

FROM 'PATIENTS' TO 'CO-CREATORS' OF INTERVENTIONS

INTEGRATED AND PERSON-
CENTERED CARE MODELS

Title

From 'patients' to 'co-creators' of interventions. Integrated and person-centered care models.

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1

INTRODUCTION

This background paper on integrated and people-centered care models builds on a series of expert sessions held during the 5th European Harm Reduction Conference in 2021¹, as well as a scoping review of the literature and expert consultation in 2022, organized by the Correlation-European Harm Reduction Network (C-EHRN).

C-EHRN is a European civil society network and center of expertise in the field of drug use, harm reduction and social inclusion. C-EHRN is hosted by Foundation De Regenboog Groep (FRG) – a non-governmental low-threshold service organization in Amsterdam, providing harm reduction services to people who use drugs (PWUD) and other individuals and communities affected by social and health inequalities. The network works towards an inclusive and just Europe, where people who use drugs and other marginalized and underserved individuals and communities have equitable and universal access to social and healthcare services without discrimination and stigma.

An integrated people-centered health approach means policies that put people and communities, not diseases, at the center of health systems and empower individuals to take charge of their health rather than being passive recipients of services. Nonetheless, people-centered care is still perceived as new and theoretical.

In the context of PWUD, the concept of integrated and person-centered care models includes two relevant notions:

"Integrated" means that PWUD can access a variety of social, (mental) health, and legal services. This holistic approach acknowledges the individual situation, history and needs of individuals. It has, therefore, the potential to strengthen the support system and challenge the predominant perception that drug use is the leading cause of problems in people's lives.

Person-centered means that the individual is at

the center of attention and that their perspectives, views and ideas lead, guide and support the process. Although this seems to be an inherent and self-evident element for effective intervention, it is clear that many services for PWUD are not based on their needs but are determined by structural, legal or political factors. Many challenges arise from the verticalization of disease-specific programs, such as a need for coordination between services and paternalistic attitudes from healthcare providers towards PWUD. With this scoping review, C-EHRN strives to assess the current state of the art by looking into different concepts and definitions and identifying critical factors affecting the development and implementation of such interventions.

This work aims to understand better whether integrated and person-centered approaches are feasible and compatible with an established vision of the care models. More precisely, this study seeks to explore the connection between harm reduction services and the referred care models and levels of commitment that are applied within an integrated and person-centered approach. Furthermore, this study explores how could civil society working with PWUD look at harm reduction strategies as an effective and responsible implementation of the integrated and person-centered care models. In conclusion, by framing these questions from an activist perspective, we ask how harm reduction can contribute to a broader implementation of this model in the European care system.

Although conclusive answers to these questions cannot be determined any time soon, this background paper aims to assess and describe the concept and idea of integrated and person-centered care models. In doing so, the study focuses on conceptual and definitional considerations, the importance of such models for harm reduction, critical factors for implementation at the structural, political, organizational or individual level, factors influencing scaling up access to and quality of interventions, and examples of best practices.

1. <https://www.harmreductionconference.eu/>

To this end, the remainder of this paper will be structured as follows. Chapter 2 describes the methodology and the step-by-step approach to the scoping review and online consultation. Chapter 3 describes various concepts and definitions concerning integrated and person-centred care models, also addressing potential differences or contradictions between concepts and ideas. Chapters 4 and 5 provide an overview of critical factors in integrated person-centered models and describes possible ways to overcome obstacles. Chapter 6 provides examples of best practices from Spain, Belgium and Russia. Finally, chapter 7 summarizes the results and provides recommendations for follow-up discussions.

METHODOLOGY AND APPROACH

To achieve a more holistic and complete view of the topics covered in this scoping review document, we consulted reports and documents from main actors in the field of drugs, such as Harm Reduction International, Correlation European Harm Reduction Network, International Network of People who Use Drugs, and European Monitoring Center for Drugs and Drug Addiction. In an attempt to ensure a broader representation of the current reality and to find possible commonalities, differentiation points, and contradictions, we crossed information from different sources.

The literature review included peer-reviewed papers from online databases (e.g., Ebsco, redalyc, b-on) and grey literature. This combination of resources gave some insights into the emerging tendencies of health issues. This was especially significant when crossing the keywords: "integrated services", "social and health", "person-centred", "social determinants of health",

"harm reduction", "people using drugs", "drug field", and "vulnerable populations". To the researchers' surprise, there were already some publications and reports on this multiple and holistic approach to health. Data originated from the treatment and rehabilitation fields in the late 1990s and the beginning of the 2000s. This suggests that researchers, health professionals, social workers and (for sure) people using drugs were already facing the need for more comprehensive approaches back then.

The literature review was followed by multi-disciplinary discussions on people-centred care models involving the participation of health professionals, harm reduction services staff, and affected communities. An expert consultation was organized to discuss the scoping review results, collect additional input and develop best practices models.

The body of literature, including intersections/crossings of variables linked with PWUD, is relatively modest. This is evident when the focus is on harm reduction. However, anecdotal evidence from experienced movements shows that some NGOs and community-based organizations successfully developed specific social-health responses. Their approach focused on the individual needs of service users and their role as social actors to ensure meaningful representation. Unfortunately, these experiences are largely yet to be documented. This reality raises some questions: Are these interventions scattered and fragmented or well-integrated? What are the costs and sources of funding to sustain such holistic responses? This paper aims to address these and other questions.

2

DEFINITIONS AND KEY CONCEPTS

2. Definitions and key concepts

To ensure a better understanding of the issues discussed in this document, we summarize key concepts, definitions, and explanations of these basic terms in the following sections.

This study understands integrated care models as combined and articulated services that merge the social and the health dimensions surrounding the person and include “responsive services that are coordinated both within and beyond the health sector” (WHO, 2015, p.12). Integrated care applies to services that are led by the needs of the person and not limited by organizational constraints. An integrated care approach “is founded on cooperation and collaboration between all relevant providers” (Effective Interventions Unit, 2005, p.6), and it ensures more holistic and quicker responses.

Through the harm reduction lens, a definition for integrated services establishes that:

“An integrated service is one that provides multiple services at once, in a way that makes it easy for clients to move between them (...) In the context of harm reduction, this commonly means providing a continuum of prevention, diagnosis and treatment for blood-borne diseases tailored to the needs of people who use drugs, alongside broader health and social services”. (HRI, 2021a, p.4).

At the same time, integrated harm reduction services apply tailor-made approaches designed

for the person using the services. *“When implemented well, integrated harm reduction services offer a more person-centred approach, giving clients more control over how they manage their drug use and access health and social services”* (HRI, 2021a, p. 6). This leads to the second component of the main theme: a person-centred approach.

Designing both a comprehensive and effective health response can only be successful with the individual's active participation, including full respect for the person's point of view, and their circumstances are carefully considered. Some professionals argue that it is no longer appropriate to talk about an individual as the system's patient (implying a passive role). Instead, we should see individuals as citizens capable of participating in the decision-making processes determining their right to the highest attainable standard of physical and mental health (Paparella, 2016). Simply put, PWUD should be seen as persons with the right to access transparent and reliable information (transparency) that is presented in an accessible manner (health literacy). Furthermore, PWUD should be provided with the necessary tools to make informed and conscious decisions (co-participation). This study understands a person-centred approach and services as empowering the individual by broadening their role in health care interventions and providing reassurance, support, comfort, and respect for autonomous decision-making. (Paparella, 2016).

Similar interventions create a unique model by combining provisions for integrated and person-centred approaches. Therefore, a more holistic

and comprehensive health strategy is understood as one which requires the effective participation of the person using drugs (person-centred) and can only be effective if considering the person's social context. This approach would promote an environment of equal collaboration between all the stakeholders (integrated care), including PWUD.

SOCIAL DETERMINANTS OF HEALTH

The social context requires the health system to look beyond its own structures and establish a continuum between the inpatient services normally provided by public institutions and outpatient services run mainly by civil society organizations working with PWUD. Furthermore, healthcare must work as an open system establishing communication channels with society whilst emphasizing reshaping the care model. For example, as already mentioned, responses provided by the health professional should be co-created with the person, and tailored to their specific needs and preferences, thus reflective of their unique combination of social determinants of health (WHO, 2015).

The life conditions determined, among others, by a particular country's political systems and public policies directly impact the realization of the

highest attainable standard of physical and mental health. **Social determinants of health** (SDH) are the non-medical factors that influence a person's health outcomes. These factors include the conditions in which people are born, grow up, work, live and retire and the broader set of forces and systems shaping the conditions of daily life (WHO, 2022). According to the WHO (2022), the following social determinants can influence health equity in positive and negative ways: income and social protection; education, unemployment and job insecurity, working life conditions, food insecurity, housing; basic amenities and the environment, early childhood development, social inclusion and non-discrimination, structural conflict, and access to affordable health services of decent quality.

Therefore, one may highlight that the realization of the right to health or/and access to harm reduction is directly linked with the life and socio-political conditions of a person using drugs. Furthermore, specific political and economic systems further support or hinder access to harm reduction services.

HARM REDUCTION AND INTEGRATED AND PERSON-CENTERED APPROACHES

Harm reduction proposes a set of political strategies, practices and debates based on core principles founded on: pragmatism, humanism and full respect for the human rights of every individual, participation and commitment to advance positive change, and of using evidence as the foundation for action. According to Harm Reduction International, “*harm reduction refers to policies, programmes and practices that aim to minimize adverse health, social and legal impacts associated with drug use, drug policies and drug laws*”². To achieve these goals, harm reduction encompasses **a range of health and social services and practices** that apply to illicit and licit drug use.

Harm reduction practices have a great propensity to integrate the demands of an integrated and person-centred care model. Indeed, most harm reduction professionals do not see the point in providing a particular service (like needle exchange programs, opioid agonist treatment, drug consumption rooms, etc.) without concurrently promoting the client's active participation. Before establishing any service, a harm reduction philosophy recognizes the need

to conduct a proper needs assessment in the relevant community. Interventions should be designed according to the needs identified by the assessment. Tailor-made services are fundamental to addressing the unique needs of a specific individual and/or community.

Concerning the integration of services, harm reduction organizations need to collaborate with other services and structures in the system, creating effective channels of referral and communication. Harm reduction professionals know they cannot be effective if they do not establish cooperation protocols with hospitals, TB treatment centres, infectious diseases departments, etc. In many cases, informal alliances and personal-level cooperation are in place when formal agreements are not feasible.

Recognizing the importance of cooperation, harm reduction services also emphasize the participation of PWUD in service delivery. Participation, in this context, needs to ensure that health information is presented in an accessible and acceptable approach, thus further empowering the person to take informed decisions. This method requires a horizontal approach where health professionals and social workers build a collaborative environment with the person, thus creating an adequate context to establish trustful relationships. In turn, this leads to more reasonable and informed decisions. In essence, harm reduction “*focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that they stop using drugs as a precondition of support*.”³.

2. <https://hri.global/what-is-harm-reduction>. Accessed on 20.12.2022.

3. <https://hri.global/what-is-harm-reduction>. Accessed on 20.12.2022.

PEOPLE WHO USE DRUGS

The definition of harm reduction cited above talks about “*working with people without judgment*”. People who use drugs are the predominant harm reduction service users addressed in this scoping review. Hence, a few issues need to be clarified. A person using drugs is not an *object* of science, research or medical practice. PWUD are active actors in the system and citizens who must and should have equal access to the care system of their country. Therefore, PWUD should not be subject to discrimination, coercion or judgement, even if continuing to use drugs of an illicit or licit nature. Any other attitude towards PWUD violates fundamental human rights principles and undermines the foundational principles of a democratic society.

PROBLEM DRUG USE AND MODEL OF HEALTH

Discussions on PWUD also include considerations to address the concept of problem drug use. Indeed, some of the PWUD could, at some point in their life, face difficulty regulating consumption levels or other challenges related to consumption methods. However, others can use psychoactive substances without developing dependency or

encountering other problems and report strong skills in managing drug use.

This scoping review identifies a link between negative realities faced by PWUD and poor or vulnerable socio-economic conditions such as housing, employment, family relationships, education, etc. In other words, people for whom the social determinants of health act as a barrier to realizing the right to health.

Closely related to considering social determinants in health responses is the importance of shifting the focus from the bio-medical understanding of health to one based on a **biopsychosocial model** (Engel, 1977). In this model, illness is not a unidimensional static phenomenon. The model proposes to look at the development of illness through the lenses of complex interactions pertaining to the biological (e.g., genetic, biochemical, etc.), psychological (e.g., personality, behaviour, etc.), and social (e.g., cultural, socio-economic, etc.) dimensions impacting health. The biopsychosocial model can be compared to the biosocial approach proposed by Harm Reduction International. This approach “*acknowledges that different health and social issues are interconnected and need to be addressed holistically*” (2021a, p.3). Finally, the right to health does not presuppose the absence of disease or ill health. However, it is instead a more dynamic process where health and quality of health are plotted on a continuum, thus starting from the bio (soma) level and moving to incorporate broader socio-economic considerations. This process recognizes that the person attending the services is a citizen capable of making an informed decision to realize their right to the highest attainable physical and mental health standard.

3

CRITICAL FACTORS IN INTEGRATED PERSON-CENTRED MODELS

3. Critical factors in integrated person-centred models

The review of the available literature and information obtained from experts facilitates the identification of critical factors directly affecting the success of integrated and person-centred care models. Depending on the positive or negative values attributed to them, these factors are being understood as elements that can facilitate or hinder access to health services and integrated social responses. This study classifies these critical factors into the following categories: ideology and law, politics and policy, structures, funding, access to information and health literacy (both for professionals and PWUD), stigma, and client participation in the decision-making processes. Operating in highly complex social systems, these categories intertwine and sometimes overlap.

is the predominant care model adopted for PWUD in the health care system (hospitals, TB centres, HIV care units, primary care units, etc.).

For several decades, the international approach to drugs and drug use has been framed within a threat-based paradigm and advanced by the famous War on Drugs motto declared by Richard Nixon in 1971. Ever since, no evidence could prove the efficiency and success of policies implemented by a prohibitionist regime in reducing either the supply or the demand for drugs (Agra, 1993; Cruz et al., 2012; Pinto et al., 2015; Romani, 1999, 2003). On the contrary, the War on Drugs propagated a culture and environment advancing policies of stigmatization of PWUD, pushing them to the margins of society and directly endangering their right to health.

IDEOLOGY AND LAW

This paper defines ideology as a “set of philosophical, social, political ideas, convictions and principles that characterize the thinking of an individual, group, movement, epoch and society.”⁴ Ideology is therefore the “machine” that produces society’s values, norms and prejudices. Ideology contributes to shaping the political regime and how society organizes itself. This also includes the creation of laws and regulations that control behaviours and interactions between citizens. In tandem, ideology and law give rise to two main questions: (i) how the society perceives drug use and what is the role of harm reduction and (ii) what

A drug use care model founded on a prohibitionist paradigm is built on a zero-tolerance, abstinence-based approach. This method gives enormous decision-making control to the health professional (typically a medical doctor) over the individual’s wishes. It is related to the phenomenon of the medicalization of drug use, where a person using psychoactive substances is considered ill and incapable of taking responsible decisions, therefore, must submit to the only possible solution: the strict abstinence-based regime (Cruz et al., 2012; Escobedo, 1998; Pinto et al., 2015; Romani, 1997). The person’s needs, socio-economic situation, moral values, life opportunities, etc. are, in principle (and traditionally) completely disregarded from this care model.

4. [https://socialsci.libretexts.org/Bookshelves/Sociology/Introduction_to_Sociology/Book%3A_Sociology_\(Boundless\)/04%3A_The_Role_of_Socialization/4.05%3A_Agents_of_Socialization/4.5K%3A_Ideology](https://socialsci.libretexts.org/Bookshelves/Sociology/Introduction_to_Sociology/Book%3A_Sociology_(Boundless)/04%3A_The_Role_of_Socialization/4.05%3A_Agents_of_Socialization/4.5K%3A_Ideology), Accessed on 20.12.2022.

Some countries have implemented (in whole or in part) more flexible yet still prohibitionist legal frameworks, the so-called *decriminalization model* (for example, the Netherlands in 1976, Portugal in 2001, and the Czech Republic in 2010). In this legal model, drug use and/or drug possession are not considered criminal acts but (at most) administrative offences. Instead of focusing on law enforcement, coercion and incarceration of PWUD, decriminalization models develop responses to drug dependence and other problems related to drug use by promoting a broader range of prevention and treatment programs and harm reduction interventions. These interventions are complemented by social services (Civil Society Forum on Drugs, 2022, p. 2).

As early as the 1980s, harm reduction services were introduced as a response to drug use in several countries, particularly in the Western hemisphere. Although harm reduction also involves ideological elements (such as human rights, respect for personal freedom and liberty, compassion, etc.), it is, in principle, a more pragmatic and humanistic approach. In this paradigm, support is not conditional upon a person's decision to discontinue drug use. The emergence of harm reduction in the drug policy field meant that the abstinence model was no longer viewed as the only solution available to address high-risk substance use (Maia Costa, 2001; Rhodes & Hedrich, 2010; SICAD, 2016). Harm reduction proposes *unconditional* support to the person, promoting their participation in the care system.

POLITICS AND POLICY

Adopting a health-oriented perspective and proposing a new set of public policies is making its way in Europe. One of the significant dimensions of this newfound approach seems to be the solidarity in effectively decreasing health inequalities across the EU. As is pointed out by the European Commission, people who are less qualified and with lower income tend to have a higher propensity of suffering from ill health and/or premature death when compared with the population of higher social and economic status (European Commission, 2014). The most vulnerable and socially excluded groups (migrants, ethnic minorities, people experiencing homelessness, etc.) tend to suffer particularly low access to quality healthcare services.

Health inequalities result from differences between various social groups. They are associated with a diversity of factors, such as: housing, education, profession and access to the job market, income level, access to health care and health promotion services, and public policies that influence these areas of life (EMCDDA, 2017). Public policies can design a harmonized and balanced set of **SDH** promoting fair and equitable access to health for all social groups, including the most marginalized. According to the European Commission's communication, after implementation, only a small number of policy measures are evaluated in terms of their impact on health inequalities (European Commission, 2015). New and different monitoring and evaluation mechanisms should be developed

3. Critical factors in integrated person-centred models

to obtain more consistent information to support establishing new and more equitable policies.

A cross-country comparison of health system performance, strategies and structures based on person-centred care in Europe, conducted by the Picker Institute Europe in 2016, describes several political areas important in creating an environment where more inclusive health and social care can flourish, for example, *patient information* (what are the information sources available and accessible), *patient choice* (are there both public and private services available with a consistent care model) or *patient involvement* (how far does the participation of the individual go in the decision about care and treatment).

In some countries (e.g., Germany or England), principles of person-centred care have been formalized in written documents like the Chart of Rights of the patient. There is also a concern to affirm the political responsibility for improving the care model by monitoring the quality of and access to health services and service user satisfaction. Policy monitoring and evaluation are closely connected to quality standards that aim to support and guide the development of safe and compassionate care systems. Creating such a system is a process that needs to be led by countries and established through co-production between governments, service providers (public, private, non-profit) and the people they serve (Paparella, 2016). Finally, “*policies and programs must cover all key sectors of society, not just the health sector*” (WHO, 2010, p. 1).

Looking at political and policy challenges presented by a person-centred model of care, governments

should invest increased attention to these principles and ensure meaningful representation of PWUD. The severe exclusion of this social group from the health and social care system can be balanced with the effective implementation of harm reduction services. Some European countries have explicitly assumed the importance of these services by embedding them in national drug policy frameworks (e.g., Portugal in 2001) or simply by ensuring that harm reduction services receive stable, adequate funding and play a role in monitoring, evaluating and reframing national drugs policies (e.g., Switzerland).

STRUCTURES

Flexible structures and coordination between different sectors promoting efficient and open communication and collaborative environments are pivotal for a sustainable and equitable care system. According to the Scottish Effective Interventions Unit (2002), an integrated care approach founded on cooperation and collaboration between all the relevant providers has many benefits for individual service users, such as: promoting early assessment and intervention, removing barriers to access services, promoting more consistent, coordinated and comprehensive care, and ensuring more holistic and quicker responses. Coordination does not necessarily require the merging of the different structures, services or workflows but rather an alignment and harmonization of the process of the different services and sectors.

3. Critical factors in integrated person-centred models

It is necessary to forego the excessive focus on the *“hospital-based, disease-centred and self-contained ‘silo’ curative care model [which] undermines the ability of health systems to provide universal, equitable, high quality and financially sustainable care”* (WHO, 2015, p.10). There is an urgent need to put people and their views at the centre of the care model and ensure the establishment of responsive services coordinated within and beyond the health sector.

Moreover, as reaffirmed by the WHO Global Strategy on Integrated People-Centred Health Services 2016-2026, it is also essential to ensure both gender and cultural sensitivity. This will help create new opportunities for intersectoral cooperation at a community level (also potentially including partnerships with the business sector) to address the social determinants of health and make the best use of limited resources.

Bureaucracy plays a vital role in the structural shift towards a holistic care model. The rigidity of bureaucratic procedures can work as a powerful obstacle to securing universal access to health care services. Procedures and regulations are often difficult to understand and arbitrary. Therefore, imposing strict criteria, such as the obligation of presenting a formal identification document, prevents people who, for various reasons, are not in the possession of one (like undocumented migrants), from accessing health care services. Furthermore, bureaucracy is often accompanied by technical jargon that is far from the language people use colloquially. This hinders communication with the client and creates an additional barrier to accessing the system. The fact that individuals and communities with lower education levels, living on the margins of the

social normative system, experience increased difficulty in accessing health services should put the focus on a commitment to reduce bureaucracy and/or simplify the procedures of entrance and maintenance in the health system. This is especially important considering that lower levels of formal education could likely correlate with poor awareness of personal legal rights and how to safeguard them. Particular attention should be devoted to addressing different cultural factors, e.g., outreach to ethnic minorities, migrants, or people who cannot express themselves in the country's language.

PWUD who live in fragile conditions tend to experience bureaucracy as a powerful obstacle to accessing health services and find enormous difficulties in coping with the rules and procedures. Sometimes, they are physically prevented from entering hospitals and other health facilities. In this context, harm reduction services have an essential function, serving as a mediator between the person using drugs and the health, social or legal system. Civil society organizations and other community-based service providers are agile in formulating special protocols or other fast-track procedures to improve and speed up access to health care. They facilitate referrals, entrance into and permanence in the care system.

FUNDING

The amount of resources available in the health care system is a common and apparent critical factor determining both the efficiency and the quality of the care structure. Due to greater optimization of scarce resources and better communication between different sectors, an integrated and person-centred care model improves efficiency and prevents overlaps in both health and social responses. Comprehensively, it also reduces financial costs for the system. At the individual level, access to care services can be constrained by the lack of health insurance on one side and the high costs of services on the other. Governments should ensure adequate social benefits so that populations living in fragile conditions can access the system equally. Employment protection, a minimum basic income, and insurance-free access to the health units, among other benefits, can contribute to establishing and maintaining connections throughout the system. Additionally, social workers play an essential role due to their ability to navigate the social care system and bridge health and social structures.

In general, harm reduction services are not particularly well funded by European governments. Lack of sufficient financial support affects both the provision of services and advocacy work to gain political support at the national level to enable scaling up of services implementation (HRI, 2021b). The funding also varies significantly between the South and North and between the East and West

of Europe. Organizations operating in Northern and Western European countries enjoy more sustainable and abundant funding from national governments.

In contrast, in Eastern and South-Eastern Europe, harm reduction services have for many years been mainly financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria. At the moment of writing, it is far from certain that the mechanism will continue beyond 2023. As national governments are reluctant to take over these responsibilities, a lack of resources exposes various harm reduction services to a greater risk of closure. This creates an insecure and precarious environment for harm reduction services, potentially weakening their effectiveness, quality and consistency of interventions and putting the communities of PWUD in jeopardy of discontinuity of care (interrupting, in many cases, the continuity of HIV, TB and HCV treatment or suspending the opioid agonist treatment).

In Southern European countries, funding can also take the form of co-funding, requiring the community service providers to obtain a large portion of the funding from non-governmental sources. Moreover, in many countries, the system governing public funding is based on short-term project logic, with (limited) funds allocated through public tenders every two years. This situation triggers a dynamic of competition between the service providers, likely affecting the solidarity chains among them and promoting rivalry instead of cooperation.

Over the years, harm reduction services have proved effective and cost-efficient in preventing

3. Critical factors in integrated person-centred models

and treating blood-borne viruses among PWUD (HRI, 2021b). Results of social return on investment (SROI) estimates can clearly show what happens with taxpayers' money. They also show the economic impact of harm reduction services on society by reducing the present and potential future costs of social and health services. For example, CSOs-conducted SROI estimations in Portugal showed that for one euro invested in harm reduction services, there was 4,70 Euro in return to society due to avoided costs related to treatment, unemployment, etc.)

HEALTH LITERACY

Access to transparent information is essential for delivering high-quality and integrated services. In reality, however, health professionals are often unaware of the system's existing resources and/or support structures and, therefore, cannot refer or connect the person to the most appropriate services. Often, they also lack sufficient information about an individual. This negatively affects the care system's effectiveness as a whole (Effective Interventions Unit, 2002).

It is common that mainstream health professionals (doctors, nurses, psychologists, etc.) are not familiar with harm reduction services and are unaware of the core principles, purpose and benefits of a harm reduction approach. On the other hand, there is also a risk that harm reduction services staff or volunteers do not possess sufficient literacy in community health. Thus, there

is a need for structured training possibilities and the introduction of harm reduction courses or contents in relevant university programs.

Access to information is a fundamental precondition for person-centred care, including understanding. It is fundamental that clients of care services can understand and process information provided by health practitioners. To achieve this, integrated and person-centred models also stipulate that people are equipped with skills and provided the support they need to make informed decisions and participate in their care (WHO, 2015). At the same time, practitioners can contribute to this aim by *translating* medical jargon into more straightforward, everyday language, thus facilitating comprehension and informed decision-making.

STIGMA

The criminalization of drug use and possession, predominantly linked with the moral panic narrative and the demonization of drugs, created the perfect conditions for the stigmatization of PWUD. Moreover, it is not exceptional that individuals facing poor living conditions are pushed further to the margins of society by being labelled as dangerous criminals, sick or insane.

The labelling of PWUD has been changing over the decades. In the 1980s and the beginning of the 1990s, one could see the predominant concept of *drug addiction* or *toxicomania*, establishing a direct

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link between illness and drug use. This shift was considered by many as a positive development, gradually progressing from categorizing PWUD simply as criminals, misfits, or outcasts to a more dignified category of being a patient. Later, *addicts* understood as sick persons, transformed into more neutral *drug users*. More recently the use of the term *people who use drugs (PWUD)*, is being adopted by various stakeholders. Terminology pertaining to PWUD highlights that drug use is only one of many activities people engage in their lives and avoids defining a person exclusively through the lens of their drug use. Increasingly, practitioners, community volunteers, and researchers started to understand the necessity to alter perceptions that view the person-substance relationship based on the concept of the *sick addict* or *drug abuser* (see INPUD, 2011). Nowadays, due to reductionist and derogatory assumptions about an individual, the terms *addict* and *addiction* are understood to be "*pejorative and stigmatizing*" (Larkin et al., 2006, pp. 207-208). For that very reason, they are also often contested in literature.

Labelling is only one element of the story. Indeed, words can express society's views on a specific social group. However, labelling also comes with a range of attitudes, behaviors, and practices reflected in communication and relationships. As mentioned earlier, the medicalization of drug use and drug services results in a relationship between the medical professional and the person using drugs that is based on the doctor's dominant role, with a top-down communication process and no opportunities to create transparent and open interaction. This is a reductionist and poor approach where the centre of the care model is

the health professional - the provider with all their biases, prejudices and fears – and not the service user. To ensure respectful, equal and person-centred care, primary and outpatient health service systems need a thorough reform to assist PWUD, who hitherto tend to experience marginalization and stigmatization from mainstream service providers (Spooner & Hetherington, 2005).

Over the years, harm reduction-oriented associations of PWUD, like EuroNPUD, INPUD and national unions have carried out large campaigns to fight against the stigmatization of their communities. Harm reduction service providers had an important role in supporting those movements. Correlation – European Harm Reduction Network has also been working to create conditions to link diverse CSOs, community-based organizations, academia and decision-makers and work together to end stigma and discrimination against PWUD.

PARTICIPATION

Integrated person-centred models can only be sustainable with the active and meaningful participation of the service users. The system should create conditions that allow health practitioners to spend enough time with clients in consultation, provide easy-to-understand explanations, allow asking questions or raising concerns, and involve service users in decisions about care and treatment (Paparella, 2016). There is a need to shift perceptions and attitudes away

3. Critical factors in integrated person-centred models

from a fragmented and limited analysis of individual *symptoms* and towards a view which treats the person as a whole, considers the individual as complex and unique, and part of an even more complex social and political system.

Harm reduction narratives propose peer involvement as an inclusive and effective strategy, opening healthcare processes to the *clients* and inviting them to become active actors in the care process. Harm reduction organizations thus emphasize that peer workers – people coming from the community who have the psychosocial skills to work as service providers – are competent and that their expertise is complementary to the knowledge and skills of harm reduction professionals.

Furthermore, it has been demonstrated that peers have the propensity to improve responsiveness (Correlation, 2010, 2012; APDES, 2012). Including PWUD (not only as peer workers) in the development, delivery and evaluation of integrated care interventions helps ensure that services are person-centred, needs-informed, and relevant to the person's situation. Service users' right to be involved (following the principle of *nothing about us without us*) and their views should be taken into account at all stages of service delivery. This should help build an integrated care system that is accessible, appropriate and credible to the service users (Effective Interventions Unit, 2022). A similar care model enhances respect for the client, facilitates the creation of an ethical environment where the person has agency and can co-construct the criteria for their health, and encourages the creation of good relationships with health professionals.

Person-centredness refers to a doctor–client encounter characterized by responsiveness to the individual's needs and preferences. Thus, person-centred approaches establish shared decision-making processes by using their informed wishes to guide activity, interaction and information-giving. It is a standard of practice that demonstrates respect for service users as individuals (Paparella, 2016). This idea of *encounter* is fundamental for harm reduction approaches. Relationships built on mutual trust between the person using drugs and the practitioner must be established as a *sine qua non condition* to provide an adequate response.

By allowing for closer and more understanding relationships with clients and by actively involving people with lived experience in the decision-making processes, services have the potential to be more responsive, convenient and appropriate to the needs of PWUD. Furthermore, they also facilitate opportunities for reaching out to and building trust with marginalized populations (HRI, 2021a). Involving clients in collaborative processes is linked to a continuous empowerment process, whereby the person develops skills and tools that ultimately encourage an attitude of self-care and behavioural change.

4

CRITICAL FACTORS IN ACCESSING HEALTH AND SOCIAL SERVICES BY PWUD

4. Critical factors in accessing health and social services by PWUD

The literature review on integrated person-centred care models was complemented by a series of online group consultations, and individual interviews with experts, including a dedicated session during the C-EHRN Members and Experts Meeting organized in Athens in November 2022. Consultations revolved around levels of access to care services among PWUD.

Information collected through these channels allowed the identification of various factors hindering access to health and social services. To facilitate the interpretation of ideas expressed

by the experts, the analysis of themes was divided into four main categories (i) ideological/political challenges; (ii) structural challenges; (iii) organizational challenges; and (iv) individual challenges (Table 1).

Not surprisingly, barriers to service access identified by the field experts exhibit a high level of similarity with critical factors described in the literature (see chapter 4). Therefore, to avoid being repetitive, only some of the critical factors mentioned by the specialists are described here in more detail.

Ideological and political challenges	Structural challenges	Organizational challenges	Individual challenges
A narrow concept of health: Need to shift the focus from disease to well-being.	Different funding streams at the national and local levels and between health and social services	Lack of cooperation between organizations and services	Stigma and discrimination: Preventing access to services
Prohibitionist and abstinence-based regime: Drugs and drug use are seen as the core problem	Lack of communication between social and health sectors: No alignment of strategies and procedures	Challenges in democratic and participatory organizational cultures: Acceptance of peer work and peer involvement in services	Fear and insecurity of PWUD to advocate for their rights
Health inequalities: Poor health status in marginalized and stigmatized social groups	Lack of system sustainability: Insufficient resources and suboptimal use of scarce existing resources	Professionalization and harm reduction training of workers in the organizations	Poor living conditions of PWUD: Housing, income, formal education, stable job (social determinants of health)
Lack of recognition of harm reduction as an important and legitimate health “branch” by some European governments	Non-priority status of PWUD	Patronizing care models	Patronizing care models
Lack of dialogue between governments and service providers (public, private, non-profit) and PWUD	Bureaucratic procedures: Lack of insurance or ID as a barrier to health access (e.g., undocumented people)	Organizational sustainability: Scarce funding leading to precariousness and discontinuation of services	Health literacy: Lack of access to tools among PWUD to understand their health situation and navigate the system
Lack of involvement: PWUD are not taken seriously and cannot engage in the design of the system	Lack of implementation of quality standards in harm reduction services	Administrative procedures contradictory with clients’ needs	Intersectionality: The needs of people with diverse sexual orientations, gender identities, gender expression, and sexual characteristics are often unmet
	Lack of systematic monitoring and evaluation of health services (including harm reduction): No specific data on cost-effectiveness	Lack of knowledge about other areas of work (e.g., sex work, homelessness, migration, trauma, etc.)	Professionals’ burnout: Absence of emotional support

4. Critical factors in accessing health and social services by PWUD

Regarding **the ideological and political challenges**, the prohibitionist paradigm was highly criticized: *"It is not a war on drugs, but a war moved against people who use drugs"* (Lynn Jefferies) or *"there is a huge need to change the political essence of drug policies based on a prohibitionist approach"* (Mika Mikkonen). Experts agreed that PWUD live in a prohibitionist regime that cannot produce better, more effective policies. Related to that is the abstinence-based model that still dominates national care systems, which *"works as a barrier because, most of the time, it does not allow a connection with the harm reduction services. Professionals led by an abstinent model tend to not accept harm reduction as an important dimension of the health services' menu"* (Hugo Faria).

Another theme highlighted by the professionals was the lack of dialogue between governments on the one hand, and an equal lack of communication with service providers and the people they serve, on the other. *"The main problem is that people do not know what is going on in the streets or on the levels below. The decision-makers do not know what is needed to improve the responses, and they do not know the details of the system and the projects implemented."* (Henrik Thiesen). This may explain why some European governments do not recognise harm reduction as an essential and legitimate health branch.

Regarding the **structural challenges**, experts underlined that lack of communication and collaboration between social and health sectors, including no alignment of strategies and procedures, is a significant barrier to realizing the right to the highest attainable physical and mental health standard. *"People who use drugs need to*

attend different places (structures) to resolve a problem (in particular, when we are talking about a social issue). There is a need to improve and to increase both the links and the connections between the structures" (Aura Roig). Interestingly, sometimes, poor cooperation is not a matter of lacking services but a reflection of disconnection: *"We have the features/services, but they are not integrated. Services do not communicate with each other"* (Hugo Faria). That is why there is a need *"for continuous work to link people and different systems"* (Henrik Thiesen).

Further, the need for systematic monitoring and evaluation of harm reduction services that could measure their cost-effectiveness was a concern raised by the group of experts. They highlighted the need for a monitoring system that goes beyond the quantitative approach that only accumulates process data, thus providing a superficial picture of reality. *"We need more than metrics. We need new and innovative metrics, more qualitative data that can complement numbers and figures"* (Aura Roig). There is an increasing focus on a qualitative approach and understanding its importance to assess better the impact of policies and services on people's lives. For example, narratives by PWUD are recognized as biographical methods and a unique approach connecting personal experiences with scientific tools of inquiry. *"The 'storytelling' that we, in EuroNPUD, are using as a powerful tool to demonstrate the life conditions of our own community"* (Lynn Jefferies).

Among **organizational challenges**, there was a large consensus regarding the lack of cooperation between organizations and services – *"The NGOs should stop fighting among themselves."*

4. Critical factors in accessing health and social services by PWUD

We need cooperation and not competition for funding.” (Aura Roig). Due to scarce funding leading to precariousness and discontinuity of services, cooperation was seen as a way to promote organizational sustainability. Another issue concerns the burden of bureaucracy. For many services, funding is inherently connected to a high administrative burden and administrative procedures that do not align with or even outrightly contradict the clients' needs. “Bureaucracy tends to be overwhelmingly damaging to the quality of the services in our daily practice” (Hugo Faria).

One of the most critical factors is peer involvement in the services/organizations. *“Peers should be involved because they improved the capacity to reach different difficult-to-access settings”* (Cristiana Merendeiro). One reason for this is that *“the person seen as a peer is perceived by the community as someone equal, able to understand the language and cultural meaning of the needs and concerns of the person using drugs (...) and equipped with a range of competences and skills that goes beyond the books and theory, these skills come from the lived experience of the peer, bringing life-learning experiences to stage of harm reduction services.”* (Lynn Jefferies). Recognition and appreciation of the living experience and skills of PWUD are essential for effective service delivery. However, it is not sufficient on its own; *“We need more than peer work per se; we need organizations with a democratic background where effective participation is part of the political structure”* (Aura Roig).

Finally, the **individual challenges** category brings to the fore critical factors that could block access to adequate care models at the micro

level. In this context, stigma and discrimination are powerful inhibitors. There is an urgent need for professionals to use more inclusive language in their daily practice. *“Words make the difference helping to remove a negative connotation from certain behaviours and promoting a change in the staff mindset. This would increase a more humane and stigma-free intervention”* (Mika Mikkonen). *“That is why we have to reinforce the notion of the therapeutic relationship to reach out to the person and make them feel integrated and heard”* (Aura Roig). Otherwise, *“services will contribute to the assimilation of the label by the client, further deepening stigma. At the same time, professionals should be able to guide the relationship process offering the client a balanced approach by attending to their needs and proposing a wider range of possibilities”* (Cristiana Merendeiro). A discriminatory attitude associated with stigma tends to preclude the establishment of a safe context for the person who uses drugs.

Furthermore, fear brings personal insecurity and hinders empowerment and engagement with staff. Merendeiro proposes the creation of a person-centered environment that can stimulate the autonomy and empowerment of the client or the communities from which they come. *“An environment moved by the full acceptance of the personal characteristics of the individual avoiding, by all means, to exclude the person because of her different behaviours our attitudes – expelling the clients from the health and social care system cannot be used as a symbolical tool of punishment”* (Aura Roig). Emotional support should be available all the time, so people using drugs can feel supported and motivated to attend the services. Personal differences

4. Critical factors in accessing health and social services by PWUD

should be respected, including considerations for gender, race, and ethical or other dimensions of that particular person. *“It is unacceptable that people could be expelled because of these”* (Lynn Jefferies). This can also happen because professionals are unaware of HR principles and the complex realities of drug use in society. *“Lack of job training and proper formation during their formal qualification process could explain much of it”* (Hugo Faria).

Therefore, to improve the quality of the services and increase accessibility to the health and social care system, stakeholders need to promote health literacy designed for and with PWUD. *“They lack access to the proper tools (like clear information) to understand their health situation and navigate the system”* (Lynn Jefferies).

Finally, professional burnout was a theme underlined by some of the experts. *“Perhaps this can be explained by the precariousness of the services, the working conditions (e.g., wages, stress, the volume of work) and the absence of emotional support”* (Hugo Faria, online consultation, 2022).

Drawing up lessons from the online consultation process and personal interviews, this study identifies several critical factors for implementing integrated and person-centred care models. This is applicable at European, national and local levels and needs to consider ideological, political, structural, organizational and individual challenges. Experts were very clear on the need to shift from ideology and medically driven approaches, towards person-centred and evidence-based policies. A similar shift would ensure the implementation of

effective interventions and create better (health) outcomes. Therefore, efforts must be made to fight stigma and discrimination and improve access to health and social services for PWUD. Initiatives to improve services include enrolling paid peer workers in professional teams and facilitating multi-professional, cross-cutting and intersectional cooperation with other domains. Finally, experts underlined the importance of establishing the services to address the needs of people with diverse sexual orientations, gender identities, gender expression and sex characteristics, thus ensuring a safe environment without discrimination and violence.

5

GOOD PRACTICES EXAMPLES

METZINERES

(CATALONIA. SPAIN)

The activity of Metzineres revolves around intersectional feminism, human rights, and the full spectrum of harm reduction. It serves women and non-binary gender people who use drugs, surviving multiple situations of violence and vulnerability. Metzineres welcomes all womxn by forming and adapting compassionate responses to their complex and changing realities. Rather than creating an exhaustive and exclusive list of entry criteria, emphasis is placed on reaching those facing multiple, simultaneous, and interconnected social variables that shape their experience and existence.

Women and non-binary gender PWUD tend to survive multiple situations of violence and vulnerability; nonetheless, they struggle to gain access to and be supported by social services and healthcare networks. They are often excluded from services, including ones focused either on drugs or gender-based violence. Lack of alternatives and barriers to access services, including institutional gaps exacerbate social control, inequality, social injustice, and exclusion. Prejudice, stigma, and discrimination result in a systematic violation of their rights.

Metzineres is an innovative, daring non-profit cooperative providing a sheltered environment exclusively for womxn. The organization focuses on human rights and gender mainstreaming and covers a full spectrum of harm reduction approaches. With both a holistic and individualized framework, Metzineres emphasizes the uniqueness of each womxn and each situation. Access to Metzineres is immediate, with widely flexible responses that consider individual expectations, concerns, interests and needs. Supported by local community strategies and a social and solidarity-

based economy, the Metzineres model aims to be the one that provides consistency, reliability, pragmatism, and cost-effectiveness and one in which each womxn plays a central role.

The importance of the almost 50 daily supports met by Metzineres—committing themselves to ensure the comfort and well-being of the womxn currently participating—has shown extraordinary results after just over four years of implementation, exceeding the highest expectations. Among the more than 400 womxn who have already joined us, they experience drug-related problems (84%), homelessness (86%), migratory experiences (37%), LGBTBIQ+ (39%), sex work (53%) and/or sex for survival (68%), imprisonment (33%), mental health disorders (74%), and functional diversity (17%).

Many participants highlighted the great gap between provisions of care and support. Their outstanding involvement shows that often the difficulties do not lie in participants but are instead embedded within broader societal structures of prejudice and injustice. This situation creates barriers to accessing beneficial activities, resources and actions.

Women and gender-diverse people who come to Metzineres recognize that they consume less, have improved their physical, emotional and mental health, and stay longer in social and healthcare networks. Ultimately, they also reported that they are more likely to go to other shelters. The stigma they used to receive from the neighborhood has not only diminished but they are now considered an essential part of the community and agents of change for the improvement of the neighborhood. The positive influence of Metzineres has also been appreciated in other social spaces seeking to integrate person-centered care interventions.

MORE INFORMATION

-  metzineres.org
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-  [@metzineres](https://www.facebook.com/metzineres)
-  [@metzineres](https://www.instagram.com/metzineres)
-  [@metzineres_org](https://twitter.com/metzineres_org)
-  [@metzineres-coop](https://www.linkedin.com/company/metzineres-coop)
-  [Metzineres Entorns d'Aixopluc](https://www.youtube.com/channel/UC...)

PROJECT - FREE CLINIC

(ANTWERP. BELGIUM)

The PROject implemented in the Free Clinic focuses on support, consultation, social support, health care, medical care, harm reduction, reintegration, and recovery. The target group of the intervention are women who use drugs, and it reaches 50 (individual) women annually, with 18 women accessing services every week.

The PROject, part of Free Clinic NGO, is an outpatient care programme established in a homely setting for women who use(d) drugs. PROject is housed in an anonymous terraced house in the city of Antwerp and provides help and support to about 50 women. The interior is cozy, homely, comfortable, and child-friendly. This quiet atmosphere respects the privacy and maximizes women's choices. This environment allows them to experience reciprocal, empathetic, healthy relationships, further promoting recovery. Women are given a place to develop confidence in themselves as competent individuals and learn from other women's experiences.

PROject advocates viewing each woman as an individual, screening for social history, patterns of

(substance) (ab)use, mental health functioning and emotional needs, and tailored treatment to address both drug use and mental health. Treatment plans are individualized and matched to the person's strengths and competencies. The PROject provides a holistic model of care with a variety of well-aligned biopsychosocial and pedagogical approaches to understand all aspects of the woman's life: physical, emotional, spiritual, cultural and socio-political.

The consequences of drug use, especially addiction, transcend the purely medical domain. Although medical consultation is undoubtedly a vital part of what the organization offers, there is also the possibility of a conversation - individually or in a group - with a social worker, therapist and/or nurse (no strings attached). The PROject creates a warm, homely atmosphere focusing on basic human connection. While waiting for the doctor's consultation, a group atmosphere develops, where the women and their children can meet their peers. Here, and during the other (group) activities, participants learn to appreciate women's full value, with the group acting as a social microcosm. Group activities are determined together with the women. They are diverse, ranging from going to the movies and engaging in social and well-being events to inviting outside partners who provide information on relevant topics, to organizing a hairdressing session. As these reciprocal, empathetic, understanding and respectful connections are modelled in the group, similar connections between participants (and others) can grow. As a result, learning skills from one another happens more effectively. This is more achievable in a casual atmosphere than in a highly structured setting, where there is too little time to exchange one's experience or experiential expertise (self-help as a methodology). To this end, PROject addresses all women's life stages and acts

as an honest, reliable and encouraging role model supporting autonomous evolution. Furthermore, through a role model approach, changes occur also at a more intimate and micro level.

Information on healthy nutrition, (physical) care, safe (intravenous) use, and safe sex are also part of services offered by PROject. Furthermore, the group also provides prescriptions for individuals requiring medication and substitution treatment, syringe exchange, and guidance on sexual and reproductive health, including assistance for women in pre- and postnatal care if required. On top of individual and group follow-up, PROject involves a broader network of family and professionals to strengthen women's social network. Involving family and the (nearby) community increases personal and social support for the client. It is necessary not to neglect a woman's relationship with her children and partner(s). Furthermore, integrating into primary health care and developing broader social care networks with relevant partnerships is a must to reduce social stigma and its associated consequences.

MORE INFORMATION

 freeclinic.be
 free-clinic.be/free-clinic/project/
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SP CHARITABLE FUND
“HUMANITARIAN ACTION”
 (SAINT PETERSBURG. RUSSIA)

Charitable Fund “Humanitarian Action” integrates medical and social services in the low-threshold

medical center for PWUD and other key populations in St. Petersburg, Russia. Its clients are PWUD, sex workers, men having sex with men, transgender people, people experiencing homelessness, migrants, and people living with HIV.

The facility offers care through the professional advice of the following medical specialists: therapist, surgeon, otolaryngologist, dermatovenerologist, nephrologist, pediatrician, ophthalmologist, neurologist, gynecologist, psychiatrist-addiction specialist, endocrinologist, as well as a psychotherapist. In addition, there is rapid testing for HIV, viral hepatitis B and C, syphilis, and ultrasound diagnostics. Clients can apply for blood tests that are being carried out in laboratories the fund has contracts with. Case managers assigned to the center for operational support of clients in medical and social institutions assist in solving legal, domestic, and other issues. All the services are provided anonymously and free of charge. The integrative model includes not only the medical center but also the mobile harm reduction units, web outreach work, and interactions with the public health and social services institutions (City Narcological Hospital, Centers for Social Assistance to Families and Children, City TB Hospital, AIDS Center), as well as criminal executive inspectorates, courts, and partner NGOs.

MORE INFORMATION

 haf-spb.org/
 [Presentation on integrated care at the 5th European Harm Reduction Conference](#)

6

CONCLUSIONS

The information collected during this project highlighted the urgent need to reform the general care model, particularly addressing high-risk drug use. First, concerning ideology and politics, this study reaffirmed that the global War on Drugs has failed and that prohibition has not effectively reduced either supply or demand of drugs. On the contrary, from a social and health perspective, policies in the past decades had detrimental side effects on PWUD and society. The War on Drugs has been destroying lives and wasting resources. Therefore, the zero-tolerance, prohibitionist paradigm should be replaced by a human rights-based approach, thus replacing the disease model with a more holistic framework founded on human rights principles.

Such care system reform needs to include strong considerations of all aspects of an individual's life, thus properly considering different social, economic, and cultural conditions. Examples include health literacy directly proportionate to levels of education, housing and regular income associated with employment and job retention and the role of gender and other intersecting identities directly impacting health and well-being.

Social determinants of health are crucial in designing efficient and beneficial policies to improve people's health and well-being. Therefore, creating a more responsive care system that views social and health dimensions as inherently connected with the needs of PWUD requires time, political will, resources and coordination between different sectors. Furthermore, it also requires greater professional openness vis-à-vis clients and establishing services empowering client participation.

While discussing the shift towards integrated person-centred care models the availability of resources has been identified as a crucial factor. By

resources, one understands not only the amount but also the way they are managed and distributed.

Irrespective of the level of economic development of each country, an increase in public funding to support the transition towards health care based on the social determinants of health – from early childhood development and education, through working and living conditions, to health services – is crucial to advance equity and prosperity in health (OMS, 2010). To achieve this, decision-makers should welcome all stakeholders, thus including private companies, civil society actors, service beneficiaries, community movements, and academia.

Civil society and community-based movements have been recognized as actors bringing a humanistic, evidence-based and pragmatic harm reduction approach to the table. Harm reduction programs have proved to be cost-effective and bridge health and social protection systems. Harm reduction services have established innovative structures and programs to provide complex, comprehensive and efficient responses, such as housing first, wet houses, drug consumption rooms, opioid agonist treatment programs, needle exchange programs, peer-delivered interventions, etc. Most of these responses combine both social and health services. Finally, a harm reduction approach supports the person to navigate the system better and empowers them to be more active and conscious of their health-decision process. When implemented well, integrated harm reduction services offer a more person-centred approach and give clients increased control over how they manage their drug use and access health and social services (HRI, 2021a). Given the above, it can be stated that harm reduction, with all its principles and features, aligns with an integrated and person-centred care model.

7

**POLICY AND
PRACTICE
RECOMMENDATIONS**

Integrated and person centred-care means putting people and communities, not diseases, at the centre of health systems and empowering people to take charge of their own health rather than being passive recipients of services. Based on the multiple, complex and multi-faceted components that constitute people's identities, person-centered frameworks acknowledge the diversity of PWUD and provide a wide range of support services. Furthermore, these care models address the negative impact of stigma and discrimination on access to health and social care, the dignity of PWUD and their right to participate in society fully.

Although not many would argue against the need for integrated and person-centred care, there are challenges and critical factors at different levels that continue to hinder implementation. These include ideological, political, structural, organizational and individual challenges.

POLICY RECOMMENDATIONS

Integrated and people-centred care models require:

→ Integrated and inclusive policy frameworks, ensuring a coordinated approach and multi-professional, cross-cutting and intersectional cooperation and synergy between relevant policy domains (e.g., health, social and welfare, economy, justice), health and social care systems and related stakeholders.

7. Policy and Practice Recommendations

- The implementation of a new set of care practices under the framework of the social determinants of health, moving from a focus on disease to a vision that appeals to the person's holistic well-being.
- Meaningful involvement of affected communities and people with lived experiences in developing and implementing policy and practice.
- Adequate funding to develop, implement and evaluate integrated and person-centred care models. This funding should cover all expenses, thus ensuring an increased guarantee of sustainable and long-term services.
- Critical factors for implementing integrated and person-centred care models must be identified and addressed at European, national and local levels. Ideological, political, structural, organizational and individual challenges must be considered.
- A shift from ideology-based to person-centred and evidence-based policies, thus ensuring the implementation of effective interventions and creating more impact and better (health) outcomes.
- A joint effort to fight stigma and discrimination and improve access to health and social services for people who use drugs.

PRACTICE RECOMMENDATIONS

Integrated and people-centred care models should:

- Be based on a proper needs assessment, including the perspectives of people who use drugs.
- Ensure a democratic work environment where the team and the client's participation is equally valued.
- Be evaluated regularly, building on the feedback and reports of service users.
- Be co-developed and co-designed by community members and peers.
- Include paid peer workers in their teams. Practice shows that teams composed of peers and other professionals provide a higher quality response because they increase proximity and relationship with drug user communities.
- Address the needs of people with diverse sexual orientations, gender identities, gender expression and sex characteristics to ensure a safe environment without discrimination and violence.
- Ensure multi-professional, cross-cutting and intersectional cooperation with other domains.

- Provide continuous and systematic training for own staff. The permanent acquisition of knowledge and new skills enhances service innovation processes by adjusting the quality of responses to clients'/community needs.
- Promote health literacy among staff and clients, thus ensuring that the person who uses drugs has sufficient skills and knowledge to make an informed decision about a given program of care.



8

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