

CHAPTER SEVEN

HARM REDUCTION

Harm Reduction

The evidence is clear that harm reduction is an important component in the continuum of health care. Harm reduction emerged from community knowledge and practice in response to treatment and care barriers that exist across the continuum of health care delivery. Harm reduction is a core component of disease prevention and management. While harm reduction services are in place at various levels in many communities, they do not exist in all. Nor are they present in some of the most vulnerable communities such as isolated First Nations communities.

One Public Health leader stated, “Our attempts to implement harm reduction services across the region have been a dismal failure”. Clearly, we need a province-wide commitment to adopting a harm reduction philosophy that can be implemented at all levels of care-including mental health care.

There is a philosophical gap in the understanding of harm reduction across the mental health care delivery continuum and when harm reduction is not implemented consistently, barriers emerge and integrated care becomes problematic. For example, the disjointed merger between Mental Health and Addictions has been stymied by Mental Health’s slow progression to adopt a harm reduction philosophy. Client’s presenting with a mental health condition and an addiction problem were and sometimes are still turned away because of a lack of ability and training to proficiently manage both mental health and addictions disorders presenting in the same client. Or clinicians were/ are philosophically opposed to providing mental health support to a client who presented an active substance abuse issue. A common complaint is that you can only access mental health services if you are clean.

Because substance use and harm reduction issues are inextricably linked to the discussion of mental health and HIV and HCV, some resources are included. Portions of the following document are included following:

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Located at: <http://www.bccdc.ca/prevention/HarmReduction/default.htm>

and

Health link BC – Health files can be accessed at:
<http://www.healthlinkbc.ca/healthfiles/index.stm>

A Manual for Frontline Staff Involved with Harm Reduction Strategies and Services

The Canadian Aboriginal AIDS Network (CAAN) has developed a harm reduction manual called *Walk with Me: A Harm Reduction Service Delivery Model* published in June 2007. The document provides a comprehensive look at harm reduction from an Aboriginal perspective. You will find an article describing the model at the end of this chapter. *Walk with Me* can found at: http://www.caan.ca/pdf/WalkWithMe_en.pdf

A Manual for Frontline Staff Involved with Harm Reduction Strategies and Services
February 2010
By BC Strategies for Harm Reduction Services
Located at: <http://www.bccdc.ca/prevention/HarmReduction/default.htm>

Introduction

The purpose of this manual is to build on the knowledge, skills, and attitudes necessary to maximize the distribution of products to reduce harms associated with substance use; and to engage, educate, and advocate for individuals. The manual outlines and encourages the use of best practice to colleagues and peers within their specific agencies and organizations. It provides a reference to what support and treatment resources are available to which they can refer individuals. Specifically frontline staff will be able to use the manual as a guide and reference tool for:

- Individual engagement
- Encourage and support needle collection and return (at the individual and community levels)
- Inform individuals about reducing risks of blood borne pathogen transmission, and safer drug using and sexual practices
- Engage with individuals to provide effective education regarding harm reduction practices associated with routes of use, substances used, and social use practices.
- Respond to individuals who report a history of past or recent trauma, abuse or violence
- Refer individuals (e.g. social services, housing, addiction and mental health treatment)
- Advocate for individuals
- Respond to community pressures and concerns.


1. Harm Reduction

At the end of this section, you will be able to explain:

Definitions of Harm Reduction

- Definition for harm reduction
- Everyday examples of harm reductions interventions.
- The guiding principles of harm reduction
- The history of harm reduction within Vancouver and globally

It is important to acknowledge that harm reduction is not a new concept. Harm reduction principles have been applied for many decades in many areas outside the field of addiction. Day to day strategies such as using a seatbelt while driving a car, wearing sunglasses while outside, or using hand rails when walking down stairs are all examples of an intervention to help reduce harm.

 ***What are some examples of harm reduction strategies that you use in your everyday life?***

Harm reduction has a variety of meanings to different people, which has made developing one general definition very difficult. Regardless of the definition, harm reduction is a philosophy, approach, and a set of principles that combined help achieve certain social and political goals. As per the BC Harm Reduction Strategies and Services Policy and Guidelines:

Harm reduction involves taking action through policy and programming to reduce the harmful effects of behaviour. It involves a range of non-judgmental approaches and strategies aimed at providing and enhancing the knowledge, skills resources and supports for individuals, their families and communities to make informed decisions to be safer and healthier.

Guiding Principles of Harm Reduction

The principles of harm reduction as outlined in the Harm Reduction: British Columbia Community Guide (2005) (Appendix 1B) are summarized below.

FOCUS ON HARMS

The fact or extent of an individual's drug use is secondary to the harms from drug use. The priority is to decrease the negative consequences of drug use to the user and others, rather than decrease drug use itself. While harm reduction emphasizes a change to safer practices and patterns of drug use, it does not rule out the longer-term goal of abstinence. In this way, harm reduction is complementary to the abstinence model of addiction treatment.

MAXIMIZE INTERVENTION OPTIONS

Harm reduction recognizes that people with drug use problems benefit from a variety of different approaches. There is no one prevention or treatment approach that works reliably for everyone. It is choice and prompt access to a broad range of interventions that helps keep people alive and safe. Individuals and communities affected by drug use need to be involved in the co-creation of effective harm reduction strategies.

PRIORITY OF IMMEDIATE GOALS

Harm reduction establishes a hierarchy of achievable steps that taken one at a time can lead to a fuller, healthier life for drug users and a safer, healthier community. It starts with "where the person is" in their drug use, with the immediate focus on the most pressing needs. Harm reduction is based on the importance of incremental gains that can be built on over time.

DRUG USER INVOLVEMENT

The active participation of drug users is at the heart of harm reduction. Drug users are seen as the best source of information about their own drug use, and are empowered to join with service providers to determine the best interventions to reduce harm from drug use. Harm reduction recognizes the competency of drug users to make choices and change their lives

For further definitions of Harm Reduction and Reducing Harms: Treatment and Beyond see Appendix 1A.

Harm Reduction in Canada and Internationally

Harm reduction started in Merseyside, England in the mid-1980s. As a result of the increasingly obvious connection between injecting drug use and the rise of HIV and hepatitis C virus (HCV) infections, harm reduction initiatives started emerging in Canada in the late 1980's with the establishment of needle exchanges, methadone maintenance and sexual health education programs. Needle exchanges, supported by provincial policy, began in BC in 1988.

During the 1990s in Vancouver, the drug market underwent a significant shift. Cocaine became available in large amounts which coincided with the increase of individuals with low incomes and mental illness in the Downtown Eastside (Kerr, Woods, 2006). In 1997, the local health authority in Vancouver declared a public health emergency when the rate of HIV infections became the highest in the Western World along with the rise in HCV infections.

Today, the prevalence of drug use and persons who use drugs in Vancouver's downtown eastside puts harm reduction in the forefront of health related issues. As a result, BC is seen as a leader within the North American context but looks internationally to research outcomes of harm reduction where harm reduction strategies are more developed.

Since 2004 the BC Centre for Disease Control has tracked the distribution of products funded by the provincial government and subsidized by Provincial Health Service Authority to reduce drug-related harms. These products include needles and syringes, sterile water, alcohol swabs, male condoms: lubricated, non-lubricated and flavoured; female condoms, and lubricant. Supplies can be ordered directly by sites which have been approved by the health authority (primary sites); smaller quantities of supplies or supplies for special events may be collected from a primary site by prior arrangement.

In November 2008 BC switched to a single source distributor so that all supplies are available from one site. The supply requisition forms (Appendix 4A) should be faxed to BCCDC where they are processed weekly (on Fridays) and sent to the distributor. The distributor has committed to having 3-months supplies in stock. Where possible sites are requested to order in bulk every 3 months to avoid handling fees for small orders. For Supply order details see Appendix 4B.

The British Columbia Harm Reduction Strategies and Services (HRSS) Committee provides the structure to facilitate coordination of evidence based harm reduction strategies and services. The BC Harm Reduction Strategies and Services Policy and Guidelines (2009) is found in Appendix 1D.

Further information on harm reduction practices can be found in the resource section of this manual. "Harm Reduction" works in cooperation with prevention, treatment and enforcement. It does not exist in isolation nor exclude prevention, treatment and enforcement. Harm reduction acknowledges the importance of prevention, treatment and enforcement 'pillars' and the need to work together to reduce harms related to illegal drug use. Vancouver's harm reduction strategies are based on the Four Pillars Drug Strategy approach.

For more information refer to Appendix 1A: Vancouver Four Pillars Drug Strategy, Appendix 1E: Harm Reduction Strategies and Services newsletter

✦ ***What are some Harm Reduction strategies you have seen implemented in your area of work?***

3. DRUG EFFECTS

At the end of this section, you will be able to explain:

- Psychological and physiological effect of depressant and stimulant drugs
- The signs of an overdose and what to do if one occurs

Psychoactive drugs are any chemical substance, natural or synthetic, which alters mood, and the level of perception or brain functioning. They may be classified by:

- o Effects on the central nervous system (CNS)
- o Legal status
- o Therapeutic use
- o Origin
- o Chemical structure

The CNS drug effects can be further divided into the following:

Depressants – decrease the activity of the central nervous system (CNS) and/or autonomic nervous system (ANS) including depression of respirations. Examples: sedative hypnotics such as alcohol, benzodiazepine and barbiturates, cannabinoids at low doses and opiates have various effects on the body mentally and physically.

Stimulants – increase the activity of the CNS and/or ANS. Examples: caffeine, nicotine, and cocaine, amphetamine and methamphetamine, prescribed amphetamine-like drugs, designer drugs such as phenylethylamines and methcathinone.

Hallucinogens – alter the state of consciousness frequently producing disturbances in thought and perception. Examples: indolealkylamines [such as Lysergic acid diethylamide (LSD), Dimethyltryptamine (DMT), magic mushrooms and morning glory], phenylethylamines [such as mescaline, MDMA (ecstasy) and some derivatives], aricycloalkylamine [such as Phencyclidine (PCP), ketamine and cannabinoids at high dose]. *Other substances* include nutmeg, mace, catnip and locoweed, betel nut, nitrous oxide, amyl or butyl nitrite. Refer to Appendix N: for a comprehensive listing of terminology or “street definitions”.

Psychiatric medications – for the treatment of acute and chronic psychiatric disorders. Examples: psychotropic medication including antidepressants such as monoamine oxidase inhibitors (MAOI), tricyclic antidepressants and selective serotonin reuptake inhibitors (SSRI); antipsychotics (such as Phenothiazine, Thioxanthene, and Risperidal) and mood stabilizers (e.g. Lithium, Tegretol).

Psychological and Physiological Effects of Depressants

Benzodiazepines- short term use at low to moderate doses

Benzodiazepines alleviate anxiety and have sedative and anticonvulsant properties. Common side effects of benzodiazepines: mild to moderate impairment of motor coordination, thinking and memory functions drowsiness, lethargy or fatigue, confusion, depression, blurred vision, vertigo, tremors, slurred speech or stuttering, euphoria, nausea, constipation, dry mouth, loss of appetite, and less commonly, vomiting and diarrhea.

Benzodiazepines- short term use at high doses

Benzodiazepine taken at a higher dose will result in sedation. As a result, the person may either appear to be intoxicated or even fall asleep. Common side effects at taking higher doses of benzodiazepines include mood swings, paradoxical excitement, erratic and hostile behaviors.

Heroin use

Opioids such as heroin (also morphine) produce analgesia, euphoria and respiratory depression. Depending on use and tolerance the effects may vary from person to person. Other effects may include: respiratory depression, nausea, vomiting, urinary retention, pin point pupils and suppression of the cough reflex. A common side effect is the decrease of gastrointestinal motility causing constipation.

Methadone

Methadone is long acting synthetic opiate antagonist with a slow onset of action. Methadone maintenance therapy (MMT) has been shown to be effective in treatment of opiate substance dependence such as addiction to heroin and morphine. When taken orally it is readily absorbed, does not cause euphoric or sedating effects and does not result in continuing tolerance. Methadone can therefore be administered orally, once daily, at a relatively constant dose to reduce cravings for heroin and block the effects of opiate withdrawal symptoms.

Psychological and Physiological Effects of Stimulants

Cocaine - short term use in low doses

Cocaine acts on the CNS and sympathetic nervous system. It creates a sense of euphoria and can trigger a fight-or-flight response. The physiological effects are increased: alertness, heart rate, respiration, blood pressure and temperature. Other symptoms include dry mouth and a decrease in appetite and sleep. Behaviors from cocaine 'high' include: elation, euphoria, excitement, pressured speech or quiet contemplation and rapture, restlessness and grinding of teeth. When ingesting lower doses of cocaine, the person experiences an immediate "rush", euphoria followed by periods of dysphoria experienced as anxiety and agitation.

Cocaine - short term use in high doses

The person using higher doses of cocaine may develop feelings of grandiosity, paranoia and even drug psychosis. Additional effects are tremors and muscle twitching, seizures, hemorrhagic stroke and cerebral infarction, headaches, rapid weak pulse and heart attack, nausea, vomiting, pulmonary edema and lung damage, acute renal failure, and hyperthermia with cold sweat.

Methamphetamine

Methamphetamine is a stimulant which acts on the CNS. D-methamphetamine hydrochloride (crystal meth) is more potent and causes more dependency than other forms of methamphetamine. It can be taken orally or rectally, injected, smoked, or snorted. The intensity and timing of the effect varies depending on how it is taken. Crystal meth causes feelings of euphoria; the person may feel powerful, have endless energy, increased productivity, enhanced sexual performance and a reduced appetite. Once the initial feeling wears off the person may experience anxiety, depression, mental confusion, fatigue, and headaches. The effects of crystal meth last longer than cocaine and can keep the person "up" for longer. Long term use of crystal meth increases a person's tolerance causing them to require larger and more frequent doses for the desired effect. Prolonged use causes irritability, paranoia, violence, weight loss, psychosis known as "tweaking". Extreme paranoia and violence may occur and the psychosis may become permanent or continue as flashbacks.

Overdoses

Street drugs are not controlled substances; this contributes to the risk of overdose due to the uncertainty of quality and strength of the substance as well as the combination of these drugs. High dose of depressants can cause the body to shut down by affecting brain function. High doses of stimulant can increase the affect of heart function by falsely causing the body to think it needs to work harder and faster to the point of exhaustion and collapse. If left untreated, it can be fatal.

Benzodiazepine overdose

Benzodiazepines are frequently involved in overdoses but are rarely the sole cause. They have a wide range in dose before they can become toxic which makes overdose difficult even if large quantities are ingested. However, an overdose of benzodiazepines is possible as it can cause respiratory depression.

Heroin overdose

Long term use of heroin decreases the effects felt by the user (tolerance) resulting in a need to increase the dose for the desired effect and the risk of overdose. A lethal dose of heroin affects level of consciousness and respiration so you will see the person lapsing in and out of consciousness (nodding) which may result in the person possibly aspirating on their own vomit or slowly going into respiratory arrest.

Cocaine overdose

Cocaine overdose has no known antidote so overdosing on cocaine is fatal. A lethal dose of cocaine depends on a person's tolerance, method of use and any underlying medical condition. The effects of a cocaine overdose are: cardiac arrhythmias, seizures, intracranial hemorrhage (bleeding in the brain), hyperthermia or respiratory arrest.

Poly drug overdose

A poly drug overdose involves a combination of drugs. Combinations of CNS depressants such as alcohol, opiates, benzodiazepines, methadone, barbiturates, psychotropic medications and/or antiepileptic together enhance each others depressant effect. Long acting substances like methadone, benzodiazepines and alcohol increase the risk of overdose when introducing heroin to the combination.

Recognizing an overdose

Often it is hard to identify when an overdose is happening. Being able to identify certain characteristic of an overdose will aid in providing the correct type of care required to assist someone in an overdose. Being able to recognize when someone is "on the nod" or "dropping" is essential. Nodding is recognized when someone appears to be falling asleep but can be roused when called by their name or by physical stimulation such as shaking them by their shoulders. Someone who has "dropped" cannot be woken up by any stimulation and are unresponsive (unconscious). Overdosing at times can be obvious. When someone has just taken a shot and immediately "drops", is unresponsive, experiencing slow shallow breaths or not breathing at all, and/or cyanotic (turning blue) they are overdosing. Unfortunately, poly drug overdose can be less apparent as it sometimes is a slower process. The person may slowly become unconscious but appear like they are sleeping while their breathing slowly stops.

What do I do if I find someone who has collapsed?

Assess the situation

Stay calm and examine the area for potential dangers to you, the victim and others. Look for needles, blood and any surrounding dangers. Ensure a safe environment for the victim and yourself by dealing with the dangers first.

Assess the victim

Check to see if they need your help by checking their level of consciousness. Call their name, if they do not respond or if they appear like they are in a deep sleep try waking them up by "shaking and shouting". Squeeze their earlobes, try to get them to open their eyes or squeeze your hand. If they do not respond, they are unconscious.

Airway and respiratory management

Check to see if the person is breathing. If the person is unconscious and lying on their back, check to see if they have anything in their mouth that may potentially be blocking their airway and remove it. Put them on their side to prevent their tongue from sliding back and blocking their airway. When putting them on their side, ensure their head is tilted back and slightly downward. If the victim is not breathing call 911 and start CPR.

Use of Narcan

Naloxone (Narcan) is a narcotic antagonist otherwise known as an antidote for opioid overdose. Narcan is administered by injection, trained medical professionals such as doctor's, nurses and paramedics. Narcan works by rapidly reversing the depressive affects of the opioid in the body but not of alcohol or barbiturates. Narcan is a temporary treatment to opioid overdose, as it only last between 1-4 hours in the body, and usually requires multiple doses. When Narcan begins to wear off the heroin in the body begins to take effect causing the victim to slowly become unconscious again.

Opportunities for prevention of overdose

Taking opportunities to engage with individuals regarding issues concerning overdosing is essential in overdose prevention. This consists of building individual relationships, discussing changes in the individuals' drug tolerance, and identifying safety concerns such as communicating safety plans when using which allows for the individual to contribute to their own care.

This section was adapted from Custodial Drug Guide: Medical Management of People in Custody with Alcohol and Drug Problems, 2nd ed.

Harm Reduction and Mental Health

At the end of this section, you will be able to explain:

- Define of co-occurring mental health and substance use problems
- Recognize the relationship between drug use and mental health disorders

Substance use problems are commonly seen in mental health. Sometimes this is referred to as concurrent disorder, dual diagnosis, dual disorders, co-morbidity and co-occurring substance abuse disorders and mental disorders. To encourage sensitivity to the stigmas associated to these terms, co-occurring mental health and substance abuse problems has been developed. Co-occurring mental health and substance abuse problems can be described as one or more mental health diagnosis along with abuse of one or more substance.

The relationship between substance use and mental health disorders are multifaceted. As explained below:

- o Substance use may be causing the psychopathology (a substance- induced mental disorder). Some of the most common substance induced disorders are alcohol-induced depressive disorders, cocaine-induced psychotic disorders and stimulant-induced anxiety disorders.
- o Substance use may be secondary to the psychopathology in various ways: Patients may use substances to self-medicate the symptoms of their mental disorder (for example, alcohol may be used to alleviate the symptoms of an anxiety disorder, such as social phobias).
- o Patients may use substances to enhance symptoms of the mental disorder (as in the use of stimulants by manic patients).
- o Patients may use substances in the attempt to counter side effects of medications that they are taking for a mental disorder (for example, a patient with schizophrenia may use cocaine in an attempt to counter neuroleptic side effects).
- o The mental disorder and the substance use problems may be coincidental and not related to each other (Miele G, Trautman K, Hasin D: Assessing co-morbid mental and substance-use disorders: a guide for clinical practice, *J Pract Psychiatry Behav Health* 2:272, 1996).

Working With Individuals

At the end of this section, you will be able to describe:

- **Personal values, attitudes and misconceptions towards harm reduction.**
- **How to refer individuals appropriately**
- **How to advocate for individuals and harm reduction**
- **The links between families, individual and community**
- **Harm reduction Strategies in relation to youth**
- **Harm reduction strategies in relation to lesbian, gay, transgender, bi-sexual, queer (LGTBQ).**

Personal values, attitudes and misconceptions

To put harm reduction into practice, it is important to convey acceptance and support individuals to become the experts in their own lives. The service provider, regardless of their beliefs should not show disapproval of active drug use as it can destroy the therapeutic relationship and the individual's sense of self worth. For service providers to keep their motivation and dedication in this area of work, we must feel like we are making a difference. If individuals don't change then we don't feel like we are doing our work and we are failing the individual. The more we enforce these expectations of ourselves, the harder our work becomes increasing our chance of burn out and disengagement

Stigma and discrimination issues that can affect harm reduction strategies

Stigma refers to negative attitudes (prejudice) and negative behaviour (discrimination). These attitudes and judgments can affect how we think about, behave and provide care to clients.

“People with substance use and mental health problems are not normal or not like us; that they caused their own problems; or that they can simply get over their problems if they want to”.

Individual Engagement Strategies

Harm reduction providers work to build relationships with people to deliver the best possible service to individuals and the community. Effective client engagement recognizes the diversity of consumers of harm reduction supplies and services. Services should understand why individuals are accessing harm reduction supplies and how best to support each person. This means knowing how and why supplies are being used, being aware of the specific issues different individuals may face and by providing education, referrals and support to each person.

It is important that service providers be able to educate about:

- o Safer using practices
- o Safer sex practices
- o Addictions issues and supports
- o Recreational drug use
- o Culturally competent services and supports for marginalized peoples
- o Transgender issues and hormone injection practices
- o Identifying health issues
- o Local programs and services to support your clients

Individuals come first:

- o Always greet the person regardless of what else you are doing – make eye contact, smile, etc.
- o Be friendly
- o Thank people for coming in
- o Understand if the client is in a rush

Meet an individuals needs: reducing the spread of infection:

- o Always give out what is asked for without judgment
- o Support secondary distribution
- o Ask people if they know how to use harm reduction supplies

Caring for our communities:

- o Always ask for or about returns
- o Harm reduction consumers are part of the community- returning used needles re-enforces that feeling
- o Thank people for returning needles

Our health is Important:

- o Goal of the program—access to healthcare services
- o Important for people to know what resources are available.
- o Understand what illness looks like – specific cues
- o Extremely sensitive issue
- o Always try to follow up with client

Respect is a two way street:

- o Consumers and service providers must be respectful to each other
- o Both staff and consumer should respect each others privacy. Staff should not share confidential information with outside services unless given permission to do so by the consumer.

Responding to a History of Abuse

Domestic violence (also referred to as intimate partner abuse) is a crime. It results from an imbalance of power and control over one's partner. Domestic violence is primarily committed by men against women but also occurs in same sex relationships and by women against men. Domestic violence does not necessarily mean the person is physically battered or beaten. Abuse comes in many forms and can include various forms of mistreatment and cruelty such as:

- Constant threatening
- Psychological/emotional abuse,
- Sexual abuse
- Financial/material abuse
- Spiritual and verbal

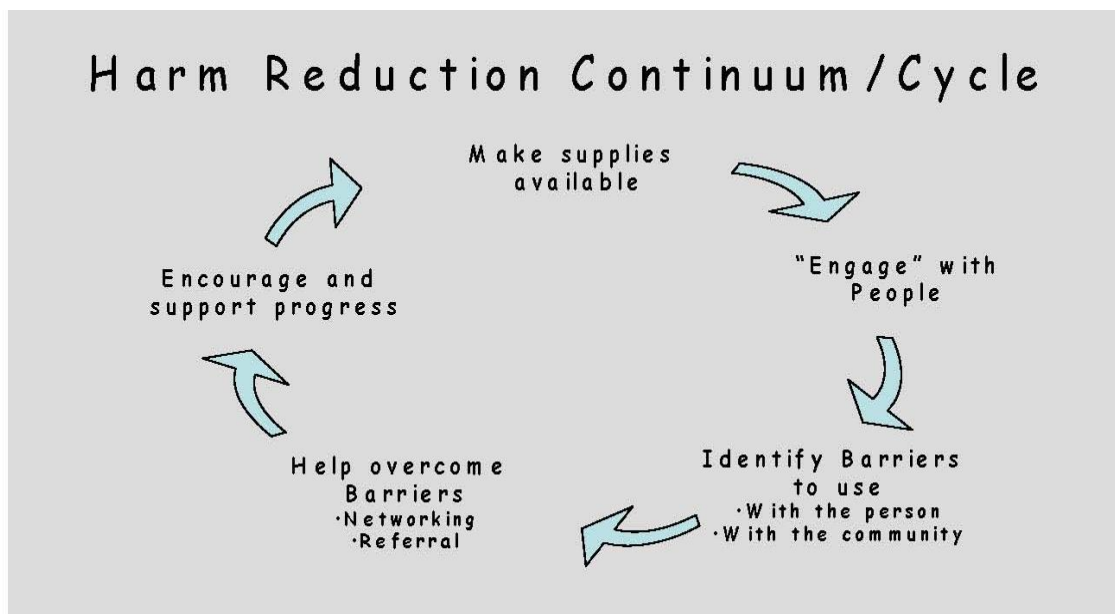
Goals in reducing harms associated with abuse:

- To increase the safety for women and men who are being abused
- To increase access to resources
- To assist in the collection of relevant medical evidence should the client choose to engage in the legal process
- Provide support and advocate for client safety

Families, Individual and Community

Harm reduction affects families, individuals and communities; building relationships at each level is essential, refer to Appendix 1D: Harm Reduction for Families and Caregivers health file for additional information related to harm reduction, families and your community. Below is a diagrammatic representation of the Harm Reduction Continuum or cycle; it is a useful tool to consider the stages of harm reduction and the need for continuous engagement and relationship building.

- An excellent resource is Canadian HIV/AIDS Legal Network: Nothing About Us Without Us — Greater, Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical, and Human Rights Imperative: <http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=85>



Various activities are included in the appendix of the manual to assist you in building these relationships. These activities include 7A, the Engagement Role Play and 7B, the 5min Elevator Pitch activity, which are exercises on how to engage with individuals regarding harm reduction. The Peer Engagement activity (7C), is a group activity to be used with colleagues, or community members to identify the benefits of peer involvement in harm reduction within your community and also to identify some challenges.

How to promote community involvement to harm reduction initiatives:

- o Build rapport and trust within the community
- o Establish relationships within the community
- o Raise awareness about prevention, care and social services for HIV/AIDS, STD's drug use addictions and homelessness
- o Educate the community about resources and current services within the community
- o Support communities and build self esteem among targeted populations
- o Respect the community and the people within it

Community barriers will always exist. Health care providers should take every opportunity possible to explain in clear culturally relevant terms the goals of their harm reduction strategies. Given the distrust that exists in various communities around drug related harm reduction initiatives, building community relations is an indispensable part of everyone's role. Listen and learn from what the clients and the communities tell you. The following are common barriers affecting harm reduction initiatives within communities:

- o Stigmas, myths and misconceptions
- o Drugs and behaviors
- o Politics
- o Lack of support
- o Lack of trust
- o Lack of funds

Building rapport and trust within the community is time consuming but is critical to the success of harm reductions initiatives. The following are individual barriers:

- o Negative attitudes, prejudices, homophobia, racism and sexism
- o Being judgmental toward target populations
- o Lack of respect for individual choices, fear of change
- o Health condition

Referring Clients to Other Services

- o Housing
- o Social Services
- o Mental Health

Advocating for Clients

Advocacy is the pursuit of influencing opinions, individual behaviors, and organizational conduct to achieve social change. Desired outcomes include influence on public policy, law, and resource allocation. Advocacy often occurs in the context of activities intended to educate and inform, while at other times may involve non-partisan political dialogue.

Youth

Harm reduction measures do not only apply to adult but youth as well.. On many occasions they are stereotyped into categories such as difficult, unmotivated and unreliable which hinders their involvement in their own care. The attitude of “we know best” frequently denies youth from the same care provided to adults.

Confidentiality is continuously a dilemma that arises when providing care for youth. Understanding the limitations to confidentiality, for many, is a challenge due to parents feeling they have the right to request information and/or withhold information from them and youth wanting to withhold information such as sexual activity or substance abuse from their parents.

Confidentiality is a right for all competent persons; therefore, all competent teens have the right to keep their health status private from family members, including parents (Canadian Paediatric Society, 2008).

The challenges at times are both ethical and legal. Many times we are inclined to tell the parents without taking into context the potential harms such physical or mental abuse that may result in disclosing information. In such case the obligation is to promote client safety and advocating for the client right to privacy.

Age of consent -decision-making in these situations should be in accordance with the Health Care Consent Act, which clearly states that consent to medical treatment depends on the mental capacity, not the chronological age of the patient (17,18). Only the province of Quebec has a fixed age of consent of 14 years, below which the consent of a parent or guardian is required (17). In all other provinces, the capacity to accept or refuse treatment is dependent on the teen’s ability to understand his or her condition and the options available to him or her. To be capable, the teen must understand and appreciate the risks and benefits of accepting or refusing treatment. More complex illnesses and treatments are harder to understand and, therefore, require a higher degree of competency to consent to treatment

Lesbian, gay, transgendered, bisexual, queer (LGBTBQ)

As with many marginalized populations, many LGBTBQ people experience substance use, mental health issues and trauma, discrimination and violence. Harm reduction service providers must be educated on how to create safe spaces and how to support LGBTBQ consumers. This means understanding LGBTBQ experiences and identities, identifying community resources and ensuring clients feel safe and supported in accessing your services. For more information including terms and additional reading refer to Appendix U: Glossary of terms and Appendix V: Suggested additional readings:

Adapted from Prism Alcohol & Drug Services: An Introduction to working with Lesbian, Gay, and Bisexual People, and Transgender people.

Aboriginal communities

The burden of disease for HIV/AIDS has been greater for Aboriginal people in the province of British Columbia (BC). Although Aboriginal people comprise approximately 5% of the population of BC, in 2007 Aboriginal people made up 13% of new HIV infections. This over representation is even more pronounced for Aboriginal women who accounted for 36% of new HIV cases in women in BC. (Chee Mamuk 2008). Studies completed on HCV prevalence among Aboriginal populations are limited in their generalizability as most have been conducted in urban centers among those self-identifying as Aboriginal. Also, compared to the population at large, the prevalence of HCV infection is high amongst Aboriginal people (Hepatitis Services, BCCDC).

Rates of infection are shaped by a number of realities for Aboriginal communities such as poverty, unemployment, poor access to health care, discrimination, residential school effects/cycles, homelessness, and addictions. These realities are pathways for infections like HIV and hepatitis into the community. Communities are at different levels of readiness to deal with these infections and there still remains a lot of stigma, fear, and misinformation.

Many Aboriginal communities follow an abstinence-based approach to addiction and strategies to make clean drug equipment available, like needles, may lack support from community leaders. Even condom distribution is discouraged in some communities. Recognizing these challenges, all Aboriginal AIDS Organizations in BC are working on harm reduction programming and education. Leaders from these organizations have come together on Aboriginal HIV/AIDS programming in an initiative called *Renewing Our Response*. This work is to renew the BC Aboriginal HIV/AIDS strategy developed in 1998 by the *Red Road HIV/AIDS Network*. One of the five strategic areas *Renewing Our Response* has identified is building readiness in Aboriginal communities for harm reduction programming.

For those who have not worked in or with Aboriginal communities it is imperative to understand that each band belongs to a Nation, with languages, traditions, processes and attitudes that are individual and distinct from each other Nation in BC. For example talking to somebody in the Carrier Nation is different than speaking to a Sylix (Okanagan) Nation member. Since each nation has their own protocols to be followed, time spent on researching the individual nations is important. Take time to get to know your local nations.

Also, when presenting information in Aboriginal settings, it is imperative to give verbal thanks to the traditional stewards of the land (the Aboriginal Nation) where the presentation is taking place. The Canadian Aboriginal AIDS Network (CAAN) has developed a manual called "Walk With Me: Pathways to Health; Harm Reduction Service Delivery Model". It is a culturally safe harm reduction model that shows a process a community or organization can go through to develop harm reduction programs. Refer to Appendix 6A: Walk with Me: Pathways to Health; Harm Reduction Services Delivery Model.

The Canadian Aboriginal AIDS Network (CAAN) has developed a manual called "Walk With Me: Pathways to Health; Harm Reduction Service Delivery Model". It is a culturally safe harm reduction model that shows a process a community or organization can go through to develop harm reduction programs. Refer to Appendix 6A: Walk with Me: Pathways to Health; Harm Reduction Services Delivery Model

Many Aboriginal AIDS Organizations in BC utilize the Community Readiness Model. This model was developed by the TriEthnic Centre at the University of Colorado. It is used to assess how ready a community is for a topic and suggests strategies that will match the communities' level of readiness. This model can assist communities to build readiness for harm reduction programs. The following website has more information on the Community Readiness Model: <http://www.triethniccenter.colostate.edu/>.

IMPLEMENTING HARM REDUCTION IN ABORIGINAL COMMUNITIES

Implementing Harm Reduction in Aboriginal Communities

By Trevor Stratton

CAAN Harm Reduction Project Coordinator

Aanii!!

The harm to Aboriginal individuals, families and communities resulting from substance use is immense, reaching across generations and across Turtle Island. Our communities need to be able to respond to these issues in a meaningful, culturally appropriate, and community-specific ways. Harm reduction is about meeting people where they are at and providing services in a non-judgmental way.

My name is Trevor Stratton and I am the project coordinator for the CAAN Harm Reduction Project. Through the project, CAAN hopes to encourage all Aboriginal people to think and talk about harm reduction and how they might be able to apply it in their setting (community, workplace, school, home, etc.).

Last fiscal year, CAAN developed the Harm Reduction Implementation Guide as a compliment to another CAAN resource called Walk With Me – Pathways to Health; Harm Reduction Service Delivery Model which focuses on certain groups of Aboriginal people statistically at higher risk for contracting HIV and Hepatitis C Virus (HCV). The four target groups of the Walk With Me document are Aboriginal women, Aboriginal youth, Aboriginal people who are or who have been in prison, and Aboriginal 2-spirit men.

Through the CAAN Harm Reduction Implementation Guide, the project utilizes the Community Readiness Model developed by the Tri-Ethnic Center for Prevention Research housed at the Colorado State University (www.triethniccenter.colostate.edu). The goal of the project is to assist Aboriginal agencies to assess their stage of readiness to implement harm reduction. We are working with four agencies within each of the three cities; Toronto, Regina and Vancouver. 2-Spirited People of the 1st Nations in Toronto, All Nations Hope AIDS Network in Regina, and Healing Our Spirit BC Aboriginal HIV/AIDS Society in Vancouver will take the role of Local Host Agency.

Local Host Agencies in each city are responsible to support the project coordinator to make contact, establish rapport, trust and cooperation with the three other collaborating Aboriginal agencies in the three cities. They will also be a part of the circle of continual dialogue around harm reduction implementation with the other three collaborating agencies.

This project involves assisting each of the 12 Aboriginal agencies through five steps:

1. Identify the issue (e.g., how ready is a site community to accept harm reduction interventions?)
2. Define “community” with respect to the issue (e.g., readiness to assess community's harm reduction stage)

3. Conduct a community readiness assessment to determine the community's level of readiness to address the issue (e.g., knowledge of harm reduction, knowledge of community issues, etc.)
4. Score community assessments and rate community stage of readiness for each dimension
5. Provide training specific to the stage the community is at, as determined by Step four (4).

Dimensions of readiness are key factors that influence your community's preparedness to take action on an issue. The six dimensions identified and measured in the Community Readiness Model are very comprehensive in nature. The dimensions are useful for "diagnosing" your community's needs and for developing strategies that meet those needs.

Stages of readiness reflect where a community is at along the continuum of readiness to address a given issue, from no awareness of the issue at all to a high level of community ownership over the issue.

Using "stage appropriate" strategies is very important to the success of your

intervention; challenging a community with strategies that are more than what it is ready for may cause tension or division and will not help create a community climate
Understanding how ready your community

conducive to change. Especially for sensitive issues, like domestic violence, child abuse, and harm reduction, for example; these are very difficult for many people to acknowledge in their communities because there is much pain associated with sharing and discussing these experiences. You do not want to "trigger" a community with the intervention you plan. Instead, meet the community where it is at.

The goal of this exercise--using the Community Readiness Model to assess your community's "readiness" in relation to implementing harm reduction service delivery models like Walk With Me—is to assess how your community views harm reduction, what might be some challenges, what resources in the community are available to help in the response, and—given the "mood" of the community—to determine which strategies might be most appropriate for influencing the creation of a community climate that values harm reduction as a tool in responding to substance use and the harms associated with it.

Together, our communities can make a difference, step by step, inch by inch. Yes we CAAN.

On a side note, I just have to mention the Canadian Aboriginal AIDS Network's AGM this year in Winnipeg (the Métis homeland as they call it).



as they call it). It was the most fun ever!! The APHA Caucus went extremely well this year bringing forward 6 AGM resolutions to the floor.

CAAN's national partners and many funders were invited to speak and to participate in the skills-building and AGM. Their presentations and feedback were informative, enthusiastic and supportive. Winnipeg Métis home girl Sierra Noble fiddled and serenaded us to our hearts' content. We all got up there with them, of course, and tried our best at jigging! My feet are still sore.

There was a round dance, a circle of women drummers, a couple of drag show numbers, and even "CAAN-CAAN" dancers in bright red dresses!! And how could I forget Monique and Tom's wedding! Fabulous! There was also a showing of a new Inuit documentary about HIV/AIDS starring one of our favorite Inuk women activists. The award ceremony acknowledging leaders in the Aboriginal HIV/AIDS movement really sent the message home.

Good work, team!



NOTES