



ONTARIO  
HIV & Substance Use  
Training Program

Harm Reduction  
Updated: August 2011

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## Harm Reduction

**Goal:**

- To increase participants understanding of the philosophy and practices of Harm Reduction.

**Objectives:**

- To help participants gain a greater appreciation of the history, principles, and practices of a Harm Reduction approach.
- To engage participants in considering how a Harm Reduction framework could be incorporated into their work.

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## Harm Reduction as we know it...

- Sun Screen
- Condoms
- Seat belts
- Bicycle Helmets
- Designated driver
- Blood alcohol levels
- Nicotine patches/gum
- Needle Exchange



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## A Few Statistics

- 13.2 million people inject drugs worldwide, 3 million are infected with HIV <sup>(1)</sup>
- In 2002, IDU accounted for 10% of all new HIV infections worldwide <sup>(2)</sup>
- 80,000-125,000 injection drug users (IDUs) in Canada (Fischer et al. 2005);
- In 2005, IDU accounted for 14% of all new HIV infections in Canada <sup>(3)</sup>
- 70% of new HCV cases are attributable to injection drug use <sup>(2)</sup>
- Prisoners are 7-10 times more likely to be infected with HIV than people outside prison; 30 times more likely to be infected with HCV
- Aboriginal people are over represented in the HIV/AIDS epidemic in Canada
- > 60% of new HIV cases among aboriginal people are attributable to IDU

(1) Harm Reduction and Injection Drug Use, Health Canada, 2001  
(2) OHTN HCV Scoping Review, 2007  
(3) Public Health Agency of Canada, 2006

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## A Few Statistics - Ontario

- ~41,000 injection drug users; 35-40% of Canadian total.
- HIV rates amongst active IDUs:
  - Toronto (5.1%)
  - Sudbury (10.1%)
  - Ottawa (11.1%)
- HCV rates amongst active IDUs:
  - Toronto (54.2%)
  - Sudbury (61.5%)
  - Ottawa (75.8%)
- Almost all HIV+ IDUs are co-infected with HCV.
  - Approximately 1,800 in Ontario

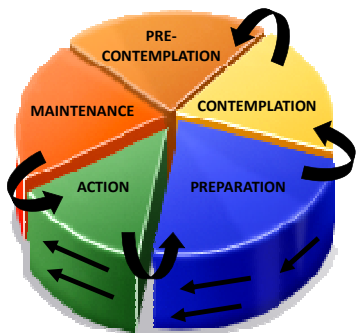
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## Continuum of use

- No Use** - the person does not use alcohol or other substances.
- Experimental Use** - the person tries a substance out of curiosity and may or may not use it again.
- Social or Occasional Use** - the person uses the substance in an amount or frequency that is not harmful (e.g., a drink on a social occasion).
- Medication Used as Directed** - the person uses a medication as prescribed, under medical supervision. The risk of harm is minimized.
- Harmful Use** - the person experiences negative consequences of medication or substance use, e.g., health problems, family, school, work problems, legal problems.
- Dependence** - the person is psychologically and/or physically dependent on a prescribed or non-prescribed substance and use continues, despite the person experiencing serious problems.

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## Stages of Change



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## Harm Reduction: Part of the Puzzle

"Harm reduction complements approaches that seek to prevent or reduce the overall level of drug consumption. It is based on the recognition that many people throughout the world continue to use psychoactive drugs despite even the strongest efforts to prevent the initiation or continued use of drugs. Harm reduction accepts that many people who use drugs are unable or unwilling to stop using drugs at any given time. Access to good treatment is important for people with drug problems, but many people with drug problems are unable or unwilling to get treatment. Furthermore, the majority of people who use drugs do not need treatment. There is a need to provide people who use drugs with options that help to minimize risks from continuing to use drugs, and of harming themselves or others. It is therefore essential that harm reduction information, services and other interventions exist to help keep people healthy and safe."

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## Key Principles

- Harm Reduction is an umbrella term that sets a framework for the design and delivery of policies, programs, services and actions, that work to reduce the health, social and economic harms to individuals, communities and society that are associated with many activities, including substance use.
- The goal is to prevent or reduce the harms associated with substance use.
- Calls for non-judgmental and non-coercive strategies and approaches and aims to provide and/or enhance skills, knowledge, resources and support for people to live safer, healthier lives.

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## Key Principles

- Recognizes that abstinence is on a continuum of substance using behaviour that may not be desirable or achievable for some.
- Recognizes the intrinsic value and dignity of human beings.
- Believes that substance use is a complex social issue which should be approached from a health perspective, not a criminal justice one.
- Does not judge licit and illicit substance use as good or bad, but rather as a normal part of human behaviour.

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## Key Principles

- Supports access to harm and risk reduction resources and equipment.
- Values the competency of substance users to make choices about their lives.
- Recognizes the need for user and community involvement.
- Advocates for changes to existing punitive drug policies and negative attitudes towards substance users.

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## What Harm Reduction is not...

- Neither for or against drug use.
- Tacit consent to use drugs.
- Anti-abstinence.
- "Don't ask, don't tell".
- "Trojan horse" for drug legalization.
- "Anything goes".

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## History

### 1960's

- Growing concern about the health risks associated with alcohol and tobacco.

### 1980's

- Focus on HIV prevention among gay men and their sexual health and people who inject substances (especially heroin and cocaine).
- Condom distribution, needle exchange programs and outreach begin.

### 1990's

- Expansion beyond NE programs to include other scenes, methods of consumption and other substances (e.g., smoking and snorting; ecstasy).

### 2000's

- Safer inhalation equipment distribution.
- Some jurisdictions developing integrated substance use strategies (e.g., Vancouver's Four Pillars Approach and Toronto's Drug Strategy).

### 2006

- Province of Ontario establishes and funds the Ontario Harm Reduction Distribution Program (OHRDP)

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## Drug Strategies

- Some communities have developed strategies to address issues relating to substance use.
- These typically have "4 pillars":
  - Prevention
  - Harm Reduction
  - Treatment
  - Law Enforcement
- All four are needed to effectively respond to substance use issues.

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## Currently (since 2006)

- Impact of localized/municipal policies
  - e.g., uneven distribution of safer crack kits; problems establishing methadone clinics
- Federal (Canadian) Anti-Drug Strategy
  - Changes to policies and legislation
    - e.g., cancellation of safer tattooing project in prisons
  - Changes to sentencing for drug related crimes
  - Research, political and scientific debates
  - Example of current prevention ([not4me.ca](http://not4me.ca))
  - CSSDP mirror site: [not4me.org](http://not4me.org)

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## Cigarettes

"Tobacco, though legal, remains the only consumer product that will kill at least one out of every two of its regular users when used exactly as intended by the manufacturer. Tobacco has been proven to have no sustenance value; it serves only to addict. Cigarettes are highly engineered drug delivery devices aimed exclusively at achieving "nicotine addiction by design", resulting in profits for the tobacco industry and its' shareholders."

Dr Charl El, University of Alberta



## Harm Reduction and Substance Use

- "Reducing the harm" (not necessarily stopping the use)
- Initiatives and strategies which reduce the negative consequences of substance use for:
  - Substance users
  - Friends/families
  - Communities
- Strategies can incorporate:
  - Safer substance use techniques and behaviours
  - Managed use
  - Abstinence
- Should ideally support the needs of individuals and address community concerns:
  - e.g., discarded needles

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## Harm Reduction and Abstinence

- Harm reduction and abstinence are highly congruent goals.
- Harm reduction expands the therapeutic conversation, allowing providers to intervene with active users who are not yet contemplating abstinence.
- Harm reduction strategies can be used at any phase in the change process.

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## Harm Reduction Strategies

Emphasize practical, short-term improvements, whether or not they can be shown to reduce drug use:

- Injecting daily but getting connected to a doctor for the first time.
- Still smoking crack daily but now using own pipe and not sharing.
- Showing up to 2 appointments out of 4, versus never coming in before.
- Learning to eat soft foods when high.



## 5 Risk Reduction Tips

Self-directed harm reduction strategies to help avoid overdosing, bad highs, missing work, dehydration, or other consequences after use:

1. Rationing
2. Rules for selecting and mixing
3. Controlling quality
4. Maintaining a healthy lifestyle
5. Following guidelines during use

Adapted from: "Greenspan, N.R., et al. "It's not rocket science, what I do": Self-directed harm reduction strategies among drug using ethno-racially diverse gay and bisexual men. *International Journal of Drug Policy* (2010), doi:10.1016/j.drugpo.2010.09.004"

## Rationing

- Limiting or regulating the quantity and/or frequency of use in a particular setting, or over a given time period.

- *"I limit myself to two pills a night."*
- *"I don't party every weekend."*
- *"I need time to recover before work on Monday."*

## Rules for selecting and mixing

- Which drugs you will use.
  - Certain characteristics maybe reasons to choose or avoid specific drugs:
    - *"It doesn't leave me hung-over.;" "I can afford it."*
    - *"I won't do that because it's illegal.;" "I don't like speedy drugs."*
- How you will take them.
  - Method of consumption can be a deterrent:
    - *"I would never stick anything up my nose."*
- Which drugs you can use at the same time.
  - Physical harms are often reason to avoid specific drugs or combinations:
    - *"If I mix these two I could pass out."*
    - *"This drug won't mix well with my prescription."*

## Controlling quality

- To ensure, as best you can, the quality of drugs used.
  - Obtaining drugs from a "reliable source"
    - Get to know your dealer
  - Using drugs that have been (safely) used by others
    - Ask around: "Peer Reviews"
  - Trial & error and inspection
    - Get to know how drugs look, taste, smell
    - Become familiar with how they feel in the body and how long the effects last

## Maintaining a healthy lifestyle

- Eating, resting, sleeping
- Drinking water
  - Not sharing water bottles
- Taking vitamins and other supplements

## Following guidelines during use

- Drinking water when partying
  - Especially in hot environments or when physically exerting yourself
- Using with people you trust and have experience
  - They can help if you have a problem
- Not sharing drug use equipment
  - To avoid HIV and Hep C but even common cough and cold viruses
- Watch out for your drinks
  - To prevent deliberate or accidental contamination

## Harm Reduction Initiatives

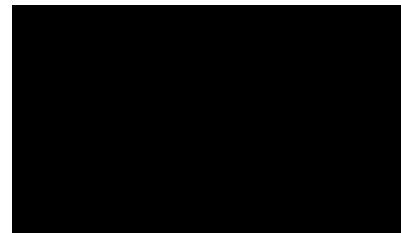
- Street Outreach
- Education, providing achievable options
- Supplying condoms
- Moderate/Controlled using strategies
- Needle Exchange and Safer Inhalation Programs
- Tolerance zones (e.g., Supervised Injection Sites)
- Methadone Maintenance Programs
- Prescription of heroin and other drugs (e.g., NAOMI)
- User groups, peer support
- Law-enforcement cooperation

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## Alcohol Harm Reduction

- Managed Alcohol Programs:
  - Wet / Damp / Dry
- Shelter Based Alcohol Harm Reduction Programs:
  - Hamilton, Ottawa, Toronto
- Ottawa Study:
  - Shelter-based Managed Alcohol Administration to Chronically Homeless People Addicted to Alcohol  
*Canadian Medical Association Journal (CMAJ), 174(1): 45-49, 2006*
  - Significantly decreased Emergency Department visits and police encounters

## Shelter-based Managed Alcohol Program (Ottawa)



## OHRDP ontario harm reduction distribution program

Established in 2006, the Ontario Harm Reduction Distribution Program (OHRDP) provides, free of charge to participating programs, harm reduction materials to be distributed alongside the traditional needles and syringes of Needle Exchange Programs (NEPs). Products available, intended to reduce the transmission of infectious disease, include:

- Sterile water · Alcohol swabs · Tourniquets
- Filters · Vitamin C (acidifier) · Cookers

In addition to the distribution of harm reduction materials, the OHRDP provides education, learning opportunities, knowledge transfer, intelligence support, and the dissemination of important literature, to the NEPs of Ontario. NEPs can access OHRDP on matters of policy and program development, including in-service education.

- 34 active NEPs in Ontario, each affiliated with local Public Health.
- NEPs remain "mandatory programs".
- In 2004 Ontario's NEPs distributed over 3.2 million new syringes.
- NEPs continue to grow and face new challenges, there remains much variation between programs.

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## Safer Injection Kit



- Alcohol swabs
- Cookers
- Sterile water
- Cotton filters
- Needles/syringes
- Tourniquet
- Safer injecting tips
- (Vitamin C)

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VIDEO: Step-by-step demonstration of safer injection:  
[http://hepcinfo.ca/videoplayer\\_e/safer\\_injection\\_e.FLV](http://hepcinfo.ca/videoplayer_e/safer_injection_e.FLV)



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## Safer Crack Kit



- Alcohol swabs
- Pyrex-glass pipe
- Rubber mouth piece
- Heat resistant metal screens
- Chopstick
  - Helps prepare screens
- (Lip Balm)

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VIDEO: Step-by-step demonstration of safer crack smoking:  
[http://hepcinfo.ca/videoplayer\\_e/safer\\_smoking\\_e.flv](http://hepcinfo.ca/videoplayer_e/safer_smoking_e.flv)



## Ontario Harm Reduction Distribution Program

OHRDP

Provincial Report: Outcome Evaluation, Wave 1-Baseline, February 2008

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## Ontario Needle Exchange Data

Table 1 Socio-demographic Profile: Gender and Age

		N=1622	
		N	(%)
Gender		N= 1620	
	Male	1111	(68.6)
	Female	502	(31.0)
	Transwoman	1	(0.1)
	Transman	2	(0.1)
	Other	4	(0.2)
		N= 1610	
Age	Mean (standard deviation)	36.99 (10.85)	
	Range	14 to 74	

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## Ontario Needle Exchange Data

Table 2 Socio-demographic Profile: Level of Education and Living Situation

		N=1622	
		N	(%)
Highest level of education completed		N= 1620	
	Less than high school completed	800	(49.4)
	Completed high school	412	(25.4)
	Completed or some post secondary	408	(25.2)
Living in unstable housing in six months prior to interview		N= 1610	
	Yes	879	(54.3)
	No	740	(45.7)
Living in unstable housing at time of interview		N= 1619	
	Yes	465	(28.7)
	No	1154	(71.3)

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## Ontario Needle Exchange Data

Table 3 Socio-demographic Profile: Needle Exchange Program User Status

		N=1622	N (%)
<b>EVER used the services of the local needle exchange program</b>		<b>N= 1616</b>	
	Yes	1400	(86.6)
	No	216	(13.4)
<b>Frequency of using the needle exchange program (past 6 months)</b>		<b>N= 1384</b>	
	Never	87	(6.3)
	Once/First time today	212	(15.3)
	Not every week	562	(40.6)
	Once or twice/week	369	(26.7)
	Three to six times/week	92	(6.6)
	Daily	62	(4.5)

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## Ontario Needle Exchange Data

Table 4 Drug Use Patterns: Frequency of Injecting Six Months Prior to Interview

		N=1622	N (%)
<b>Frequency of Injecting Six Months Prior to Interview</b>		<b>N= 1606</b>	
	Not every week	395	(24.6)
	Once or twice a week	310	(19.3)
	Three or more times per week	322	(20.0)
	Daily	579	(36.1)
<b>Days injected in month prior to interview</b>		<b>N= 1415</b>	
	Mean (standard deviation)	16.39	(11.29)
	Range	1 to 31	
<b>Number of times a day injected</b>		<b>N= 1598</b>	
	Mean (standard deviation)	5.17	(6.78)
	Range	1 to 70	

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## Ontario Needle Exchange Data

Table 5 Drug Use Patterns: Drugs Injected in the Six Months Prior to Interview

		N=1622	N (%)
<b>Drugs injected, at least once, in the six months prior to interview</b>		<b>N= 1622</b>	
	Amphetamines	375	(23.1)
	Cocaine	1149	(70.8)
	Crack	691	(42.6)
	Dilaudid	727	(44.8)
	Heroin	321	(19.8)
	Speedballs (Heroin + Cocaine)	151	(9.3)
	Methodone (prescribed)	71	(4.4)
	Methodone (non-prescribed)	112	(6.9)
	Methamphetamine	293	(18.1)
	Morphine (prescribed)	145	(8.9)
	Morphine (non-prescribed)	861	(53.1)
	Oxycontin/Oxycodone	863	(53.2)
	Percocet	166	(10.2)
	Tylenol #3's	71	(4.4)
	Other drugs <sup>1</sup>	182	(11.3)

<sup>1</sup> Includes other: depressants (n=32); dissociative anesthetics (n=12); hallucinogens (n=2); opioids/morphine derivatives (n=56); stimulants (n=78); steroids (n=9); other drugs or combination of two drugs (n=45).

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## Ontario Needle Exchange Data

Table 6 Drug Use Patterns: Drugs Injected Most Often in the Six Months Prior to Interview

		N=1622	N (%)
<b>Drugs injected, MOST often, in the six months prior to interview</b>		<b>N= 1605</b>	
	Amphetamines	50	(3.1)
	Cocaine	463	(28.8)
	Crack	157	(9.8)
	Dilaudid	167	(10.4)
	Heroin	69	(4.3)
	Speedballs (Heroin + Cocaine)	6	(0.4)
	Methodone (prescribed)	3	(0.2)
	Methodone (non-prescribed)	2	(0.1)
	Methamphetamine	75	(4.7)
	Morphine (prescribed)	45	(2.8)
	Morphine (non-prescribed)	303	(18.9)
	Oxycontin/Oxycodone	203	(12.6)
	Percocet	4	(0.2)
	Tylenol #3's	3	(0.2)
	Other drugs <sup>1</sup>	55	(3.4)

<sup>1</sup> Includes other: dissociative anesthetics (n=1); opioids/morphine derivatives (n=5); stimulants (n=22); steroids (n=6); other drugs or combination of two drugs (n=26).

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## Drugs Not Injected

Table 7 Drug Use Patterns: Drugs Used in the Six Months Prior to Interview without Injecting

		N=1622	N (%)
<b>Drugs used, at least once, in the six months prior to interview</b>		<b>N= 1576</b>	
	Alcohol	1105	(70.1)
	Amphetamines	345	(21.8)
	Benzodiazepines	737	(46.8)
	Cocaine	920	(58.4)
	Crack	1044	(66.2)
	Dilaudid	402	(25.5)
	Ecstasy	372	(23.6)
	Heroin	428	(27.2)
	Marijuana	1168	(74.1)
	Methodone (prescribed)	376	(23.9)
	Methodone (non-prescribed)	249	(15.8)
	Methamphetamine	232	(14.7)
	Morphine (prescribed)	130	(8.2)
	Morphine (non-prescribed)	546	(34.6)
	Mushrooms	300	(19.0)
	Oxycontin/Oxycodone	702	(44.5)
	Percocet	731	(46.4)
	Solvents	16	(1.0)
	Tylenol #3's	601	(38.1)
	Other drugs <sup>1</sup>	203	(12.9)

<sup>1</sup> Includes other: cannabinoids (n=21); depressants (n=6); dissociative anesthetics (n=27); hallucinogens (n=22); opioids/morphine derivatives (n=57); stimulants (n=48); inhalants (n=2); Tylenol #1 or #2 or #4 (n=34); other drugs or combination of two drugs (n=65).

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## Ontario Needle Exchange Data

Table 8 Drug Use Patterns: Drug Used Most Often in the Six Months Prior to Interview without Injecting

		N=1622	N (%)
<b>Drugs used, MOST often, in the six months prior to interview</b>		<b>N= 1562</b>	
	Alcohol	150	(9.6)
	Amphetamines	5	(0.3)
	Benzodiazepines	56	(3.6)
	Cocaine	123	(7.9)
	Crack	403	(25.8)
	Dilaudid	32	(2.0)
	Ecstasy	6	(0.4)
	Heroin	6	(0.4)
	Marijuana	309	(19.8)
	Methodone (prescribed)	140	(9.0)
	Methodone (non-prescribed)	4	(0.3)
	Methamphetamine	20	(1.3)
	Morphine (prescribed)	24	(1.5)
	Morphine (non-prescribed)	51	(3.3)
	Mushrooms	1	(0.1)
	Oxycontin/Oxycodone	112	(7.2)
	Percocet	47	(3.0)
	Solvents	2	(0.1)
	Tylenol #3's	25	(1.6)
	Other drugs <sup>1</sup>	46	(2.9)

<sup>1</sup> Includes other: hallucinogens (n=3); opioids/morphine derivatives (n=1); stimulants (n=9); Tylenol #1 or #2 or #4 (n=23); other drugs or combination of two drugs (n=21).

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## Ontario Needle Exchange Data

Table 9 Drug Use Patterns: Engagement in Smoking Crack

		N=1044
		N (%)
Frequency of smoking crack in the six months prior to interview		
		N=1036
	Not every week	375 (36.2)
	Once or twice a week	179 (17.3)
	Three or more times a week	221 (21.3)
	Daily	261 (25.2)
		N=930
Days smoked crack in month prior to interview	Mean (Standard Deviation)	14.00 (10.69)
	Range	1 to 31
		N=982
Number of times a day smoked crack	Mean (Standard Deviation)	21.90 (49.63)
	Range	1 to 1000

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## Ontario Needle Exchange Data

Table 10 Drug Use Patterns: Engagement in Smoking Crystal Meth

		N=185
		N (%)
Frequency of smoking crystal meth in the six months prior to interview		
		N=182
	Not every week	140 (76.9)
	Once or twice a week	25 (13.7)
	Three or more times a week	11 (6.0)
	Daily	6 (3.3)
		N=119
Days smoked crystal meth in month prior to interview	Mean (Standard Deviation)	5.78 (6.41)
	Range	1 to 30
		N=147
Number of times a day smoked crystal meth	Mean (Standard Deviation)	7.65 (11.54)
	Range	1 to 50

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## Supervised Injection Programs

Opened on September 21, 2003, Insite is the first supervised injection facility in North America (there are more than 50 throughout the world). Insite is a clean, safe environment where users can inject their own drugs, off the streets and under the supervision of nurses. They can also be connected to other health and social services such as primary health care and housing, as well as be streamlined in to detox and drug treatment.

[www.communityinsite.ca](http://www.communityinsite.ca)

[www.cbc.ca/fifth](http://www.cbc.ca/fifth) ("Staying Alive")



## NAOMI

The North American Opiate Medication Initiative is a clinical trial that will test whether heroin-assisted therapy benefits people suffering from chronic opiate addictions who have not benefited from other treatments.

[www.naomistudy.ca/index.html](http://www.naomistudy.ca/index.html)



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## Benefits / Risks

- Decrease stigma \_\_\_\_\_ Normalize substance use
- Lower threshold \_\_\_\_\_ Lower expectations
- Increase client autonomy \_\_\_\_\_ Difficulties with limit-setting
- Decrease risk behaviours \_\_\_\_\_ Increase risk behaviours
- Decrease intensity of use \_\_\_\_\_ Increase intensity of use
- Decrease criminality \_\_\_\_\_ Increase criminality and legal entanglement
- Increase engagement & \_\_\_\_\_ Decrease treatment access to services
- Decrease societal costs \_\_\_\_\_ At expense of individual health
- Improve individual health \_\_\_\_\_ At expense of society society

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## Reaching Out

Harm Reduction Programs are often the first or only contact "drug users" have with health or social service providers.



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## Roth, 1999

“Customizing the helping response to the client’s stage of treatment and recovery, combined with a pragmatic harm-reduction orientation, appears to enhance engagement and lead to better working relationships between client and counsellor, and to better outcomes.”

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## Fred

Fred is a 32 year old heterosexual who uses injection drugs. He was diagnosed HIV positive 3 years ago when he was accessing the local methadone clinic. Since then, he has spent most of his time in jail or in treatment facilities. Fred has become “institutionalized”. Fred has fetal alcohol syndrome and is unsure how he got HIV or what the consequences might be.



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## Questions to consider...

- Is he still using? What and how does he use?
- Does he use alone or with others?
- What is his source of income?
- Was contact tracing done by him or public health after his positive test?
- Does he have any outstanding legal issues?
- What harm reduction strategies can you encourage?
- Is he capable of understanding and disclosing his status to sexual or drug using partners?
- Does he have stable housing?
- Any family supports?
- Is he still on methadone?

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## Risk Reduction Interview

- *Instructions to Interviewer:* This instrument is intended to be administered individually to each client using an interview format. Read each question or statement to the client exactly as it is written. **Do not change the wording of the items.** Text that should be read aloud to the client is shown in bold. Record the client’s responses by checking the appropriate box following each question or statement. Some of the 15 risk reduction behaviors may be skipped, as determined by the client’s responses to the four general risk questions that are administered first.
- For each one of the risk reduction behaviors listed, read the behavior aloud to the client (e.g., “using condoms for vaginal sex,” then read each of the nine statements below it and mark “Yes,” “Somewhat,” or “No” for each statement according to the client’s response. **Do not let the client fill out the form him or herself.** Be sure that the client responds to all of the statements in each block that is administered. As each block of statements is administered, check for obvious inconsistencies in responding (e.g., saying “No” to “I have tried doing this in the last 90 days,” and “Yes” to “I have had 100% success doing this in the last 30 days”), and bring these to the attention of the client. Resolve response inconsistencies as they are encountered.

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## Harm Reduction Practice Tips

- Be non-judgmental and self-aware.
- Be patient with yourself and the client.
- Be realistic in your expectations.
- Listen well – actively and empathetically.
- Remember you are witnessing their important events and struggles. You will be affected.
- Regular participation in the harm reduction process can reduce “magical thinking” or dissociative behaviours associated with substance use.
- Create an opportunity for the client to think of themselves as part of a community.

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## Harm Reduction Practice Tips

- Interventions that imply pathology or require the wearing of labels are not useful.
- Keep asking what’s working and why? What doesn’t and why not? Who is being reached? Who is not?
- Experience tells us that a higher level of participation by the client (over time) often means more sustained change.
- Be objective, reflective, a mirror. Resist evaluating or projecting.
- Ask yourself: What do you want to achieve? What do you want to prevent?
- Ask the client: What do you want to achieve? What do you want to prevent?
- Empowerment adds to peoples’ skills and abilities.

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## Key Points

- Focus on risks, not the substances.
- Focus on ways to reduce the risks, which may/may not include stopping the substance use.
- Focuses on “any positive change”.
- Support client’s right to choose their goal(s) to reduce risks.
- Treat your client the way you would want to be treated.

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Inconvenience stores

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Proudly providing secure and affordable supportive housing and support services for people living with HIV/AIDS.

### Fife House Harm Reduction Policy

Fife House recognizes that harm reduction is an integral approach in addressing the supportive housing and support service needs of the persons we serve. Fife House values harm reduction as one approach along a continuum of interventions that address the use of substances. The idea of reducing the harms associated with substance use is neither a new concept nor an alternative approach. Instead, it has emerged as an extension of existing and accepted public health practices.

### Definition of Harm Reduction

Harm reduction is a holistic philosophy and set of practical strategies that seek to reduce the harm associated with substance use. Harm reduction prioritizes giving accurate information and providing supportive services without bias to people who use substances so they can make and carry out informed decisions for themselves.

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## Fife House Harm Reduction Policy

### Harm Reduction Values

In addition to the core values (Section 2.0), Fife House endorses the following set of values which derive from a harm reduction philosophy as follows:

- People who use substances are competent to make choices;
- Using substances is neither good nor bad, it is the person’s relationship to the substance and the consequent behavior that results which is important;
- People who use substances have as equal a right to housing and support services as people who do not;
- People, whether or not they use substances, will be treated with dignity and respect in a non-judgmental and equitable manner;
- Fife House will communicate its harm reduction policy to individuals, communities and community agencies.

### Harm Reduction Strategies

- The specific harm reduction strategies employed may vary by program. The Executive Director will monitor which programs use which strategies and will report this information to the Board of Directors (through the Executive Committee) on a quarterly basis.

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## To help... or at least do no harm.

GABOR MATE (Globe and Mail, June 4, 2008)

Canada’s Health Minister urgently needs an education in harm reduction. Announcing his intention to shut down Insite, the supervised injection facility serving drug addicts in Vancouver’s Downtown Eastside, Tony Clement told the House of Commons health committee that “supervised injection is not medicine; it does not heal the person addicted to drugs.”

Mr. Clement got one thing right: Supervised injection does not heal addiction. It is, however, completely in line with accepted medical practice.

Consider other areas of medicine. Prescribing inhalant medication to open airways and reduce lung inflammation in smokers also does not “heal” nicotine addiction: It only saves lives and improves quality of life. Similarly, quadruple bypass surgery in overstressed type-A business executives does not heal workaholicism; insulin does not cure people whose eating patterns and sedentary habits have triggered diabetes, and intestinal bypass surgery in relief of morbid obesity does not cure food addiction. But all of these medical interventions are harm-reduction measures.

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## To help... or at least do no harm.

GABOR MATÉ (Globe and Mail , June 4, 2008 )

Harm reduction is often seen as being inimical to the ultimate purpose of helping addicts to transcend their habits and to heal. People believe it "coddles" addicts, enabling them to continue their destructive ways. It's also considered to be the opposite of abstinence, which many regard as the only legitimate goal of addiction treatment.

Such a distinction is artificial. The issue in medical practice is always how best to help a patient. If a cure is possible and probable without doing greater harm, then cure is the objective. When it isn't - and in most chronic medical conditions cure is not the expected outcome - the physician's role is to help the patient with the symptoms and to mitigate the harm done by the disease process.

In rheumatoid arthritis, for example, one aims to prevent joint inflammation and bone destruction and, in all events, to reduce pain. In other words, harm reduction means making the lives of afflicted human beings more bearable, more worth living. That is also a goal of harm reduction in the context of addiction.

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## To help... or at least do no harm.

GABOR MATÉ (Globe and Mail , June 4, 2008 )

Given the chronic and relapsing nature of injection drug use among hardcore addicts, cure is not often achieved. That leaves us with the need to reduce the depredations of the condition on the afflicted person and that's what supervised injection does: it minimizes disease transmission and affords first-line access to health care.

As the physician at Onsite, the detox facility attached to Insite, I can assure Mr. Clement that staff do their utmost to steer clients toward abstinence and recovery. Many people have entered recovery programs owing to their contact with health personnel during supervised injection. For all too many addicts, Insite is their first exposure to a caring, compassionate and non-judgmental model of medical care.

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## To help... or at least do no harm.

GABOR MATÉ (Globe and Mail , June 4, 2008 )

Mr. Clement told the Commons health committee that "government-sponsored supervised injection sends a very mixed message to young people who are contemplating the use of illicit drugs." Does the minister have any evidence for that astonishing assertion?

No one "contemplates" addiction and no one becomes addicted because of such "messages." The chronic condition of severe substance addiction is caused, in most cases, by the distorting effects of early childhood abuse or stress on the developing brain, often in the context of multigenerational trauma and social dislocation.

Much more could be done - and much more needs to be done - to prevent addiction, and much more to cure it. Harm reduction programs such as Insite are a small but necessary step, a practical way for our health-care system to extend compassionate treatment to those who most need it.

- Gabor Maté is a Vancouver physician and author of *In The Realm of Hungry Ghosts: Close Encounters With Addiction*.

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## Brian Day, President - Canadian Medical Association *The Toronto Star*, Sunday, 8 June 2008

When the federal government announced it would appeal the B.C. Supreme Court's decision on Vancouver's safe injection site, it chose to dismiss growing scientific evidence of the positive role harm-reduction programs can play in society.

It is hardly a surprise, however, that the Conservatives would favour a "law- and-order" approach. They made their position pretty clear when they rejected harm-reduction programs in the new national drug strategy.

While the federal government rejects scientific evidence that harm- reduction programs are successful, health-care professionals and public-health experts know they are an important part of the puzzle in addressing illegal drug use. Harm reduction, along with treatment, policing and prevention are cornerstones of a comprehensive, integrated public-health strategy.

Conservatives contend that money could be diverted away from Insite into treatment and rehabilitation programs for addicts. Money does need to be diverted, but it's not from facilities like Insite.

Of all the money that Canada spends to combat illegal drug use, less than 10 per cent is spent on treatment and rehabilitation. The vast majority of the money goes to interdiction and law enforcement. While law enforcement has an important role to play, it is obvious we need a rebalancing of resources and focus.

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## Brian Day, President - Canadian Medical Association *The Toronto Star*, Sunday, 8 June 2008

Not unlike mental illness, there exists a negative view and stigma around addiction, that these members of society are somehow weaker than others, that it is acceptable for us to turn a blind eye to their suffering. It's time to clear the air - addiction is a disease and those who suffer with it need medical assistance just as those who suffer from heart disease or cancer.

We know that stigma prevents individuals with an addiction from seeking help. We are now concerned that this stigma may also be affecting the development of appropriate public policy in this area.

Evaluation of safe injection sites show that they help prevent overdose fatalities. They help reduce needle-sharing, which is an important contributor to the spread of HIV and other infectious diseases. They encourage users to seek counselling and treatment. They do not increase the rate of injection drug use or crime in surrounding neighbourhoods. In fact, the government's own Expert Advisory Committee confirmed many of these facts.

Programs such as Insite are often the first and only contact people have with mainstream health and social services. It can also act as an important door into other areas of the health-care system for those who likely wouldn't or couldn't access the care they need.

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## Brian Day, President - Canadian Medical Association *The Toronto Star*, Sunday, 8 June 2008

Instead of closing down this site, the federal government should be working with public-health officials to see if such sites might work in other areas.

Health Minister Tony Clement has stated that "science is one of the issues that must be taken into account when it comes to a public policy decision." In this matter, the science is clear: Harm reduction is a proven and effective tool.

Marginalizing an already vulnerable population and leaving them at even greater risk of disease and death is bad medicine and, as the polls show, even worse politics. And with the B.C. government's plans to intervene on behalf of Insite, Canadians should rightly wonder why their tax dollars are going to be financing both sides of this argument.

They also should wonder why the federal government seems to be opposed to safe injection sites in British Columbia, but is willing to consider them in Quebec. Clement's public hedging on Quebec's proposal is further proof that his decision appears to be based on political science and not the real thing.

When it comes to safe injection sites, Conservatives need to consider the health of all Canadians, not just those who agree with the government's ideological bias against drug-addicted patients.

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## Resources

- **Ontario Harm Reduction Distribution Program**  
The Ontario Harm Reduction Distribution Program provides harm reduction materials, as well as knowledge and support, to Ontario's needle exchange and harm reduction programs.  
[www.ohrdp.ca](http://www.ohrdp.ca)
- **Ontario Needle Exchange Programs**  
[www.ohrdp.ca/NEP%20CORE%20PROGRAMS.pdf](http://www.ohrdp.ca/NEP%20CORE%20PROGRAMS.pdf)
- **Canadian Harm Reduction Network**  
A virtual meeting place for individuals and organizations dedicated to reducing the social, health, and economic harms associated with drugs and drug policies. Includes a discussion board, links to relevant articles, events, and job postings.  
[www.canadianharmreduction.com](http://www.canadianharmreduction.com)
- **Canadian Centre for Substance Abuse**  
[www.ccsa.ca/CCSA/EN/Topics/Intervention/HarmReduction.htm](http://www.ccsa.ca/CCSA/EN/Topics/Intervention/HarmReduction.htm)
- **Canadian Students for Sensible Drug Policy**  
[www.ccsdp-ecpsd.ca](http://www.ccsdp-ecpsd.ca)

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## Resources

- **BOOKLET: Pre-fix : harm reduction for + users** / Canadian AIDS Treatment Information Exchange (CATIE), The Canadian Harm Reduction Network. - Toronto : CATIE, c2002.
- **VIDEO: The Sleeping Giant – A Day in the Life of a Needle Exchange Program** / The Ontario Needle Exchange Coordinating Committee / [www.ohcn.on.ca](http://www.ohcn.on.ca) c2006
- **REPORT: Spreading the light of science : guidelines on harm reduction related to injecting drug use** / International Federation of Red Cross and Red Crescent Societies. -- Geneva : International Federation of Red Cross and Red Crescent Societies, 2003.  
[www.ifrc.org/what/health/tools/harm\\_reduction.asp](http://www.ifrc.org/what/health/tools/harm_reduction.asp)

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