



Community based low threshold substance use services: Practitioner approaches and challenges

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Ballymun Youth Action
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Contents

About the authors.....	2
Acknowledgements.....	3
1. Introduction and background	6
Research aim	6
Research objectives	6
2. Literature review.....	8
Policy context of low threshold service provision	8
Prevalence & treatment data	9
Harm reduction and low threshold service provision	10
Challenges and outcomes.....	12
Impact on practitioners	12
3. Methodology.....	14
Research design.....	14
Participants.....	14
Procedure	14
4. Results: Defining low threshold services and providing drop-in	16
Defining low threshold work	16
The drop in service	17
Safe spaces and meeting needs.....	18
5. Results: Practitioner approach and engagement	20
Relationship building & collaboration	20
Professional boundaries	22
Expectations and hope	23
6. Results: Skills and outcomes in low threshold work.....	25
Skill sets in low threshold interventions	25
Focusing on change talk	26
Harm minimisation interventions.....	26
Outcomes in low threshold work	27
7. Results: Impact of low threshold client work on practitioners	29
Impact of low threshold work	29

Burnout.....	31
Organisational approach	31
8. Discussion.....	33
Addressing barriers to service delivery.....	33
Practitioner and client relationship	35
Managing risk in low threshold environment.....	36
Client outcomes.....	36
Impact on practitioners	36
9. Recommendations	38
References	40
Appendix: Inquiry Group Themes	46

1. Introduction and background

The provision of 'low threshold' drug services is a relatively recent development to emerge within the range of responses to problematic substance use within Ireland. The term 'low threshold' refers to the accessibility and pre-requisites to obtaining a service, and within the substance use field, low threshold provision is often underpinned by principles of harm reduction. Client work typically focuses on ensuring that the basic needs of the client are being met (housing, food, medical) and on collaboratively supporting the client to implement harm reduction strategies in their lives, according to the pattern and type of substances they are using. This type of service is generally provided on a drop-in basis during specific time periods, does not require service users to be abstinent or substance free and may work with service users if they are intoxicated. Existing research (Wood et al., 2006; Gilchrist et al., 2014) and policy (Butler & Mayock, 2005; O'Shea, 2007; Randal, 2011) supports the belief that the provision of low threshold services, coupled with harm reduction interventions, can both address and reduce immediate risk in the lives of service users (Toumbourou et al., 2007) and provide a pathway into drug stabilization, reduction or further treatment for substance use (Lee & Zerai, 2010).

Low threshold services are typically provided within community or city settings, either by statutory or community organisations. Services may be staffed by counsellors, key workers or support workers who would normally seek to engage informally with clients and deliver brief, harm reduction focused interventions. In addition, low threshold services often depend on volunteers for staffing and provide new drugs workers who may require high levels of supervision with an entry point into drugs work. A range of issues have emerged in relation to low threshold service provision including high volumes of clients accessing a service, variation in approach and aims of low threshold services and health and safety implications for workers and clients in regard to service users being severely intoxicated, using substances on the premises or overdosing.

Research aim

The aim of this research project is to explore the efficacy and challenges of delivering low threshold substance use services within a community setting, with particular consideration of practitioner approaches.

Research objectives

The objectives of this research were:

- To identify the challenges and benefits and policy responses to the provision of low threshold substance use services within a community setting.

- To explore the features and intervention approach of the low threshold service provided by the Ballymun Youth Action Project (BYAP), including the identification of practitioner skills and responses to challenging client behaviour.
- To explore the benefits and potential impacts on clients of low threshold service provision.

The following section of the report presents the literature in relation to drug policy, harm reduction and low threshold provision. The review of literature considers the impact of low threshold service provision on client outcomes and the barriers to accessing low threshold services. This is followed by an overview of the research methods. Sections four to seven present the research findings and section eight discusses the findings. The final section outlines the conclusions and recommendations arising from the research.

2. Literature review

Policy context of low threshold service provision

Statutory policy responses to problematic drug use in Ireland have evolved since the mid 1960's with the current National Drug Strategy 2009-2016 (Department of Community, Rural and Gaeltacht Affairs, 2009) placed within an overarching government driven social inclusion strategy. Prior to the 1960s it was widely documented that drug addiction was not recognized as an issue in Irish Society. As noted by Butler (2002), drug addiction was first discussed in the context of the Mental Health Treatment Act (1945) with a subsequent statement in The Report of the Commission of Inquiry on Mental Illness (1966) locating addiction as a mental illness requiring treatment by the psychiatric services. The 1980's and 1990's saw greater recognition of the link between drug use and social disadvantage and exclusion, as heroin and other drugs problems emerged within urban centres including Dublin (Butler, 1997).

Throughout Ireland's evolving policy responses to drug and alcohol use it is important to note that up to the 1980's responses to drug use and addiction assumed an abstinence and medical based approach to the treatment of addiction. The ethos of this approach to treatment was that a client must be totally committed to abstinence before treatment can begin (Dillon, 2001). Understanding and responding to drug use and drug treatment through abstinence based policies and strategies were criticized for not addressing the link between socio-economic factors and addiction (Murphy, 1996). This represented a shift in Irish drug policy from one that adopted a drug free approach to one of harm reduction. Harm reduction has been broadly defined as a *"pragmatic approach to reduce the harmful consequences of alcohol or drug use or other high-risk activities by incorporating several strategies that cut across the spectrum from safer use to managed use to abstinence"* (Marlatt & Witkiewitz, 2010: 591).

This shift in policy response in Ireland occurred in light of the growing trend towards the use of opiates and intravenous opiate use, the increase in the numbers seeking and receiving treatment for opiate related problems and the increased risk of the spread of HIV and AIDS among our heroin using population (O'Gorman, 1998; Butler, 1991). Harm reduction was delivered through the provision of needle exchange, methadone maintenance, and outreach work (Butler, 2002). Butler and Mayock (2005) argue that the introduction of a harm reduction response to the increasing Irish drug problem was not adequately debated at a national level, or formally announced as the basis of Irish Drug Policy. The implications of this shift in policy were profound as a harm reduction approach in the Irish context required a total rearrangement of health services for drug users in which services would be decentralised, methadone maintenance and needle exchange would be introduced and power

would be shared with drug users in outreach and peer-led service initiatives (Butler, 2002). Today, Ireland's drug policy is predominantly shaped by a harm reduction approach rather than a drug free approach (Butler, 1991, 1996).

Along with the harm reduction initiatives implemented in Ireland, other strategies currently under consideration are the introduction of Safer Injecting Facilities (SIFs) (Broadhead, Kerr, Grund & Altice, 2002; Marlatt & Witkiewitz, 2010) and the decriminalization of drug use (Hughes & Stevens, 2012). Like other harm reductionist initiatives safer injecting facilities have become a feature of harm reduction policy in some European countries, Canada and Australia (De Jong & Weber, 1999; Kimber, Dolan, Beek, Hedrich & Zurhold, 2003). They are essentially indoor facilities where injecting drug users are permitted to self-administer drugs intravenously under supervision and with access to sterile equipment (O'Shea, 2007: 75). Reviews and evaluations have found SIFs to be making a positive contribution in reducing drug related overdose, reducing injecting behaviour and improving clients' health (Broadhead et al., 2003; Dolan et al., 2000; EMCDDA, 2004; Kimber et al., 2003; MSIC Evaluation Committee, 2003; Roberts et al., 2004; Zurhold, Degkwitz, Verthein & Haasen, 2003).

A further step in implementing explicit harm reduction measures within Ireland, has been the political consideration of decriminalization. In 2015, a Joint Inter-Party Justice Committee (House of the Oireachtas, 2015) recommended the introduction of decriminalization of small amounts of illicit drugs for personal use. Recommendations included the diversion of individuals into an administration health response rather than a judicial one, similar to the system currently utilized in Portugal since 2001 (Allen, Trace & Klein, 2004; Hughes & Stevens, 2012). Both of these measures illustrate a shift in policy towards an explicit harm reduction approach within the Irish context, though neither have yet been implemented or integrated into policy.

Prevalence & treatment data

Communities in Dublin and around Ireland have continued to experience rising rates of drug use and drug related issues (NACD & PHIRB, 2011; Loughran & McCann, 2011). The most recent estimate of the prevalence of drug use in Ireland and Northern Ireland 2010/2011, reveals an increase in the number of adults reporting the use of any illegal drug in their lifetime compared to the previous survey (2006/7). More recent results also indicate that the proportion of adults (aged 15-64 years) who reported using an illegal drug in their lifetime was 27.2%, again an increase of 3.2% from the 2006/7 survey (24%). These surveys indicate that the prevalence of drug use in Ireland is increasing which has implications for drug treatment service provision and for the national drug policy.

Just as the recent prevalence studies reveal an increase in lifetime drug use in Ireland, the

most recent drug treatment reporting period, from 2005 to 2010, indicated that overall in Ireland the number of drug users presenting to drug treatment has increased, an indicator of the increased problematic drug use issue in the country (Bellerose et al., 2011). The majority of cases (61%) entering into treatment between 2005 and 2010 were treated for problematic opiate use followed by cannabis (21%) and cocaine (11%). The majority of cases (68%) entering treatment between 2005 and 2010 reported problem use of more than one substance with cannabis, alcohol, cocaine, and benzodiazepines the most common additional substances reported. Treatment options included for reporting refer to one or more of the following: medication (detoxification, methadone reduction and substitution programmes), addiction counselling, group therapy, psychotherapy and/or life skills training with treatment provided in both residential and non-residential settings. The majority of cases (68%) were receiving treatment in an outpatient setting; 58% were receiving counselling; 32% were receiving a brief intervention; 25% received methadone substitution; and 23% attended an education/awareness programme (Bellerose et al. 2011).

Drug treatment data indicators along with health data, mortality data and law enforcement data are the predominant indicators of drug misuse in Ireland. Loughran & McCann (2011) argue that these indicators can be limited and don't always represent the reality of community drug problems and instead propose the establishment of a set of community indicators which would more accurately capture the drug related experiences of communities. The community indicators established refer to the range of drugs being used, alcohol use, profile of local housing development, drug related deaths, crime, social capital and school attendance.

Harm reduction and low threshold service provision

According to Marlatt (1996), harm reduction is a set of strategies aimed at reducing the harmful consequences of substance use for the user and the wider community. In his exploration of the assumptions that underpin harm reduction approaches, Marlatt maintains that a harm reduction intervention or strategy is an alternative to the abstinence and moral models of response, allowing for alternatives beyond abstinence. He further maintains that harm reduction strategies, when implemented within service delivery, mean that the 'thresholds' to support are lowered or removed, thus reducing stigma and *"providing an integrative, normalized approach to high-risk substance use and sexual practices"* (Marlatt, 1996: 787). Low threshold services typically have few barriers or requirements to be met to secure access, but this has meant many services have had to consider structures and programme approaches that will ensure safety for staff, service users and the community (Eversman, 2010).

However, there is some difficulty defining and interpreting what is meant by 'low threshold' in terms of substance use intervention (Melles, Márványkövi, & Rácz, 2007) and the term

can be used to refer to services that do not require abstinence, that provide specific supports such as needle exchange, to those that provide a range of health related supports such as food and showering facilities. The term low threshold is often also applied to very specific services such as drug consumption facilities or supervised injecting facilities. In their consideration of what criteria should be used to define a drug service or service user as 'low threshold', Islam et al. (2013) propose three criteria; that drug users should be a key (but not necessarily only) target population; that abstinence from drug use should not be necessary; and finally that other barriers to service access must be reduced as far as possible. These criteria, they argue, make low threshold services clearly definable and reiterate the purpose of low threshold services to address the stigma and shame drug users may experience.

There has been some consideration of the barriers to accessing drug services and how these can be addressed by low threshold services. In their ethnographic study, Edland-Gryt and Skatvedt (2013) concluded that beyond the three thresholds already identified in the literature (registration, effectiveness and competence), a fourth threshold was 'trust'. In this study, 'registration' referred to the accessibility and ease with which a person could access the service. 'Competence' referred to the requirement of the service that the service user be capable of expressing their needs. This capacity could be based on education, abstinence and mental health, therefore meaning that if the client was intoxicated or suffering mental health issues, they may be blocked from accessing the service. The 'efficiency' threshold referred to the expectations from the service provider in regard to client change and progress. Edland-Gryt and Skatvedt (2013) concluded that the building of client trust is a vital fourth element in low threshold drug work, and it is an issue that threads through the other three aspects that increase accessibility.

Similarly previous research has found that the barriers to accessing drug treatment were related to system, social and personal/interpersonal dimensions (Tsogia, Copello and Orford; Notley et al., 2012). System barriers referred to previous treatment experiences and the expectations and perceptions of and actual long waiting time for an appointment with a drug treatment service (Fountain et al, 2000; Notley et al., 2012); a lack of flexibility around missed appointments and a lack of communication between services (Notley et al., 2012). Social barriers were organised around a strong sense of stigma that surrounds drug use and drug users, a stigma that is experienced within individual relationships and between social groups. Personal and interpersonal barriers referred to perceptions that services don't understand drug user's problems and subsequently do not offer sufficient treatment options and supports.

Challenges and outcomes

The literature also refers to some of the problems and difficulties in providing low threshold drug services. These include maintaining safety for staff, service users and the wider community (Eversman, 2010) and dealing with ethical issues inherent in engaging and supporting those actively using substances that are illicit or may be causing harm to the user or others (Solai et al. 2006). Past research evaluating the impact of some low threshold drug services (Ryrie et al., 1997; Islam et al., 2013) has also drawn conclusions on the impact of such services on client outcomes. Ryrie et al. (1997) concluded that low threshold clinics are effective in targeting clients who are typically unlikely to engage with or enter into drug treatment programmes. Through engagement with this cohort, clients reported less frequent injecting drug use, less frequent sharing of injecting equipment, reduced criminal activity and reduced levels of methadone use (Ryrie et al., 1997). Islam et al. (2013) concluded that harm minimization clinics can be underutilised demonstrating limited capacity to attract high risk poly drug users. Making this type of service accessible is necessary due to the common occurrence of relapse following drug treatment and rehabilitation (Darke et al., 2005), overdose (Strang et al., 2003) and other risks associated with injecting drug use (Havard et al., 2006). Considering and understanding the barriers to drug treatment is necessary as time spent in treatment and maximizing treatment time length is associated with a range of health, social and economic outcomes (Ryrie et al., 1997; Notley et al., 2012).

It is important to note the factors that are associated with positive drug treatment outcomes for clients. Previous findings argue that engaging and retaining clients in treatment and treatment outcomes are strongly correlated with the quality of the therapeutic alliance (Gossop, Marsden and Stewart, 1999; Simpson et al., 1997; Meier, Barrowclough and Donmall, 2005) and the personal values that drugs workers' hold (Phillips and Bourne, 2008). With respect to values Schwartz (1992) proposes that values are a determinant of attitudes and behavior and later argued that values may play a significant role in eliciting behavioural responses (Bardi and Schwartz, 2003). Schwartz identified "*two higher order and conflicting motivational dimensions that give structure to the value system: 'openness to change' versus 'conservation'*" (1992: 34). Phillips and Bourne (2008) found that a relationship exists between personal value priorities of drugs workers and client outcomes with drugs workers who prioritise an 'openness to change' value type are more suited to drugs work rather than those who prioritise 'conservation' value type because "they are motivated to follow their own intellectual and emotional interests in unpredictable and uncertain directions" (Schwartz, 1992: 43).

Impact on practitioners

Working with and responding to client's traumatic experiences is a feature of low threshold work and there has been growing recognition of the impact on practitioners of this type of

'emotional labor' (Baird & Jenkins, 2003; Clemens, 2008; Fabianowska, 2012; Iliffe & Steed, 2000). A number of different terms are utilized to capture different aspects of this phenomena and the terms are sometimes used synonymously (Chouliara, Hutchinson & Karatzias, 2009). Figley (1995) first developed the term secondary traumatic stress to describe symptoms similar to those in posttraumatic stress disorder (PTSD) experienced by those working with or hearing about others' traumatic experiences. Vicarious trauma, introduced by McCann and Pearlman (1990), focuses on the emotional and physical transformations experienced by those who work with traumatized people (Clemens, 2005). According to Baird and Jenkins (2003) both terms describe the changes in the practitioner as a result of exposure to someone's experience of trauma. However, they suggest that secondary traumatic stress emphasizes PTSD symptoms whereas vicarious trauma considers more gradual, covert, and permanent changes to cognitive schema in relation to fear, vulnerability, and worldview (Baird & Jenkins, 2003; Clemens, 2008). Burnout tends to refer to negative emotional, physical, and attitudinal change due to work context and organizational pressures such as lack of autonomy, time constraints, workload, and low support (Bemiller & Williams, 2011).

A range of protective factors have been identified within the literature in relation to the impact of working with trauma and chaos. These include higher levels of education, advanced coping skills and rigorous organizational staff support systems (Baird & Jenkins, 2003). Particular client issues and presentations may also impact on practitioners. In a survey of 147 practitioners who worked with clients with trauma histories and problematic substance use Najavits (2002) found that clients with complex histories and those engaging in high risk behaviour were the most challenging for practitioners to work with. However, she also found that practitioners found their work gratifying where they perceived their clients were developing coping skills or where the client ultimately achieved abstinence.

The literature indicates the important role of harm reduction interventions within low threshold service provision in responding to the harms associated with substance use but also in providing progression pathways into other forms of treatment and rehabilitation. In addition to highlighting the positive client outcomes that low threshold services provide, the literature also indicates the barriers experienced by substance users in accessing services and the challenges faced by both organisations and practitioners providing low threshold services.

3. Methodology

Research design

The aim of this research project is to explore the efficacy and challenges of delivering low threshold substance use services within a community setting, with particular consideration of practitioner approaches. The research project took place over an eighteen month period and was co-ordinated by the Principle Investigator (PI), in partnership with the Ballymun Youth Action Project (BYAP). The research took a qualitative approach and sought to build on an existing research capacity and knowledge within BYAP, as well as a considerable and strong base of reflective practice within the organisation. Phase one involved briefing of potential participants, obtaining consent and the scheduling of focus group sessions. Phase two included data collection, while phase three involved data analysis and the writing up of the research findings.

Participants

All Ballymun Youth Action Project practitioners ($n = 9$) involved in responding to problematic substance use and related issues were invited to take part in the research with all agreeing to take part. Of these, five were men and four were women. They ranged in age from 36 years to 56 years. All research participants had extensive experience, accreditation and professional recognition in carrying out drugs work.

Procedure

Ethical approval was gained from the PI's University's ethics committee. All participants signed forms of consent and were informed that they could leave the research at any time. The study used a qualitative design in an effort to provide a more concrete view of what life is like from the point of view of the person concerned, with the data acting as a source of well grounded, rich descriptions and explanations of processes in identifiable local contexts (Miles and Huberman, 1994). The primary method of data collection was through four cycles of reflective practice focus group sessions. Research participants were involved in the structure and design of the reflective practice focus groups in order to ensure minimal risk of traumatic impact on research participants. Reflective practice focus groups were run over a three month period with one inquiry group at three week intervals. The reflective practice focus groups considered and explored the approaches and skills being utilised in the low threshold service delivery, how risk and harm are identified and managed and practitioner understandings of client change processes. Existing support and supervision structures were highlighted in the event of issues arising from the research. Participants were informed of the discussion themes prior to each inquiry group.

The reflective practice inquiry groups ran for ninety minutes, were audio recorded (with permission from the research participants) and later transcribed. The inquiry groups

generated a good deal of qualitative data which was analysed thematically (Hardwick and Worsley, 2011) to explore key issues emerging from the data. To reduce the data and make it more manageable (Miles and Huberman, 1994) two levels of coding, open and axial, (Strauss and Corbin, 1998) were conducted. The first step allowed for categories to be identified and assigned to elements of the recorded material and the second step allowed for relationships between the categories to be established (Strauss and Corbin, 1998). Themes were constructed providing the foundation for later analysis of the participants' experiences with respect to the efficacy and challenges of delivering low threshold substance use services, with particular consideration of practitioner approaches. To protect the identity of the research participants, alias names were assigned to each participant in the writing of findings.

4. Results: Defining low threshold services and providing drop-in

The practitioners discussed their understanding of and approach to low threshold work and how this had evolved in the drop-in service. Three sub-themes emerged; how BYAP practitioners defined low threshold work; the drop in service; and safe spaces and meeting needs.

Defining low threshold work

The practitioners discussed their understanding of low threshold work from the BYAP perspective. For some practitioners it referred to open access or drop-in services and was associated with homelessness:

The lads we met last night would be the lowest threshold in Ballymun, the ones that are vulnerable in the community, they are being intimidated, robbed, they are homeless and have huge medical needs, really, really chaotic addiction. But there are only five or six people like that. (Practitioner 7)

'Low threshold' did not always refer to homelessness but rather to a difficulty in maintaining routines and ensuring basic needs were met, both for themselves or children if they had them. One practitioner described this:

I am working with a few homeless mums but I wouldn't see them as chaotic, they just happen to be living in hotels with their children. To me some of the chaotic mums would have housing but would need huge support. They would have social work involvement and a family support worker coming in a couple of times per day just to help keep them on track with their basic needs of family routine, feeding the kids, getting the kids out to school. They just can't meet the threshold of organising their lives or the lives of their children. (Practitioner 1)

There was further agreement that someone could be defined as 'low threshold' even if they had a home, although it was noted that those described above, often went to the city centre to access services. The practitioners raised a particular issue about the role of housing in low threshold work, with one worker giving examples of the detrimental impact of the housing first approach, where supports were not put in place to back up the provision of accommodation, particularly if the individual is engaging in highly problematic substance use.

The practitioners agreed that when working with low threshold clients they are working with and responding to a variety of complex needs namely chaotic drug use and associated risky behaviours; homelessness; complex physical and mental health issues and previous challenging backgrounds and emotions. One practitioner said:

When I talk about low threshold I'm talking about homeless people, chaotic drug use, not eating and no access to showers, complicated needs and medical needs. (Practitioner 6)

The practitioners agreed that the implication for them and their practice when engaging with low threshold clients is that this work requires more frequent interactions and engagement with clients. One practitioner stated:

For me it's the mental health status, the level of chaotic use and the risk of that use. Then I try to be more involved between sessions with a call or text just to help get them to the next session. (Practitioner 5)

The practitioners described how due to the complex needs that clients present with and often due to the level of risk associated with their drug use that they require a high level of support. However, due to their chaotic lifestyles they are a client group who do not demonstrate the capacity to keep appointments, something which is reflected in other daily activities and appointments in their lives. Low threshold clients tend to engage more effectively with a less formal drop-in approach rather than the more structured one to one appointments which was often felt to be because the clients were heavily invested in their substance use.

Practitioners added that not only was the structure of a one to one session more difficult to engage with but also the emotional content of this more individualised support. One practitioner highlighted:

Those clients have a low threshold for talking about something with an emotional content. They have a low threshold for how much of that they can deal with before they say 'oh I don't want to talk about it anymore'. (Practitioner 5)

The practitioners described how low threshold clients tended to engage with more needs based issues and crises such as financial debt, a looming prison sentence or a health need:

I think they come in here on a needs basis because they go to the clinic for their methadone and there are other places they can go, but in here it is a needs basis and their needs aren't about change. There is crisis, there is a debt it is always an immediate need, whereas with other clients there is a growth happening. (Practitioner 2)

[The drop in service](#)

The practitioners discussed the BYAP experience of developing a low threshold service in Ballymun through the provision of a drop-in. The drop in was originally aimed at engaging and supporting opiate users, but as this population aged, younger poly-drug users began to

also use the drop-in service. This meant the team had to consider the possible impact of the two broad groups on each other, with the younger cohort also starting to use opiates. Further to this there were issues of violence and dealing occurring within or connected to the drop-in service. One practitioner described the drop-in environment:

We try to bring a 360° view to the drop-in. There are different spaces we need to operate in so if people come in for a game of pool in the pool room, some are inside for a discussion but you could have 10-20 people in the drop-in in that hour so there is something about the qualities needed in a team to ensure that the service is delivered professionally and properly in that way and making risk assessments. It doesn't always work but that is the optimal way of working. (Practitioner 3)

There was an approach within the drop in which involved moving clients into other types of services as their substance use stabilised or they engaged consistently with the low threshold services. This was a flexible process where some one-to-one sessions might be scheduled, but also allowing for ongoing engagement with the drop-in service or a return to the drop-in service. The practitioners spoke about working with older opiate users and younger poly drug users in the drop-in setting and the progression made to more structured group and individual supports within the organisation. The practitioners described how the younger poly drug using clients tended to make the progression from the drop-in to individual counselling and key working and educational courses which were commonly referred to as moving up the building. The practitioners agreed that this often created a tension between older and younger cohorts of clients who were making this progress. One practitioner added:

When the younger poly-drug users come in and see the older opiate users not moving on, you worry that this is not what you want them to see. If the younger ones are moving and getting into courses the older ones are looking and saying 'I'm not getting courses, so why is that?' That can be difficult to manage. It is hard to verbalise why the older ones are not moving up through the building like the younger ones. Essentially they are moving on because they are willing and able to change. (Practitioner 1)

Safe spaces and meeting needs

Practitioners described risk and the management of risk in two different contexts. Risk management was described as managing any potential risk to the client and secondly the management of any potential risk to the practitioner engaged in low threshold work. With respect to managing the potential risks to the client practitioners agreed that conducting an assessment of needs with a specific focus on risk assessment was a vital piece of work to be engaged in with low threshold work. One practitioner stated:

You are risk assessing all the time, whether it is doing street outreach or in the drop-in, risk assessing overdose if someone is becoming over stimulated. There are things you are looking out for that you never would be in a one-to-one. There are a whole range of skills you are employing to ensure the safety of one or multiple people in the drop in. (Practitioner 4)

The practitioners also agreed that the very nature of low threshold work, the level of drug and alcohol use clients are engaged in and the range of physical and mental health issues that they experience at times meant that clients don't even make the lowest threshold. On this basis low threshold work often involved meeting and working with clients in their homes, as stated by one practitioner:

Contact is also beginning to work with that ageing opiate group in their homes because they are not presenting to the drop in. Sometimes they are really heavily affected and not making even the lowest threshold. We have had many conversations about bringing this service to them. (Practitioner 4)

It was agreed that engaging in client work in people's homes or on the street could potentially pose a risk to the practitioner's themselves, a risk that at all times needs to be managed. One practitioner highlighted:

You don't know what you are going to work with some days. Someone says just leave, you know what I mean. And it could be families, it could be weapons. We just leave and talk about it later. (Practitioner 7)

They spoke about the importance of creating a safe environment, particularly when service users were intoxicated. The practitioners spoke about having to work hard to create a safe environment for the drop-in service. This included being clear about staff roles, being consistent with service users in regard to what was acceptable and unacceptable behaviour and engaging with those who were creating difficulties in order to agree solutions. The importance of speaking to service users whose behaviour was creating difficulties for other service users was felt to be an important aspect of ensuring the drop-in was a safe environment:

Being able to have the genuine conversation with people about their destructive behaviour and then being able to offer a one-to-one service as the drop-in service is not working for you due to the dynamics of your behaviours. It was a struggle to say to people this is not about exclusion but inclusion in a different way. (Practitioner 4)

5. Results: Practitioner approach and engagement

The practitioners discussed their approach to low threshold work and expectations of this work and how they engaged in low threshold client work. Three sub-themes emerged; relationship building and collaboration; professional boundaries; and expectations and hope.

Relationship building & collaboration

Practitioners described the importance of relationship building and working in collaboration with the client when engaging in low threshold work. Quite often this meant that the work engaged in with the client was more focused on the relationship building process rather than carrying out specific work in relation to their substance use. The practitioners agreed that by maintaining a focus on the practitioner and client relationship, there was a greater possibility of sustaining the engagement with a low threshold client. One practitioner highlighted:

The key aim is to 'come as you are' is trying to get the person to come back to us again. The more the relationship develops, the more we can see the range of responses that is possible for that person and I think the challenge is to continue to stay with 'come as you are'. This is my challenge, as well as needing to be mindful that what I do doesn't lose the trust that has been built within the relationship with the client. (Practitioner 3)

Practitioners added that the relationship building process allowed the space for trust to develop between the practitioner and the client and a space for a sense of acceptance to be fostered and experienced. The practitioners believed that this was important as the low threshold client group typically experience negative interactions with services and at times they do not even reach the threshold for access. One practitioner stated:

I say a lot of the times people won't give them the time of day, so when they come here you sit down with them, you listen to them. (Practitioner 6)

By paying attention to the relationship building process it was agreed by the practitioners that further and more direct drugs work could emerge. One practitioner stated:

It's about developing any kind of channel for change to happen, those early sessions create the relationship, so you can begin to do some work on change, it's really important. (Practitioner 5)

The practitioners agreed that relationship building is a vital part of all client work. It was noted that building relationship with low threshold clients required more time and a

particular focus compared to work carried out with more stable clients in a one to one setting. One practitioner stated:

When we meet low threshold clients, their agenda can be a bit different, but we have to go with that agenda. Sometimes they are just coming in to have a cup of tea, and for them it could be well someone is listening to me, someone is talking to me. (Practitioner 3)

Another practitioner added:

Even though we might think that we are not doing much I think that humanistic model of just spending time with someone is important, they might not have ever got that from other services. It might build up to them being able to trust us or maybe to go on to another service. Even though it might not seem like a lot it can lead on and may be a profound change for someone. (Practitioner 1)

The practitioners agreed that working with clients 'where they are at', a 'come as you are' approach was an essential feature of the approach taken with the low threshold client group. Practitioners also described how this involved 'being alongside' and 'walking with' the client as an important feature of low threshold work. This approach was typically utilised when engaging with low threshold clients who are at the end stages of life. One practitioner stated:

There are times when people are dying and I think that's what we are talking about when we say 'come as you are'. They come and they don't want to talk about addiction, they are heavily using but we are still working on relationship building, we are looking at the options for the next step, but when people are dying we just provide a more humane response. (Practitioner 5)

The practitioners highlighted the importance of the qualities that the practitioners bring to the relationship and to the doing of low threshold work. It was agreed that when doing low threshold work it was necessary to be humane, patient, authentic, non-judgemental and accepting of the client and their lifestyle. Having and bringing these qualities to the relationship and the practice allowed for more sustained engagement with clients and greater opportunities to make appropriate interventions. One practitioner highlighted:

There's a lot to be said about having patience. If you're going to get somewhere with somebody it's mightn't be tomorrow, it could be three or four weeks or a month or six months down the road. So it's being able to just hold somebody in contact with you until you maybe get that bit of change. (Practitioner 6)

Professional boundaries

Closely linked to the key features of relationship building and collaboration is professional boundaries. The practitioners described the process of establishing professional boundaries in the context of low threshold work. This was described as challenging at times and connected to the time and effort invested in establishing and building a relationship with the client and the client's expectations of that relationship:

They don't see you as a worker but probably more as a friend somebody who will spend time with them and accept them and that is a really difficult thing to manage. It brings up questions for you as a worker and as a team. (Practitioner 3)

The nature of the work carried out within the remit of low threshold work added to the existing challenge of establishing and maintaining boundaries in a professional setting. Practitioners agreed that the varied work of low threshold engagement which they identified as including home visits, hospital visits and attending medical appointments may have posed a challenge to clients in understanding the practitioner and client relationship. Practitioners also described how this different work often meant for them that they shifted the boundary of what they would normally do as a response to the needs of the client, as one practitioner described:

There was a call made from a concerned family member about this person. He was in treatment he didn't or couldn't manage so they kicked him out. We drove 40 miles or something like that to go and collect him. He hadn't drunk in a few days, we were thinking trigger, so let's clear the flat of all the drink that was in there. So that's a line that we felt that we needed to make, we felt that was the right response at that time for the client. (Practitioner 3)

Because of the scope of this work and the nature of the practitioner and client interactions, practitioners agreed that clients often became confused and blurred about the nature of the relationship with practitioners describing how the client often referred to and described them as a friend. Efforts made on behalf of all practitioners to establish, maintain and at times to re-establish the professional boundaries were at times experienced as challenging as they attempted to hold the boundary, responding to any confusion about practitioner/friendship roles. The main challenges experienced were trying to hold the boundary without damaging the relationship. One practitioner highlighted:

I was a bit shocked when this person described me as his friend, it was 'you and me mate'. I said we do have a relationship, it's a professional relationship. Again, it's the point I was trying to get across to them without killing the relationship. I don't think I really did. He just didn't get it. I think there is an inevitability when you are

working with somebody for 2 years how they are going to see it, you know.
(Practitioner 6)

The capacity to manage and respond to any boundary issues emerging was handled in ways that allowed practitioners to draw on previous experiences and on the support and experience of the staff team. It was also pointed out that friendship was by its very nature a two way relationship, whereas the relationship with clients obviously did not have this quality.

Expectations and hope

The practitioners agreed that low threshold work was often characterised by the type of expectation that they as practitioners placed on the client. Practitioners spoke about how typically when working in a low threshold context that their engagement with clients was in a drop-in setting. Practitioners outlined that the expectations they placed on clients within this context were different to those expectations placed on more stable clients engaging with a more structured one to one counselling support. A practitioner stated:

For me low threshold is about the expectations that we put on people. In a drug free group we expect them to be drug free, and consistent in their attendance. If they can't make an appointment they will ring up and apologise so that the appointment can be offered to someone else. With lower threshold to get the people we have described here into the service, when they come in they might be intoxicated, and we are OK with that. Depending on the threshold our expectations change.
(Practitioner 5)

Another practitioner added:

We make more minimal demands on someone who is low threshold but if someone isn't low threshold we might try to engage more. (Practitioner 6)

The practitioners agreed that although there may be different expectations of low threshold clients engaging with a drop-in service there was still therapeutic work that could be carried out with the client. The focus was on harm reduction and working with the client where they are at on any particular day. Practitioners also felt a greater degree of flexibility is required when working with clients perceived to be 'low threshold':

Say for instance if they're affected (by recent substance use), you're not going to get the big plan you had thought you were going to get done in that hour. Maybe it's just about being there with them being okay with that. (Practitioner 1)

Hope of change for their client's was a critical element that the practitioners agreed motivated them in delivering low threshold services. There was general agreement that

under Prochaska & Diclemente's (1983) model for understanding changes in substance use, clients accessing low threshold services were often at the 'pre-contemplation' stage. Practitioners described how at this stage of change the clients were unaware of a change process; that clients didn't want to make a change or that clients were not ready, willing or able to make a change at this particular time. Despite this, the practitioners agreed that hope and hope for the client's capacity to make life changes is an important element of low threshold work. The practitioners all described a hope in the belief that all people can and do change. One practitioner said:

Whether it is a client who is coming to the end of life or a client who really is just heavily intoxicated, my challenge is holding on to the concept of hope, often in the absence of hope. I always have to have hope no matter where someone is on the continuum. Hope that they have the ability to change, that they have the possibility to change and that they have the skills to change with the right supports. I don't think I could do what I do if I don't hold onto that concept of hope, personal hope for other people. (Practitioner 4)

6. Results: Skills and outcomes in low threshold work

Beyond the elements mentioned in section four the practitioners identified the skills and ways of being that are central to working with low threshold clients. Four sub themes emerged; general range of skills; relationship and trust; focusing on change talk; and harm minimization interventions.

Skill sets in low threshold interventions

The practitioners discussed that a range of approaches and interventions are applied when engaging with low threshold clients. The practitioners stated that these approaches and interventions include motivational interviewing, cognitive behavioural therapy, solution focused brief therapy and client-centred therapy along with a drugs knowledge base. One practitioner highlighted:

Motivational Interviewing always fit well for me because of the motivational task before someone begins to change. (Practitioner 5)

The practitioners agreed that when doing low threshold work the skill of conducting formal and informal assessments and screenings was necessary. On the basis of the assessments and screenings practitioners stated that they had the opportunity to determine where the client was at, if there were any potential risk factors and to decide on the most appropriate intervention for the client on the basis of need. One practitioner stated:

You have to be skilled at making that assessment around what is the intervention required here, what is the best response. You have to be screening for all the issues- is it a drug issue, is it a mental health issue, is it a homeless issue, is it primary health care issue. (Practitioner 3)

The practitioners agreed that there was a skill in the ability to engage with low threshold clients at a level where there were no expectation or requirement for them to change. They felt there was skill involved in being able to work with people from a 'come as you are' and a harm reduction perspective. One practitioner highlighted:

The thing you are trying to do is be in the moment with them, working with their primary healthcare and not thinking 'wouldn't it be great if this person could stop using drugs because they are so bright'. The challenge is to pull back, hold the space and challenge the resistance or even just be with someone. (Practitioner 4)

Practitioners also described adaptability as a skill required to work within a low threshold setting. One practitioner stated:

A skill needed in the drop-in is the ability to adapt. So you go from working with someone in a detox preparation to being in the drop-in. (Practitioner 3)

The practitioners agreed that a combination of different approaches were applied when working with low threshold clients. A multi model approach was seen as effective to build a knowledge base and a skill set. The practitioners agreed that the skill of having the ability to create, maintain and enhance the practitioner and client relationship was vital when doing low threshold work. Beyond this general discussion on approaches and broad skill-sets, two key aspects were identified that the practitioners felt were central to working with clients in low threshold settings; focusing on and encouraging action based on change talk; and harm minimization interventions.

Focusing on change talk

The practitioners agreed that when working with low threshold clients there was no requirement or expectation on the client to engage with a change process. However, the practitioners stated that they still held the belief that they could engage in effective and meaningful work with a low threshold client group. In holding on to the belief in the possibility of change, the practitioners described how they continuously listened for change talk and for opportunities to make an intervention and address the client's substance use or related harms. This was considered to be an essential skill set. One practitioner stated:

There can be different agendas all the time. Clients might come in looking for a letter but we are always looking out for an opportunity for an intervention that can effect change. It's about looking for those opportunities to do drugs work. At the end of it you have had contact and the person feels ok and that they might come back again in a better space than they were when they came in first. (Practitioner 5)

The practitioners agreed that listening for change talk was connected to the importance they placed on having and maintaining a sense of hope in the client's ability to change. One practitioner stated:

We are walking their path with them, while always listening for change talk and being able to grasp the smallest change. We can be working with people who don't want to change, which brings it back to keeping that sense of hope that people can and do change. (Practitioner 4)

Harm minimisation interventions

The practitioners spoke about the importance of being able to normalise the client's drug use, behaviours and lifestyle. The practitioner's ability to normalise substance use was a critical element if they were to accept the client wherever they are at. One practitioner

explained how normalizing drug use provided a basis for further harm minimisation with the client:

You can normalise their drug use. You are talking about something abnormal in a normal way, so that you can help them to be honest about their use and health. (Practitioner 4)

The practitioners spoke about harm minimisation as a key feature of low threshold work with the main aim of supporting the client to reduce the harm caused to themselves and others. Through the process of assessment the client's needs are prioritised and responded to. One practitioner highlighted:

It might be talking to them about the positives of attending the doctor and then getting a referral in. If this is the most immediate need when the person shows up then everything else will be parked. So it is pure harm reduction for them and their health and then we can start looking at other issues. (Practitioner 8)

The practitioners spoke about the importance of being adaptable and flexible when doing low threshold work. Often a planned piece of work or intervention is put on hold in order to respond to or manage chaos that has emerged in the client's life. One practitioner said:

There might be a lot of issues when working with someone and you have a plan that can completely go out the window because when you meet there is chaos. I think you have to learn to just roll with that because if she (the client) is crying because her partner has left her, then that's not the time to sit on the floor having a play therapy session. I think you have to be willing to be completely adaptable, don't take it personally and meet them where they are at that day. (Practitioner 1)

Outcomes in low threshold work

The practitioners discussed their understanding of client outcomes in low threshold work identifying two main issues; that there was less possibility of change in low threshold work and therefore outcomes were harder to evidence; and that outcomes might vary within low threshold work as opposed to other types of drug intervention.

The practitioners agreed that within low threshold service provision there were a cohort of service users who were not actively seeking change in terms of their substance use. One practitioner talked about her own approach to working with this:

There are many who won't change. It is accepting them, and with all the wisdom and knowledge that we do have, that no matter what it just doesn't sometimes reach them. It's about not trying to force something else on them. (Practitioner 9)

Another practitioner noted that evidencing outcomes within the drop-in service could also be a challenge, because some of the clients may be deteriorating over time or be at an end-of-life stage. The practitioners agreed that in low threshold service provision there was no requirement or expectation of the client that they may change. One practitioner pointed out that clients will often access the service intoxicated or having recently used substances, so that practitioner intervention focused on harm reduction or providing a space for social contact or meet basic needs around eating, meaning that for that hour, the client was not using substances, which the practitioner pointed out was an outcome:

I did some harm reduction and I gave him affirmations and the hour he was with me he wasn't using drugs. He just wanted to have a game of pool. If I think about 'have I done anything progressive with this client today', I would probably say no but he would say well I wasn't using drugs, so something is happening. (Practitioner 8)

The practitioners also highlighted the fact that a client can be extensively supported in low threshold work, yet the ultimate outcome is not 'good', either in terms of the client's substance use or health. However the practitioners pointed out that all time spent with service users is of value, regardless of the outcome. One practitioner said:

Even the ones who didn't change, like the ones who died, we don't regret one minute of the time spent with them. (Practitioner 2)

The practitioners agreed that establishing and maintaining a relationship with the person was in itself an outcome in low threshold work. This was particularly relevant to the cohort of aging opiate users using the low threshold service, where support tended to focus on healthcare needs and end of life care. In discussing this point, the practitioners noted that it was difficult to evidence this type of outcome to funders and within treatment data statistics:

When we sit down and talk about what we have done we can name those things, but in terms of funders and outcomes and value for money that is where it becomes more of a struggle. (Practitioner 5).

It was also noted that small improvements in quality of life due to harm reduction measure could be difficult to quantify or evidence. It was noted that with other interventions, such as a day programme, it was easier to see the client progression, however with low threshold services the impact on the client may be less direct or obvious.

7. Results: Impact of low threshold client work on practitioners

The practitioners talked about how they understood the impact on them of working with low threshold clients and in low threshold settings. They identified how they understood the impact on them, but also factors that sustained them in the work, including maintaining hope of change for service users and having variation in the types of clients being supported.

Impact of low threshold work

The practitioners agreed that with low threshold service users they had to be exceptionally alert and tuned in to everything that was going on, both with the client, and in the environment. They felt this was particularly important if the client had mental health issues or was intoxicated. Added to this could be periods of time when they were working exclusively with clients where there was little or no positive change. This could be demanding and even demoralising, and one practitioner spoke about actively seeking other client work where there was greater change happening:

I noticed that with the clients I am working with, if there isn't change happening that could be quite sapping. And it is very important to have your work peppered with different interventions. When nothing is really moving, what impact is that going to have on you? So at times if my case load is stuck like that, I would be looking for a mix in my caseload so there is a change process happening somewhere. (Practitioner 3)

Another practitioner pointed out that you can start to question your skills and abilities if there is very little change occurring for the majority of the clients, while another pointed out that it sometimes can be perceived that a narrower range of therapeutic skills are required. The practitioners pointed out that the range of skills is different in low threshold work, as it can include both having to be very aware of the environment or client, but can also mean waiting for clients to appear and missed appointments, which can also impact negatively on the practitioner. However, one practitioner stated that he is energised by work with low threshold clients:

I think I'm more comfortable in low threshold work. It's energising. Because when there is a victory in low threshold it is a huge victory. I have worked in aftercare and they (clients) are doing all the work. (Practitioner 7)

The practitioners agreed that it was important to note the positive change and progress for some low threshold clients:

A number of the practitioners also spoke about becoming de-sensitised to both the traumatic impact of low threshold work and to possible client risks, such as self-harm, because of working daily with significant levels of risk and harm.

I think that we can become de-sensitized to some of the trauma in low threshold work. (Practitioner 7)

It was pointed out that being based in the community was different from working on a day programme or in a treatment centre. For instance, the practitioners spoke about the impact of client deaths and choosing whether or not to attend funerals. One practitioner explained:

The amount of deaths that occur in low threshold. In regard to the impact on me in terms of the acceptance of the process and understanding the grief, I can be very de-sensitised to the whole process. I suppose for me, I made the decision around not going to as many funerals. (Practitioner 3)

They also noted the impact on other clients of a death, particularly in a community setting. One practitioner explained:

Sometimes after a death (of a drop-in client) I get a bit frustrated because of the fact that you would see that the relationships were there (with other service users) and none of the services users would go to the funeral. You would see it as loyalties and friendships that are there and they wouldn't take the hour to go to the funeral. (Practitioner 3)

The practitioners concluded that clients did not attend the funerals of other clients they knew because either they were de-sensitised to deaths within the community or that the family of the client who had passed away would not want people at the funeral that they perceived as substance users.

One of the practitioners spoke about what kept him sustained in low threshold work:

What keeps us energized in the work is we see a process, we see people that have been in the drop- in, we see people that no longer need the drug service to manage their lives. (Practitioner 3)

Beyond the progress of individual clients, other factors that the practitioners felt were sustaining included communication and support with colleagues, strong relationships with other agencies and a supportive organisational structure.

Burnout

The practitioners used the term 'burnout' to describe the negative effects of low threshold client work. In discussing what 'burnout' meant, the practitioners identified burnout as a lack of interest in their work, a physical and/or mental exhaustion in relation to client work or feeling agitated, tired or disinterested. They all talked about being aware of the warning signs of burnout and knowing they needed to seek support within the organisational structures and amongst their colleagues. One practitioner spoke about their understanding of what contributed to feeling burnt out on one occasion from undertaking drop-in low threshold work:

The drop-in just demanded more of my experience, just demanded more of my energy. Also when people come in really heavily intoxicated, I find that it drains me a lot. In one to one work you can have a combination and you can have a choice. But the drop in, it's multi-tasking on a level that you don't do at one to one's. It's watching, thinking, feeling, wondering, phone calling. All of that kind of octopus arms is what I was thinking I should have. (Practitioner 9)

However, another practitioner described feeling energised by this type of work and environment:

I enjoy it absolutely, it gives me energy. Doing the aftercare thing and the detox thing, I just got bored in it. (Practitioner 7)

This practitioner noted that even though they enjoyed the low threshold work and found it energising, they were careful to build in and avail of the support of colleagues:

I think the burnout would come from not being able to explore, you know. I think I talk about my work a lot and it sounds repetitive sometimes. I talk to whoever is around, I'm always going to talk about the movement of clients, I think when you're down and not discussing it, it can weigh heavy on you. (Practitioner 7)

The practitioners agreed that having a variation in client types and work settings was helpful in addressing the impact of low threshold work. They related this to the fact that in low threshold work there is less possibility of client change, as well as the pressures of managing risk or violence in the setting.

Organisational approach

The practitioners spoke about how the organisational approach to community based low threshold work was a factor in regard to the impact of this work on practitioners. They agreed that for some of them, the fact that the organisation was structured to allow practitioners to work with a range of clients, from low threshold to drug free, was important

to them. For others, the fact they were based in the community and were always generating new client relationships, helped sustain them positively in low threshold work:

I think if it is the same client group for a long period of time it gets stagnant, where we have the freedom to go out and kind of generate new clients. If you're getting a bit stagnant with the same stuff you can go out and find new clients and change it up a bit. (Practitioner 7).

A number of the practitioners also spoke about the importance of being able to debrief with colleagues after challenging client work, as well as discussing within the team how to best support individual clients and how to best deliver effective low threshold services. The practitioners felt that within their own organisational structure, there was always an opportunity to discuss and debate both the individual impact on them of the client work, as well as the safety, client engagement and outcomes of any particular low threshold intervention. They pointed out that having the space, time and organizational supports to discuss these issues may be more challenging in larger services where the volume of clients can be much higher and therefore managing the environment and ensuring a safe environment may take priority.

8. Discussion

The Ballymun Youth Action Project provides a number of services that according to the literature can be deemed 'low threshold', in that barriers to access are reduced to the lowest level possible to encourage those with problematic substance use to engage and seek support (Islam, 2012) and reduce the stigma and shame associated with problematic use and accessing services (Edland et al., 2013). This includes providing a drop-in service, outreach via the contact team and home visit services (provided through mother and baby care and the contact team). In addition workers will provide appointment accompaniment to clients who are accessing the low threshold services outlined. These services meet the criteria purposed by Edland et al., (2013) for low threshold services; that they are easy to access as a client; that they do not require the client to meet certain levels of competency in articulating their own needs; and that the continued provision service is not dependent on the client engaging in a change process.

In discussing their understanding of low threshold services the practitioners recognised that they were providing the range of services described above, that all met this criteria. They noted that with the sector of substance use services within Ireland, 'low threshold' is a term often applied to drop-in services only. It is interesting to note that the practitioners also often referred to some of their clients or client groups as 'low threshold'. This usually meant the client or client group had difficulty meeting basic access criteria set down by some types of substance use intervention; such as being able to meet own basic needs, articulate these needs and be actively seeking change in their substance use.

Typically the supports and interventions offered are those which are termed 'harm minimising' or 'harm reduction' interventions that aim to reduce the harm caused by substance use to the substance user themselves and to others. This research, consistent with the literature (Marlatt, 1996) found that adopting a normalised approach to and view of drug use is an important feature of 'low threshold' work that can provide the basis for a harm reductionist approach to drugs work. Community based 'low threshold' services also involves engaging with clients and providing interventions in settings outside of the organisation. Clients are met and engaged with on the street and in their homes as part of the outreach service and accompanied to medical and other appointments within the wider social context.

Addressing barriers to service delivery

Substance users have identified barriers to accessing drug treatment services (Fountain et al., 2000; Tsogia et al., 2001; Notley et al., 2012; Edland-Gryt and Skatvedt, 2013). These barriers have been identified as occurring at three different levels and are related to system, social and personal/interpersonal dimensions (Tsogia et al., 2001; Notley et al., 2012).

These barriers refer to a lack of flexibility around missed appointments; lack of communication between services; shame and stigma; lack of understanding of substance user's issues and a lack of sufficient treatment supports (Tsogia et al., 2001; Notley et al., 2012). This research found that the practitioners described similar barriers as experienced by 'low threshold' clients when accessing a variety of drug treatment services over the course of their drug using careers. This research found that the way in which practitioners approach 'low threshold' work and engage with 'low threshold' clients is important in responding to and lifting the barriers experienced and essentially making the threshold to the service accessible.

The practitioners approached 'low threshold' work in a way that created a greater flexibility and adaptability to respond to the emerging and frequently changing needs of the client and an approach that embodied an inter-agency way of working to support progression pathways and to meet the clients' varied, multi and complex needs. The organisation and the practitioners adopted a more flexible approach to drugs work by meeting clients on the street and in their homes within and out of normal working hours thus removing the barriers of access. Flexibility and adaptability were also demonstrated in the practitioners approach through engagement with substance users who quite often are under the influence of a substance therefore removing the demands of being substance free at that particular time.

This research consistent with the literature (Marlatt, 1996) revealed that the practitioners were aware of the shame and stigma felt by problematic substance users and how these feelings posed a barrier to accessing drug treatment services. The practitioners approached this barrier through placing a concerted effort on reducing stigma and shame by promoting and fostering a sense of acceptance in their practice. The practitioners approached the work and the clients in a dignified and respectful way. A sense of acceptance, dignity and respect was fostered as the practitioners approached the work and clients in a humane, compassionate, empathic and non-judgemental way accepting the client 'where they are at' at all times. This research revealed that the practitioners emphasised the importance of listening to the needs of the client and being 'with them' and 'alongside them'.

In describing the way in which they approached 'low threshold' work the practitioners described placing different expectations on low threshold clients. Through understanding the client's issues and understanding that clients are still engaged in active substance use and may even present to the service intoxicated or effected and as a result may not consistently attend the service they placed more minimal demands on the client. By reducing their expectations and the demands placed on clients this enables clients to reach the threshold for access into the service and to engage with low threshold interventions. However, it is important to note that reducing expectations did not mean that there was a

lack of belief in the client's ability to change, to progress and to address their multi, varied and complex needs. The findings highlight that maintaining a sense of hope of change was critical for the clients but also for them as practitioners in motivating them in their practice.

Practitioner and client relationship

The practitioners engaged in this research placed particular focus on the development and maintenance of a practitioner and client relationship. The literature has documented that engaging with and retaining clients in treatment and treatment outcomes are strongly correlated with the quality of the therapeutic alliance (Simpson et al., 1997; Gossop et al., 2000; Meier et al., 2005). This research, consistent with the literature, has reported the importance of the building and maintaining of the practitioner and client relationship in doing 'low threshold' drugs work and having a continuous focus on the relationship. By maintaining a strong focus on the practitioner client relationship there is a greater opportunity to work from a low threshold approach and to evidence an understanding of the needs of the client and in turn to provide the client with appropriate and sufficient treatment options and supports. This research noted that maintaining hope in the client's ability to change and establishing trust was a key feature of this.

This research identified that the relationship building process and sustainment of the relationship are vital if the way is to be paved for more direct drugs work to occur. Consistent with the literature (Schwartz, 1992; Bardi and Schwartz, 2003) this research found that the values held by the practitioners were important to allow for a more sustained engagement with clients and in providing greater opportunities to make appropriate interventions. Connected to the process of relationship building are professional boundaries. This research found that the practitioners established and maintained boundaries in the same way the therapeutic relationships developed with stable and drug free clients.

However, it is noteworthy that the boundaries of the client and practitioner relationship in 'low threshold' work were more likely to shift and change and at times may become more blurred when delivering 'low threshold' work. This was also particularly related to providing 'low threshold' services in a community context as the work is often delivered off site and typically involves home visits, hospital visits, street outreach and advocating on the client's behalf with other agencies. This research has shown that the practitioners were very aware of the importance of maintaining professional boundaries and often made considered decisions about their interventions and actions, how these might affect their client relationships, professional standing and outcome for the client.

Managing risk in low threshold environment

Low threshold service providers have reported encountering many challenges in engaging with and responding to the needs of 'low threshold' service users (Eversman, 2010). Consistent with the literature the practitioners described many of the overt challenges that are inherent in working with such client groups, including managing risk to staff and other service users from the behaviour of some clients, managing clients under the influence of alcohol and other substances and dealing with threats and violence. Responses to these risks included having a clearly defined risk assessment procedure in place which allowed for the early identification of any potential risks. The research highlighted that practitioners made a concerted effort to create a safe 'low threshold' environment particularly in the drop-in by ensuring that all staff were clear on their role and responsibilities within the setting; through the management of unhealthy dynamics and behaviours that were commonly presented to the drop-in and through the modelling of behaviours deemed to be acceptable.

Client outcomes

Due to the very nature of low threshold work and the multi, varied and complex issues clients are faced with and their corresponding needs, a particular challenge highlighted was the fact that in low threshold work there may be less obvious outcomes particularly with respect to change processes and client progression. As clients accessing low threshold services may not be actively choosing to make changes to their substance use, related behaviours and lifestyle it is difficult for practitioners to support, work with and evidence change as an outcome. With less of a possibility of change to occur, client progression pathways are better able to be evidenced in other types of drug interventions rather than 'low threshold' work which was identified as having a potential impact with respect to funders, drug treatment statistics and on the practitioners sense of competence as at times they questioned their skills and abilities.

Impact on practitioners

This research has highlighted that when met with these challenges it can have an impact on the practitioner who is working with low threshold clients and in low threshold contexts in addition to a questioning of their skills and abilities. The traumatic impact of continuously working with client risks such as self harm was noted. Another challenge that they noted was related to maintaining the ability to sustain their practice despite the challenges that 'low threshold' work presented and to avoid burnout. Similarly to the literature (Bemiller & Williams, 2011) burnout was described as being disinterested in work, feelings of physical and mental exhaustion and feelings of agitation and fatigue. The ability to sustain their practice and to avoid burnout was enhanced by the supportive organizational structure, a supportive team and colleagues and strong relationships with other agencies which allowed for the discussion of the challenges they were faced with and an opportunity to respond to

the challenges they encountered in their practice. The research also indicated that the capacity to avoid burnout and sustain professional practice was supported through the potential to hold a varied client caseload, essentially the opportunity to work with active, stable and drug free clients. This allowed practitioners to experience successes that are often lacking in 'low threshold' work and is consistent with the literature (Najavits, 2002) indicating that client outcomes including the achievement of abstinence provides practitioners with a sense of professional satisfaction.

The practitioners also discussed other challenges they are faced with when providing a 'low threshold' service, challenges particularly encountered when delivering a community based 'low threshold' service. As previously explored, delivering 'low threshold' work in a community context involves engaging with clients and providing interventions in settings outside of the organisation. Clients are met and engaged with on the street and in their homes as part of the outreach and infant parent support service and accompanied to medical and other appointments within the wider social context. Delivering a service in these contexts may at times pose challenges and essentially risks to the practitioner and the organisation. Ethical and safety issues must be considered at all times through constant and consistent assessment of risk, review of and implementation of policies, team meetings and line management support.

9. Recommendations

This research considered the approach and challenges for practitioners in delivering low threshold community based substance use services within a single setting. The recommendations below emanate directly from the research data generated within this community setting and aim to support the development of effective policy, practice and service delivery.

1. Developing and sustaining relationship

It is clear from the research that developing and sustaining professional practitioner and client relationships is an essential feature to delivering effective low threshold services within a community setting. Developing and sustaining practitioner and client relationships needs to be valued and considered to be not only an important feature of this work but also an outcome on the basis of which there is the potential for further drugs work and change to occur. It is important that the pivotal role of the practitioner and client relationship and the quality of the therapeutic alliance in low threshold work is considered as a key feature in the training of potential low threshold practitioners and the up-skilling of already existing low threshold practitioners.

These issues need to be considered by service providers and commissioners, both in community settings and in other low threshold services where the volume of clients can be much higher and therefore managing the environment and ensuring a safe environment may take priority of over developing and maintaining relationships with service users.

2. Outcomes within community based low threshold work

Outcome measures for low threshold based services need to be based on the core aspects of low threshold service delivery. While progression to stabilisation or treatment are important, outcome measures need to also capture aspects such as sustained engagement with service, facilitated engagement with other relevant services, improvement in health and wellbeing and improvements in pattern, type or mode of substance use.

3. Impact on practitioners

Low threshold substance use work has particular features that can add to the pressures and impact on staff. The impact on practitioners of delivering community based low threshold substance use work arose organically within this research process. A continued policy and practice focus on the impact on practitioners of this type of intervention will enhance the potential of practitioners to sustain their practice in low threshold work and to avoid burnout by boosting protective factors

and ensuring that relevant, appropriate and timely support structures are available at team, organizational and inter-agency level. These support structures could be informal and formal and include supervision, team meetings, de-briefs and further training and up-skilling. Opportunity for practitioners to have a varied client type case load was a critical factor for the practitioners within this research and this should be a consideration for funders, organisations and practitioners.

4. Future research

As noted, this study considered the approach and challenges in delivering community based low threshold interventions within one agency. Further exploration of the pivotal role of building and sustaining practitioner and client relationships and the development of client trust in delivering 'low threshold' service provision within a range of low threshold services would be valuable. In addition further research is required on managing risk and the often chaotic lives of clients and the impact of this on practitioners within both community and city based low threshold services.

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Appendix: Inquiry Group Themes

- What therapeutic approach/es do you utilize within low threshold service delivery?
- What skills and knowledge do you utilize/have you developed?
- What challenges have you experienced in providing effective support to individuals accessing low threshold services?
- Is there anything you would highlight in terms of your practice that you feel has been effective in working in low threshold service provision?
- What (if any) differences are there between low threshold service delivery and other types of substance use intervention that you deliver or are delivered within this setting?
- What is your understanding of supporting change processes for individuals accessing low threshold services? How do you support these in your practice?
- What has been productive and what has been challenging in terms of team working and relationships, both in delivering the services and in supporting participant's change processes?
- How has being involved in delivering these services impacted on you and how do you understand this impact and how have you addressed that impact.

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