POLICY

20 A pragmatic, humanistic and effective approach to addictions: The Importance of Harm Reduction

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Think about the child who spins madly in order to make themselves dizzy or experience euphoria; the student who says "I can't face this class without another big cup of coffee;" the professional who ends the day with a glass (or two) of wine or bourbon. Engaging in practices that are pleasurable, mind altering or stimulating—including the use of substances—is not unusual in any society. For most people, and this includes the majority of individuals who experience homelessness, such practices are not particularly harmful, and may even have a positive impact on health and well-being. For others, however, the use of substances—both legal and illegal—can be debilitating, and can undermine relationships, health and survival.

Throughout many of the stories in this volume, people write about their personal struggles with substance use and addictions. In some cases, addictions were identified as a contributing factor that led to homelessness. The problematic use of substances can be traced to other life challenges, such as the experience of violence and trauma. This can be seen in the compelling story "Officer Down" (Anonymous, 2015, p. 46). In this case, the author

worked as a police officer, where he was constantly exposed to violence (including his own), threats and trauma. All of this takes its toll, and one way of coping is to rely on substances like alcohol. This man eventually lost everything and became homeless. Contributing to his challenges was the fact he worked in an environment where one could not show weakness or even ask for help. In dealing with addictions, we often expect people to 'pull themselves together' when they may really be incapable. While now housed, the author of "Officer Down" continues to struggle, and feels that his personal resources are used up. He has experienced considerable loss.

For others, the experience of homelessness itself leads to struggles with substance use. The rigours of life on the streets, feelings of loss and sadness, lack of safety, continuous exposure to trauma and the high risk of criminal victimization can all lead people to use various substances in order to self-medicate. In "Hope Eternal," Sean LeBlanc (2015) explains that:

> *A lot of the problematic substance abuse in shelters is because one almost has to be intoxicated just to deal with all of the drama that the homeless face daily: violence, oppression, condescending attitudes, a horrid diet and, worst of all: nothing to do. There are so many things that can mess with your day in such a place (p. 99).*

All of this raises the question about what to do: how do we deal with addictions? An important place to start is to acknowledge that, as a society, we are profoundly conflicted about how we think about addictions and what we want to do about it. On the one hand, we see addictions through the lens of disease: alcoholism and drug addiction are framed as medical problems that will stay with people throughout their lives, and require medical intervention, such as treatment. This is a well-established view that most certainly many Canadians agree with, and can help elicit more sympathetic responses to the plight of individuals and their families who cope with the struggles of addictions.

In spite of the belief that addiction is a disease, many of us equally hold to the Victorian and prohibition-era notion that substance use is indicative of moral failure: that people who are drug addicts or alcoholics are weak, lack willpower and are bad people or deviants who should pay the price for their decisions. The remedy, in this case, is at best encouraging a spiritual and moral shift, asking people to pull themselves up by the bootstraps; at

its worst, it is using law enforcement to deal with the problem. We invest incredible amounts of money in policing and corrections not only to address the outcomes of some people's substance use (violence, vandalism, disorderliness), but also to criminalize personal choices and behaviours that may not necessarily negatively impact on an individual's life, their family or community (the 'War on Drugs' and our prohibitionist laws concerning illicit drugs). The outcome of holding these contradictory positions simultaneously is inherently curious; can you think of any other health issue (cancer, diabetes) for which an incredible investment in the criminalization of individuals beset by disease is considered justified?

For many years, people have raised valid questions about the effectiveness and efficacy of the 'War on Drugs.' A recent report by the London School of Economics reviewed the literature, and provided compelling evidence that the prohibitionist model that uses law enforcement as a key strategy to address substance use and addictions is expensive, counter productive and, in essence, a wasted effort (Quah et al., 2014).

All of this is important to consider when we think about how to address the addiction challenges of people who experience homelessness. Many homelessness serving organizations adopt an abstinence-only policy for their clients, meaning individuals cannot use or be under the influence of substances while accessing services. In some cases, this is driven by a desire to 'control' environments for the safety of all clients. In other cases, it is a reflection of a moral lens being cast upon those who use substances.

While most certainly abstinence-only services should be available as part of a range of options, this should not be the only approach or the single standard of practice. In fact, one could argue that in some ways, strict adherence to abstinence-only produces harm for some individuals (because, addictions being what they are, many individuals cannot manage their problems in this way). It also arguably results in the unintentional infantilization of service users. For instance, the requirement that people not smell of alcohol in order to access a shelter is a standard that is not practiced broadly for people who are housed. If this were the rule in my house, I would be forced to spend many a night outside. We must think carefully about our service responses, and how they may actually exacerbate the problem of homelessness.

This brings us to the role of harm reduction, an approach that has been recommended by the World Health Organization (WHO) (1974), and is well established in many communities in Canada and worldwide. An examination of the philosophy and practice of harm reduction provides some insight into where and how we should proceed.

Harm reduction is an approach or strategy aimed at reducing the risks and harmful effects associated with substance use and addictive behaviours for the individual, the community and society as a whole. It is deemed a realistic, pragmatic, humane and successful approach to addressing issues of substance use. Recognizing that abstinence may be neither a realistic or a desirable goal for some users (especially in the short term), the use of substances is accepted as a fact, and the main focus is placed on reducing harm while use continues. While harm reduction is a practice specifically associated with mitigating the harms associated drug or alcohol use, we should understand that we all engage in activities and practices designed to reduce harm. Many of these practices are so entrenched in our daily lives that we do not even think about them. Mandatory use of seatbelts in cars, bike helmets, hand washing, safe sex practices, infant and toddler car seats and speed limits are all harm reduction measures.

So why not harm reduction for substance use? As Gabor Mate puts it:

> *The question is: is it better for people to inject drugs with puddle water or sterile water? Is it better to use clean needles or share so that you pass on HIV and hepatitis C? This is what harm reduction is. It doesn't treat addiction, it just reduces harm. In medicine, we do this all the time. People smoke but we still give them inhalers to open airways, so what's different? You're not enabling anything they're not already using (as cited in Szalavitz, 2012, para. 9).*

We advocate harm reduction because it is not only a humane and client-centered approach, but it is also considered effective (Ball, 2007; Hunt et al., 2003; Wodak & McLeod, 2008). At its most basic level, it is designed to reduce harms to individuals, their families, and communities by working from 'where people are at.' In this way, it is heavily steeped in an understanding of 'stages of change,' which means that people must not only consent to treatment or interventions, but also demonstrate willingness and readiness for change.

Stages of Change model

Developed by Prochaska and DiClemente (1982) and applied to behaviour change regarding substance abuse (Prochaska, DiClemente & Norcross, 1992), the stages of change model takes a stepped approach to addictions.

1. **Precontemplation** - During this stage there is no intention of change.
2. **Contemplation** - An awareness of the problem develops as the individual weighs the pros and cons of taking action.
3. **Preparation** - This stage combines intention to change with behavioural criteria; the individual in this stage has decided to act and makes plans to do so in the near future.
4. **Action** - At this point the individual modifies his or her behaviour, experiences, or environment to overcome the problems.
5. **Maintenance** - The behaviour that occurred in the action stage is maintained as the individual works to prevent relapse and consolidate the gains that have been attained.

We know from research that treatment does not work when people are forced into it without recognition that they have a problem. Prochaska and his colleagues (1992) suggest that the vast majority of addicted people seeking substance abuse services (85 to 90%) are not in the action stage. Fewer than 20% of those who seek treatment complete it, but among those who do complete treatment, drug use is reduced by 40 to 60%. All of this points to the fact that people must be ready for and desire change if treatment is to have any impact at all.

The essence of harm reduction is embodied in the following statement: "If a person is not willing to give up his or her drug use, should we not assist them in reducing harm to himself or herself and others?" Some key characteristics or principles of harm reduction include:

1. Pragmatism underlies harm reduction. As Riley et al. (1999) wrote:

> *Harm reduction accepts that some use of mind-altering substances is a common feature of human experience. It acknowledges that, while carrying risks, drug use also provides*

> *the user with benefits that must be taken into account if drug using behaviour is to be understood" (p. 11)*

So from a pragmatic perspective, the goal of a community should be to contain the most negative impacts of drug use, rather than focusing on efforts to eliminate the use of drugs entirely.

2. Harm reduction is both a philosophy and practice. Providing an environment where substance use is allowed, but where individuals are not provided with supports to reduce the risk of use is not in fact harm reduction. A true harm reduction program must proactively engage people regarding their use, and work towards reducing the negative impacts of that use to themselves, the people around them (including their family) and the community.

3. Humanistic values are central. Dignity and respect for the rights of users should be paramount, and the decision of some people to use drugs should be accepted as a fact (Riley et al., 1999). People should not be judged for their use, but instead must be made to feel valued.

4. Focus on harms. This means actively working towards reducing the physical, social, and economic harms associated with drug use. Active strategies include needle exchanges and availability of safe drug use supplies, safe injection sites and methadone treatment. It also means actively engaging with individuals and groups to offer education and support to reduce risks (including levels of use); providing safe environments in which to use substances; and using motivational interviewing and support to help people move forward with their lives.

5. Harm reduction does not preclude abstinence or treatment. Harm reduction and abstinence-based programs are often imagined as being incompatible or oppositional. "Many people incorrectly interpret a harm reduction approach as promoting, supporting or—minimally—being indifferent to substance use, and ignoring those who want to quit. This is clearly a misunderstanding of the concept." (Gaetz, 2014,p. 71). Harm reduction is inherently a client-driven approach that respects individual choice, and it opens the possibility that many individuals will desire or seek out abstinence either now or in the future. Many people, as part of their recovery, can only survive in environments where there are no users present

and actively consuming substances, so abstinence approaches have their place; but they must not be the only available option. Providing a range of options is the true approach to harm reduction.

6. Treatment programs on their own are not enough. There is no doubt that quality treatment programs can be highly effective in helping people quit using substances. Moreover, many individuals want to go that route. The problem is accessing programs in a timely way. In this volume, Richard explains: "I think for the most part, the major contributor to my ending up on the streets was the lack of addiction treatment programs available. Any long-term treatment has a six- to eight-month minimum wait time" (Henry, 2015, p. 57). Getting access to treatment is one thing, but what happens next is equally important. First, sending people exiting treatment back into environments where other users are present, as well as the risk factors that produce substance use in the first place (violence and poverty, for example) can make it very difficult to stay 'clean.' Second, the underlying factors that lead to homelessness and addiction must inevitably be dealt with—ensuring people have safe and affordable housing, income, food to eat, opportunities for positive social interaction and meaningful engagement in activities. Moving from treatment back to homelessness may not produce the outcomes we desire.

Despite the fact that harm reduction is both pragmatic and effective, many communities are slow to adopt the practice. In 2010, Toronto became the first city in the world and the first government to endorse the Vienna Declaration[1], which advocates harm reduction as a method of lowering HIV transmission rates caused by injection drug use. In fact, harm reduction is one of the four pillars of Toronto's drug strategy (the others are law enforcement, treatment and prevention)[2]. The Insite program in Vancouver is an example of an evidence-based best practice[3]. As Stephen Hwang (2007) has pointed out in the past, the strong evidence base for the effectiveness of the Insite program should put questions about whether this approach makes sense or not to rest. Other communities have managed alcohol programs, wet or damp shelters (meaning they allow the consumption of alcohol by

1 For more information, visit http://www.viennadeclaration.com.

2 Toronto's full drug strategy can be accessed at http://www1.toronto.ca/wps/portal/contentonly?vgnextoid=b51afc4890047410VgnVCM10000071d60f89RCRD.

3 Insite was North America's first legal supervised safe injection site. Despite some opposition, it remains open. Learn more at http://supervisedinjection.vch.ca/.

their residents), housing and harm reduction frameworks, needle exchange programs and other programs that support harm reduction philosophies. In Housing First programs, harm reduction and a recovery orientation are central components.

Governments, communities, agencies, and individuals really need to think about the role of harm reduction in improving the lives of people who experience homelessness. In moving towards implementing harm reduction, you must consider how to engage your community around this issue. How are you going to build supports for harm reduction? How will you provide training for staff and volunteers? How are you going to help people understand what it means? Efforts to put harm reduction into practice often fail because of popular misconceptions about its meaning and implementation. There are many communities in Canada that have been doing great work in this area, but there are many communities where it is not even on the radar. We need to support this change in communities.

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