death rates continued to soar in British Columbia throughout 2016, a ground-level group, the Overdose Prevention Society (OPS), formed from frontline providers attending to record numbers of overdoses. The Overdose Prevention Society established a number of pop-up safe injection tents on streets and in alleyways on Vancouver's Downtown Eastside functioning primarily to distribute and administer naloxone, an opioid antagonist medication that counters the effects of opioid overdose. Differentiated from the two federally funded safe injection sites operating legally in Vancouver at the time, these unsanctioned pop-up sites were built and operated by public donation with the aim of saving lives in the face of government lag in response to the crisis (Brend, 2019). Many on the ground level have criticized the Canadian government for its failure to respond quickly and urgently to the opioid crisis, forcing frontline providers to try to manage the crisis without governmental funding or support. These critics have argued that "the stigma against and criminalisation of people who use drugs are impeding [a] public health response" (Kolla, Dodd, Ko, Boyce, & Ovens, 2019, p. e180).

In November 2017, the Canadian government released a report confirming its intention to coordinate a "whole-of-government approach [to the opioid crisis] that is grounded in compassion and evidence" (Government of Canada, Health Canada, 2017, p. iv). Outlined in the report is the replacement of the National Anti-Drug Strategy in December 2016, which was heavily focused on the

enforcement of drug laws, with the Canadian Drugs and Substances Strategy, an approach grounded in public health and emphasizing collaboration. This shift came with the announcement of the new strategy's intended focus as a federal approach that "restores harm reduction as a pillar" (Government of Canada, Health Canada, 2017, p. 4) as well as a declaration of the federal funds to support it. Removing regulatory barriers to harm reduction measures and addressing stigma related to opioid use are documented in the report as central aspects of the strategy (Government of Canada, Health Canada, 2017).

Despite a decrease observed in opioid-related overdose deaths in 2019 across the province of British Columbia, an average of nearly 100 people continue to die as a result of overdose there each month (Duran, 2019). As in the United States, the harm caused to people, families, and communities in Canada as a result of the crisis is immeasurable.

Review of Treatment Landscape

Although there is evidence that people are helped by addiction treatment methods that focus on the goal of abstinence—frequently through participation in inpatient and outpatient programs and engagement in 12-step fellowships—vast numbers of people are not assisted effectively by these interventions alone (Denning & Little, 2012; Marlatt & Tapert, 1993; Rothschild, 2010; Tatarsky & Kellogg, 2010). While studies that have collected outcome data associated with success in maintaining abstinence are relatively scarce, research has shown that abstinence, when identified as the only viable outcome of drug treatment, results in very low rates of success (e.g., McKeganey, Bloor, Robertson, Neale, &

MacDougall, 2006). Despite these limitations, an abstinence-based protocol has continued to be the predominant model of intensive treatment (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019), both in Canada and the United States, and is often considered the gold standard, regardless of the lack of evidenced-based data to support its widespread implementation (Denning & Little, 2012).

The National Institute on Drug Abuse (2020) provides a list of treatment options currently available in the United States. These options include behavioral therapies (in the context of inpatient and outpatient treatment programs), medications (methadone and buprenorphine, among others), and assistance with potential co-occurring disorders through medication and additional treatment avenues. The National Institute on Drug Abuse advocates for addiction treatment serving to help an individual "stop using drugs" ("Can drug addiction be treated?," para. 2) and "stay drug free" ("Can drug addiction be treated?," para. 2), with the goal of abstinence being explicitly highlighted in these statements.

Tatarsky and Marlatt (2010) contend that "the overwhelming majority of problem [drug] users are not being attracted, retained, or effectively helped, [particularly] if we use abstinence as the measure of success" (p. 118). This relates in large part to the ability to effectively access services. Effective access in the context of abstinence-based programs often rests in a very real way on an individual having (among other factors) financial resources, support, and some level of personal and interpersonal stability. In other words, these programs and services are often considered "high-threshold" (Lee & Petersen, 2009, p. 623).

Harm reduction approaches can act as a bridge, effectively engaging individuals in "low-threshold" (Lee & Petersen, 2009, p. 624) services where abstinence-based programs and services often fail to reach and engage individuals with more barriers. Harm reduction treatment services are available in the United States largely under the umbrella of public health (low-threshold health care, needle exchange, and overdose prevention) and outpatient treatment (harm reduction psychotherapy) (Lee & Petersen, 2009).

Denning and Little (2012) draw attention to the social context of any individual engaged in substance use, a context very much "defined and limited by the current mores of society" (p. 9). They posit that the long history of narcotics control measures, policies, and laws in the United States has, at its core, been significantly shaped by international political forces, medical practices, and racial prejudice. They argue that

> the public health system continues to struggle with the problem of attending to the needs of a drug-using population in the current climate of zero tolerance and the War on Drugs, which has created a mutual mistrust when drug users try to access services. (pp. 24–25)

Although the Canadian government has attempted to facilitate a shift away from this stance in its explicit embrace of harm reduction strategies and practices (Corace et al., 2019), the position of the federal government in the United States appears more fixed (Singer, 2018).

Addiction treatment in the United States comes overwhelmingly through the criminal justice system. Up to 85% of incarcerated individuals throughout the country having a history of substance abuse and up to 25% of those newly arrested test positive for opioids on urinalysis (Aronowitz & Laurent, 2016, p.

98). Despite the irrefutable link between problematic substance use and crime, those who are incarcerated have limited access to evidence-based treatment, such as medication-assisted approaches, and are typically subject to a protocol of abstinence without necessary support. This lack of support, both during phases of incarceration and while transitioning back into the community, has been shown to increase the risk of drug-related death (Binswanger et al., 2012).

Speaking further to issues of access, researchers Lee and Petersen (2009) contend that "the dominant service delivery model [in North America] presents a paradox in substance abuse treatment wherein when one is most in need of help, they are least likely to get it because of high-threshold requirements for entry" (p. 623). Barriers to access are exacerbated in the United States by lack of universal health care and by disparities between need and access. While percentages of those in need of treatment appear to be relatively equitable across racial groups, access is heavily weighted in favor of white people in the United States. Lee and Petersen (2009) believe that a low-threshold service delivery model that highlights humanization and destigmatization in an effort to increase access and engagement holds vast potential for typically "hard-to-reach" (p. 622) and marginalized populations. Lee and Petersen suggest that "unlearning the dehumanizing discourse around substance use is indeed a radical notion, and perhaps a critical component in increasing access to underserved individuals in treatment" (p. 634).

Denning and Little (2012) ask the important question,

> how are we to provide [intensive, abstinence-oriented treatment] for the thousands of homeless and marginally housed people with drug problems

> or to all of the people who cannot afford the cost or the time or who lack child care and leave time from work to go to a residential program? (p. 95)

They acknowledge the fact that, even with access to treatment, these individuals often have to return to "high-crime and high-substance-using neighborhoods" (p. 95). This provides compelling rationale for the utility of outpatient, low-threshold services. Not only have outpatient services been shown to be at least as effective as residential treatment "at a fraction of the cost" (p. 97) but harm reduction strategies have been found to contribute to social stability and employment, and ultimately to a reduction in illicit opioid use.

Numbers from 2007, now over a decade old, suggest that while there were 22.2 million people in the United States with substance abuse or dependence diagnoses, only about 2 million were treated annually at the time the data was collected (Tatarsky & Marlatt, 2010). There was a reported 900% increase in those seeking treatment for opioid addiction between 1997 and 2011 (Kolodny et al., 2015, p. 560). Urgency to engage individuals in services is even more considerable in the context of the opioid crisis. Barriers to access contribute unquestionably to rising overdose death rates.

Many of the strategies employed to support access to addiction treatment by federal, state, and provincial level policy makers throughout Canada and the United States have failed to significantly reduce the rate of opioid-related overdose deaths, despite some exceptions. Kolodny et al. (2015) advocate for the position that efforts should include interventions that focus on ensuring access to effective addiction treatment under the label of "tertiary intervention." Tertiary intervention, from a public health perspective, involves both therapeutic and

rehabilitative measures and prioritizes the harm reduction goals of preventing fatal overdose and reducing medical complications, psychosocial deterioration, and injection-related infectious diseases. Kolodny et al. argue simply that "the need for opioid addiction treatment is great and largely unmet" (Kolodny et al., p. 568). Harm reduction approaches—including buprenorphine and methadone maintenance strategies, access to naloxone, syringe exchange, and safe injection sites—are backed by strong evidence (Government of Canada, Health Canada, 2017; Logan & Marlatt, 2010; National Institute on Drug Abuse, 2018). Newer and potentially more publicly controversial harm reduction approaches, such as the prescribing of medical heroin, are equally supported by research (Ferri, Davoli, & Perucci, 2011).

Kolodny et al. (2015) contend that "just as public health authorities would approach other disease outbreaks, efforts must be made to reduce the incidence of opioid addiction . . . and ensure access to effective treatment" (p. 569). Denning and Little speak to the ways in which the HIV epidemic propelled public health initiatives to develop a broad range of services with which to meet the needs of those most impacted and at risk, with many similarities drawn to what is needed as far as addressing the impact of addiction. They highlight the overall success of these strategies (Denning & Little, 2012). As with any other public health crisis, federal governments in both Canada and the United States must vitally consider the ways in which frontline services are delivered.

Several U.S. cities have made announcements about plans to open supervised drug-consumption sites like those in Canada (Bernstein, 2018).

Bernstein (2018) speaks to the "gulf between the two nations" (para. 6) represented in these plans: While Canada has increased funding for harm reduction approaches, organizations in the United States face federal law violations for implementing the same programs and services (para. 3). Barbara Garcia, former director of health for the city and county of San Francisco, offers the position that "We just have to do what's best for the client, and we hope the federal government will understand . . . I'm not looking to change federal law. I'm looking to save lives" (para. 10).

Review of Harm Reduction History

Harm reduction as a public health strategy first emerged in the 1970s and 1980s in parts of western Europe (Amsterdam, The Netherlands, and Merseyside, England) in the midst of rapid increases in illicit drug use in those cities. The intention was to target the poor rates of abstinence-based programs in engaging and retaining illicit drug users in treatment and respond to hepatitis and HIV epidemics from blood-borne disease transmission associated with drug use. The term "harm reduction" was introduced in the 1980s in reference to these public health approaches (Denning & Little, 2012).

The Junkie Bond, a union formed of intravenous drug users, worked to establish the first needle exchange program in Amsterdam in 1984. In 1985, The Mersey Drug Training and Information Center opened in response to the spread of HIV in Liverpool, England as a harm reduction clinic where drug users could connect with medical and outreach staff. The staff there offered a number of services that continue to characterize a harm reduction approach, including the

provision of prescription opioid substitution, trainings on safe and sterile intravenous (IV) use, clean drug-using supplies, and access to social services for a broad range of problems. The clinic continues to stand out from programs in the United States in that it not only prescribed "clean" heroin and morphine in addition to buprenorphine and methadone, but it offered them in a variety of formulations amenable to injecting, smoking, and oral use. Community involvement, both in terms of police and local families, meant that supplies were available even during the hours that the clinic was closed, and that those caught in possession of drugs were referred to the clinic rather than charged and detained (Denning & Little, 2012). Comparing rates of HIV infection among intravenous drug users with those seen in New York (70%) and in London (60%) in 1989, the rate in Liverpool was dramatically reduced (0.01%) (p. 20). The black market for heroin was also significantly impacted, attributed to a lack of demand (Denning & Little, 2012).

Methadone programs emerged in the United States in the 1960s. Harm reduction public health approaches were first broadly implemented during the HIV and AIDS epidemic as government, policy makers, and practitioners began to recognize the need for nonabstinence-oriented strategies to stop the spread of HIV in intravenous drug users, specifically, and in the community generally (Tatarsky and Marlatt, 2010). Needle exchanges were established in a formal capacity in 1986 in New Haven, Connecticut and in 1988 in Tacoma, Washington. The federal government in the United States issued a ban on needle exchange services that same year which remained in effect until it was overturned

by Congress at the end of 2009. The first supervised injection site in North America opened in Vancouver in 2003 where it has continued to operate since that time (Denning & Little, 2012). Several cities in the United States continue to push for measures that would legally allow for the establishment of supervised injection sites (Fracassa, 2018; The New York Times Editorial Board, 2018).

Review of Harm Reduction Philosophy

Denning and Little (2012), along with Tatarsky and Marlatt (2010), are central figures in the movement that has adapted harm reduction principles for use as a therapeutic approach. These researchers, writers, and clinicians have been instrumental in articulating the terms and practices that have come to define the modality of harm reduction therapy. Denning and Little (2012) argue that, at its core, harm reduction is both a philosophy, "a way of working with people to facilitate healthy choices," (p. 44) *and* "a set of practical strategies to reduce harm" (p. 44). It is "compassionate pragmatism" (p. 117) in that it starts with the recognition and acceptance that people use drugs, even if it is sometimes in ways that "pose threats to themselves and their communities" (Tatarsky & Marlatt, 2010, p. 117). Harm reduction as both a practical and a philosophical approach rests on several principles: low-threshold treatment access with few barriers to entry, emphasis on collaboration between provider and drug user, prioritization of drug users' goals in the context of collaboration, and consideration of any reduction in harm in a drug user's life as a success. Harm reduction from this perspective is an attempt to "do the greatest good for the greatest number of

people [while seeing] one person's problem [as] also the community's problem" (Denning & Little, 2012, p. 32).

Low-Threshold Treatment Access

Denning and Little (2012) argue that "emotional issues and drug-using behaviors coexist" (p. 15) and that "any treatment must take into account the complex interactions among these factors" (p. 15). They outline the evolution of the harm reduction psychotherapy model from the notions of G. Alan Marlatt who took several central ideas from the work of Edith Springer. Springer, a social worker who practiced in a methadone clinic in New York, had traveled to the United Kingdom in the 1980s and had been exposed to harm reduction strategies during her time there. Marlatt shared Springer's embracement of harm reduction as a therapeutic stance in addition to a set of practical public health strategies. Rather than focusing exclusively on overt symptoms, the philosophy of harm reduction stresses the need to take into account the impact of culture, experiences of trauma, and "the resulting disruption of affect and attachment" (p. 116) in order to understand the circumstances of those seen in harm reduction settings more fully.

Emphasis on Collaboration and Prioritization of Drug Users' Goals

Rothschild (2010) describes harm reduction broadly as "an expanded way of thinking about treatment, which allows for individualized approaches based upon the needs and desires of the specific patient" (p. 137). The overarching goal of harm reduction is the improvement of mental and physical health with a focus

on the individual and the individual's context rather than specifically on their substance use (Rothschild, 2010).

Denning and Little (2012) speak to the full spectrum of strategies typically employed by harm reduction practitioners, ranging from the promotion of safer drug use to abstinence, even if only from specific substances. Interventions from a harm reduction perspective prioritize self-efficacy. Drug use is framed as adaptive, and the multitude of other ways a drug user may demonstrate adaptive behavior and choices is acknowledged and highlighted. Denning and Little argue that every individual's sense of self-efficacy is comprised of "how much they feel that things generally work out for them; how confident they are that they can count on themselves to do well; [and] how they feel other people react to them" (p. 66). These points are essential to consider when working therapeutically with drug users from a harm reduction perspective.

Lee and Petersen (2009) argue that the core values and principles that underlie a harm reduction approach are really those emphasized by "good clinical practice" (p. 627). They offer a simple and powerful flow chart, from earlier work by Lee, that illustrates the ways in which services provided under the umbrella of harm reduction may result in change for an individual in a number of different areas. Examples include enhanced quality of life and social functioning, increased engagement, changes in substance use, and an expanded ability and desire to consider future goals and plans. Service provision characterized by respect for the individual, that employ a client-centered perspective, and that encourage open conversation is thought to foster in clients a strengthened sense of self-esteem,

self-efficacy, and sense of possibilities. Development of trust in the relationship with providers and with agencies as a whole through predictability, reliability, and stability is thought to contribute significantly to improved outcomes for drug users engaged in services, leading to enhanced potential and motivation for change.

Denning and Little (2012) discuss research suggesting that despite the widespread view that offering addicted individuals a choice regarding their substance use will lead to an individual choosing a more harmful option, this is not what the evidence shows. This research confirms that with the provision of empathic contact and unbiased information, most people will actually choose the goal that their provider would be likely to choose for them (Miller, 1983). In fact, when given the choice to set their own goal around their relationship to substance use, those who begin with choosing some form of moderation are more likely to cut back or stop using with greater long-term success than those who begin with the goal of stopping or who are not given a choice at all (Denning & Little, 2012).

Any Reduction in Harm as Success

Lee and Zerai suggest that harm reduction is an approach to dealing with drug-related issues that prioritizes reducing the negative consequences of drug use before reducing or eliminating the drug use itself. They argue that harm reduction is an approach "that keeps drug/alcohol users alive long enough so that positive change can happen" (Lee & Zerai, 2010, p. 2412). This consideration is essential in current contexts.

Tatarsky and Marlatt offer that "by accepting goals other than abstinence as reasonable starting places for treatment, harm reduction opens the door . . . in a way that traditional abstinence-oriented approaches cannot" (p. 118), potentially engaging groups of people who, for a number of reasons, may not be ready, willing, able, or interested in abstinence (Tatarsky and Marlatt, 2010). Harm reduction services appear to be more effective in engaging a larger proportion of vulnerable individuals and in connecting with several populations (e.g., homeless) that traditional treatment models rarely reach (Logan and Marlatt, 2010).

Expanding definitions of success beyond abstinence in the context of treatment allows for the celebration of even incremental changes, leading to "engagement (a deeper commitment to the program and wellness), and additional (and/or consistent accomplishment of) externally verifiable outcomes" (Lee & Zerai, 2010, p. 2415). Many, including Lee and Zerai (2010), argue that the low-threshold nature of harm reduction approaches is often the primary reason participants choose to consistently engage in programs and services. Furthermore, consistent engagement may lead to the optimal clinical outcomes often discussed in abstinence-oriented treatment research, such as changes in legal status, employment, housing, and overall improvement in quality of life. Tatarsky and Marlatt (2010) claim that harm reduction has "a human rights agenda in that it is committed to bringing effective treatment to marginalized groups that have traditionally been denied quality care" (p. 117).

Tatarsky (2018) offers harm reduction as

> a radical departure from the punishment and criminalization that has dominated our nation's failed drug policy and from traditional abstinence-

> only treatment. Harm reduction seeks to help people live as safely as possible, causing minimal damage to themselves and society, whether they are using drugs or not . . . We need not wait until people who use drugs are homeless, sick or living a life of crime to give them the tools to get well. (social media post, para. 5)

Current Implementation of Harm Reduction

Harm reduction is currently practiced in the United States under the broad areas of public health (in the form of access to low-threshold health care and even to low-threshold housing, needle exchange, and overdose prevention), advocacy (the push to develop and instate more compassionate and unbiased drug laws), and treatment (including harm reduction psychotherapy). Globally, harm reduction strategies, particularly from the perspective of public health, are now part of the drug control policies of most developed (and many developing) nations (Tatarsky & Marlatt, 2010).

A number of published studies have demonstrated the relationship between safe injection facility implementation and significant reductions in fatal overdose and overdose generally, needle sharing and reuse, and both the injecting and discarding of needles in public spaces (e.g., Bayoumi & Zaric, 2008; Ng, Sutherland, & Kolber, 2017). These studies have also demonstrated that safe injection sites may lead to "increased enrollment in detoxification and other addiction treatments" (Logan & Marlatt, 2010, p. 208). A number of countries have implemented safe injection sites (e.g., Canada, Australia, Norway, Switzerland, the Netherlands, Germany, and Spain). Advocates in the United States are pushing to pass bills that would allow safe injection sites to open in several cities throughout the country (Fracassa, 2018; The New York Times Editorial Board, 2018). There are currently 200 needle exchange programs in

operation in the United States (Des Jarlais, 2017). “Heroin replacement therapy” has consistently demonstrated positive results worldwide in the countries that have adopted it, including Canada, Switzerland, The Netherlands, Germany, Denmark, and Britain (Denning & Little, 2012).

The provisional pop-up safe injection tents and safe injection spaces that were established by frontline harm reduction workers and first responders in the city of Vancouver in 2017 have responded to an overwhelmingly high occurrence of fentanyl-related overdoses on a case-by-case, daily basis. Since these spaces were implemented by those on the ground fighting for the lives of drug users, the government has slowly begun to legitimize and fund these tents and facilities (Lupick, 2017).

Tatarsky and Marlatt (2010) have claimed that approaches in support of harm reduction and harm reduction psychotherapy are developing and growing throughout the United States, despite long-standing opposition to harm reduction by all levels of government. These approaches are thought to incorporate the following principles:

> (a) an increased interest in treating drug users rather than incarcerating them; (b) a growing recognition that substance use problems often exist in the context of serious co-occurring psychiatric, medical, and social problems; (c) an escalating promotion of “evidence-based” practice rather than the traditional favoring of ideological treatments. (p. 119)

Written during the Obama administration, the authors discuss a final point, offering the position that the then-new federal government had “pledged to support science over ideology regarding the treatment of substance use disorders” (Tatarsky & Marlatt, 2010, p. 119). Strategies regarding the treatment of

substance use disorders remain a critical point in the context of the Trump administration and the opioid crisis.

Relational Aspect of Harm Reduction Philosophy

Harm reduction provides a model that "allows clinicians to treat addicted individuals as people with problems, not as problem people" (Denning & Little, 2012, p. 18). Harm reduction stresses respect and development of trust as fundamental elements of successful treatment, relying heavily on a mutual relationship between the provider and the individual. Denning and Little (2012) contend that harm reduction is "a person-centered approach that fundamentally respects and accepts each person's choices" (p. 44). The foundation on which harm reduction approaches are delivered is a humanizing stance toward drug users and drug use. The relational aspect of harm reduction as a service delivery model is arguably its most essential component.

General Relational Concepts

Bordin (1979) proposes that "the working alliance between the person who seeks change and the one who offers to be a change agent is one of the keys, if not *the* key, to the change process" (p. 252). He maintains that this is a central aspect of a broad range of relationships: among them student and teacher, parent and child, and community leader and community group. Bordin considers the concept of a working alliance universally applicable and emphasizes collaboration as an essential component of this relational model.

Along similar lines, Kahn (1997) claims that "the relationship *is* the therapy" and that, in and of itself, the relationship holds "enormous therapeutic

potential" (pp. 1–2). Relational psychoanalytic authors writing on the topic of substance use emphasize the importance of the therapeutic relationship as a mechanism of change as well (Rothschild, 2010). Not only is this claim echoed by many involved in contemporary clinical work, but it is a notion that has likewise been substantiated by research (Middleton, Shaw, Collier, Purser, & Ferguson, 2014. Kahn (1997) proposes that it is one thing for a provider to understand the general frame of clinical work—the holding of confidentiality, the maintenance of boundaries, the adherence to a professional code of ethics and role—but another to fully grasp "just how subtle and complex the [therapeutic] relationship can be and how important the therapist becomes to the client" (p. 3).

Denhov and Topor (2011) cite a number of studies that highlight the relationship between providers and those treated for severe mental illness. Participants who had received services and were involved in these studies spoke to their relationship with providers as a significant, often pivotal, factor that either helped or obstructed their recovery process. Building upon these findings, Denhov and Topor's own study found that the provider characteristics identified by participants as most impactful were not necessarily associated with a specific role or profession. This identified group of providers—referred to in the study ultimately as "helping professionals"—shared significant commonalities in how they went about establishing relationships with those they worked with. It was for this reason that Denhov and Topor chose not to distinguish between medical professionals, psychotherapists, social workers, or case managers and instead brought them together under one broad term when they reported their findings

(Denhov & Topor, 2011). This choice in terminology helps to underline three important factors that warrant further consideration: the significance of the relationship—rather than a specific technique, intervention, or model—in terms of therapeutic outcomes; a provider's relational stance as potentially paramount to their professional role (i.e., universal applicability); and the identification of therapeutic commonalities held by providers that may meaningfully contribute to theory, training, and real-world practice.

Trauma and Characteristics of Those Who Typically Access Harm Reduction Services

Researchers have demonstrated an irrefutable link between a history of trauma and substance dependence (Johnston, O'Malley, Bachman, & Schulenberg, 2012). Even in instances where there is not a clear trauma history, experiences in the context of chronic substance use "can create a traumatic life" (Rothschild, 2010, p. 141). Denning and Little (2012) contend that, with the exception of alcohol and drug use, "experiences of trauma are the most common characteristic of drinkers and drug users in clinical settings" (p. 31). They speak extensively to the histories of the clients with whom they work, arguing that a thoughtful review of psychosocial histories often reveals clear emotional or social problems and a searching for solutions that led to the discovery of drugs. Drug use is often a legitimate and effective (albeit temporary) means of coping and in substance use of this nature "the primary motivation is usually self-care, not self-destruction" (Denning & Little, 2012, p. 39). Drug use, when viewed from this position, can be seen as an attempt to take control of and to reverse the

overwhelming feelings of helplessness that trauma induces. Viewing drug use as an active attempt to secure relief from emotional pain is crucial to understanding the forms of chronic addiction often seen in harm reduction settings. It is also vital to consider in terms of developing appropriate treatment strategies for vulnerable, hard-to-reach populations (Marlatt & Tapert, 1993).

The kind of relational trauma that is common to those served in harm reduction settings may be understood in part through the lens of attachment theory. Denning and Little (2012) maintain that attachment theory

> offers the best way to understand the relationship that develops between users and their drugs. Problems of attachment in the interpersonal sphere often lead to an attachment to things not human. The interaction between these two spheres creates the unique set of relationships that characterizes the life of someone who has a drug problem. (p. 141)

Though there is a dearth of research that specifically links childhood abuse with the later development of substance abuse, several studies do make this correlation, if not providing solid evidence for causation (i.e., adverse childhood experiences [ACES]; Shanta et al., 2003).

Lee and Petersen's 2009 study with drug users found that for many participants “trauma preceded initiation of substance use . . . [and] feeling powerless in the treatment setting often held the potential to re-traumatize” (Lee & Petersen, 2009, p. 622–623). This notion highlights a vital piece to consider when working to improve service delivery to vulnerable populations. The stakes involved in the quality of contact with providers—stakes that may not always be recognized by providers or agencies—can be tremendously high when it comes to laying the groundwork for engagement and effective service delivery. This is

particularly true of entry points and initial opportunities for contact with those accessing services.

If providers and agencies want to effectively engage vulnerable groups, there are important facts to hold in mind. These include extraordinarily high rates of reported histories of sexual violence for both women (70–90%) and men (56–67%) entering treatment (Denning & Little, 2012, p. 119; Plummer, 2005). Women, including trans women, who are engaged in sex work are at extremely high risk for sexual victimization. Violence in all forms is a common context for many engaged in chronic substance use and is often particularly so for trans-identified people (Heslin, Robinson, Baker, & Gelberg, 2007; Lombardi, Wilchins, Priesing, & Malouf, 2002).

The experience of homelessness is likewise crucial to consider in the context of harm reduction service delivery. The pervasive need for hypervigilance that often emerges as a result of homelessness, coupled with the ongoing experience of marginalization, carries the potential to have a significant impact on contact with providers (Denning & Little, 2012).

A deep and long-standing history of racial prejudice resulting in pervasive discrimination and violence toward people of color in both Canada and the United States must be taken into account by providers working with this population as well. Factors to consider include involvement in the criminal justice system, subjection to police brutality, and exposure to prejudice within systems of care. These experiences are likely to significantly impact the establishment of trust in providers (DeGruy, 2005; Denning & Little, 2012; Loury, 2008).

Characteristics of Providers

The development of trust in a provider or in an agency for people who have lived lives that include chronic exposure to trauma is an enormous feat. Denning and Little (2012) maintain that the burden of building trust is on the provider by proving consistency, reliability, sensitivity, and open-mindedness. Speaking specifically to the translation of harm reduction principles to the practice of psychotherapy, Tatarsky and Kellogg (2010) advocate for the position that, transversely, a psychotherapeutic approach can be used effectively and beneficially to supplement services such as syringe exchange and medication-assisted treatment. They contend that the central techniques embodied in a harm reduction psychotherapy approach can be adapted for workers with a wide range of educational experience, training, and job tasks and to any professional who may come into contact with those seeking services in harm reduction settings, such as security guards, nurses, peer educators, receptionists, and outreach workers. Speaking to the universally applicable working alliance described by Bordin (1979), and to the common characteristics of the helping professionals identified in Denhov and Topor's (2011) study, Tatarsky and Kellogg (2010) claim, unsurprisingly, that the working alliance between providers and those who access services is built and strengthened by skills and interventions such as empathy, reflection, active listening, collaborative inquiry, and management of countertransference.

Providers working effectively in harm reduction settings must be flexible, and this flexibility is embodied in one of the central tenets of the harm reduction

approach, to “meet people where they are” (Denning & Little, 2012). It is important to acknowledge that “where a person is” shifts constantly. While remaining conscious of the scope of practice considerations, on any given day a provider working in a harm reduction setting may be responding to a need for medical attention, housing referrals, psychological and emotional support, or simply the provision of clean supplies and a safe space to use. Denning and Little (2012) argue that often the most effective thing a provider can do is to engage an individual in dialogue, holding enough flexibility and respect for the ideas being shared so that “a bridge can be built” (p. 128). Establishing trust and making special efforts to counteract the ways in which those seeking services are repeatedly stigmatized is essential in terms of offering a different relational experience.

How the initial contact is handled at entry points to treatment is often critical to whether an individual returns and becomes further engaged. The quality of this contact is contingent in part on the provider's ability to meet the individual with respect and empathy and without a preconceived set of assumptions (Tatarsky & Kellogg, 2010). Engagement strategies rely on a provider’s ability to read an individual’s general mood and level of need quickly in order to respond most effectively (Little & Franskoviak, 2010). Denning and Little (2012) contend that simply “welcoming, expressing curiosity, and conveying a wish to help are basic to all engagement” (p. 77). They stress the importance of knowing “why the person has come now, today, and what help he or she hopes to get” (Denning & Little, 2012, p. 78). By attending to an individual’s stated needs, rather than

responding from something prescribed by the provider or the agency, rapport is built and help is offered with the goal of having an individual remain engaged (Little & Franskoviak, 2010). Over time, Denning and Little (2012) assert, all of an individual's needs will eventually emerge.

Tatarsky and Marlatt (2010) further outline the suggestions to meet the client as an individual, to challenge stigmatization, and to hold engagement in treatment as the primary goal. Further to Denning and Little's (2012) views, they argue that "many clients are lost in the initial engagement phase of treatment due to failures to respect and empathize with their concerns and problem definitions" (Tatarsky & Marlatt, 2010, p. 120). Starting where someone is and, imperatively, developing a relationship with them characterized by collaboration and empowerment "redefines the nature of authority in [treatment] from a top-down model to one that is more equal" (Tatarsky & Marlatt, 2010, p. 120). Inherent to this approach is the assumption that individuals possess agency and an intuitive understanding of what they need.

Intrinsic Motivation

Intrinsic motivation is a central concern in harm reduction approaches whereby the agency of those seeking services is highly valued and encouraged. Where trauma works to destroy one's sense of control and autonomy, rendering a lasting impact on an individual's view of their own level of competence, intrinsic motivation has been shown to be positively associated with confidence, self-esteem, vitality, creativity, and well-being. Given that those seen in harm reduction settings often have significant trauma histories, intrinsic motivation is

an important concept for providers to hold in the context of their work. The provider's job is to lay the groundwork for a trusting relationship, to support and encourage autonomy, and to help individuals experience competence—however that may be possible (Denning & Little, 2012). Denning and Little (2012) argue that providers accomplish these tasks in part "by offering [themselves] as trusted and nonintrusive attachment figures" (p. 92). Providers can foster a sense of an individual's autonomy by making it clear that they have choice, volition, and freedom from external pressure, to the extent that this may be the case.

Denhov and Topor (2011) contend that actions on the part of the provider that contribute to a sense of equality and that contradict what a drug user may have learned to expect from professionals involved in service delivery seem to hold enormous potential for healing. They state that "a non-stigmatizing attitude" (p. 422) holds not only the potential to create opportunities for establishing a helping relationship, but it also works to mitigate an individual's sense of demoralization and internalized stigma. Allman et al. (2007) argue that it is "human capital which ultimately controls the service encounter, and it is the management of this control coupled with clients' perception of this power which are instrumental in creating a context for effective substance abuse treatment" (p. 199). Drawing from Bonner, they assert that

> it is not programmes alone that lead people to change or minimise harm-causing behaviour. Rather, it is . . . programmes in tandem with individual service providers that do so. It is individuals who have some of the greatest potential to generate change in specific contexts through interactions built upon their powers and capacities, and use thereof. (p. 200)

Allman et al. maintain that the concept of "best practices" in the context of harm reduction services on its own may not suffice. They call for additional training specific to the work with these populations in these environments, taking into account the uniqueness and complexity that it presents (Allman et al., 2007). This notion points to the need for and utility of a theory to guide the relational aspect of the work with those who access services in these settings, regardless of professional role.

Relationships Between Providers and Those Accessing Services

The development of a positive therapeutic alliance with the individuals seen in harm reduction settings is one of the most important considerations on which a provider can focus (Tatarsky & Kellogg, 2010). Anel Muller, the director of the pro bono firm that designed the demonstration safe injection site at Glide Memorial Church in San Francisco, spoke about opportunities to engage vulnerable individuals in an interview with the *San Francisco Chronicle*. She argued simply that "the readiness to take that next step or maybe go [in]to recovery . . . [starts] in a place where there's dignity and respect and relationships" (Fracassa, 2018, para. 11).

Harm reduction approaches offer a redefinition of relationships typically seen in clinical settings. Several aspects of the relationship have been found to be particularly significant (Denhov & Topor, 2011). These include the concept of interpersonal continuity, referring to a stable relationship with one or more providers and the development of trust in these providers (sometimes over a significant period of time) often "involving tremendous emotional investment"

(Denhov & Topor, 2011, p. 419). Another important aspect, emotional climate, refers to the sense of a "good fit" with a provider. Lastly, the concept of social interaction, an experience of exchanges with providers as humanizing, was also identified as central to a harm reduction approach. In many instances there was indication that good fit providers seemed to be internalized by the respondents in Denhov and Topor's research, with vivid descriptions of these providers reported by participants even years after their formal treatment had ended (Denhov & Topor, 2011).

Allman et al. (2007) identified a range of common experiences and expectations thought to significantly contribute to effective relationships in harm reduction settings. Participants in their research included both providers and illicit drug users who had been recipients of services in the past. Commonalities identified included attentive interaction (the ability of providers to actively listen and respond to information shared within the relationship), direct interaction (providers who are seen as "straight up"), the maintenance of confidentiality, provider patience (particularly pertaining to relapse), respect in the context of service provision, and supportive interaction (regardless of a provider's personal stance concerning an individual's choices or drug use). "Experiential" as a characteristic referring to providers with lived experience in addiction was most frequently named as effective by drug users involved in the study. This was particularly true for providers who had successfully migrated from chronic addiction to less harmful substance use or abstinence. Such providers were seen "as an example and an inspiration" (p. 196).

The constructivist perspective of Greene, Lee, and Hoffpauir (2005) highlights clinical practice as partly involving the construction of a definition of self as empowered or disempowered through interaction and dialogue. Drawing from this perspective, Lee and Petersen (2009) offer that harm reduction programs provide those they serve with "an experience of having reflected back to them a self that's different than a self that is reflected back when people are on the street" (p. 633). The rehumanization that is inherent to harm reduction approaches "treats the individual as 'engagable,' nurtures a culture of respect, acknowledges a capacity to make choices, and acknowledges contextual and social factors" (Lee & Petersen, 2009, p. 634). The healing that comes as a result of this process is likely to have a far-reaching impact in terms of the way in which an individual engages in relationship beyond the treatment setting.

Lee and Petersen (2009) offer the concept of demarginalization as an essential component of harm reduction theory and practice. They describe demarginalization as an experience in which an individual who has been consistently marginalized due to substance use and other factors encounters a treatment setting that is destigmatizing, normalizing, and humanizing. They contend that a demarginalizing approach to harm reduction services offers a "revolutionary experience" (p. 632) for participants, one that is "corrective" (p. 627) in nature. Services centered on providing a demarginalizing experience for individuals prioritize participant empowerment to set treatment goals and guide the structure of the care. In the context of Lee and Petersen's research, demarginalization is conceived as a critical reason why participants chose to

engage in services, despite long-held negative perceptions of treatment in many instances. Demarginalization was seen as "a catalyst for subsequent changes in quality of life, social functioning, changes in substance use, and articulation of future goals and plans which offered a markedly new experience with service providers" (p. 625).

Lee and Zerai (2010) conceptualize demarginalization and the motivation to engage in treatment as "internal processes that show up in the participant interactions with staff in the program" (p. 2412). They advocate, as other researchers have (e.g., Denning & Little, 2012; Tatarsky & Marlatt, 2010), for a redefinition of successful outcomes for those that seek services in harm reduction settings. The low-threshold nature of settings that adhere to a harm reduction approach "sets a foundation for trust and open dialog" (p. 2414) between providers and individuals seeking services, and demarginalization appears to be a critical outcome of this approach.

Returning to what may be offered from attachment theory, Denning and Little (2012) suggest that the work of early attachment theorists are rich sources of ideas and strategies for work in addiction settings. Providers can offer an attachment experience that will foster a renewed sense of agency with whom they work, enhancing the ability to connect more intimately with other people. Through the frame of trauma- and attachment-informed work with addicted patients, relationships with providers are seen as sources of corrective experiences in which dyadic exchanges become the foundation for increased trust and reliance on community organizations. It is thought that ongoing, secure relationships with

providers may also contribute to the potential development of self-regulatory capacities that were previously only accessible, often unsuccessfully, through substance use (LaFond Padykula & Conklin, 2010; Ogden, Minton, & Pain, 2006). The development of self-regulation that can arise as a consequence of the relationship between an individual and a trusted provider may allow for the maintenance of connections to new attachment figures, greater attunement to (and tolerance of) one's internal state, and greater navigation of and adjustment to the external environment (LaFond Padykula & Conklin, 2010).

A provider may come to serve as a "secure base," representing a relationship that is more responsive than the one with a substance (Zimmer Hofler & Kooyman, 1996). In the initial contact between a provider and an individual seeking services, the bulk of dyadic exchanges with therapeutic benefit may actually be nonverbal. It appears that somatic attunement, nonverbal holding, and bonding carry a particular weight when working with addicted individuals from an attachment-informed perspective (Fishbane, 2007; Fosha, 2003; Ogden et al., 2006; Zimmer Hofler & Kooyman, 1996).

Rationale for Further Research on Relational Aspect of Harm Reduction

There remains "significant unmet treatment needs in the United States" (Lee and Petersen, 2009, p. 624), substantiating the importance of ongoing research in the area of harm-reduction-based treatment. While the Canadian Psychological Association provides recommendations that include both practical harm reduction interventions (namely opioid agonist treatment in the form of buprenorphine and naloxone) and psychosocial interventions, the subtle qualities

of what comprises therapeutic social contact in the settings where providers interact with individuals seeking services remains relatively unarticulated (Corace et al., 2019).

Allman et al. (2007) outline important points to consider in terms of the improvement of the delivery of harm reduction services, suggesting that governments generally heighten the respect for providers' roles and recognize the "necessity and importance of frontline work" (p. 199). Research has shown that

> not only can sensitively delivered services help to reduce the harm associated with an individual's drug use, they can lead also to broader improvements in health and employment outcomes and reduction in the risk of other harms, like crime and related violence. (p. 195)

Even brief therapies and interventions have been shown to be highly effective in medical contexts in terms of having a significant impact on reducing harm-causing behaviors (Bien, Miller, & Tonigan, 1993; Denning & Little, 2012).

Given that the relationship between providers and those who receive services is proven to be a central and defining aspect of what contributes to healing and therapeutic outcomes in a wide variety of contexts (Bordin, 1979; Kahn, 1997) and that the process of destigmatization appears to be a significant component of what propels individuals toward stabilization and health when it comes to addiction services (Lee & Petersen, 2009; Lee & Zerai, 2010), a continued exploration of this relational process remains vital. The interpersonal mechanisms arising within the therapeutic relationship that are associated with positive outcomes with individuals experiencing severe mental illness represents a progressive area of research. There is immense value in "a new field of research investigating the components of, and process behind, the creation of a good

relationship" (Denhov & Topor, 2011, p. 423). This area continues to offer opportunities for research with significant practical value in the context of the opioid crisis.

Problem Statement and Research Question

It is crucial to continue to investigate factors that may immediately impact rates of fatal overdose and broaden our understanding of effective addiction services. Returning to the assumptions that individuals at the greatest risk of fatal overdose experience multiple barriers, including histories of relational trauma (Denning & Little, 2012; Lee & Petersen, 2009; Rothschild, 2010), pervasive feelings of shame (Denning & Little, 2012; Lee & Petersen, 2009); and significant disconnection from positive social supports (Denning & Little, 2012; Little & Franskoviak, 2010), the current research asks the following question: What is the relational process theory that describes the therapeutic potential in the contact between providers and those accessing services in harm reduction contexts?

CHAPTER 3: METHOD

Given the socio-political context of the present research, the open acknowledgement of the researcher's position was felt to be particularly relevant. A constructivist grounded theory approach was chosen in order to authentically express the personhood of the researcher, to account for bias, and to situate the researcher's particular ties to the area of study candidly, both personally and professionally (Charmaz, 2014; Creswell & Poth, 2018). The researcher's connection to both Canada and the United States, and to identification as a person in sustained recovery from an opioid use disorder, was therefore accounted for as much as possible in terms of the structure of the research.

Guided by constructivist grounded theory methodology, data was gathered from a series of intensive interviews, each building upon and focusing on themes revealed throughout the interviewing process. Attention was paid to constructing a loose interview guide (attached as Appendix A) that aimed to allow for as much freedom, flexibility, and open-endedness in participant responses as possible. Interviews were structured with as little input from the researcher as possible aside from encouraging participants to elaborate on their experience. This approach was meant to foster data collection that accounted for bias and was also true to a constructivist grounded theory approach.

Word of mouth through professional connections with providers was the primary mode through which participants were recruited. As per research guidelines, the study proposal was approved by the Human Research Review Committee (HRRC) to ensure the safety and protection of participants prior to

data collection taking place. Participants signed and were provided a copy of the informed consent document, which included the participant bill of rights. No tangible or monetary compensation was provided for participation in the study.

Demographic information was collected with participant consent at the outset of each interview. Interviews were conducted with six individuals: three male-identified, two female-identified, and one gender-fluid identified[1]. Five participants identified as ethnically white; one participant identified as mixed Indigenous–Latina. Participant ages ranged from 25 to 54. All have worked, in the past or currently, as providers in harm reduction settings in Canada (primarily Vancouver) and in the United States (primarily the San Francisco Bay Area). Harm reduction settings were defined as methadone and buprenorphine clinics, needle exchange, safe injection sites, outpatient medical and mental health clinics, nonprofit community agencies, and street outreach. Experience working in these settings ranged from 4 to 25-plus years. In order to qualify for participation, providers needed to be over the age of 18 and have experience providing frontline services in one or more of these settings. In-person interviews were held wherever possible with phone interviews being held when necessary to address feasibility. Interviews were audio-recorded with participant's permission, were approximately 1 hour, and were held in a neutral meeting space when not by phone.

[1] They/their/theirs pronouns utilized for this participant throughout results section.

Interviews were transcribed with the assistance of a paid professional who was held to the terms of confidentiality outlined in the study. Interviews were then coded and follow-up with participants was held as themes emerged from the data. Two individuals employed in health care, with personal histories of substance use but with no other ties to the area of study, were employed to assist with coding interview transcripts. These individuals were held to the terms of confidentiality outlined in the study as well. Drawing from the codes that these individuals provided and unifying them with codes determined by the researcher was meant to reduce researcher bias. In line with constructivist grounded theory methodology, when it was believed that the data had ultimately been exhausted, data collection was considered complete (Charmaz, 2014; Creswell & Poth, 2018). An articulation of a theory from what was discovered was then undertaken based on the themes identified. Pseudonyms were not used in an effort to safeguard participant confidentiality.

CHAPTER 4: RESULTS

During the interviews, participants spoke exclusively to their work with severely marginalized and "hard-to-reach" individuals in harm reduction settings. The subsequent coding process revealed several themes. Taken together, these themes point to an underlying relational process by which therapeutic potential may emerge in even brief moments of contact between providers and drug users accessing services in harm reduction settings. Themes included: service provision grounded in a radical form of unconditional love; providers (or the agencies, organizations, and groups within which they work) consistently demonstrating attunement, respect, integrity, and trustworthiness grounded in humility over an indeterminate amount of time (sometimes minutes, sometimes years); providers having something helpful to offer (helpful as defined by the drug user) and the provider's willingness to offer it, often creatively; providers offering a different relational experience from typical exchanges with providers working within systems of care, one in which contact is ultimately guided by the drug user and their wants and needs rather than something externally prescribed, one that does not require individuals to trade, perform, or demonstrate something in order to receive services; providers liaising between and working both within and outside of traditional systems of care on behalf of the individuals they serve; providers consistently maintaining awareness of drug users' current contexts, histories, and needs as a frame for their work, an unwavering commitment to being an ally; and work based on the values that guide harm reduction service provision and a redefinition of "successful" outcomes.

Radical Unconditional Love

Going beyond what Tatarsky and Marlatt referred to as harm reduction's "human rights agenda" (Tatarsky & Marlatt, 2010, p. 117), participants spoke to what the researcher has termed "radical unconditional love" as a foundational component of the service provision they described. "Radical" was felt to be an important concept to include in the description of love revealed in the interviews. From the researcher's perspective, the form of love described by participants remains somewhat taboo in the field of clinical psychology when speaking about those who are on the receiving end of services; it threatens the boundaries that are traditionally constructed between provider and "patient," boundaries that hold important functions. For providers to love those with whom they work means that they are shifting out of a space of safe professional neutrality and defying what the majority of professional training, at least on the surface, advises about holding relationships with patients. It also means that providers are allowing themselves to be more significantly impacted by the suffering that they witness.

The word "love" was mentioned without exception in all six interviews. When participants spoke about the individuals they have worked with in harm reduction settings, each used this term in their descriptions of relationships at least once. The form of love they spoke of came to be further understood as a kind of unconditional love in that it was unwavering, immovable, and unshakable in some respects. It was unconditional even in the face of verbal assaults, aggression, and other grossly inappropriate behavior by societal standards and, likewise, by the standards of traditional systems of care, including many abstinence-based

treatment settings (Denning & Little, 2012). Distinct both from more traditional approaches to treating addiction and from criticisms of harm reduction as "too allowing," one participant described the way in which harm reduction programs are grounded in unconditional love and restorative justice:

> In a weird way we actually have more of an accountability in our structure [than traditional systems] because people are more accountable for their behavior to their community . . . the whole idea of restorative or transformative justice is, like, keeping people in the social fabric . . . and keeping people who have violated an agreement in the community *in the community*. And that's the hard part, right? Like, how do we keep you in the fold, and keep you coming back here, even if you caused harm?

Another participant shared the following of radical unconditional love in the context of frontline work in the opioid crisis:

> [Absence of love] is actually the reason that we, as human beings, become marginalized and isolated. The only healing that will make a true difference . . . is through unconditional love. Even though this is "taboo" in the "professional" community, it is the only way to heal. The downside to this unconditional love is that it is difficult to contain and it does produce side effects for those working in these difficult spaces. I believe that part of my [posttraumatic stress disorder] is due to the love I have for the individuals I work with . . . and [losing] hundreds of human beings and community members over the last few years has been hard on my heart. Still, I believe the only way to heal when working with people is [with] open-hearted, unconditional love. It truly changes lives.

Demonstration of Relational Position in Context of Role Over Time

Several participants spoke in detail about the importance of demonstrating certain traits as providers working with marginalized populations, similar to what has been described by Denhov and Topor (2011), Denning and Little (2012), Little and Franskoviak (2010), Tatarsky and Kellogg (2010), and Tatarsky and Marlatt (2010). Participants acknowledged the infinite number of reasons why those they have worked with would initially hesitate to trust a person in their role, a notion that the researchers referenced here have also highlighted.

Intimately connected with the theme of maintaining awareness of drug users' contexts, one participant spoke to the process of demonstrating attunement, integrity, and trustworthiness with those he has worked with:

> The trust is something that's built, and I let them know that . . . I'm going to earn that trust. When I was working in [street] outreach and in the shelters and stuff, it took six to eight months or a year of me saying hi to someone . . . just to get them to interact. Finally, one year down the road and they're like, "hey, I've got this little thing that I need help with." "Yeah, for sure man, no problem, I'm on it." You know, and when that comes . . . when that time comes . . . you complete it and you don't do anything else until that's done. They might not trust you again for another six months, and it's not about me. . . . Building relationships in these settings is complex, and it takes a lot of balance and it takes a lot of trust in yourself . . . the trust in yourself is that you know that you can show up for all of these things that you promise . . . because the minute that you let someone down, break that trust, you have to start the relationship at a lower level . . . You built up the space for this person to ask something of you . . . some way, some form of help, and you have to show up. . . . For me it's not the people that are difficult to engage . . . they're not difficult to engage if you are compassionate, understanding, and 100% truthful with them. If you twinge, hold back, or have anything that's going to make them feel unsafe . . . they're not going to be there.

Several participants spoke to the power imbalance inherent in their relationships with those they work with and about actively seeking to challenge it. Many spoke to the need to relinquish any sense of themselves as an authority in the dynamic, continually turning back to the humility and respect for an individual's autonomy espoused by harm reduction philosophy. One participant described it this way:

> Sometimes, you're working with someone, and you see a train coming . . . and you just want to intervene. You gotta not look at the big picture sometimes and take it really small . . . and you know what that means? I may look at you and I can tell you exactly what I think you need, but I need to actually listen to what the fuck *you* think you need and help you get that before I impose my agenda all over you.

Patience to consistently demonstrate these traits over an indeterminate amount of time with the only goal being to earn an individual's trust and increase the likelihood of being able to offer them something helpful is a model of service provision that stands outside of more traditional systems. It likewise differs dramatically from how services tend to be thought about and delivered within those systems.

Something Helpful to Offer

One participant shared a story from Edith Springer which he referred to as a "classic harm reduction story." Springer was attempting to do HIV prevention work in New York City during the 1980s and had been trying to hand out condoms to sex workers in Times Square, without success. The reason for the challenges in accomplishing this, it was concluded, was that the workers could not be seen by their pimps talking to someone handing out condoms, and the truth was that they also just really "didn't give a shit." Springer decided to do a quick survey with the workers (without condoms in her hand) and walked around asking two questions: "What do you care about?" and "What is bothering you most?" What she discovered was that it was high heels; high heels were causing these workers a lot of foot pain. In a beautiful example of the flexibility and creativity that is possible within a harm reduction frame of service provision, Springer opened a foot massage store front where she effectively handed out condoms in the back.

Many of the participants interviewed spoke to this theme: the idea of marrying the provision of something helpful—helpful according to the drug

user—with something that also seeks to reduce harm. One participant described it as “the wedge that opens the door to connection.” Some examples of this wedge are the following: foot massages and condom dispensing; a safe place to rest, snacks, and clean supplies (syringes, pipes, and other equipment); a pack of cigarettes and a provider offering connection to services. Illustrated in this last example is the tension that exists at times between what drug users want and what public health initiatives deem appropriate. One participant spoke to an example from several decades ago centered on the drug user practice of dissolving crack cocaine with lemon juice in order to render it injectable. Some advocates of harm reduction, particularly those centered on drug user rights, felt that spaces offering clean supplies should include lemon juice, despite some of the potential health consequences of injecting the yeast the juice contained. Proponents of public health strongly advocated against it for those reasons. A creative solution was found in offering vitamin C tablets to drug users. The tablets could be crushed and used to render crack injectable, without the yeast content and potential health concerns, or simply taken orally to prevent colds. Thus, a win-win.

Another participant spoke further to the flexibility inherent to harm reduction service provision. The ability to read someone, the ability to offer whatever might be needed to forge a connection, whether humor or a strong assertion of allyship. One participant shared her belief that “the best form of harm reduction you can give anybody is a sandwich well-made.”

A Different Relational Experience

Speaking to the types of relational frames described by Allman et al. (2007); Denning and Little (2012); LaFond Padykula and Conklin (2010); Lee and Peterson (2009); Lee and Zerai (2010); Little and Franskoviak (2010); Ogden, Minton, and Pain (2006); Tatarsky and Kellogg (2010); and Zimmer Hofler and Kooyman (1996), participants described the relational spaces that they continually seek to create in their work as providers. These spaces often differ considerably from what individuals typically encounter in traditional systems of care.

Each participant recalled examples of connections made through their work that had been deeply meaningful to both parties. One participant spoke about a woman he had encountered during his medical residency, who he described as a "difficult patient." This patient was admitted to the hospital he was training in at the time with a serious heart valve infection from intravenous heroin use. She smoked crack and engaged in sex work to support her drug use. He described the way that he had forged a connection with her: He had sat with her, he had listened to her, and he had coached her on how to work with the nurses who she had previously been having conflict with. He prescribed her an opioid during her stay with the knowledge that she would have left the hospital untreated otherwise. One night when he was doing his rounds, he went into her room to check on her and found her watching a Harry Potter movie. He happened to be reading the same book at the time and had been carrying it around in his pocket. He shared his personal belief that the book was better than the movie and asked if he could read a little to her, which she agreed to. When his pager went off, he left

and ultimately did not have much contact with her again. She was discharged and despite a couple of other instances of readmission to the hospital, he had no real knowledge of what had happened to her. He acknowledged in the interview that he had actually assumed she had died. Yet years later, he received a message from this patient stating that she was not only alive and healthy, free from chronic drug use, but that she attributed the ability to make these changes in part to the connection they had shared, when he had come into her room at 2:00 a.m. and read her Harry Potter.

Another participant spoke about being trusted enough to sit (as a six-foot-four, 270-pound man) in a pregnant woman's room alone with her ("bless her soul") while her boyfriend left to attend to something. He had thus been afforded the opportunity to speak to her, in his role as a social worker, about her options around the baby. This participant acknowledged that "it's these spaces that nobody else gets to see."

One participant described it this way:

> It's just . . . knowing that people are going to get a reprieve from whatever fucked up shit they are going through. That feels special. That's what keeps me going. I think what sustains me [in how challenging and heartbreaking the work can be] are those little moments where you know that . . . and they're not always there, especially when there are really hard times . . . but, like, the little moments where you know that people have been impacted by the work that you do . . . and you are able to provide something for them that . . . they can't get somewhere else.

This participant went on to speak to the process of nurturing the connections with those they have worked with. These connections, they felt, not only fostered a sense of safety in the individual relationship, encouraging people to return to the

same provider again and again to seek help and access services over extended periods of time, but they also fostered trust in the provider's agency as a whole.

Another participant shared the following of the relational spaces offered within harm reduction settings:

> Harm reduction programs are oriented around the needs of participants instead of participants having to behave in a way that is [centered on] the needs of the program. So, if a program is sort of true to the values and practices of harm reduction, the participant will learn experientially that there are no expectations of them that are outside of their own expectations for themselves. So, for example, you come to a program that's a drop-in center, let's say. And you walk in and the people greet you, and what's available to you are some snacks, and some socks, and a place to sit . . . and nobody bugs you, and nobody says you have to fill anything out, and nobody says you have to go to treatment, and no one says you have to [complete] an intake, and no one says there's a time limit that you can, you know, hang out. And there's other services, there are supplies that you need for daily survival. Things available to you if you choose them, but nobody's telling you that you have to choose. There's something that happens I think when people really start to realize that that's true . . . like, nobody [is going to make] me do anything in order to get something here. It creates this space where people develop a curiosity about what else there is, right?

Working With, Within, and Outside of Traditional Systems

Speaking to his decision to go into medicine and to his focus on prescribing naloxone and researching alternative medications to treat addiction, one participant shared the following thoughts on working within traditional systems of care while operating from a personal philosophy centered on harm reduction:

> I was thinking about what I could do that would be most helpful for people who use drugs . . . I wanted to build the infrastructure, build the bureaucracy, build the culture that would allow for better health outcomes, if, for example, people were successful at changing law and decriminalizing drug use . . . I don't agree with the economic model of medicine, so I put myself in situations where I am not profiting from any individual patient that I see . . . that's not where my resources come from. I do salaried work . . . I put myself in places where I do salaried work for

> anyone who walks in the door . . . The other side of it is . . . I like to imagine that the reason healthcare providers treat people who use drugs without respect and don't want to take care of them is because they don't think they have anything to offer them. Just like with diabetes 50, 100 years ago . . . there wasn't much to offer them. They were going to get sicker, you know, so doctors didn't really want to take care of this disease. So part of my mission in my career has been to try to build up . . . those things that doctors can offer to people who use drugs . . . the concrete things. The most important thing they can offer is to sit down and listen, but sometimes that's going to come later. So I focus on the easier thing . . . [to] empower the doctors to feel like they have something to offer.

Speaking to working with more traditional systems, and liaising between these systems and harm-reduction-focused settings, one participant shared the following:

> I believe it is my job to leverage what I have to help people get what they need. I view my job as seeing what hoops I need to jump through to get the funding or the services needed [from larger systems], and then to figure out what information I need to get the funding or services, and then take what I'm able to get and offer it to [those I work with] with as little strings attached as possible.

One participant, a licensed social worker, spoke to the respect held for his work within the context of his agency because he was reaching people that others could not, despite the incongruities between his approach and what he termed the "task-oriented model of working" embraced by traditional systems. He wondered aloud during the interview: When a marginalized individual struggles to meet the requirements to receive services, "how do we make space for the most complex to be able to access things that may save their lives?"

One participant was able to skillfully articulate the way in which harm reduction providers and programs often stand outside of traditional systems of care:

> Healthcare systems are so siloed in the way that they see humans, and harm reduction programs, because they are sort of an "extra" system, they exist outside. They're not really substance use treatment; they are not really mental health treatment. They are not housing programs necessarily. They're doing some weird catch-all thing for people that's built around relationship and trust. They are so uncategorizable and therefore the system can't understand them and can't fund them . . . or can't measure their "success" . . . and so they continue to kind of be outside and on the margins. Serving marginalized people on the margins, which is super fascinating.

Awareness of Drug Users' Contexts and Commitment to Being an Ally

Bringing the link researchers have underscored between trauma and substance use into discussions of real-world practice (Denning & Little, 2012; Johnston et al., 2012; Lee & Peterson, 2009; Marlatt & Tapert, 1993; Shanta et al., 2003; Rothschild, 2010), participants spoke throughout the interviews about maintaining consistent awareness of the contexts of the people with whom they work. Providers holding these contexts in mind—histories, needs, and current challenges—is intimately connected to the idea of working from a stance of unconditional love. From knowledge emerges compassion, and from compassion emerges love, which, as one participant put it, is "non-negotiable if you're going to be any good at this." Aggression, frustration, and inappropriate behavior are "acts of survival," as one participant described it:

> Everything that's happened prior to this very moment is what guides what happens here, and if you're frustrated at me, 100% of the time it's not about me, and so I don't have to take it personally. The minute that I start taking your shit personally, then I'm not going to see you as a person. I'm going to see you as someone who's attacking me, and that's not how it is. I'm standing with a person who is scared, who doesn't have any need or reason to trust anyone. . . . There is no reason . . . in no way, shape, or form because of who I am, or that I'm sitting in this chair, should they trust me at all. If people could understand that part and recognize that each negative interaction that happens with a clinician or service provider [that] further stigmatizes that person . . . further isolates them and puts them closer to dying.

Another participant shared the following along the same lines:

> This is what I signed up for! I'm going to be dealing with people who are challenging and don't always have attractive behaviors. My job is to be professional and remind myself that it's not personal at all. It has nothing to do with me. Many times it is a symptom of some really legitimate struggles or diagnoses. It's never, ever acceptable or okay to be abusive in any way to a person who is struggling, fragile, and compromised.

One participant succinctly stated it this way: "There has to be a really firm fucking understanding of privilege and marginalization. And there has to be a really clear understanding of how you can hold both."

Value-Based Rather than Outcome-Based Service Provision

Denning and Little (2012), Denhov and Topor (2011), and Lee and Zerai (2010) all speak to the notion that the outcomes revered in the context of more traditional systems are not the explicit focus of harm reduction. The commitment is not to a prescribed outcome, it is continually returning to the values that underlie the work. The idea of "therapeutic potential" underscores this notion in that it points to the fact that nothing is a given; providers can only set the stage and the rest respects the autonomy of the drug user.

One participant shared the following of working from a value-based, rather than an outcome-based, perspective:

> It is ultimately about self-determination and respect, and the hardest part about harm reduction is . . . sometimes a person's path . . . sometimes they die. We get very caught up in "why couldn't we have prevented that?" . . . and sometimes we just can't. I think for me, personally, being able to do harm reduction for 20 years has been about . . . really looking deeply at my own power and role in other people's lives.

Speaking about harm reduction in the context of heath care, one participant shared the following:

> Our job in medicine isn't to fix everybody, because, guess what? We are all going to die and most of us are not going to die in perfect health. So, the goal isn't to magically create situations where people live forever healthy; . . . that's not my goal. My goal is to provide people with the tools that can help them tack on days, months, years, decades to their life or quality to their remaining life. And if you think about it like that, that's where harm reduction really makes a lot of sense.

Speaking further to the value-centered work in harm reduction, another participant shared the following:

> For me, a successful outcome—stop looking at the forest, and look at the trees—is the humanization of somebody who has been treated like shit. *That's* a successful outcome.

When asked what they wished providers and organizations outside of harm reduction would recognize about working with marginalized, "hard-to-reach" drug users, one participant shared the following:

> I think that people deserve more than a second chance. You know the whole idea of "second chance, second chance" and you hear that all the time in nonprofit worlds . . . but I think that people deserve more than a second chance. They deserve as many chances as it takes. And maybe they never get there, and that's okay too, but that doesn't mean anybody is undeserving of help.

CHAPTER 5: DISCUSSION

In the course of each interview, participants spoke to their personal connection to their work in harm reduction. Many acknowledged the costs they had experienced: burnout, exposure to trauma, and tremendous loss. Several described the way in which working within harm reduction and the values that guide it had brought about a profound personal transformation. As one participant described it, a process of becoming "a better person," "kinder," "more open," and "more compassionate" as a result of their work. Another participant shared the following:

> There is nothing to me . . . more honorable than to try to help somebody to heal and to be better, to be a little happier, a little healthier, a little safer, . . . and I know that every time I genuinely try to help somebody to be better in any way, regardless of if I succeed or not, or regardless of the outcome, I'm a little bit transformed for the better for it, right? And there's a gift there. I have become better over this time as a result of doing this work.

Perhaps colored in part by researcher bias, the notion of participants navigating their work within broader systems that often render them outsiders and fighting for the rights and dignity of individuals who live their lives on the margins, heroism as a thematic element was also apparent throughout the interviews. Each participant related in one way or another to rebellion in service of those who need it most or cannot advocate for themselves against larger, oppressive systems. Social justice, the role and impact of government legislation, and activism entered discussions with participants repeatedly. Thematically, the idea of fighting against powerful forces for justice was ever-present throughout the research, whether by bias or in part by participants themselves holding this image as a sustaining aspect of their work.

For the providers interviewed, the relational component of service provision appeared to be their heart connection to working within harm reduction settings. The quality of the contact with the individuals accessing their services—the ability to forge a connection with them—appeared to be the component that brought the greatest sense of meaning for these providers. Interviews were energized and alive, even joyful at times, as providers spoke to the dynamics of their work with drug users. At times they were also deeply affecting as participants described the losses they had experienced in the context of their work. This loss has been intensified dramatically by the opioid crisis, particularly for the providers working in Canada.

In reality, and as is often the case, themes identified in the interviews were not distinct. Demonstration of various traits in terms of how a provider holds their role over an indeterminate amount of time is strongly connected to redefining what counts as a successful outcome, for example. Additionally, both of the aforementioned themes are intrinsically connected to allowing drug users to guide interactions with providers and not the other way around. This research makes the claim that commitment to being an ally—particularly in terms of working with the populations discussed here—must come from a place of unconditional love.

The notion of incorporating the concept of unconditional love into the practice of clinical psychology presents a challenging tension. It is important to acknowledge the question of whether unconditional love as a construct even exists in human relationships to begin with, let alone in the context of clinical relationships such as those discussed here. Perhaps there is not yet a more

appropriate term to describe what came through the interviews, a term more amenable to discussions of work within the discipline of clinical psychology. It is the claim being made here that there is no more appropriate term—no clinical term more fitting—that captures the magnitude and intensity of the acceptance and care needed to lay the ground for therapeutic contact in working with the populations discussed in this research.

Some may argue that the concept of unconditional love is suitable to community-oriented work but far less so to disciplines that require such rigorous standards of education and training, particularly those that place such enormous value on neutrality and professionalism. Who gets missed, however, if one, even as a clinical psychologist, cannot connect from the heart as a provider in community settings? Who will remain at the margins, unreachable, without some room for the values of harm reduction to enter into clinical practice, even (and perhaps even especially) in its most educated and "highly trained" form? Is it possible to remain professional and appropriately boundaried while loving those that one works with, no matter who they are and what they do? Is it possible to be connected and "affectable" without abandoning the way that one is taught to hold the frame with those with whom one works? Can one, as a clinician, continue to draw on one's knowledge while challenging the dynamics of power in treatment exchanges? How do the high stakes involved in the opioid crisis change any of the answers to these questions?

Another important underlying theme woven throughout both the review of past research and the interviews, but not explicitly addressed in the results, is the

"undoing" of negative expectations of providers that individuals seeking services very often carry from settings outside of those focused on the values of harm reduction. Given that negative experiences with providers remains such a pervasive phenomenon in relation to the populations discussed here, the way in which providers are trained to hold their work and to deliver services with marginalized, typically "hard-to-reach" individuals is crucial to reconsider within the context of training in clinical psychology and related fields. The scope of this consideration must extend from an individual level, in a provider's education and training, to the way in which a provider's work is ultimately held by the organizations or agencies within which they work. Consideration must also be paid to the way in which the work of organizations and agencies is held by funding sources and those in power.

Despite what the interviews revealed, there was another question that seemed to be present throughout the research process: Is the relational (termed "soft") component of service provision almost too obvious to necessitate study? While it was not downplayed for a single moment by the participants interviewed and appeared to be both at the heart of their work and what they believed made them most effective as providers, it was discovered that the quality of the relational contact outlined in the themes described above is so intrinsic to the values underpinning harm reduction philosophy that it is incontrovertible and manifest in every aspect of the way in which harm reduction providers work. Likewise, there was an ever-present acknowledgement throughout the interviews that the entities that exist as potential funding sources (i.e., state, provincial, and

federal levels of government) see the relational component of service provision as secondary to more tangible, "hard" elements of services, such as medication and clean supplies.

Several other questions emerge from this discussion. What if the ideas presented in this research were not considered "soft" by funding sources? What if the quality of relational exchanges in harm reduction settings were thought by broader systems of care and funding sources to be as legitimate in terms of clinical utility as "hard" interventions such as opioid replacement and a safe supply of syringes? Would that have any impact on the way in which providers are trained to deliver services? How would that alter the way in which "outcomes" are held by the systems that fail to reach so many?

Perhaps it is in part the overlap between the personal and the professional, the shared humanity and messiness, that continues to not only place the populations that harm reduction serves but, as one participant shared, *harm reduction itself* at the margins. With each participant interviewed, there was an energy sensed—a cunning, tenacious, beautifully shrewd, and often ingenious drive grounded in an unremitting love—to navigate and find opportunities for the people they serve within the very systems that harm and exclude them.

Limitations

It is important to acknowledge that the present study rested on the assumption that therapeutic potential does exist in even brief moments of contact between providers and those they serve. Thus, bias is inherent even in the research question posed, exacerbated further by researcher bias as a result of

personal and professional connection to the topic of study. Other critical limitations to acknowledge include the small scale of the study, the scope of which was further constrained by factors related to the COVID-19 pandemic. The research only captured the perspective of providers, crucially missing the perspective of drug users in the question of what makes for therapeutic contact in harm reduction settings. Additionally, there was a glaring lack of diversity in the demographic of providers interviewed (participants overwhelmingly identified as white and between the ages of 35 and 50). The small scale of the study and lack of diversity amongst those interviewed was further accentuated by participant recruitment through the researcher's professional connections, only a tiny portion of a vast network of gifted and experienced harm reduction providers working on the frontlines in Canada and the United States.

Areas for Future Research

Future research on this topic might include an expanded scope and scale, specifically working to include the crucial perspective of drug users in the question of what constitutes therapeutic contact in harm reduction settings. Expanding the scope and scale of the research could involve sampling providers from a broader range of geographical areas involved in harm reduction and engaging a larger sample of providers to include a more diverse range of backgrounds, identifications, and experiences. Including the perspective of drug users on this topic is the most significant consideration for future research. Drug users comprise the essential "other half" in the relational process described in this

study; they are the individuals impacted by any "therapeutic potential" of said process, and their lives provide the substance of any value it might hold.

Themes that were outlined in the discussion but that may be investigated more fully in future research include reconsiderations for how clinicians are trained to think about and hold their work with marginalized populations, given that negative experiences with providers remains such a pervasive and concerning phenomenon. On the other side, in acknowledging the significant personal costs that harm reduction providers have experienced in their work, an important area for ongoing research are the characteristics of contexts (organizations, agencies, groups, nonprofits) that not only support providers working in the ways that are suggested here to be effective but that address trauma and burnout as well. Witnessing tremendous suffering and death on an ongoing basis in the context of frontline work carries an enormous toll, and further research into the strategies that organizations, agencies, and policy makers can implement in both broad and specific ways to support providers working to prioritize relationships under these circumstances is vital.

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APPENDIX A

Interview Guide

Introduction to the study and interview: I am interested in aspects of the contact between providers in harm reduction settings (needle exchange, methadone clinics, safe injection sites, outreach) and those who utilize the services offered in those settings. I chose to study this topic because I am wanting to develop a theory about the relational aspect of service provision from a harm reduction perspective. I have a personal connection to this topic: I am myself a former heroin addict and have been on the receiving end of harm reduction service provision. I'm hoping that my research can benefit the lives of the people most impacted by addiction, marginalization, and overdose. I will begin by asking questions regarding your background, and then will move into asking questions about your experiences in relationship to those seeking services where you work.

I. Background

- How did you come to work in this setting/context?
- What was your image of what the work would be like before you started?

II. Training Experience

- What kind of training did your organization or agency provide for you to take up your role?

III. Relationships with Individuals Accessing Services

- Describe an example of ideal contact with someone accessing services.
- Describe the worst experience with contact you have had in your role.

- How have events in the local community impacted your work with the individuals you have contact with?

VII. General questions and issues (if they have not addressed these questions thus far)

- How have you been personally and professionally impacted by your work?
- If it hasn't been included thus far, is there anything you hope becomes more widely recognized about what is needed to assist drug users?