Peers, politics and community involvement in harm reduction: a qualitative exploration of barriers to service provision across Europe

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This thesis has been written as a study assignment under the supervision of an Utrecht University teacher. Ethical permission has been granted for this thesis project by the ethics board of the Faculty of Social and Behavioural Sciences, Utrecht University, and the thesis has been assessed by two university teachers. However, the thesis has not undergone a thorough peer-review process so conclusions and findings should be read as such.

Abstract

Harm reduction has been found to be a successful approach in attempting to mitigate the risks associated with drug use. However, a number of barriers arise for service provision. The current research set out to examine these barriers within the context of a social-ecological model, with each key stakeholder situated at each level of the model. The study used existing qualitative data. Participants were the directors or held senior positions in drug-related organisations in 25 countries in Europe. Using a framework analysis, 25 qualitative interview transcripts were coded and several themes emerged at each social-ecological level. The findings suggest that examining harm reduction service provision from a social-ecological perspective sheds light on the complex relationships between all key stakeholders, and the importance of considering all stakeholders in policy development, funding allocation and service provision.

Introduction

Approaches to drug policy and service provision in Europe are often divisive and contradictory, with various geographical and political factors influencing the type of policy taken up in a specific country (Houborg & Jauffret-Roustide, 2022). Harm reduction is an example of a person-centred, low-threshold strategy of reducing the harms related to using drugs and other risky behaviours without requiring abstinence from that risky behaviour. Despite research suggesting the benefits of harm reduction for all involved stakeholders (Hawk et al., 2017), harm reduction service provision is often not recognized as a valuable method of attempting to combat drug-related harm. Research has demonstrated that this is due to a number of barriers that arise through various stakeholders such as people who use drugs (PWUD)/peers (Marshall et al., 2015), service providers (Knaak et al., 2019), local community members (Marshall et al., 2015), and policy makers (Nadelmann & LaSalle, 2017). However, little research has examined harm reduction service provision from a broad perspective and has not examined the ways in which the relationships between all key stakeholders may affect service provision. Although harm reduction is grounded in a set of principles and practices, existing literature has not agreed on a concrete definition of harm reduction and much of the literature comes from civil society or non-governmental organisations working in the area. This lack of scientific agreement may be attributed to the influence of social, cultural, economic and historical factors specific to each country when it comes to implementing harm reduction measures (Bucccieri, 2010), and further research is needed to examine how these specific influences can be generalised to contribute to a more solid definition and operationalisation.

Harm Reduction

Harm Reduction initiatives involve attempts at reducing the risks attached to behaviours that often have dangerous consequences. It is most often associated with reducing the risks

involved with taking drugs and other illegal substances but can be applied to a vast array of risky behaviours including sex work, sexual activity and smoking. Harm reduction has been found to be extremely effective in a variety of contexts. For example, a systematic review and meta-analysis of studies examining the relationship between opiate substitution treatment (OST) and HIV transmission in people who inject drugs (PWID) found that OST is strongly associated with the reduction in HIV transmission and risk (MacArthur et al., 2012). Similar findings have been demonstrated in relation to harm reductionist approaches to alcohol use in adults (Marlatt & Witkiewitz, 2002) and adolescents (Leslie, 2008). Wilson et al. (2015) conducted an analysis of existing research on various types of harm reduction interventions and found them to be cost-effective with 'benefits outweighing costs', and having a strong positive impact on public health, reducing crime and improving social and economic outcomes for people who use drugs (PWUD).

Despite the evidence supporting the efficacy and cost-effectiveness of harm reduction, alongside a number of additional benefits, harm reduction is an area that is often under-funded and under-appreciated by governments and members of society. Drug use and services seen to support drug use are highly stigmatised, leading to both PWUD and service centres becoming alienated from their surrounding community (Childs et al., 2021).

Peer Involvement in Harm Reduction Initiatives

Harm Reduction is a largely understudied area of the social sciences. It is a unique low-threshold approach as unlike other areas of drug treatment or addiction services, there is no requirement that an individual stays or is on the road to abstinence. Harm reduction was developed by, with and for PWUD. It is founded on the idea that policies around drug use should be based on the amount of risk involved in the drug use, and that the non-health related consequences should not be the most damaging aspects of drug use. Harm reduction was founded in grassroots advocacy

from drug users themselves such as the 'Junkiebond' activist group formed in the 1970s in Rotterdam (Friedman et al., 1987). It is a compassionate set of principles which sets out to reduce harm for both drug users themselves and the society in which they live (Marlatt, 1996). Thus, harm reduction has strong roots in peer participation in service design and delivery, and there are benefits to peer involvement for all stakeholders involved including PWUD, service providers, and broader communities (Marshall et al., 2015).

Community involvement refers to "the range of activities whereby individuals and organisations are actively involved in health-service planning, decision-making, programme implementation or evaluation" (Bath et al., 2015). It can lead to community empowerment, more appropriate, tailored and sustainable service provision and can strengthen social ties for all involved individuals. The World Health Organization strongly recommends the development and strengthening of community involvement in any health promotion initiative (WHO, 2020). Harm reduction is an example of an area that often attempts to utilise peer involvement (Marshall et al., 2015). One of the key principles defined by the USA's National Harm Reduction Coalition details that Harm Reduction "ensures that people who use drugs and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them" (National Harm Reduction Coalition, n.d.). Thus, peer involvement underpins the ethos and mechanisms of harm reduction practices. However, research has demonstrated that vulnerable service users often have very little opportunity to participate in the production of health and social care services "as organizations have become more bureaucratized and professionalized" (Park, 2020, p.452).

Including the target population in the design and implementation of interventions for social risks has been of increasing importance in recent years across various domains (Haldane et al.,

2019; Simplican et al., 2015) and geographical locations (George et al., 2015; Jahun et al, 2021). However, it has also been described as 'tokenism' (Ocloo & Matthews, 2016). The extent to which communities are actually involved can be ambiguous, and often there is a discrepancy between the idealised theorising of what works, and what happens in practice. "Although community participation is widely advocated for at the policy level, designing and successfully implementing participatory programmes remains a challenge in most settings" (Silumbwe et al., 2020). Research suggests that when PWUD participate in research and other initiatives, it is for altruistic reasons; wanting to help their community (Souleymanov et al., 2016). However, little research has examined how peer involvement occurs in a more practical sense, and how it is shaped by the wider social-ecological levels and various other stakeholders involved in service provision. This is particularly poignant given that drug-related social care services are often overstretched with low resources and funding and heightened staff burnout and turnover (Oser et al., 2013).

Local Community Members

Drug use is a largely stigmatised activity, and often PWUD are excluded from society. There is an attitude of 'Not in My Backyard' (NIMBY) amongst many local community members (Smith, 2010). Stigma about the development of harm reduction initiatives such as needle exchange programmes, opioid substitution clinics and drug consumption rooms are usually grounded in the idea that these initiatives bring 'bad' people to the area rather than trying to help an already existing problem within the community. The involvement of members of the local community has been described as a key determinant to any harm reduction strategy (Childs et al., 2021). However, given the high levels of stigma around drug use, further research is needed to demonstrate the extent to which local communities are aware of and understand harm reduction initiatives and how this process may be affected by processes at the interpersonal and policy levels.

Davidson and Howe (2014) found that much of the 'NIMBY'ism felt by local community members was due to a lack of information about services, and a fear of drug use and its implications for criminal activity, proposing that service providers and policy makers should acknowledge community concerns while increasing education around harm reduction in order to engage the community and help their understanding of the benefits of harm reduction programmes and the benefit harm reduction initiatives have to wider society. Similarly, Earnshaw (2020) found that stigma towards PWUD leads to various negative outcomes, including reduced treatment-seeking behavior, limited access to care, social isolation, and worsened health outcomes and pointed to advocacy at the local and public policy levels as a means to mitigate the stigma felt towards PWUD.

Research has demonstrated that harm reduction or other drug-related services are often placed within already disadvantaged communities, who fear the additional burden of added services and potentially increased crime rates to their neighbourhood. Within the context of an intervention seeking to expand, normalise and destigmatise the harm reduction model within communities most affected by drug use, Owczarzak et al. found that "the involvement of PWUD as peer workers in harm reduction initiatives can facilitate access to services among stigmatized and marginalized communities that distrust traditional providers, and benefit both the peer and the community members with whom they interact" (2020, p. 8). Their research suggests that peer involvement has benefits at multiple levels of society.

Policy and Political Environment

In many countries, challenging political environments and policies counteract harm reduction efforts. There is a growing trend of right-wing conservative political narratives emerging in many European countries (Gairaud, 2022; Stochita, 2022; Kirby, 2022), with the EU

Commissioner for home affairs, Ylva Johansson, equating drug crime with terrorism (Campenhout et al., 2023). This leads not only to a lack of resources and available funding for harm reduction services, but also a reinforcement of already existing stigmatisation and discrimination among local communities and wider societies. Budget cuts decrease the likelihood of services to be able to hire PWUD as peer workers and prevent the necessary training and supervision mechanisms needed for successful service delivery (Souleymanov et al., 2016). PWUD may also have difficulties in entering the workforce due to policies that prevent current drug users from working. Because of this, many peer workers are ex-drug users rather than PWUD.

Miovský et al (2020) examined the 'crisis' of the under-funding of harm reduction services in Central and Eastern Europe and found that political and social dynamics in the region contributed to issues surrounding funding of harm reduction services and that the stigmatisation of drug users directly impacted funding of services. Their findings demonstrate that this lack of adequate funding has severe repercussions not only for drug-specific services and users but can lead to an increase in HIV and blood-borne infection amongst a number of vulnerable populations. Their research recommended increasing international co-operation in order to help support services in this area. Similar research examined the differences in the welfare state models of Denmark and France and their implications on the local acceptance of drug consumption rooms (Houborg & Jauffret-Roustide, 2022). Their findings suggest that examining the interaction between welfare state typology, cultural diversity and social acceptance is key to the development of successful drug policy and harm reduction initiatives. It is clear that policy and the political landscape of a city or country can have a strong influence on harm reduction service provision, impacting all involved stakeholders.

Current Research

Current research on the topic of harm reduction has looked at very specific examples in very specific contexts, for example within the population of patients experiencing chronic pain (Mardian et al., 2022), or in primary health care facilities in Kenya (Sitienei et al., 2021), or in specifically non-urban contexts (Childs et al., 2021). It has highlighted a number of issues that arise in various different aspects of harm reduction service provision without exploring their potential interconnectedness. This research sets out to examine the ways in which processes at the individual, community and policy levels may interact with each other and affect harm reduction service provision across a number of countries in Europe through the analysis of qualitative interviews of the directors of drug-related organisations. Service providers were chosen as the target population with the aim to examine their positionality within a social-ecological framework in relation to harm reduction initiatives. It will examine their views of the barriers and facilitating factors that affect service provision from these three distinct social-ecological levels. Taking a broad, exploratory approach will allow for a wider-scale evaluation of the factors influencing harm reduction services in Europe from an ecological perspective. This will have implications related to potential areas for future research, service provision, funding, and policy development.

This research is socially relevant given the increasing statistics surrounding drug use, and in particular opioid substances which carry the most risk (EMCDDA, 2022). Although harm reduction efforts have shown to have a very positive association with reducing the risks involved with taking drugs (Childs, 2021), services are often overlooked and misunderstood. Understanding the mechanisms that affect harm reduction services in a practical sense will ensure that service provision can work to its full capacity and potential and allow opportunities for collaboration and relationship building for all stakeholders. It is scientifically relevant given the increased research focus on community involvement in social and health care initiatives, as well as recommendations

from the WHO on involving community members (WHO, 2022). Examining the topic with an evidence-based approach by highlighting barriers to service provision may inform the development of successful harm reduction interventions. It is hoped that the findings of the current research can contribute to a more thorough understanding of harm reduction service provision, and aid in scientific consensus around a more specific definition of harm reduction, particularly given its exploratory nature, broad focus, and large geographical scale.

Interdisciplinarity and Theoretical Framework

Drug use and services attempting to help drug users are an extremely complex and interdisciplinary phenomenon. Within this, harm reduction as a construct is interdisciplinary in nature. It exists as a response to the negative social, health and legal issues that arise for people who use drugs. Therefore, the areas of social policy and the public health and legal systems are involved, as well as influences from public policy and government administration structures. As harm reduction often deals with addiction, psychology is also an important discipline to consider in this research. Given the importance of inter-group relations, and socio-economic status to the field of harm reduction, sociology is also a key discipline to consider.

A Social - Ecological Approach

Considering the interdisciplinary nature of the subject of the current research, identification of the key stakeholders involved in harm reduction service provision indicated that each key stakeholder exists at a different level of the social-ecological framework. The social-ecological framework has roots in the policy research of McLeroy et al., (1988), but has been adapted and applied to countless areas of the social sciences and public health including conceptualising substance use and services (Baral et al., 2013; Latkin et al., 2013; Sudhinaraset et al., 2016). The social-ecological model positions the individual within a complex interaction between various

parts of their social environment and can explain how this may impact their health. The social-ecological model proposes several levels: the individual, the interpersonal, the organisational, the community, and the public policy levels (see Figure 1 below).

Peers and peer involvement in harm reduction services exists at the interpersonal level. Service providers can be seen at the organizational level, local community members at the community level and policy makers and government officials exist at the policy level.

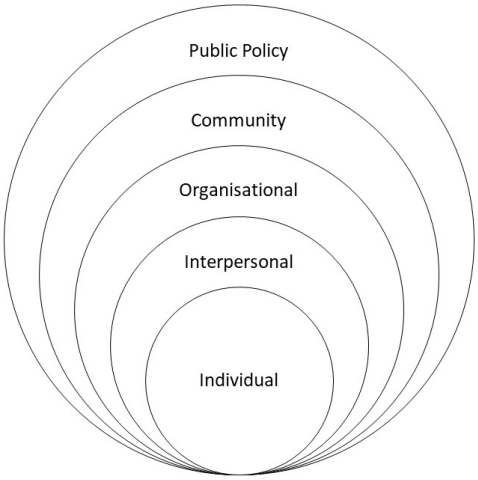

Figure 1 - The Social-Ecological Model. Adapted from McLeroy et al., (1988)

Stigmatisation Theory

Stigmatisation theory proposed that stigmatisation is a complex mix of the processes of labelling, stereotyping, separation, status loss, and discrimination at the individual and social levels (Link & Phelan, 2001). Link and Phelan (2001) describe the influences of stigma processes on the distribution of life chances, including the area of criminal involvement. The stigmatisation of PWUD can interrupt their chance of success in almost all areas of life including career prospects, romantic relationships, housing etc. (Galea & Vlahov, 2002; Huang et al., 2011; Cusick et al., 2011; Sigurdsson et al., 2012). The existence of this stigma on a wide scale or policy level in

society causes many members of society to take on these stigmatising or discriminatory views. This relates to the stigma PWUD and harm reduction services face by local community members and may help to explain the lack of local community involvement in harm reduction initiatives.

Symbolic Interactionism

The theory of Symbolic Interaction (Mead et al., 2015) depicts the subjective meaning that people attach to their surroundings and relationships to others and how this influences individual behaviours. Despite the fact that harm reduction is an effective method of reducing the negative consequences of drug use, many people see harm reduction initiatives as negative and encouraging of drug use, as they believe drug users to be 'bad people'. This theory may complement the social-ecological model and help to explain why there is a lack of resources available to harm reduction services as harm reduction services are not prioritised at the governance level, and not advocated for at the community level. It also may help to explain why peers and local community members do not work together although often their end goal is the same.

Harm Reduction

Harm reduction itself can be seen as a theoretical framework or set of principles. It is grounded in 'meeting people where they are', and working with community members without judgement or the expectation that the risky behaviour must be completely avoided or abstained from (Coulson & Hartman, 2022). Drug use has been described as a sensitive topic (Bos., 2020), but harm-reduction aims to create an open dialogue about drug use, and to involve PWUD in the decision making at every level of harm reduction initiatives. It allows PWUD autonomy to choose their own level of involvement in projects, research, and policy. The current research project will

be grounded in the principles of harm reduction, and therefore will take the stance that the topic of drug use should not be deemed as sensitive or needing additional ethical considerations.

Research questions

The current research aims to answer the following research questions and sub-questions.

RQ: What are the barriers to harm reduction service provision in Europe from the perspective of harm reduction service providers?

SQ: How are PWUD involved in service design and provision? What are the facilitating or hindering factors?

SQ: How do the attitudes and views of local community members surrounding service centres impact service provision?

SQ: How do policy and the political landscape of a city or country shape harm reduction service provision?

SQ: How do the stakeholders at each social-ecological level interact with and influence each other?

Methodology

Design

This thesis uses existing data which was collected by an intern at Correlation – European Harm Reduction Network. The data was collected to supplement the Europe-wide monitoring of the countries (known as focal points) within the network. A qualitative, interpretative research design was chosen in order to explore the topic from a broad approach, particularly given the large sample size involved in the research. The existing data had not been analysed before and was chosen for the current research in order to provide insight into the complex mechanisms involved in harm reduction service provision.

25 participants/focal points were involved in the current research. The countries involved were: Albania, Belgium, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Ireland, Italy, Macedonia, Malta, Netherlands, Poland, Portugal, Russia, Scotland, Slovakia, Slovenia, Spain, and Switzerland.

The data was collected in May 2022. Each semi-structured interview was conducted online via Zoom and recorded using the Zoom recording software. Interviews were transcribed using Descript transcription software. Interviews were between 30-60 minutes long each.

Sample

The participants were the heads of the main drug-related organisation from each focal point. Participants were aware that their network membership would involve being asked to contribute towards research taking place by network staff and were asked to participate in the current research with no obligation to do so. Participants were not selected based on any criteria other than that they were the representative for the focal point from their city. Each participant

held a senior position or was the director of a civil society organisation or NGO in the area of drug-related service provision which adopted a harm reductionist approach and can be considered to have extensive knowledge on drug policy and service provision within their city. The inclusion of a large range of countries/cities from across Europe adds a richness to the data.

Variables of interest and operationalisation

Questions were developed to be used in the semi-structured interviews. Topics for discussion were broad and related to community involvement, staff mental health and job difficulties, service provision, research, and monitoring.

Data analysis

This research is qualitative and interpretive in nature, in order to explore the topic from a broad perspective. It incorporates framework analysis as it sets out to explore how harm reduction service provision in Europe fits a social-ecological framework. Framework analysis is a method of analysing qualitative data which involves a systematic approach, allowing the researcher to explore how their data set may fit within a pre-established structure (Ritchie & Spencer, 1994). It is often recommended for use in policy and health research (Gale et al., 2013).

Data was read and re-read closely to ensure that the researcher was familiar with the entire dataset, using an iterative process. Initial notes were taken on any interesting or meaningful aspect of the data. A coding framework was developed based on the different social-ecological levels and the stakeholders at each level, based on the social-ecological model. The coding framework was then applied to the research systematically, by identifying and noting relevant themes within the data. Coding for relevant themes was based on steps recommended by Braun and Clarke (2006). These themes were charted and a table of each theme with corresponding quotes from the data was

developed. An excerpt from the master table can be seen in Table 1 in the appendix. Various relationships and patterns arose from the themes, which were then compared to and synthesised with existing research presented in the literature review, and can be seen in the discussion section.

Ethical aspects

Both anonymity and confidentiality are key to this research (Bos., 2020). The existing data was anonymised, and an agreement has already been made between the participants and Correlation-European Harm Reduction Network and its respective countries. Country and City names will be included as agreed upon with the participants, but any information at the organisation or individual level will be removed or anonymised. Given the geographically large scale of the research and its Europe-wide scope, issues with anonymity or identification of participants will likely not occur. Participants took part in the interviews with the knowledge that their responses would be published as part of the annual Civil Society Monitoring project at Correlation and could additionally be used for other related projects.

Ethical approval for the current research project was gained through Faculty Ethical Review Board (FERB) of the department of Social and Behavioural Sciences at Utrecht University before the beginning of any data analysis.

Role of the researcher

As in any qualitative research initiative, the role of the researcher in the data analysis process is extremely important. The lived experience of the researcher and their thoughts, assumptions and biases can influence the data analysis. This research will ensure the utmost transparency in this regard. Although clear themes emerged through the data, there was a certain amount of subjectivity to the analysis process. The researcher reflexively and consistently ensured

they were consulting literature on the analysis process and followed all recommended steps. Utilising a framework analysis method was helpful for this, as was ensuring an iterative process of coding. It should also be noted that the researcher was completing an internship in the area of harm reduction at Correlation - European Harm Reduction Network at the time that the research took place, so held pre-existing practical and theoretical information on the topic before the research began.

Results

Themes were developed based on the three social-ecological levels which were the focus of the current research. At the interpersonal level, of which peers were the target stakeholder, themes 'importance of peer involvement', 'user-self organisation' and 'barriers to peer involvement' emerged. At the community level, of which local community members were the target stakeholder, themes 'community attitudes' and 'NIMBY and the complexity of living near drug use' emerged. At the policy level of which policy makers were the target stakeholder, themes 'importance of political support' and 'co-operation of services' emerged. These themes and their connections are described below and depicted in Figure 2 and Table 1 and Figure 3 in the appendix.

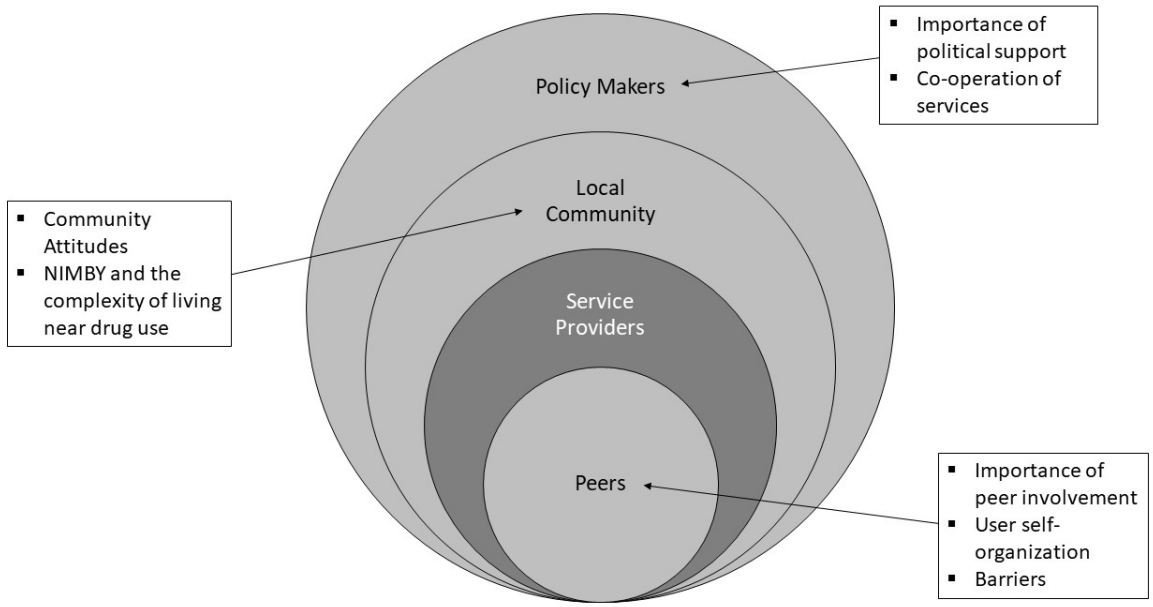

Figure 2 - Themes represented in a social-ecological framework of harm reduction services

Although peer involvement in harm reduction initiatives is one of the key principles of harm reduction, and has been demonstrated to increase success rates, it has been shown that in practicality, a number of issues arise when attempting to implement peer work in harm reduction

services. Secondly, members of the local community surrounding services either have a lack of awareness of harm reduction services or often there is strong stigmatisation and opposition felt towards the services. This can create tension between service users, providers and their surrounding communities. Harm reduction services are extremely susceptible to changes in their country's political environment. Harm reduction in most cases is most supported by Westen, left-leaning governments and policy-makers, whereas more right-wing, conservative governments such as in Central and Eastern Europe tend to take up a more abstinence or zero-tolerance approach to drug consumption.

The Policy Level

Importance of Political Support

Tension between all stakeholders involved in HR services can be seen at the policy level. Government support for harm reduction services varied greatly across responses and was strongly affected by geographical location. Western and Nordic respondents depicted a much more positive picture than more conservative Central and Eastern European Governments. Several Central and Eastern European respondents reported that politics and election time were very difficult for harm reduction services. They argue that the topic of drug policy is often used as a political crutch to win over voters, and PWUD are used as scapegoats to blame for a variety of other social issues. For example, comparing the responses from participants from Bern and Prague, clear differences in political attitudes towards harm reduction can be observed:

> *Switzerland is quite on a high level of harm reduction. Drug policy consists of four pillars, of which one is harm reduction. In the narcotics law, it's written down that there are four*

pillars: repression, prevention, treatment, and harm reduction [...] it's quite well established, all the harm reduction services.

- Bern

We have quite good national drug policy, but drug users are many times used as topic for populist political parties. We are having, in few months, municipal elections, so we are expecting some troubles again [...] politicians sometimes misuse the subject of the drug treatment, prevention, harm reduction as a political issue and they are building their career on it, on that. So, they are building career that "there will be no drugs harm reduction services in your background, my dear voters"

- Prague

The respondent from Glasgow, which now has well established harm reduction programmes and services, points to crisis response as the main factor underlying changing government views towards harm reduction. This response also indicates the ways in which politics influences the community level, as the most socio-economically disadvantaged communities are affected most but protected the least from drug policies.

Recently, [The Government] has basically called or said that the number of deaths is actually shameful and a disgrace for the country. There is an ownership of the issue now that there wasn't before. There's been quite a bit of extra investment in the problem. [...] The policy developments have virtually always been at the point of crisis [...] Sadly crisis is the thing, and in the Glasgow context, in the Scottish context as a whole, largely that's because the 1400 people that are dying that are not exclusively from the poorest communities, but largely from the poorest communities. And that, therefore, is seen as,

> *you've got this notion that it's a lifestyle choice, etc., but also that it's a marginalized poor population without a voice. So that's been a huge factor in the lack of progress on some of these agendas. I gave private evidence to the Scottish Affair Select committee, the UK committee that was looking at this. I said, "if this, if we had 1400 middle class people dying, then we'd have a drug consumption room probably on every corner. And have it straight away". But the reality is quite different.*
>
> - Glasgow

It is clear that government officials who initially oppose harm reduction as an option for combating drug-related harm and mortality, turn to harm reduction as an option when all else fails. Similarly in Bratislava, worsening conditions are a motivating factor for political support: *"Even the mayor recognizes that this is a difficult topic and that we cannot ignore it anymore if we want to have not worsening situation."* However, in Bratislava as well as other cities, officials are not doing enough to spread awareness about the benefits of harm reduction and the stigma surrounding PWUD trickles into other services and to local community members: "*But the municipality mayor should work with this and maybe try to lessen this view, NIMBY phenomenon, but they are actually supporting it and helping*." The respondent from Milan also identified the ways in which change at one level can trickle down and influence the others.

> *And, of course, if we had this shift at the higher level, political level, everything would then change in the lower level. So, people would be treated differently, considered differently, more involved in decisions concerning their lives. The services probably would be designed differently, harm reduction would be more important, and the workers would be recognized for the hard work that they do. So this is missing on the low level, because at the political level there is no interest. I think that some people[...]in the right-wing parties, some people*

would like to see people using drugs disappear or put in prison, or wiped out of society. [...] I think it'll take a long time to make a change. A long time.

- Milan

Co-operation of Services

Increasing funding for and support of harm reduction services goes beyond just benefiting the services themselves, but also increases opportunities for co-operation between services. Respondents demonstrated that the degree to which services within society work well with each other had strong implications for service provision.

I have to say that the police is more important for us than drug counselling units. Good cooperation is really essential because they do their job, and doing their jobs they can destroy our work. So we are in close cooperation with them to find a good balance between police work and harm reduction.

- Berlin

Across respondents, it was clear that building up a relationship with local law enforcement was a difficult yet worthwhile endeavour.

But from the police hierarchy, there's leadership to support a harm reduction approach and there is much more recognition within the police that harm reduction is crucial, and that rather than just, arresting people and trying to get them into prison, they should be diverting them as to other services and away from the criminal justice system. But that is a cultural shift that takes time as well.

- Glasgow

> *At least like in some areas where [the police] want to improve the safety of the area, then they ask the mobile harm reduction services also to join meetings considering how they could improve the safety of the area, so there's some kind of cooperation.*
>
> \- Helsinki

Usually this can be seen as an act of desperation on the part of the police or other services who do not know how to handle difficult situations with PWUD. This can be seen in the response from Bratislava *"The local police is getting so much pressure from the residents to solve the situation with the drug using and the homeless, but they don't have any tools how to do it"*, with harm reduction again being turned to at the point of crisis.

The Community Level

Community Attitudes

Responses varied in terms of how respondents felt that their services were viewed by the wider community. Lack of awareness of harm reduction services was mentioned in Paris: *"I think the average French person doesn't even know what a harm reduction service is"* and "indifference" towards long withstanding services was noted in Amsterdam where *"people just don't know about it [...] if they were more visible, the stigma would quite easily come back."* and some respondents from Western or Nordic countries (Berlin, Bern, Helsinki), felt that harm reduction services were viewed positively in their societies. However, the vast majority of respondents felt there was a strong sense of stigma felt towards both service users and the services themselves.

> *In Milano, and in Italy in general, I would say, but let's talk about Milano, people are not very supportive and understanding towards people using drugs, not at all, they're very*

stigmatized. I would say also the same about harm reduction services, because people do not understand why the municipality or the health system spends money to help people who cause the trouble and in a situation of crisis, especially in these last years with the many problems, they are not very prone in helping people.

- Milan

Often this stigmatisation towards service providers was due to a lack of understanding about harm reduction services and the idea that these services encourage and facilitate drug use.

"A really common, misunderstanding is they don't understand why harm reduction services provide clean, syringes, needles, condoms. "Why do they need it? It's like you are helping them to use drugs. And if you don't give them those things, they don't use drugs".

- Tallinn

Generally, they think that people who use drugs are weak, immoral people and that their main problem is not disease of addiction itself, but their lack of self-control and lack of strong will, plans for the future and so forth. [...] If you read some comments on our social media [...]we are like enemies of the state who promote drug use and who do not want people to quit drugs. Because the constant feedback is "why are you helping this drug users when you should help sick children or sick animals?".

- St. Petersburg

Stigmatisation of drug users by society leads to a rejection of harm reduction services at a more local level and push back from local community members who do not want services to be established near their homes.

> *...people who use drugs are the most condemned and negatively perceived group of society in Hungary. There is this survey which asks people whom they don't want to have as a neighbor. And the group that they don't want the most is actually people use drugs.*
>
> - Budapest

NIMBY and the complexity of living near drug use.

The 'Not in My Backyard' phenomenon was mentioned in almost all interviews as being a barrier to both service provision and peer involvement. In some cities, the effects of NIMBY are extreme: *"If you go now to the centre of Athens and ask the average guy who lives there, he will actually tell you that "get these bastards out of my steps", so not very tolerant."* Despite the fact that increased knowledge around harm reduction often means that local community members are more supportive of service initiatives, this change occurs on more of a theoretical level, and in practicality, NIMBY attitudes can persist:

> *So "not in my backyard and not over there either". This kind of "not anywhere". That's not true of everybody, of course, but it is quite common. And it only becomes really apparent when you get to the stage where you say that service will be here, in this building, now. Then you get people who you thought perhaps were a little more cool about it going, "well yeah, but this isn't the right place for it, right?". People there look into their self interest, even though it's evidenced around the globe, if you take drug consumption rooms, that they enhance an area. The evidence is really clear that it improves the amenity of the area. It improves that for people.*
>
> - Dublin

However, time has been suggested as a buffer for the effects of NIMBY. Service provision in Copenhagen, which is generally accepted by local communities, also experiences the effects of NIMBY when opening new services. This highlights that it is the unfamiliarity with services rather than the services themselves that communities have issue with:

> *There was a lot of 'not in my backyard' problems in the beginning, but it disappeared. As always, it disappears within two years. We started a clinic for the local drug users in 2008. There was a lot of NIMBY problems with that. It disappeared when we opened and 2, 3, 4 years later, we opened the first drug consumption room and there was a lot of NIMBY problems with that, and it disappeared again.*
>
> - Copenhagen

Similarly in Antwerp, stigma from local community members began to lessen as they realised the long-term benefits of harm reduction. A combination of time and increased knowledge and awareness of the benefits of harm reduction services seem to be the most effective way of increasing community involvement and

> *I think a lot of people have experienced some nuisance. But towards our services, I think they are accepting it because they see what we do and they see what we try to do.[...] I think if you ask general public what they want us to do with people who use drugs, I think the answer is: keep them clean, don't let them use drugs. But reality is different, and I think people who live a long time in the city of Antwerp, they know that it's not easy to work with people who use drugs and it's quite utopic to keep them clean.*
>
> - Antwerp

It is clear that respondents are not unsympathetic to the concerns of local community members, and acknowledge the complex effects of drug use, particularly in cities whose governments do not prioritise drug-related or harm reduction services:

> *There is a horrible condition in the centre of Athens of 6 or 7 open drug scenes and the neighbours are not very happy about that. And they have all the rights in the world know not to be happy with that. When they face every day this kind of condition outside the door. People in Athens are abandoned, people who use drugs in the streets are abandoned in their fate.*
>
> - Athens

Increased understanding of the underlying psycho-social processes of drug use were also seen as a buffer to the effects of NIMBY and stigma towards drug users.

> *Probably over the years, there's been an increased understanding from the public, that this is not a lifestyle choice for people. That this is a problem that's, developed through particularly childhood trauma and an adult trauma as well. So it's very much an issue of self medication. People trying to survive with underlying mental health issues through the use of drugs. I think increasingly, I would hope anyway, that the public is more aware of some of that rather than seeing people with a drug problem and thinking "they brought it on themselves, they chose to use drugs and therefore they get what they deserve"*
>
> - Glasgow

The Interpersonal Level

Importance of peer involvement

All respondents agreed on the importance of involving PWUD in service design and delivery. In both Paris and Amsterdam, peer involvement is a legal obligation. The respondent from Bern also referred to a manual on peer involvement, and that peers are involved in almost all institutions.

> *It's very important to empower people. And one of them is, obviously, [that] you want to be proactive and just get people's feedback on a proactive basis in a positive way. But I do think that complaint procedures are very important. People being empowered to complain about the service that they're getting, and a proper process being followed so that they're taken seriously.*
>
> - Dublin

> *And if they don't change the laws quickly, there is a risk that we don't have peer counselors and social workers next year in our company, for example, and it's so important. It's so important!*
>
> - Tallinn

Respondents who noted very little or no peer involvement in their services mentioned having attempted to introduce it or having it as a top priority.

> *I think that we should start from the community, we should really listen what they think, and they should organize focus groups with the communities, and based on the findings of the focus group, we should actually start the community planning. We should start to*

implement or trying to write activities according to the focus group, according to the direct community. I think this would be much better than the communities at the end is approving things that we came up with.

- Bratislava

User self-organisation

User self-organisation was seen as key to both peer involvement and successful service provision. The existence of user organisations was directly linked to both the political influence of the city and the degree to which society and local community members displayed stigma towards PWUD, demonstrating the ways in which the various stakeholder levels interact with each other.

There is definitely a need for user organizing in Hungary, which is nonexistent at the moment. I'm not able to do that from outside and I tried to support some activists, but this is not possible without their active contribution. We definitely need an organization that represents people who use drugs.

- Budapest

Actually we were trying to establish like a forum of people who use drugs [...] We tried to invite people. We contacted all the treatment services and we said that we want to establish a forum, like a city society forum of people used to use drugs or are currently using. And we invited them at our organization here and we tried to explain what would be the added value of this, how they could help us draft policies and evaluate policies, but there was no real interest in that. They were saying that they didn't feel ready [...]Maybe it's because of the stigma again, I don't know.

- Nicosia

Respondents mentioned that PWUD can feel disillusioned by policy makers and have a lack of belief in themselves as agents of change:

> *Not much because most of them are homeless and active drug users, so they don't have any agendas, being more involved in trying to be more political or activist movement or something. They're like "nothing is gonna change". They're not optimistic about that.*

- Ljubljana

A lack of resources was also mentioned as a reason for a lack of user self-organization. Respondents mentioned the impossibility PWUD focusing on attempting to push back at policy makers when their basic needs were not being met:

> *[We] encourage active drug user networks to push back a bit and take some ownership. The challenge with that is that if you take the population in Glasgow, particularly the street injectors, that those folks are struggling to stay alive. So, if you're asking them to get together collectively to actually take action, that's very hard for people. When people are struggling to get enough money and enough food, enough drugs, etc.*

- Glasgow

Barriers to peer involvement

A number of barriers to peer involvement were presented by the respondents. Often PWUD do not want to reveal themselves as a drug user due the stigma they will likely face and the potential repercussions this may have on their life, or they are ashamed of their past drug use.

They are not so visible, some of them don't want to be visible, that's a problem. So, some of them after the five or six, seven years, they don't want to be identified as former drug users. But they are here. Not officially, not formally, but they are here.

- Prague

They don't want to get known as people who use drugs. Because their other family members will see them or they will perceive them that they are people who use drugs and so on. Even though at some point, they know that their parents and so on know, but they don't want their community to know that they are people use drugs as they would receive a lot of stigma and discrimination

- Tirana

Some clients that are stable, they eventually they stop coming to the services because they want completely different life and they want to leave it behind.

- Ljubljana

As with self-organisation, peer involvement was inhibited by a lack of self-confidence or what the Glasgow respondent identified as 'self-stigma'. This was demonstrated through an anecdote:

"He thought his voice was worthless, he didn't deserve to have a voice. And then he realized, because he heard this guy speak, that actually "no, even though I'm on methadone I'm entitled to a view of services and a voice". So the big challenge that we've got is that we've had a recovery focused agenda, which has meant that the dominant voices have been

those with lived experience prior, previous experience of drug problems, as opposed to living experience and current users.

- Glasgow

The respondent from Athens was sceptical of the intentions behind peer involvement and felt that it was often due to 'tokenism':

Community involvement is something very controversial in Greece in general. Because in my understanding they involved us when they want to use us as tokens.[...] I don't think there is any kind of substantial community involvement in services, in the design and the implementation of the services…

- Athens

A lack of peer involvement also occurs at the organisation level, with drug use seen as a barrier to employability. The respondent from St. Petersburg named 'distrust' as the main factor in a lack of peer involvement in their services.

We are all very open to people with lived experience of drug use, but there are still some rules that you need to abide by, such as work discipline. And it is not always possible with active drug users to schedule something or plan something.

- St. Petersburg

Discussion

The aim of the current research was to examine the barriers to harm reduction service provision in Europe from the perspective of harm reduction service providers, and taking a social-ecological perspective, explore how these barriers interact with and influence each other. Analysis of the data within the context of a social-ecological framework revealed that stakeholders acted at each level of the social-ecological model, and themes emerged from and interacted with each other from these levels. The findings suggest that examining the views of harm reduction service providers from a social-ecological perspective demonstrates the complexities of drug-related and harm reduction service provision, the difficulties faced by all involved stakeholders, and the important role each stakeholder plays in the entire process.

A Social-Ecological Model of Harm Reduction Service Provision

As depicted in the literature review, the findings of the current research demonstrate the importance that policy and the political environment have on harm reduction service provision. As seen at a more micro-level in research by Houborg & Jauffret-Roustide (2022) focusing on Denmark and France, the current research found that respondents' experiences of service provision were greatly impacted by the political landscape of the city at a certain point in time. The fragility of the situation can be seen in the fact that some respondents became nervous around election time, and they found that harm reduction services were used as a political tool for politicians to gain votes. Thus, the connection between the community level and the policy level can be observed. Often, harm reduction services were seen as a 'last resort', with several respondents reporting that politicians and other stakeholders at the policy level only turned to or saw the value in harm reduction services in crisis situations. The fragility of the political environment can also be seen in the difficulties in co-operation between various services. The majority of the respondents

pointed out the benefits of good co-operation, but the difficulties in doing so when the higher up policies of the various services do not align.

The geographical location of a city had a direct impact on the respondents reporting difficulties with policy and politics leading to issues with funding, local community attitudes and peer involvement. In this way, the current research aligned with the research of Miovský et al (2020), and considerable differences were reported in cities in Central and Eastern Europe compared to Western or Nordic countries. These findings suggest that welfare state typology and the political positionality of a country or city has a direct impact on harm reduction service provision.

Negative community attitudes followed a similar geo-political pattern as the policy level did, with respondents from Western and Nordic countries reporting more welcome attitudes by local community members towards service provision. Respondents felt that a lack of knowledge about harm reduction services or the benefits to the community were the main factors which affected community attitudes and service provision, aligning with research by Davidson and Howe (2014). The importance of local community members as stakeholders was evident in the current research as in Childs et al. (2021) and Earnshaw (2020).

Even though almost all respondents reported the effects of the NIMBY phenomenon on their services to varying degrees, respondents also acknowledged that local community residents are entitled to be sceptical about living near drug use and service centres. The findings suggest that further interventions that target multiple stakeholders, such as presented in the research of Owczarzak et al. (2020) are needed to try and tackle the complex situation of drug use and harm reduction service provision. Education, time, and familiarity can be seen as key aspects to relationship formation and trust between peers, community members and service providers. This

is particularly poignant given that often service centres are placed in already disadvantaged communities which may themselves be subject to a lack of resource allocation from politicians and policy makers (Childs et al., 2021). The theory of symbolic interaction (Mead et al., 2015) is evident here, as local community members often view PWUD and services as negative due to their own experiences in life. Interaction between the various social-ecological levels and stakeholders is clear here, as under-funding service provision also hinders service providers from attempting to develop outreach and educational programmes in communities to tackle stigma, thus trickling down within the various levels.

Peer involvement in harm reduction services was also seen across a geo-political arena, with cities such as Bratislava, Tirana, and Prague reporting difficulties in introducing peer involvement in their services. Barriers were often directly related to the stigma PWUD face by local communities and wider society, and often ex-users no longer want to involve themselves in services, instead moving on with their lives outside of harm reduction and no longer wanting to associate themselves with the stigma attached to drug use. The importance of both user self-organisation and peer involvement was evident in the data and complements existing research on community involvement in the wider social sciences and public health realms (WHO, 2020; Bath et al., 2015). Despite the fact that harm reduction was founded by user self-organised groups, and has strong roots in peer involvement in services, the findings of the current research aligns with that of Silumbwe et al. (2020) suggesting that peer involvement occurs less often than providers would like, and a number of barriers emerged through the data.

The current study demonstrates the importance of peer involvement in harm reduction service provision, but as seen in the literature review, several barriers impede the ability for peer involvement to happen in practice. In line with existing research by Ocloo & Matthews (2016),

the participant from Athens felt that current instances of peer involvement were more tokenistic than meaningful, and participants from other cities also felt that stigma and fear of discrimination from local community members and society prevented peers from becoming involved. The complexity of the situation can also be seen through the respondent from St. Petersburg, who felt that a certain degree of distrust towards PWUD was warranted in the context of them working within the organisation, where specific standards of work are important. This aligns with the research of Park (2020). Interestingly, this participant also comes from a more traditional, conservative political environment. The current research also supports Link and Phelan's Stigmatisation theory, as the stigma PWUD prevents them from becoming involved in harm reduction services or organisations even after they have stopped taking drugs.

Each level could not be examined in isolation without evidencing links to other themes. Existing research focused on one or more stakeholder at a more micro level, whereas the current research took a broad approach to examine how stakeholders at various social-ecological levels interact with each other. The findings give evidence to an almost cyclical relationship between the various levels, as policy and politics influence not only funding opportunities for services, but also impact on the attitudes or awareness community members have about services. The complex nature of this relationship can be seen in the fact that politicians also use harm reduction as a political tool to gain votes, and that local community members are themselves the voters. Both community attitudes and policy and funding allocation hinder peer involvement in harm reduction initiatives. A lack of peer involvement or advocacy can inhibit service provision from running to full efficiency which can then cause stakeholders at other levels to undervalue services. Thus, as a whole, the findings confirm the importance of peer involvement in harm reduction initiatives, the complex issue of involving peers in service provision, and the benefit that harbouring meaningful

relationships between stakeholders has on harm reduction service provision. It is clear that each of the social-ecological levels of the model are inextricably linked in the case of harm reduction service provision, creating a complex series of relationships between the various stakeholders. These linkages and relationships must be considered in order to allow successful harm reduction service provision.

Limitations

The current study was based on existing qualitative data that was not collected by the researcher. The process of interviewing respondents is often crucial in qualitative research endeavours as the researcher can note any specific nuances or help to create a flow from topic to topic that may influence the resulting data. Using existing data created a distance between the research and the researcher that would not be found in primary data collection, potentially influencing interpretation of the data. The topics covered in the interviews were quite broad and general, meaning that more specific topics could not be explored with considerable depth. For this reason, the current research has set out to examine barriers to service provision from a broad perspective. Primary research on the same topic could ensure that respondents were asked questions more specifically related to the research topic and research questions. Furthermore, the interviews were conducted in English, which may have hindered the respondents' ability to express themselves in comparison to using their own native language.

Recommendations

This research focused on the experiences and perspectives of the heads of drug-related organisations in Europe, who can be seen at the organisational level. It is their unique perspective of the challenges to service provision. Future research should examine similar topics from the perspectives of the other involved stakeholders at the ecological levels and then can be compared

to look for similarities and differences in perspective at each level. Creating a more fixed definition of harm reduction and what constitutes harm reduction may help to inform policy and contribute to more synthesised scientific research going forward. Quantitative research explicitly examining the relationship between each of the stakeholders/levels would allow for a more concrete understanding of this social-ecological framework of harm reduction service provision. It is clear from the current research that stakeholder inter-relations are crucial to harm reduction service provision initiatives. Developing interventions and allocating resources to harm reduction services should engage the stakeholders at each social-ecological level in order to bring about the most successful results. The current research took a broad, top-down approach and utilised a framework analysis. Future research should take a narrower focus examining each of the social-ecological levels in more detail to complement this research.

Conclusion

The current research suggests that harm reduction service provision is comprised within a complex social-ecological system giving evidence not only to the complex relationship between service providers and stakeholders at each level but also the complex relationship that occurs between all levels. Barriers faced at each social-ecological level were directly linked to each other. It is hoped that the findings of the current research project shed light on the fact that despite being a complex and multifaceted topic, harm reduction service provision should not be viewed as a 'last-resort' or form of crisis management, and instead should be viewed as a valuable approach to drug-related service provision which includes adapting to the needs of multiple stakeholders, and improving the risks involved in drug use. There is a need to allocate sufficient resources to increase understanding, combat stigma, and give recognition to harm reduction as a successful and viable method of reducing the risks associated with drug use, in order to support the well-being and health of communities and individuals affected by drug use, particularly as these individuals and communities are often already socio-economically disadvantaged.

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Appendix

Table 1 - Excerpt from master table of themes developed from each ecological level and their supporting Transcript Extracts

Ecological Level/Superordinate Theme	Subordinate Theme	Quote	Participant
Peers	**Importance of involvement**	In France, it's compulsory for the structures to have to make their users participate in the life of the structure. It's the law of 2 January of 2002. So actually, there are people, there are structures who are really engaged in that. For example, there are users that are peer professionals. Most of the structures at least do the minimum in making the users participate in their projects. Some structures are doing real projects with peer professionals or other things that make the users part of it.	Paris
		I think, for example, if there was a safe injecting site open, I think there would be some kind of [involvement], at least some ex-users. The field is now… There's so many ex-users now working on the field, so you get the feedback from the user community through them as well.	Helsinki
		They is involvement there. Like for planning or feedback, there are a lot of different interviews for people who use drugs to get their experience to get their sight. There are a lot of questionnaires when they are planning something new they ask their clients	Tallinn
		When it comes to the participation in focus groups, we tried to organize focus groups in all our centers, in all our 9 centers. So it's kind of practice that we have used a lot lately, the last, let's say, 3 or 4 years, because we have seen that for them [PWUD], it's more easier, and we could get more information when they are like in their community, kind of, you know, and they are just one part of the staff here	Tirana
		Sometimes the peers are involved in planning and implementing, and also managing a project. Peer involvement is quite common in Switzerland. Almost every institution works somehow with peers. In the drug checking services, as well as low threshold facilities. [...] We have a manual about peer involvement, which gives advice somehow of how to involve peers.It's about the whole process of involving peers in a project, like „ you should involve them while you are planning the project", „you should remunerate them", etc.	Bern
		But they were just approving things. And I think that it was not actually meaningful involvement, because most of the times they… What I listen, the feedback from the client who was there. I was not in these meetings, but she told me that they didn't understand what about. They were disapproving the things, and difficult language, it was not low-threshold. I already gave feedback to the city how to maybe involve better.	Bratislava
		. I think that we should start from the community, we should really listen what they think, and they should organize focus groups with the communities, and based on the findings of the focus group, we should actually start the community planning. We should start to implement or trying to write activities according to the focus group, according to the direct community. I think this would be much better than the communities at the end is approving things, what we came up with. Also, we collected some questionnaires at the beginning of these community planning, which was also part of it, the community part. I don't think that it was meaningful.	
		think it's really connected with the socio-economical situation of our clients. Our clients are in a really bad socio-economical situation. They are homeless, they are from Roma community, they don't have access to internet, or maybe they don't know know how to work with computer. And these type of meetings were just not, accessible for them.	
		I think is that stigma is massive. I think there's also the issue for people of what you might call self stigma. That people, because of how society views people with a drug problem, that people	Glasgow

	have that same view of themselves.	
	he thought his voice was worthless, he didn't deserve to have a voice. And then he realized, because he heard this guy speak, that actually „no, even though I'm on methadone I'm entitled to a view of services and a voice". So the big challenge that we've got is that we've had a recovery focused agenda, which has meant that the dominant voices have been those with lived experience prior, previous experience of drug problems, as opposed to living experience and current users.	
	It's very important to empower people. And one of them is, obviously, [that] you want to be proactive and just get people's feedback on a proactive basis in a positive way. But I do think that complaint procedures are very important. People being empowered to complain about the service that they're getting, and a proper process being followed so that they're taken seriously.	Dublin
User self-organisation	There used to be this organization of injecting drug users in Finland, in Helsinki. Now they're not so active anymore. That would've been a way previously, but I don't know how it would be done now.	Helsinki
	But we have two rather influential drug user groups who are based in Copenhagen. One of them does a lot of… They have found a way to get a lot of funding, and it's quite interesting [...] So, that's the Drug Users Academy, and we do a lot of work with them. [...] So, I come with my staff and they come with theirs and then we try to connect and do things, so we can have a stronger effort together	Copenhagen
	We have this one organisation in Estonia called LUNEST. I'm gonna say in English what it means. That means Estonian Association of Users of Psychotropic Substances. So they are fighting for the rights of the users, and they are fighting for the laws in Estonia to be changed, to be more helpful to drug users. There are people who use drugs actively right now, also. And it's a really, really important organization in Estonia. They are doing so much work.	Tallinn
	Actually we were trying to establish like a forum of people who use drugs or ex, who used to use drugs. We tried to invite people. We contacted all the treatment services and we said that we want to establish a forum, like a city society forum of people used to use drugs or are currently using. And we invited them at our organization here and we tried to explain what would be the added value of this, how they could help us draft policies and evaluate policies, but there was no real interest in that. They were saying that they didn't feel ready [...]Maybe it's because of the stigma again, I don't know.	Nicosia
	In Czech Republic, we don't have an official network of people using drugs. We are still in long-term building this network, but it's still not working. So, at the moment, there is no official platform how to get people using drugs involved.[...] mainly organizations are coming and not too much the voice of people using drugs is involved. So that's something Czech Republic has definitely to work on because it's more about us without us, than the people would be involved.	Prague
	That's completely missing in Hungary. We have been trying for many years to, at least, assist the creation of an organization that represents people who use drugs. But unfortunately it is very difficult, to organize that from outside.	Budapest
	Marginalized people, it's really difficult for them to organize without support. I think that's the reason why we don't have it, because the service providers really did not provide this support and assistance to the local communities. We try to raise awareness on this, but still there is an attitude that active drug users are not able to organize, it's only former drug users who can be talked to. In Hungary, still, we have a very much abstinence focused approach to this, even among harm reduction service providers, unfortunately, who only consider harm reduction as a tool to facilitate people's move to recovery.	
	There is definitely a need for user organizing in Hungary, which is nonexistent at the moment. I'm not able to do that from outside and I tried to support some activists, but this is not possible without their active contribution. We definitely need an organization that represents people who use drugs. I would talk to INPUD and they could send some trainers, but the real issue is, we need active people from the local communities who would give some effort, some time in it. Without this… We can invite a trainer but whom he would train. We really need some kind of community leaders to found, who could start this organizing.	
	encourage active drug user networks to push back a bit and take some ownership. The challenge with that is that if you take the population in Glasgow, particularly the street injectors, that those folks are struggling to stay alive. So, if you're asking them to get together collectively to actually	Glasgow

	take action, that's very hard for people. When people are struggling to to get enough money and enough food, enough drugs, etc.	
	As I mentioned previously, people who use drugs here have always been described or as a criminal or as a patient, and never as thinking person capable of being able to contribute to the discussion, unless you stop using drugs.	St. Lucija
	We also have peer counselors in Recuro where I work, but those medical companies right now, don't provide salary for, for example, peer counselors or social workers [...] And if they don't change the laws quickly, there is a risk that we don't have peer counselors and social workers next year in our company, for example, and it's so important. It's so important! .	Tallinn
	Right now in Estonia, we have a new problem with a new synthetic opioid called Metonitazene, it's really, really potent and really strong. There are so many overdoses for the past couple of weeks that it's insane [...]So it also is really hard for workers especially for peer counselors.	Estonia
Barriers	They are not so visible, some of them don't want to be visible, that's a problem. So, some of them after the five or six, seven years, they don't want to be identified as former drug users. But they are here. Not officially, not formally, but they are here.	Prague
	Not much because most of them are homeless and active drug users, so they don't have any agendas, being more involved in trying to be more political or activist movement or something. They're like „nothing is gonna change". They're not optimistic about that. It's just a daily routine, they're living their daily routines, completing a lot, but nothing to do about that.	Ljubljana
	they live in hard conditions, they may live on the street or in the shelters, so they're not motivated to do anything or they're not stable. Some clients that are stable, they eventually they stop coming to the services because they want completely different life and they want to leave it behind.	
	I think that main barriers are distrust to the ability of these active drug users to perform their services. This is a problem that has been going on since the very beginning of the organization. Though, as far as I know, during the first years of operations, there were more people, more active drug users who took part in providing services and in designing the services themselves. Nowadays, I think that it's mainly legal barriers. Of course, we should always think about [incomprehensible], and our laws on drug propaganda, and something like that. Of course, this is a barrier, but I think that the main barrier is distrust, because the organization has turned from the community-led organization into the community-based organization. We are all very open to people with lived experience of drug use, but there are still some rules that you need to abide by, such as work discipline. And it is not always possible with active drug users to schedule something or plan something. I think that this is one of the main reasons why they are not so actively involved into the the organization.	St. Petersburg
	Community involvement is something very controversial in Greece in general. Because in my understanding they involved us when they want to use us as tokens.[...] I don't think there is any kind of substantial community involvement in services, in the design and the implementation of the services they are addressed to drug users.	Athens

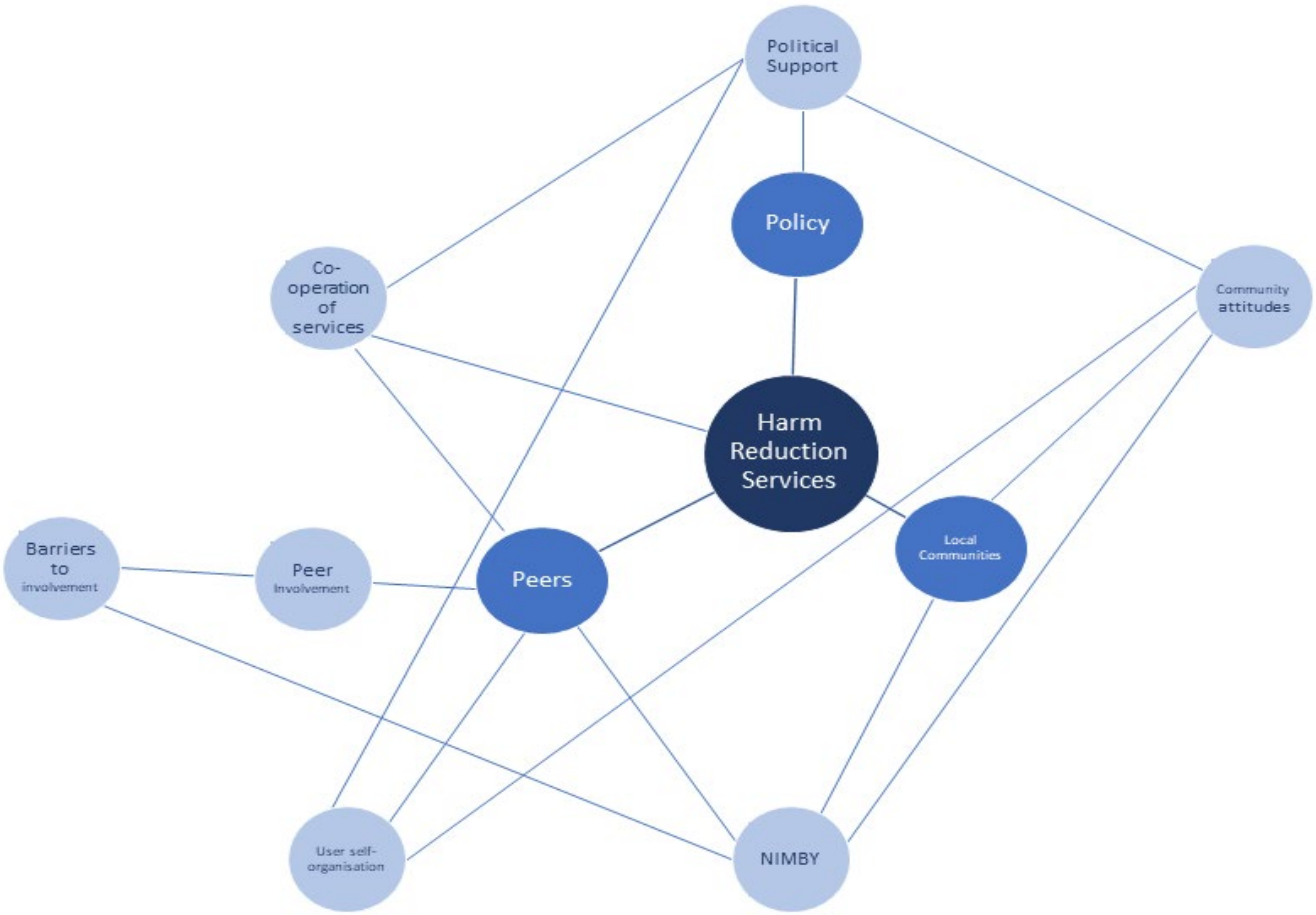

Figure 3 - Diagram depicting the complex relationship between themes at each level