Harm Reduction
Policy Background Paper

Prepared for the AADAC Board

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PURPOSE

In 1998 the AADAC Board adopted a Position on Harm Reduction. Development of the position was intended to assist AADAC staff and stakeholders in their understanding of this approach, and its fit with the work of the Commission in supporting province-wide and community-based addiction programs and services.

Since that time AADAC's Policy on Harm Reduction has evolved. The Commission has consulted with staff and external stakeholders, conducted research and critically appraised the role of the AADAC in providing effective addiction services that integrate a harm reduction approach.[1]

The purpose of this paper is to provide the Commission Board with background information for their current review of AADAC's Policy on Harm Reduction.[2] It is not meant to be a comprehensive review of the research literature, nor is it an inventory or complete description of harm reduction programs and initiatives in Alberta.

The paper consists of four main sections. First, the definition of harm reduction is considered. Second, a brief history of harm reduction is presented. Third, evidence for the effectiveness of harm reduction is discussed along with examples of harm reduction interventions in Alberta and in other jurisdictions. Finally policy and program implications and key considerations for AADAC arising from this information are put forward.

WHAT IS HARM REDUCTION?

Harm reduction is a term that is used a great deal, and there is not always consensus on its meaning.[3]

Harm reduction is a philosophical approach or theoretical concept that is applied in practice.[4] As a result, it is not uncommon for addiction treatment services that require abstinence to argue that they deliver harm reduction, because abstinence does, in fact, reduce the harm incurred by people who gamble or use alcohol and other drugs. Similarly, legislation and law enforcement activities may be seen as harm reduction. Eliminating the supply or removing access to drugs means fewer individuals are consuming them, and by extension, society is experiencing less drug-related harm.[5]

These points are valid but present a problem because the term harm reduction takes on such broad and diverse meaning that it encompasses virtually any policy or program. When the definition becomes all-inclusive, it is no longer useful in distinguishing harm reduction interventions from other interventions, and it is no longer meaningful in directing policy or program priorities. [6, 7]

Although it may be true that there is no universally accepted definition, and that the meaning of the term will continue to be debated, the primary feature of harm reduction is that it is intended to reduce individual and social harm, without requiring abstinence or a reduction in consumption.[3,5,8] This definition of harm reduction is accepted by AADAC and is integrated across the service continuum.

Principles

Harm reduction is based on a number of principles, and these are summarized below.[4,6,9,10,11,12]

Pragmatism: Substance use and gambling are complex yet common behaviours; a reality that cannot be ignored. Harm reduction accepts that individuals derive benefit from this behaviour but are also subject to risks because of it. Harm reduction strategies are practical and are intended to minimize risks and consequences. The emphasis is on a change to safer practices and patterns, rather than elimination of substance use or gambling behaviours.

Respect: This is an essential feature of harm reduction. An individual's decision to gamble or to use alcohol or other drugs in not judged as good nor bad, right or wrong, but viewed as what exists. Human dignity and the right to self-determination are respected, acknowledging that inherent with rights, people have responsibilities and obligations related to personal choice.

Priority of Goals: Decreasing the negative consequences of substance use and gambling is more critical than stopping use or discontinuing behaviour. Harm reduction strategies try to address the most pressing problems, as identified by the individual or the community. Harm reduction recognizes readiness to change and that people may be anywhere along a change continuum. Harm reduction begins 'where the person is at' and considers incremental gains that can be achieved over time.

Maximizing Intervention Options: Harm reduction supports the reality that people benefit from a variety of options when addressing substance use or gambling problems. There is no single treatment or prevention approach that works reliably or consistently for everyone. Active participation by those people who gamble or use substances is essential in determining the range and type of interventions that are most needed and most helpful in reducing harm.

Harm reduction implicitly and explicitly acknowledges the social determinants of health; the effects of poverty, class, racism, past trauma and social isolation on individual behaviour, and more importantly, people's capacity for resilience and change.

HISTORY/CONTEXT

A drug-free or addiction-free society may be the ideal. In reality however, substance use and compulsive behaviours like gambling are part of our world, and have been a component of virtually every society from the dawn of recorded history.[11]

Harm reduction is not a new concept. It is an extension of existing and accepted public health practices.[9] Harm reduction has a long history outside North America, particularly in the United Kingdom, Netherlands, Switzerland and Australia. British physicians, for example, were providing heroin to addicts in the early part of the 20th century as a means of permitting them to lead more useful lives. [6]

Over the past 20 years in Canada, harm reduction has played an increasingly prominent role in substance use policy and programs.[4] For example, needle exchange programs have been around since the late 1980s, and these programs exist in every province.[3] Methadone maintenance has an even longer history. [6]

Legitimacy

Initially harm reduction gained momentum in response to the crisis of HIV/AIDS.[4] It has since gained acceptance largely because there is no longer any question that the expansion of abstinence-based treatment programs alone will not resolve the issues and problems related to alcohol, other drug use, or gambling.[13]

- ◊ Not all people who use substances or gamble are in need of treatment.
- ◊ Not all problems are the result of abuse, dependence or addiction. There is a clear and observable distinction between acute and chronic consequences related to substance use and gambling (e.g., in relation to alcohol consumption, acute problems such as accidents are more prominent).
- ◊ Not all people who use substances or gamble will access available treatment.

Harm reduction has also gained ground in reaction to the 'War on Drugs' ideology where the goal is 'zero tolerance'; the elimination of drugs in society, and the penalization and incarceration of drug users.[5,14,15] This is not to say that legislation, criminal sanctions and enforcement of existing laws are ineffective or unwarranted. They do deter many people from using alcohol or other drugs, and from using particular drugs. However, the focus of supply reduction is on illegal substances and legal drugs like alcohol and tobacco are not a priority. Furthermore, some of the harm associated with illegal drug use is due to drug law rather than drug use per se (i.e., direct and indirect consequences that result from attempts to regulate individual and social behaviour, such as criminalization and stigmatization).[4,9,11,16]

Harm reduction offers a direct point of contact for individuals who are experiencing difficulties with alcohol, other drugs and gambling. In fact, harm reduction programs and services may be the first point of access to services for those people who might otherwise never access service through traditional health care or addiction treatment settings.[6,12] Although this contact may be a first step toward cessation, this is not the goal. Rather, the emphasis is on change that is relevant, beneficial and realistic for the client.[13]

Harm reduction focuses on achievable improvements that can reduce adverse health and safety consequences for the individual, their family and the community. Over the long-term, harm reduction emphasizes measurable health, social and economic outcomes and the cost effectiveness of interventions.[6,9,13] Sound research, program evaluation and cost-benefit analyses continue to weigh heavily in any debate about the merit of harm reduction strategies that do, or are likely to reduce the consequences of substance use or gambling.[12]

Harm reduction strategies have been successful over the years, particularly in reducing the spread of infectious diseases among people who use drugs by injection.[6,17,18] This success has led to attempts to broaden the application of harm reduction to other forms of substance use as well as other public health issues. For a variety of reasons, however, harm reduction has not progressed as quickly for licit drugs like alcohol and tobacco, or for behaviours like gambling.[4,8]

HARM REDUCTION (EXAMPLES AND EVIDENCE)

Europe, the United Kingdom and Australia continue to the lead the harm reduction field in both the development and evaluation of harm reduction policy and programs. Examples include cautioning (i.e., giving warnings and drug treatment information to first-time offenders), prescription heroin, street outreach and safe injection sites.[19]

One of the earliest examples of a harm reduction strategy for alcohol was implemented in Edmonton in the early 1990s. It involved early opening hours for liquor stores in the inner city to reduce consumption of non-beverage alcohol products (e.g., Lysol®, rubbing alcohol) by chronic drinkers.[7]

Other well recognized, lesser-known and more controversial harm reduction strategies include:

Needle and syringe exchange programs: In cities around the world these programs operate from fixed or mobile sites to provide access to sterile needles and other equipment to people who use drugs by injection. The purpose is to prevent the transmission of blood-borne pathogens such as HIV and hepatitis, and to help people improve their health. Distribution of free condoms to encourage safer sex practices, health advice and education, needle drop boxes and sharps disposals are generally provided in conjunction with exchange services.[3] Studies strongly demonstrate that needle exchange programs do not lead to increased drug use, and they have resulted in

reduced needle sharing and lower levels of HIV infection among people who use drugs by injection. These programs have been proven to be cost-effective and have been shown to contribute to community safety by reducing the number of publicly discarded needles and syringes.[4, 6, 12]

Needle exchange programs operate in six Alberta communities; Edmonton, Calgary, Red Deer, Lethbridge, Medicine Hat and Grande Prairie. In 2006/07, 1.4 million needles were exchanged through these community programs.[20]

Safe or supervised consumption sites: These facilities were first established in the 1980s and some 70 or more facilities currently exist in several European countries. Programs share many common elements, but also differ in terms of design, operations and the scope of services provided. Most are legally sanctioned, publicly funded and medically supervised facilities where people can inject or inhale pre-obtained illegal drugs. Clean needles and other injecting equipment, emergency assistance and in some cases social and community services (e.g., laundry and shower facilities, food distribution, housing referral, support groups) are available to people using safe or supervised consumption sites.[21] The purpose is to reduce overdose, needle sharing, health impacts that result from injecting drugs in unsanitary conditions and to provide a point of contact with health and addiction services.[4,12] Accumulating evidence (from Europe, Australia and Canada) shows that safe or supervised consumption sites reduce the incidence of overdose, decrease needle sharing, increase the number of people seeking detoxification and other addictions treatment, and reduce public nuisance (e.g., discarded syringes, litter) associated with use of illicit drug use.[6, 15]

In 2003, Health Canada granted an exemption under s. 56 of *the Controlled Drugs and Substances Act* (CDSA) to establish a supervised injection facility in downtown Vancouver. 'InSite' was created as a research pilot project and establishing the facility required written agreement from the BC Ministry of Health, Vancouver Coastal Health Authority, City of Vancouver and Vancouver Police Department.[12] Since inception, this facility has not been without critics and detractors despite scientific scrutiny and ongoing program evaluation showing positive results for clients and the community.[*] In September 2006 the federal Minister of Health stated that the government would extend the CDSA exemption to InSite until December 2007.[22] In August 2007, InSite announced provincial funding for expansion of their services to include 12 medically supervised detoxification beds and 18 temporary housing units (the program expansion is called OnSite).[23] In October 2007, the federal Minister of Health granted a second extension (to June 2008) to InSite, but there is no indication the government will renew the legal exemption beyond that date.[24]

[*] A summary of previously published evaluation results for the InSite program in Vancouver are summarized in the Canadian Medical Association Journal (November 21, 2006). The evaluation findings show that the Vancouver site has been associated with a number of community and public health benefits without evidence of adverse impacts. In particular, the program has been successful in attracting people who use drugs by injection and who are at increased risk of HIV infection and overdose. There have been reductions in public drug use and discarded syringes. Use of the facility has been associated with increased uptake of detoxification services and decreased needle sharing by clients. InSite has also served as a central education and referral service for a range of other community and medical resources.

In June 2007 the City of Victoria announced plans to request an exemption from Health Canada to proceed with application for a pilot project for one to three safe injection sites.[25] A feasibility study was conducted by researchers from the Centre for Addictions Research of British Columbia (CARBC) to assess the need for this type of harm reduction programming. The feasibility study included stakeholder consultation, analysis of the nature and consequences of illicit drug use in the community, legal context for design and operation of a safe injection site and existing services in Victoria for people who use drugs.[21]

Outreach: Outreach programs acknowledge substance use and provide explicit educational materials and methods to inform people on how to reduce risk when they use. This may include teaching about safer injection practices and overdose prevention, as well as the distribution of free condoms to encourage safer sex practices and prevent transmission of sexually transmitted diseases such as HIV and hepatitis. Outreach is considered a cost-effective and outcome-effective harm reduction strategy that connects 'hard to reach' populations such as the homeless and street-involved youth with heath and addiction service providers.[6,12]

Drug substitution: For individuals who are resistant to other forms of treatment, some countries have programs that allow physicians to prescribe heroin, morphine and amphetamines. These programs may or may not help people reduce their level of consumption, but they do remove the need for black market drug purchases and clandestine use.[6] Experience and clinical studies from the Netherlands, Switzerland and the United Kingdom suggest the medical prescription of heroin can result in positive health outcomes and improved social stability.[12,19] In addition, a limited number of pilot studies of amphetamine prescribing have been undertaken in the UK with promising results; including reductions or abstinence from use of street drugs, declines in the use of drugs by injection and less chaos in lifestyle functioning. Investigators note that more research is required to adequately assess the effects of amphetamine prescribing and to address the reservations among health professionals about the consequences of this practice.[26]

In Canada, a three-year prescription heroin trial was initiated in Montreal and Vancouver in 2005. Called the North American Opiate Medications Initiative (NAOMI), this research is examining whether prescribing heroin is a better option than methadone for people who are opiate dependent, use primarily by injection and have been unsuccessful in previous treatment settings. Outcomes measured in the study will include retention in treatment, reductions in illicit drug use and crime associated with drug use.[12, 27]

In July 2007 Vancouver City Council voted to support a research trial to transition people using illegal street drugs to using legal prescription drugs. The trial is called Chronic Addiction Substitution Treatment (CAST) and would target people who have been unsuccessful using traditional treatment methods. The objectives of the program include individual and community outcomes; improved health, housing access and employment options, a reduction in open-air drug markets and lowered property crime.

Program participants would be provided with legal and orally administered prescription drugs, including stimulants, and offered counselling and housing services. Implementation of the pilot project requires an exemption from Health Canada.[28]

Methadone maintenance treatment: Methadone is a legally prescribed opioid, and methadone maintenance is medically supervised drug therapy. While it can be argued that methadone maintenance is a form of treatment rather than harm reduction, the use of this drug is well established, clinically accepted and has demonstrated effectiveness in reducing harm over many decades.[6] Methadone maintenance is considered a 'gold standard' or best practice in the addiction field, and extensive research has shown that it not only reduces illicit drug use but is also effective in decreasing the risk of overdose death, reducing crime and improving health and social functioning.[12] Other drug replacement therapies being used for opioid dependency include buprenorphine and LAAM (levo-alpha-acetylmethadol). LAAM is not approved for use in Canada and has recently been withdrawn from use in Europe.[29]

AADAC has been providing methadone maintenance treatment since 1971. The AADAC Opioid Dependency Program (ODP) includes two clinics - one in Calgary and one in Edmonton - that offer a staged-care model for the delivery of services. Clients enter the program through one of the clinics, and once stabilized on methadone are transferred to community-based physicians and pharmacists for their prescription, dosing and ongoing health care. The AADAC ODP provides comprehensive medical and addiction assessment, outpatient counselling, referral to other services, and ongoing support and monitoring (including urine testing).[30]

Methadone treatment in Alberta is also provided by the Central Alberta Methadone Program (Red Deer), Chinook Alberta Methadone Program (Medicine Hat), First Street Methadone Program (Calgary) and Panorama Medical Clinic (Edmonton).[31]

Alberta physicians who practice addiction medicine can be licensed to prescribe methadone independent of the clinics listed above. Physicians require an exemption from Health Canada, must complete a recognized training course in providing methadone maintenance treatment and must complete ongoing professional certification in this area. The College of Physicians and Surgeons of Alberta has established formal standards and guidelines for all physicians that provide methadone treatment in the province.[31]

'Party Safe' or 'Street Safe' strategies: Research indicates that the presence of unknown ingredients in various illicit drugs is associated with increased health risk. 'Party safe' strategies have emerged to address concerns at large gatherings where the environment and the consumption of drugs may put individuals at risk. Initiatives of this type may include pill testing so that users 'know what they are taking', provide context specific education on drug effects and interactions, and work with the event organizers to ensure adequate water and ventilation for participants.[4] In many European cities early warning systems have developed as 'street safe' strategies to alert health

authorities, enforcement agencies and people who use illicit drugs about the presence of contaminated, adulterated or high potency drugs that are being sold.[12]

Crack pipe programs: Recent research has pointed to an increase in crack use. People using crack cocaine can experience cuts and burns to their lips and pipe sharing can transmit blood borne infections. This reality has led to the implementation of harm reduction initiatives specifically targeted at those who use crack cocaine in order to reduce the spread of HIV, hepatitis and tuberculosis. Programs typically include distribution of 'safer crack kits' that consist of clean pipes, screens, mouthpieces and other tools as well as distribution of condoms and information on safer use of crack cocaine. These programs are not meant to 'wean' people off drugs but to prevent disease. Worldwide, policy support has been lacking on this issue and very limited research is available to determine the efficacy of this type of intervention.[4,32]

In Canada at least four cities (Ottawa, Toronto, Winnipeg and Nanaimo) have established and operated harm reduction programs for crack. Since June 2007, however, both Ottawa City Council and the Vancouver Island Health Authority (for Nanaimo) have suspended their safer crack use programs after concerns were expressed about the nature and effectiveness of this harm reduction service.[33,34] The City of Ottawa public health department operated the 'Safer Inhalation Program' since 2005 whereas the program in Nanaimo was in operation less than a year.[†]

Winnipeg Regional Health Authority continues to operate a safer crack use program (Street Connections) in conjunction with public health and harm reduction outreach services; including needle exchange at fixed and mobile sites, pregnancy, HIV and STD testing, immunization, condom distribution, information and counselling, referral for addictions treatment and other social services, etc. The Winnipeg program is targeted to people involved with prostitution, intravenous drug use, crack or meth smoking, solvent use and street life. The goal of this service is to help people reduce their risk of HIV/AIDS, hepatitis and other sexually transmitted infections.[35] In Toronto, the Public Health Department administers the Crack Users Project, which is operated by Street Health. The program includes a drop-in centre and peer outreach program with distribution of crack-use kits.[36]

Brief interventions: In the context of harm reduction, brief interventions are aimed at changing risk behaviour without focusing on use reduction. They include motivational interviewing and solution-focused therapy that is generally delivered in context of primary health care. There is limited but promising evidence on the use of brief interventions with people who use drugs in preventing transition from oral or nasal use to use by injection.[6] There is also some evidence to suggest brief interventions can be effective in changing drinking behaviours among pregnant women, and when used in hospital emergency departments to assist heavy drinkers in moderating their alcohol consumption.[37] Studies of brief interventions with college-age students who use alcohol

[†] Since Ottawa City Council voted to disband the program, a number of organizations have been advocating for renewal, including the Canadian Harm Reduction Network and the Canadian HIV/AIDS Legal Network which have both sent letters of support for the program to the mayor of Ottawa.

and other drugs show promise, but more evaluation is needed to establish the efficacy of these harm reduction programs.[8]

Regulation and environmental controls in licensed establishments: Alcohol is widely accepted, enjoyed socially and has economic benefits for society. Recent evidence has also determined that moderate use can have health benefits for some consumers.[‡] As such, abstinence is not a necessary or realistic goal for public policy. Harm reduction, as applied to alcohol, focuses on high-risk patterns of consumption and reduction of risk for certain people or in certain situations.[4]

Research has shown a relationship between hours of closing, management of aggression and crowding in licensed premises, and the incidence of alcohol-related harm for patrons and staff. These results suggest that efforts to modify the drinking environment may reduce the harm associated with alcohol consumption, although more research is needed to establish the efficacy of this approach. For example, very little evidence exists for the effectiveness of using non-breakable bottles and glassware to prevent injury in bar settings, yet this strategy is employed extensively in the UK. [6]

Server training and intervention: Server intervention or responsible beverage training programs operate in many jurisdictions. These programs are intended to discourage public inebriation, excessive consumption by adult bar patrons, reduce impaired driving and decrease access to alcohol by minors.[3] The research literature supports the effectiveness of server intervention training to reduce over consumption and related problems, but suggests this training should be mandatory to have optimum effect.[38]

The Alberta Server Intervention Program is managed by the Alberta Gaming and Liquor Commission (AGLC) and is a mandatory program for all liquor licensees. The program provides consistent training for liquor service and sales staff to help reduce underage drinking, over-consumption, impaired driving and the risk of violence in and around licensed premises.[39]

Controlled drinking programs: Controlled drinking programs are targeted to non-dependent drinkers. They offer information and practical strategies to moderate alcohol consumption. These programs recognize reduced consumption (rather than abstinence) and avoidance of problems as appropriate goals for some drinkers.[4]

Drinking Decisions is a controlled drinking program that was developed and initially delivered by Capital Health. Delivery of the program has since been taken over by the Family Centre in Edmonton. *Drinking Decisions* is a brief intervention that uses either a group or self-help format and is targeted to people who want to evaluate their drinking behaviour and reduce their alcohol consumption. AADAC has permission to print the

[‡] Moderate drinking is broadly defined as the level of alcohol consumption that has a low risk of harm for both the drinker and others. The benefits of moderate consumption derive mostly from the reduced risk of coronary heart disease in men over 45 living in developed countries. Some studies have also shown moderate alcohol consumption to be associated with decreased risk of arterial disease, ischemic stroke and Type 2 diabetes.

Drinking Decisions guide. At present however, this resource is being reviewed within AADAC and unavailable to staff.

Wet/damp shelters: To address the needs of people who are homeless, and to respond to issues related to public inebriation, wet shelters have been opened in a number of jurisdictions. These facilities allow alcohol consumption on premises (in managed doses or in specific areas). They are meant to accommodate people who are disadvantaged and would otherwise avoid accessing a shelter or similar service, sometimes because they would have to relinquish their alcohol (i.e., individuals will often drink every thing they have, rather than "wasting it" before entering a drop-in or overnight shelter). Those who choose not to enter a shelter often run the risk of exposure to extreme weather conditions, assault on the street, alcohol poisoning, or the substitution of non-beverage for alcohol products.[4,9] Although evaluation of wet shelter services is still limited, studies have shown that they help clients reduce their overall alcohol consumption, improve hygiene, nutrition and health status, decrease time in prison, provide connections to community services including stable housing options, and reduce per client expenses for emergency services.[40,41]

Two Canadian cities have accommodation services that are not abstinence-based. The Managed Alcohol Program in Ottawa is a 23-bed shelter for homeless people addicted to alcohol. Clients are provided alcohol on an hourly basis. A similar program exists at Seaton House in Toronto (Annex Harm Reduction Program). This is a 140-bed facility for men who are living on the street and have difficulty accessing shelter services due to difficult behaviours, mental illness or severe alcohol and drug problems. Clients are provided beer while staying at the Annex and can exchange non-beverage (e.g., mouthwash, Lysol®) for beverage alcohol. Although these programs are often referred to as 'wet shelters', both have specific criteria for admission and are more comprehensive in the scope of services offered than a traditional shelter (e.g., they provide medical, mental health and social services on-site or through direct referral).[42,43]

Designated driver programs: Both voluntary (e.g., *Operation Red Nose*) and commercial services (e.g., *Keys Please*) as well as informal agreements with parents, friends or colleagues who are sober, exist to provide safe transport for individuals who have been drinking. Although these alternative transportation arrangements are popular, there is very limited evidence to support their effectiveness in reducing impaired driving or alcohol-related traffic accidents.[6]

Nicotine replacement therapy: Many have argued that harm reduction cannot be applied to tobacco use since smoking even a small amount is associated with significant health risks. At the same time, reducing tobacco use is regarded as a pressing public health issue, and changing realities have led to a focus on harm reduction with 'hard core' smokers.[6] For example, attention has been given to safer methods of nicotine delivery such as patches, gum and inhalers; although some would say that the use of nicotine replacement is an adjunct to cessation rather than a harm reduction strategy.[4, 6]

Smokeless tobacco: Research has also focused on the use of smokeless tobacco such as snuff (or Snus in Sweden) as a means to reduce the harm from smoking. However, there is no consensus that using smokeless tobacco should be considered a harm reduction approach. On one hand it can be argued that the use of smokeless tobacco reduces individual risk for some forms of cancer and respiratory disease, and at the societal level, it reduces exposure to second-hand smoke. Alternatively, individuals who use smokeless tobacco are at continued and high risk for other forms of cancer, tooth, gum and cardiovascular disease.[6]

Smoking bans: Restricting where smoking is allowed, in public and in the workplace, has become common. These efforts are widely accepted as a form of health protection or harm reduction.[3,4] The intent is to reduce exposure to environmental tobacco smoke rather than requiring abstinence from tobacco use. There is good research evidence that bans on smoking in enclosed public spaces achieve this outcome.[6] There is also accumulating research that suggests formal smoking bans convey a powerful message, and many smokers subsequently reduce their own tobacco use, or choose to impose similar restrictions in their homes, especially if children are present.[44]

Controlled gambling programs: Controlled gambling programs are intended for people who are at mild or moderate risk of developing gambling problems. They are not generally targeted to problem or pathological gamblers. Controlled gambling programs provide information and practical strategies to help participants moderate their gambling behaviour (i.e., in terms of time and money spent on gambling activities), offering them a choice that includes, but is not limited to abstinence.[45]

Gambling Decisions is a six-week program developed in 1994 that was initially offered by Capital Health and subsequently offered in conjunction with other agencies in Alberta, including AADAC. *Gambling Decisions* is a brief intervention for early-stage problem gamblers, using either a group or self-help format. The goals of the program are to assist clients reduce the severity of existing problems related to gambling, help them better manage their money and financial concerns, help them identify mental health issues related to gambling (e.g., depression), and for some individuals, help them abstain from gambling. Evaluation of the first pilot phase of the program was completed in 1998-99 with a second evaluation completed in 2004-05. Findings from these evaluations demonstrated that controlled gambling is a viable option for some people. It helps reduce the time and money spent on gambling activities and contributes to reductions in gambling related problems, especially in personal and family relationships.[45]

KEY CONSIDERATIONS

Harm reduction is and will continue to be an important aspect of the continuum of addiction services in Alberta. AADAC assists people with chronic substance use or gambling problems, as well as people who are infrequent users and occasional

gamblers. AADAC ascribes to a client-centred approach to treatment and the relationship between service provider and client is one of mutual respect, collaboration and choice.[14] These aspects of service delivery are consistent with a harm reduction approach.

One question that seems to frequently arise: "Is it possible to reconcile harm reduction with abstinence in treating addiction?" Based on recent history and current practice, the answer is 'yes'. The philosophy of harm reduction is consistent with the approach taken by many addictions service providers, including AADAC.[1,3] Harm reduction:

Respects people and their abilities

⇒ AADAC is a helping organization that values client and community input in addressing addiction issues and problems.
⇒ AADAC takes an individualized and strength-based approach to treatment, starting 'where the client is at', and actively involving clients in setting treatment goals and developing strategies to achieve these goals.

Recognizes the many 'stages of change'

⇒ AADAC programming is congruent with the Transtheoretical Stages of Change model.[46] This model suggests an incremental process of behaviour change, and pays particular attention to the needs of people in the early stages of harmful substance use and gambling.[14] Within this framework it is understood that meaningful life change is likely to be protracted; individuals will move forward, and they will also encounter setbacks.
⇒ Relapse is common among addiction clients. This aspect of recovery is well understood within AADAC and is addressed in programming and in annual performance reporting. Treatment success is not viewed as a black and white dichotomy (abstinence vs. substance use).

Removes barriers to accessing programs and services

⇒ AADAC continually strives to improve access to programs and services. This is especially important when dealing with people with co-existing mental health problems, or when intervening with people who have previous detox or treatment experiences.
⇒ AADAC recognizes that the traditional abstinence-only model of treatment can be an insurmountable barrier for those people who are unwilling or unable to stop gambling or using alcohol or other drugs.[14]

Challenges

Perhaps one of the greatest challenges to implementing harm reduction is community resistance. Harm reduction is commonly misunderstood and misperceived as encouraging or condoning substance use or gambling; and in the case of illicit drugs, encouraging violation of the law.[4]

It is important to acknowledge that some community members have moral values that oppose substance use and gambling.[47] Other community stakeholders have differing opinions on what is the cause or the best way to deal with addiction. They may be unfamiliar or uncomfortable with harm reduction as a legitimate and accepted approach. In either instance, educating community stakeholders is critical and addressing substance use and gambling as health and social issues rather than moral or criminal concerns is key.

As noted by the BC Ministry of Health in their community guide, the most common concerns about harm reduction as expressed by the public include:[12]

> "Harm reduction encourages drug use among non-drug users. This is based on the notion that harm reduction 'sends out the wrong signal' and undermines primary prevention efforts. Some feel that helping drug users stay alive, reduce their exposure to risk and become healthier may encourage non-users to regard drug use as safe and to want to start using drugs. This view underestimates the complexity of factors that shape people's decisions…[and]…ignores numerous scientific studies that have found no evidence that the introduction of needle exchange or other harm reduction programs increases drug use."
>
> "Harm reduction enables drug use and entrenches addictive behaviour. This is rooted in the belief that drug users have to hit 'rock bottom'…For those who do not want to quit, cannot quit, or relapse into drug use….Harm reduction is often the first or only link that drug users have to the health and social service system and, as such, it is a gateway to addiction treatment. Harm reduction services increase the possibility that drug users will re-engage in broader society, lead productive lives and quit using drugs, instead of contracting and transmitting infectious diseases and/or succumbing to drug overdose death."
>
> "Harm reduction increases disorder and threatens public safety and health. Often referred to as the 'honey pot effect', this concern assumes that harm reduction programs will attract drug dealers and compromise the safety and well being of the surrounding community. Evidence has conclusively demonstrated that harm reduction programs do the opposite. They have a positive impact on public health by reducing the prevalence of blood borne viruses such as HIV and hepatitis C. Needle exchange programs often recover more needles than they distribute, which means fewer used needles discarded publicly in the community. Supervised injection facilities reduce the number of public injections by providing a safe, indoor alternative to open drug use. Protocols between police and harm reduction service providers ensure drug trafficking laws are enforced."
>
> "Harm reduction is a Trojan Horse for decriminalization and legalization. Harm reduction attempts to deal with the harms from drug use as it occurs within the current global regulatory regime. Some advocates of harm reduction want to

see changes in the way governments have been attempting to control the trade and use of currently illegal drugs; others do not. Harm reduction itself is neutral regarding the question of legalization. The philosophy of harm reduction applies equally to alcohol and tobacco use, which is legal in most countries."

A second obstacle is that harm reduction strategies often involve working with highly marginalized populations. For example, the socially and economically disadvantaged, street youth, the homeless, criminal justice populations, and those who use drugs by injection.[6] If there is a hierarchy of stigma associated with addiction, then these are the most stigmatized groups. Admitting a problem with alcohol, other drugs or gambling is not easy, and seeking help can be even more difficult.[14] People are often isolated, ambivalent, fearful of being judged or fearful of legal consequences, and resistant to confrontation. Even for those who wish to change their behaviour, goals are difficult to set, achieve and maintain.[12] Harm reduction strategies are humane, inclusive and non-coercive.

A subsequent challenge to accepting and implementing harm reduction strategies is knowledge and training. Despite more than two decades of research, advocacy and opinion, confusion about the meaning and outcome of harm reduction still exists. There is considerable evidence demonstrating the effectiveness of harm reduction policies and programs, but this evidence is of little value unless communicated, understood and translated into effective programming. By adopting and promoting a harm reduction approach, certain demands will be placed on an organization in terms of learning, and in embracing diversity when delivering and supporting a broad range of community addiction services.[6,9,13,14]

Finally, adequate resources are required to initiate and maintain harm reduction initiatives within AADAC, and within the community. It does little good to implement a program, garner support for that program, demonstrate the success of the program, and then be unable to sustain it because of inadequate resources. Harm reduction initiatives are relatively inexpensive and cost effective. They increase financial return on investment for the individual and for society by reducing costs associated with criminal activity, morbidity, unemployment, risk behaviours and the transmission of infectious disease rather than using limited resources to treat complications of advanced illness.[12]

Special Populations

Youth: Advocating harm reduction for youth is controversial despite knowledge that many adolescents use alcohol, tobacco, cannabis and other drugs. Abstinence is formally reflected in federal law and provincial regulation related to illegal and legal drug use (i.e., alcohol and tobacco), and is supported by universal prevention efforts. Application of harm reduction to youth programming can be difficult because[8]:

- Adolescents are accorded limited autonomy in decision making due to the wide variability in emotional, social and intellectual maturity during this stage of life. The

right to self-determination and choice is a principle tenet of harm reduction but not all would agree that adolescents have this right. There is formal entrenchment in law and formal recognition by society that only those youth, over a specified age, are qualified to make informed decisions about substance use. The current question of debate centres on at what age are the benefits of a harm reduction approach expected to exceed the risks to the youth population as a whole?

- There are specific risks and harm associated with substance use and gambling by youth that are not present for adults. Adolescents are, in a real way, vulnerable to the effects of substance use and gambling due to their stage of physical and emotional development. Youth frequently experience acute problems related to alcohol, other drug use and gambling such as trouble with friends and parents, driving under the influence, accidents, unprotected sexual intercourse, academic failure and infection with a communicable disease. While these problems can be serious, youth are not subject to the chronic consequences that tend to affect adult populations (e.g., cirrhosis, financial instability, emphysema). They do not always recognize the potential for long-lasting personal health and social harm.

- Gaps exist in the evidence base to support effective harm reduction programs and services for youth. Youth are most often the target of prevention programs with an undifferentiated goal of abstinence. However, the effectiveness of these initiatives has repeatedly been shown to be minimal. Questions continue to arise as to how prevention and harm reduction can be reconciled. This is especially true in the school setting where a large number of students (most underage) could benefit from a harm reduction framework, yet school administrators are constrained by legal responsibilities that make this framework implausible.

For street-involved youth and those youth who are homeless, substance use patterns differ dramatically from adolescents in school and living at home. Street-involved youth tend to be at very high risk for harm from blood borne infections such as HIV, sexually transmitted diseases, participation in the sex trade, pregnancy, victimization, physical abuse, participation in criminal activities, drug overdose and suicide. Harm reduction initiatives for high-risk youth are far more acceptable, warranted and critical from the perspective of health and community safety.[8]

Aboriginal Peoples: The principles of harm reduction, and particularly the emphasis on respect and human dignity, overlap well with traditional Aboriginal values.[§] The fundamental features of harm reduction, especially the important link between the individual and the community, are very similar to the holistic approach to healing that is well known in Aboriginal cultures.[47] Despite this connection, Aboriginal communities in Canada continue to be under-served by harm reduction strategies. For example, needle exchange programs and methadone maintenance are unavailable on reserves, although federally funded treatment facilities will accept clients who are on methadone.[48]

[§] Canadian people of Aboriginal descent include First Nations (Status Indians living on reserve), Inuit and Métis although their histories and current status differ considerably. They are a heterogeneous group.

Part of the reason for this derives from the historical experiences of Aboriginal communities where the introduction of alcohol and drug use has had a devastating effect. Substance abuse has been associated with many problems, including poverty, family breakdown, violence, unemployment and poor economic structures. This may explain the strong reliance on abstinence-based approaches to alcohol, other drug use (and in some cases, gambling). For some Aboriginal groups, the emphasis on abstinence is and has been embedded in the traditions and customs that place a person that uses mood altering drugs 'outside of balance'. For others, the focus of treatment programs offered by the National Native Alcohol and Drug Abuse Program (NNADAP) is at root, where an abstinence-orientation stems from the time at which these programs were established (i.e., the disease model of addiction predominated).[47]

As such, harm reduction policies and programs for Aboriginal peoples are not always easy to implement, and must be based on the diversity and needs of the community. Not all harm reduction measures can or will be applicable to all Aboriginal groups. There are a number of innovative and established harm reduction initiatives for Aboriginal peoples in Canada that merit attention. The key to furthering adoption of these initiatives requires that: [47]

- Health equality and health sustainability form the basis for substance abuse and gambling programs in Aboriginal communities. Whether these programs and services are described as abstinence-oriented, incorporate abstinence, or are based solely on the principles of harm reduction, improvements in health and social functioning are critically important given that the overall health and socio-economic status of Aboriginal peoples in Canada is well below the national average.

- Aboriginal people have access to the same continuum of services that is available to non-Aboriginal people. Harm reduction programs and services must recognize and accommodate spiritual, cultural and language barriers. They must also be funded in a way that is flexible and outside the long-standing arrangements of federal-provincial-territorial relationships to ensure communities have options in allocating resources as needed for service delivery.

- Policies and programs emphasize the compatibility of assisting individuals with the harm they are currently experiencing, without requiring or excluding abstinence as a goal. Substance abuse and gambling programs in Aboriginal communities should reflect the values and needs of the community, yet they can be directly linked to harm reduction services outside the community.

- Stigma is reduced regarding harm reduction services, and professional education expanded within Aboriginal communities. The research literature suggests that several reserves in Canada have 'engaged in a war on drugs' that shames people who use alcohol or other drugs; particularly those who use drugs by injection. This approach creates tension within the community and does little to reduce the harm to

individuals and their families, or to foster effective linkages between service providers that focus on harm reduction and those that do not.

- Needs assessment, program evaluation and surveillance research incorporates methods and models that are appropriate to the Aboriginal community in terms of knowledge acquisition and the translation of knowledge to best practices in harm reduction programming.

Prison Populations: Distinct harm reduction measures are needed for inmates in correctional facilities. There is a high prevalence of substance use in this population, particularly the use of drugs by injection, and a high risk of HIV and hepatitis C infection from drug use, from unsafe tattooing practices and from unprotected sex.[49] Despite this knowledge, correction authorities, politicians and the general public are resistant to offering needle exchange or other harm reduction programs to prison populations.[4] This contrasts with the evaluation literature which shows positive results in terms of risk reduction by inmates who have access to bleach kits, needle exchange, opioid replacement therapy, HIV testing, counselling and education.[6] It also contrasts with estimates that show there are substantial cost savings to government from providing prison harm reduction programs. Furthermore, it contrasts with common knowledge that prisoners, prison staff and their family members all benefit from reducing the prevalence of communicable disease (e.g., inmates eventually leave prison and return to their communities with whatever health problems they have acquired while incarcerated).[49]

Police, correction, court and other justice personnel have considerable contact with people who use alcohol and other drugs. They are well placed to assist in the implementation of harm reduction initiatives. Rates of HIV infection in the federal correctional system are estimated to be 10 times higher than in the general population and rates of hepatitis C infection are estimated more than 20 times higher than the Canadian population. As noted by Thomas, "While every effort is made to enforce the legal conditions of abstinence within our jails and prisons, the fact is that some federal and provincial prisoners consume alcohol and other drugs while incarcerated. This means that correctional staff and administrators have significant opportunities to implement policies and programs to reduce harms among substance-abusing prisoners in their care."[9]

Many of the intervention programs currently in place for criminal justice populations are abstinence-oriented, although these can and often do incorporate harm reduction measures. For example:[9]

- Arrest referral schemes - in the UK, these programs place trained addiction professionals in police stations to conduct assessments and refer people arrested on drug charges to voluntary treatment.

- Altered enforcement protocols - are used in a number of jurisdictions including Canada. These protocols change the way police personnel (1) respond to overdose

calls (i.e., only if asked by ambulance and other emergency medical personnel) and (2) enforce drug laws in and around harm reduction facilities such as needle exchange.

- Education and information strategies - are provided by enforcement officials because they have significant involvement with people who use alcohol or other drugs. Police, for example, are well positioned to provide at-risk populations with information on safer drug use practices, and information on where to access harm reduction services such as needle exchange and treatment for substance use. They often have the most up-to-date information on the potency of drugs being sold on the street and can easily link with community health providers and people who use drugs to establish early warning systems that will prevent overdose death.

- Prison-based substance use programs - are traditionally abstinence-based, although this is not always the sole criterion for participation. The Correctional Service of Canada (CSC) has removed abstinence as a requirement for program participants, and CSC lists harm reduction as a 'theoretical influence' in their treatment programming.

- Bleach kits - are provided to inmates in prisons around the world (e.g., Scotland, Germany, France, Denmark, Italy, Switzerland, Greece, Australia) to sterilize syringes and prevent the spread of HIV. As of September 2002, all CSC prisons in Canada and in the provinces of BC, NF and PQ provide bleach kits to inmates explicitly as a harm reduction measure. …

- Syringe exchange services for prison populations have been established in a number of countries. The concept of piloting prison-based needle exchange programs in Canada was first raised in 1992 and has since been reviewed several times by government. To date, however, no correctional facilities in Canada offer this type of harm reduction programming for inmates.

- Methadone maintenance treatment - is available to prisoners in several countries around the globe. In Canada, most correctional facilities (excluding PEI, Nunavut and NF) allow continuation of methadone for prisoners who enter jail while receiving this treatment. Fewer provinces (BC, AB, ON, PQ, YK and SK) allow initiation of methadone once a person has been sentenced to prison.[**]

Public Opinion

Results from the 2004 Canadian Addiction Survey (CAS) indicate that most Albertans (>75%) see alcohol and illicit drug use as serious or very serious issues in this province and in their community. The vast majority (80.4%) of Albertans felt the best way to deal with these issues is to provide prevention and treatment, rather than through law enforcement and incarceration (19.6%).[50]

[**] Initiation of methadone is allowed within all federal corrections facilities.

Findings from the CAS showed that about two-thirds of Albertans (69.2%) support harm reduction measures. Public opinion on specific interventions suggests that Albertans:[50]

- favour increased efforts to prevent intoxicated customers from being served (75.4%)
- support needle exchange programs (75.3%)
- support methadone maintenance (83.4%)
- agree with health programs that don't require abstinence (61.5%)
- somewhat agree with overnight shelters for the homeless that don't require abstinence (37.5%)

The Canada West Foundation recently released a report on priority social issues based on a survey of residents in seven Canadian cities (including Calgary and Edmonton). Findings from the survey indicate that most urban residents feel drug addiction should be treated as a health issue rather than a criminal issue and a sizeable minority of respondents felt that offering safe injection sites was a good or very idea.[51] Results for Edmonton and Calgary are shown below and few differences are notable when the two cities are compared.

	Edmonton	Calgary
Governments should treat illegal drug use as a health issue, not a criminal issue.	50.8%	54.9%
Offer safe injection sites for drug addicts.	47.4%	45.7%

CONCLUSION

Substance use and gambling are individual and community issues. Harm reduction offers a non-judgemental and necessary response to the range of problems that affect people who gamble or use alcohol or drugs, their families, friends, and employers.[14]

Experience in jurisdictions around the world demonstrates that harm reduction interventions work best when they are part of a comprehensive mix of policy and program responses that include prevention, treatment and enforcement.[4,12]

Currently, harm reduction initiatives in Canada and elsewhere are strongly influenced by politics and ideology.[22] This makes it essential for harm reduction to be consistently aligned with evidence-based standards and measures, both conceptually and in practice. At the same time, it is prudent to recognize that there are instances where policy makers and programmers will choose to ignore the evidence and benefit of harm reduction in favour of those interventions that are less effective but have greater appeal because they are expedient or publicly accepted.[4,6]

FURTHER READING

The Canadian Centre on Substance Abuse (CCSA) offers a series of excellent publications on harm reduction for special populations in Canada. These documents can be accessed on the CCSA website at www.ccsa.ca. They include:

- Harm Reduction Policies and Programs for Persons Involved in the Criminal Justice System (May 2005).
- Harm Reduction Policies and Programs for Youth (August 2006)
- Harm Reduction Policies and Programs for Persons of Aboriginal Descent (June 2007)
- Harm Reduction Policies and Programs for Persons with Concurrent Disorders (in press)

In conjunction with the Alberta Non-Prescription Needle Use Initiative[††], AADAC recently developed a resource called, *Working with people who use drugs: A harm reduction approach*. This resource is intended for professionals (nurses and physicians, pharmacists, social workers and other counsellors, police officers, etc.) and presents practical strategies that reflect a harm reduction approach in working with people who use drugs. It recognizes that health and safety are as important to those using drugs as they are to members of their family or community.

Organizations with web links to news articles, publications and other resources on harm reduction include:

- Canadian Harm Reduction Network (www.canadianharmreduction.com)
- International Harm Reduction Association (www.ihra.net)
- Burnet Institute Centre for Harm Reduction (www.chr.asn.au)
- Drug Policy Alliance (www.dpf.org)
- Harm Reduction Coalition (www.harmreduction.org)

[††] Established in 1995, the NPNU is a 37-member multi-sectoral alliance of government, community agencies and associations in Alberta. Policy makers meet with field staff and other stakeholders to identify issues, develop shared plans of action and respond to recommendations to reduce harm associated with drug use, particularly the transmission of HIV and hepatitis C. The NPNU includes a steering committee, provincial co-ordinating committee and seven specific task groups.

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