



Harm Reduction Policy for Social Work Practice

Policy Considerations for the Ontario College of Social Workers and Social Service Workers

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EXECUTIVE SUMMARY

Harm reduction refers to policies, programs and practices that aim to reduce the negative health, social and economic consequences that may ensue from the use of legal and illegal psychoactive drugs, without necessarily reducing drug use (CHRN, 2012). Harm reduction policies and practices emphasize the universal human right for the highest attainable standard for health of people who use drugs, and their families and communities.

People who use drugs are often engaged with helping professionals, including social workers and social service workers. There is a clear need for social workers and social service workers to have the support of their governing agencies to serve all of their clients, free from a prohibitionist, judgmental stance. Social work core values mirror those of harm reduction; they recognize the inherent worth and dignity of all people, take a non-judgmental stance, respect diverse populations, encourage professional competency and the right to self-determination, advocate for social justice, adopt a strengths perspective, encourage ongoing research and evaluation, and facilitate interprofessional practice. Despite these similar values, there is no mandate by Ontario College of Social Workers and Social Service Workers (OCSWSSW) surrounding harm reduction. This lack of guidelines within social work and social service work is identified as a major concern in the realm of harm reduction practice (Cavalieri, private communication, Oct. 17, 2012).

The need for harm reduction practices within social work and social service work is further evidenced by the correlation between injection drug use and HIV and Hepatitis C transmission. Injection drug users represent 71% of all newly transmitted HIV cases annually in Canada (CHNR, 2008). Current or former injection drug users represent 70% of all people infected with hepatitis C (CHNR, 2008). Every year, approximately 47 000 Canadian deaths are linked to substance abuse, including alcohol, psychotropic drugs and tobacco use (CCSA, 2012). Incorporating harm reduction practices, values and supportive guidelines in social work will effectively reduce the negative health and social burdens on people who use drugs.

We recommend an agency wide harm reduction mandate that incorporates harm reduction principles into social work practice, research and education. Our strategic proposal is embedded in evidence-based practice to scientifically support this integration of harm reduction policies into OCSWSSW mandates. Ethical formulation and implementation of harm reduction policy at an agency-wide level can, and will, influence social workers in direct practice with people who use drugs.



APPENDIX OF ACROYNMS AND DEFINITIONS

BSW: Baccalaureate of Social Work

CASW: Canadian Association of Social Workers

CNA: Canadian Nurses Association

CHRN: Canadian Harm Reduction Network

Harm Reduction: Harm reduction refers to policies, programs and practices that aim to reduce the negative health, social and economic consequences that may ensue from the use of legal and illegal psychoactive drugs, without necessarily reducing drug use. Its cornerstones are public health, human rights and social justice. It benefits people who use drugs, families and communities (CHRN, 2012)

HCV: Hepatitis C Virus

HIV/AIDS: Human Immunodeficiency Virus; Acquired Immunodeficiency Syndrome

IDU: Injection Drug Use

MSW: Masters of Social Work

NASW: National Association of Social Workers

NGOs: Non-Governmental Organizations

OCSWSSW: Ontario College of Social Workers and Social Service Workers



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MEMORANDUM

MEMORANDUM INTRODUCTION

Harm reduction refers to policies, programs and practices that aim to reduce the negative health, social and economic consequences that may ensue from the use of legal and illegal psychoactive drugs, without necessarily reducing drug use. Its cornerstones are public health, human rights and social justice. Harm reduction benefits people who use drugs, families and communities (CHRN, 2012).

The Ontario College of Social Workers and Social Service Worker (OCSWSSW) does not provide a framework within their mandate to address harm reduction as it pertains to the use of alcohol and drugs. Although the focus of this policy recommendation is the OCSWSSW, it is important to note that the Canadian Association for Social Workers (CASW) also lacks a mandate that addresses harm reduction. Because both agencies govern social workers in Ontario, it is important to make a make reference to both bodies. With a commitment to the pursuit of social justice and a focus on the self-determination of clients, the OCSWSSW and CASW codes of ethics support the underlying values and principles necessary for implementing an evidence-based harm reduction strategy in the field of social work.

Social workers have an active role in the frontline support of people who use drugs and people with mental health and addiction issues. Social workers are often employed by community agencies that implement harm reduction strategies; however, they do not have a guiding set of principles to inform their practice.

As a set of client-focused principles, programs and policies, harm reduction mirrors the fundamental values of social work: recognizing the inherent worth and dignity of all persons,



mutual participation, collaboration, and client self-determination. Congruent with social work principles, harm reduction also promotes social justice, engages with multifaceted resources, respects diverse populations, utilizes a strengths perspective, encourages ongoing research and evaluation, and facilitates interprofessional practice.

It is recommended that the OCSWSSW develop a policy statement and associated ethical framework to incorporate the principles of harm reduction for social work practice in Ontario.

CONTEXT

The need for harm reduction practice within social work and social service work is fundamental to recognize the health and human rights of people who use drugs. The correlation between injection drug use (IDU) and communicable disease transmission clearly demonstrates unequal risk for people who use drugs compared to non-drug using populations. Current HIV/AIDS and Hepatitis C transmission rates are elevated among injection drug use populations, and are overrepresented in certain minority populations, such as aboriginal peoples: approximately 4.4% of all deaths in Canada annually are caused by the use of psychotropic drugs (CCSA, 2012). Other helping professionals, such as nurses, recognize the link between injection drug use and increased risk for blood-borne disease, and as a result have been leading advocates in the promotion of harm reduction programs (CNA, 2011; Hardill, 2007; Lightfoot et al., 2009; Ruiterman & Biette, 1973).

The Ministry of Health has been at the forefront in implementing harm reduction strategies into its policies and service delivery models, with the goal of preventing the transmission of blood-borne diseases (Ministry of Health, 1997); however, the Government of



Canada continues to support the criminalization of drug use through their prohibitionist National Anti-Drug Strategy.

Despite federal constraints and with the support and advocacy of harm reduction from the Ministry of Health and local community advocates, Ontario has become a leader in needle exchange and crack kit distribution programs (Cavalieri & Riley, 2012). Since 1997, local boards of health have been required by law to provide access to needle syringe programs as a harm reduction strategy (Canadian HIV/AIDS Legal Network, 2007). Toronto currently has 36 programs providing harm reduction supplies to the public in agencies where social workers are employed (City of Toronto, 2012).

POLICY CONSIDERATIONS: STRATEGIC APPROACH

The context of harm reduction service provision in Ontario necessitates the establishment of guiding social work principles for harm reduction practice by the OCSWSSW to support social workers in the field. We suggest that by 2014 the OCSWSSW:

1. Adopts harm reduction as both a college and program framework
2. Integrates harm reduction principles into a code of ethics memorandum
3. Issues concrete harm reduction guidelines for social work and social service practice
4. Includes key stakeholders and client-population perspectives in harm reduction strategy development, implementation and evaluation
5. Supports the integration of harm reduction into social work and social service worker education curriculum and professional development programs



6. Promotes continual innovation and evidence-based decision making in social work and social service work practice through participatory research and evaluation of harm reduction strategies

7. Disseminates relevant harm reduction strategies, principles, program planning, research, and evaluation to educational institutions, college members and OCSWSSW-affiliated agencies

SUGGESTED AGENCY POLICY STATEMENT

The OCSWSSW supports the incorporation of harm reduction principles into social work practice, research and education. The position of the OCSWSSW is as follows:

- The ethics and values outlined by the OCSWSSW (social justice, self-determination, respect for the intrinsic worth of people) are harm reduction principles.
- Social workers and social service workers work to eradicate the use of stigmatizing and objectifying language and labels in reference to oppressed and vulnerable people who use drugs.
- Social workers and social services workers strive to implement harm reduction programs and strategies that respect diverse needs and human rights with regard to gender, sexual orientation, ethnicity, culture, religion and spiritual beliefs, socioeconomic status, disability, and other factors.
- Social workers and social service workers must implement harm reduction services based on research and evidence-based practices that demonstrate effectiveness.



- Social workers and social service workers in all settings need to be knowledgeable about harm reduction practices and the skills necessary to engage clients, their families and communities in appropriate services.
- Social workers and social service workers engage in and contribute to ongoing research and evaluation of harm reduction policies and program implementation.

SWOT ANALYSIS OF PROPOSED POLICY CONSIDERATIONS

A strategic planning methodology, SWOT (Strengths, Weaknesses, Opportunities, Threats) analyses determine the internal and external factors relevant to the achievement of policy change. The following matrix outlines factors pertinent to the incorporation of a harm reduction mandate for the OCSWSSW.

STRENGTHS:	WEAKNESSES:
<ul style="list-style-type: none">• Harm reduction principles are congruent with the values of social work.• Social workers are equipped with a strong skill set for developing trust, building relationships, and advocating on behalf of vulnerable persons in society, all of which are key factors when working within a harm reduction framework.• The OCSWSSW has oversight over its members and is able to guide ethical practice to implement harm reduction strategies.• Adoption of specific harm reduction guidelines provides incentive for the OCSWSSW to adopt other evidence-based population-specific guidelines to work with unaddressed populations.• Integration of harm reduction principles provides a framework for future work with diverse populations.	<ul style="list-style-type: none">• The OCSWSSW does not have an established framework within their mandate to address harm reduction. This puts social workers at a disadvantage when working and advocating in the field, relative to other healthcare professionals that have clearly stated harm reduction agendas.• The OCSWSSW does not have any working guidelines for specific social work practice with vulnerable diverse populations (i.e. disability, sexual orientation, gender, ethnicity, culture, sex workers).• The OCSWSSW mandates are very general.



OPPORTUNITIES:	THREATS:
<ul style="list-style-type: none">• Explicitly addressing harm reduction in the OCSWSSW would make both Ontario and Canada an international leader among social work governing bodies.• There is an absence of harm reduction mandates within governing bodies of social work in other countries, such as the United States and New Zealand.• Implementation of the suggested harm reduction principles would provide comprehensive social work standards for other countries around the world that can be augmented to suit the needs of their populations.• Having agency support for harm reduction will allow social workers to make sounder, evidence-based, ethically supported decisions in their direct and indirect practice with clients.	<ul style="list-style-type: none">• The public perception that harm reduction strategies encourage drug use among people who do not use drugs; enables drug use and entrench criminal and addictive behaviours that harm families and communities; increase disorder and threaten public safety; redirect resources from addictions treatment and other life-saving interventions; promote the decriminalization or legalization of drugs.• Demonstrated Federal government resistance to harm reduction principles and strategies.

Table 1: *SWOT Analysis*

MEMORANDUM CONCLUSION

Harm reduction policies and practices emphasize the universal human right for the highest attainable standard for health of people who use drugs. As a solution-focused intervention that respects the inherent dignity and worth of individuals, harm reduction is compatible with social work principles and values. This memorandum provides a framework for the OCSWSSW to include harm reduction strategies as part of their organization. Harm reduction policies are a vital aspect of social work practice, which need to be integrated into the OCSWSSW. Harm reduction policies must be integrated into the code of ethics, educational practices, research and evaluation to regulate social workers in the profession. As Des Jarlais (1995) urges, policy initiatives must take a pragmatic stance and “be assessed on their actual



consequences, not on whether they symbolically send the right, the wrong, or mixed messages” (p. 10). It is vital that we integrate harm reduction policies not only as a guideline, but also as an essential way to support people who use drugs through social work practice.



BACKGROUND PAPER

INTRODUCTION

HARM REDUCTION

As a set of practical policies, programs, and practices, harm reduction aims to primarily reduce the negative health, social and economic consequences that may ensue from the use of legal and illegal psychoactive drugs, without necessarily reducing drug use, including family disruption, gang involvement, criminal activity, violent behaviour, overdose, HIV/AIDS, HCV, and death (Bigler, 2005; CHRN, 2012). With commitment to public health and human rights, harm reduction strategies focus on the minimization of risk and harm through targeted interventions while simultaneously recognizing that drug use is a complex and multifaceted phenomenon (HRC, 2012; HRI, 2012). As such, harm reduction practices offer an alternative to criminal and moral ideologies by providing evidence-based, cost-effective, effective, feasible, and safe frameworks for intervention (HRI, 2012; WHO, 2012).

Grounded in the principles of respect, dignity, and compassion, harm reduction emphasizes the universality of human rights for the highest attainable standard of freedom, health, and wellbeing (HRI, 2012). Through non-coercive and non-judgmental provision of services and resources for individuals and communities, harm reduction emphasizes transparent and accountable strategies that promote the self-determination and autonomy of people who use drugs, their families, and communities affected by oppression and discrimination (CHRN, 2012; HRC, 2012; HRI, 2012).



Based upon the preceding characteristics of harm reduction, six guiding principles of harm reduction are recognized (Bigler, 2005; Brocato & Wagner, 2003; CHRN, 2012; HRC, 2012; HRI, 2012; MacMaster, 2004):

1. Pragmatism: Harm reduction accepts that the non-medical use of psychoactive substances is a universal phenomenon. Harm reduction recognizes that drug use is complex and multifaceted and can encompass a continuum of behaviours that produce varying degrees of social harm and benefit.
2. Human Rights: Harm reduction respects the basic human dignity and rights of people who use drugs, their families, and communities by adopting a humanistic perspective. It accepts an individual's decision to use drugs and no judgment is made to condone or condemn the use of drugs.
3. Focus on Harms: The fact or extent of an individual's drug use is secondary to the harms from drug use. These harms can be individualized or present significant strains to the system, such as the effects of increased criminalization on the judicial system. The ecosystemic perspective of social work would be beneficial in addressing the micro to macro harms of drug use. With regards to individual harm, priority is to decrease the negative consequences of drug use to the user and others, rather than to reduce the drug use itself.
4. Maximize Intervention Options: Harm reduction recognizes that people who use drugs are not a homogenous group and thus may require a variety of different interventions that can minimize or even prevent risks and harm. There is no one prevention or treatment approach that works reliably for everyone.
5. Priority of Immediate Goals: Harm reduction starts "where the client is" in their drug use,



beginning with immediate focus on the most pressing needs and working in a stepwise progression towards long-term goals.

6. Participation and Collaboration: Harm reduction acknowledges that people who use drugs are autonomous, competent, and capable individuals that can determine best interventions to reduce harms.

EXAMPLES OF HARM REDUCTION INTERVENTIONS

Harm reduction policies, programs and practices are diverse and multifaceted. Lenton and Single (1998) define harm reduction strategies as policies, programs, or interventions that recognize: “(1) the primary goal is the reduction of drug-related harm rather than drug use *per se*; (2) where abstinence-oriented strategies are include, strategies are also included to reduce the harm for those who continue to use drugs; and (3) strategies are included which aim to demonstrate that, on the balance of probabilities, it is likely to result in a net reduction in drug-related harm” (p. 219).

Although focus has primarily been directed towards harm reduction for illicit drug use, licit substances and legal activities have also received support from harm reduction intervention strategies. Using this framework, examples of efficacious interventions include: needle and syringe exchange programs, safe or supervised consumption sites, bleach distribution programs, outreach, drug substitution, methadone maintenance treatment, “party safe” or “street safe” strategies, crack pipe programs, condom distribution, brief solution-focused motivational interviewing, regulation and environmental controls in licensed establishments, server training and interventions for alcohol, controlled drinking programs, designated driver programs,



seatbelt laws, wet/damp shelters, non-smoking bans, nicotine replacement therapy, smokeless tobacco, and controlled gambling programs (CCSA, 2012; HRC, 2012; HRI 2012; Ritter & Cameron, 2006; WHO, 2012).

CHALLENGES FOR HARM REDUCTION POLICY DEVELOPMENT

Three primary challenges for harm reduction are identified in the literature: 1) ineffective formulation and implementation of policy specific to harm reduction in macro environments; 2) a climate of intolerance towards people who use drugs; and 3) not establishing a clear and understood concept of harm reduction (Wellbourne-Wood, 1999).

Research regarding Canada's origins of drug laws suggests that groups with power influence drug laws to exert control over powerless and marginalized groups based upon moralistic ideology (Hathaway & Erickson, 2003). Thus it can be argued that an ideological approach to drug use has been created in reaction to drug users and not to the drugs itself (Hathaway & Erickson, 2003). The discourse surrounding harm reduction principles must be reflected in evidence based research and not moral or ideological ideals of drug policies in Canada: a task that has not been historically embraced at the federal level (Hathaway & Erickson, 2003).

In the past, public policy regarding drug policies has reflected a constructionist view by promoting abstinence; however, public discourse has begun to shift towards the inclusion of drug reform approaches based on scientific knowledge and evidence based practice (Hathaway & Erickson, 2003). Despite public demand for evidence-informed policy, evidence-based research has had little impact on Canada's drug laws, as detailed in proceeding sections (Debeck



et al., 2009; Des Jarlais, 2009; Hathaway & Erickson, 2003). However, the evidence is clear: scientific research supports harm reduction policies and rationalizes its use and effectiveness as a substance use policy in Canada (Debeck et al., 2009; Des Jarlais, 2009; Hathaway & Erickson, 2003).

Further challenges to the implementation of both harm reduction policy and practice remain. Current backlash against drug use as a widespread and inevitable social activity is exhibited through public opinions of drug use normalization, including perceptions of easier access to drugs, higher use rates, the correlation between drug use and crime, and an observed greater cultural tolerance of drug use by non-users (Erickson & Hathaway, 2010; Hathaway & Tousaw, 2008; Wellbourne-Wood, 1999). As such fears indicate, a lack of accessible and objective information threatens the implementation of policy, as ideologically informed arguments offer counter narrative to the positive effects exhibited by harm reduction, convoluting definitions and skewing facts.

Lastly, an additional threat to the implementation of harm reduction policies and practices includes the homogenization of people who use drugs (Erickson & Hathaway, 2010). People who use drugs are a diverse population and represent a multitude of social contexts and experiences. It is worthwhile to note that not all people who use drugs are addicted to drugs. Many people who use drugs are recreational users and indulge in socially acceptable forms of substance use, such as alcohol and tobacco. If diversity of experience is not considered, effective policy is not impactful.



STRATEGIES FOR EFFECTIVE POLICY DEVELOPMENT

In a review of the influences that contribute to the development of evidence-based health policy, Gareth (2010) concludes that six factors support effective policy: 1) establishing multi-disciplinary teams; 2) using a broad evidence base; 3) maintaining a reciprocal relationship between research and policy; 4) implementing locally-sensitive policy; 5) involving diverse stakeholders; and 6) encouragement by the Federal government. Although the OCSWSSW is not a federal government, it *is* a governing body of over 14,500 professional members across Ontario and these considerations for effective harm reduction policy implementation must be considered (OCSWSSW, 2011). As Mayer and colleagues (2007) argue, ethical leadership is transmitted from one organizational level to the next; thus, the inclusive and ethical formulation and implementation of harm reduction policy at an agency-wide level can, and will, influence social workers in direct practice with people who use drugs. The presented memorandum is informed by such considerations and will support effective OCSWSSW harm reduction policy development based on nuanced understanding of history, evidence and values for practice.

CONTEXTUAL INFLUENCES ON HARM REDUCTION

FEDERAL GOVERNMENT: HISTORY OF DRUG POLICY

Harm reduction in Canada has made some progress as drug policy has evolved from taking a prohibitionist stance to being more supportive of including harm reduction strategies when addressing drug use; however, in recent years it has been scaled back (Cavalieri & Riley, 2012). The Conservative Government of Canada's prohibitionist ideology has enabled the



development of a new rationale to devalue, reject and exclude drug users from scientifically supported health promotion efforts (Link & Phelan 2006). The use of moral arguments to develop an anti-harm reduction drug-policy in Canada has politically disentangled drug users from the general population, enabling a selective provision of healthcare rights.

The rising prevalence of drug use throughout the 1960s and 1970s was met with increased resources channeled to enforcement and greater criminalization of the possession and use of illicit substances (Cavalieri & Riley, 2012). These tactics lead to an elevated strain on the judicial system, as well as increased social and economic costs. The Commission for the Inquiry of Non-Medicinal Use of Drugs, otherwise known as the Le Dain Commission, was formed in 1969 for the purpose of addressing the costs associated with criminalization and prohibition (Cavalieri & Riley, 2012). Not surprisingly, the Le Dain Commission found that a prohibitionist stance on drug enforcement was met with little societal benefit and great economic costs. Unfortunately the results of the Le Dain Inquiry did not stimulate much public attention for the reformation of drug laws and policies.

However, in 1987, the Canadian Federal Government announced Canada's Drug Strategy titled the "Action on Drug Abuse". This strategy was aimed at reducing drug related harm by addressing substance use "through supply and demand reduction strategies" (Cavalieri & Riley, 2012, p. 2). The initiative was funded for a five-year period, and extended again until 1997. Action on Drug Abuse clearly demonstrated, through research and evidence-based practice, the effectiveness of harm reduction strategies in reducing the morbidity and mortality associated with drug use. Moreover, it provided a reasonable alternative to Canada's prohibitionist stance.



In 1996, the Chretien government passed the *Controlled Drug and Substance Act*, which served to further criminalize persons using illicit drugs (Cavalieri & Riley, 2012). In 2008, when the Harper government took office, they thwarted Canada's national drug strategies and replaced it with their \$64 million dollar National Anti-Drug Strategy which eliminated all mention of harm reduction and reverted back to a prohibitionist stance on drug strategy (Cavalieri & Riley, 2012; DeBeck et al. 2009; Government of Canada, 2012). Moreover, this strategy served to stall the Liberal party's impending initiative to legalize possession of small amounts of marijuana, which would have reduced strain on the judicial system.

The National Anti-Drug Strategy ignored domestic and international evidence relating to prohibitionist harms and the inadequacies of drug enforcement measures to reduce the demand and supply of illicit substances. It also transferred drug issues from the jurisdiction of the Ministry of Health to the Ministry of Justice (International Drug Policy Consortium (IDPC), 2010). Drug use was viewed as a contributor and source of crime; incarceration and increased prison sentences were seen as means to "curing" drug use (Cavalieri & Riley, 2012; Government of Canada, 2012). As such, the new strategy stipulated that 70% of funding would be directed towards law enforcement measures, with only 4% earmarked for prevention and 17% for treatment (Kerr et al. 2005; DeBeck et al. 2009). Such an approach is inconsistent with Canada's "National Framework for Action to Reduce Harms from Alcohol, Drugs, and Other Substances" (2005) that explicitly requires drug policy to be knowledge-based, evidence-informed, and evaluated for results (DeBeck et al. 2009).

Though the responsibility of drug issues is currently under the jurisdiction of the Ministry of Justice (Department of Justice Canada, 2012), the Ministry of Health nonetheless addresses



harm reduction strategies for injection drug users. The “Mandatory Health Programs and Service Guidelines” (Ministry of Health, 1997) implements harm reduction as prevention of the transmission of HIV, hepatitis C, and hepatitis B, and other blood borne infections. As such, the Public Health Agency of Canada has been at the forefront of including harm reduction in its policies.

THE CANADIAN CONTEXT OF HARM REDUCTION:

Harm reduction first occurred in Toronto in the early 1980s, in the form of controlled drinking programs (Riley & O’Hare, 2000 in Cavalieri & Riley, 2012). Since then, much of the focus of Canadian harm reduction programs has been on addressing the association of IDU in the transmission of HIV and AIDS. In 1987, bleach programs were established in Alexandra Park stemming from a growing concern about the transmission of HIV through injection drug use. By 1988 bleach programs developed into syringe exchange programs, which were then taken over by the City of Toronto in 1989 (Riley & McCrimmon, 1988 in Cavalieri & Riley, 2012). This same year, syringe exchange programs were established in communities across Canada, including Montreal and Vancouver (Canadian HIV/AIDS Legal Network, 2007; Cavalieri & Riley, 2012). To supplement governmental health initiatives, Non-Governmental Organizations (NGOs) provided harm reduction education and advocacy across Canada. By the 1980s and 1990s, methadone programmes were prevalent in Canada (Cavalieri & Riley, 2012).

The Ministry of Health in every Canadian province and all but one territory provide some form of harm reduction programming, mostly identified as Needle Syringe Programs (Canadian HIV/AIDS Legal Network, 2007). Some provinces are more developed than others, such as British



Columbia, who have successfully implemented two safe injection sites: InSite and Dr. Peter's Centre (Cavalieri & Riley, 2012; Vancouver Coastal Health, 2011). As a result of these initiatives and other harm reduction strategies, British Columbia is viewed as a leader of harm reduction in Canada.

Harm reduction programs across the Yukon, Northwest Territories and Nunavut are characterized by community-based initiatives (CHRN, 2007). Given the vast amount of land, sparse population and limited funding, programs have been implemented using community partnerships among agencies, colleges, community members and volunteers (CHRN, 2007). Partnerships have resulted in greater available resources and a shared responsibility among community stakeholders (CHRN, 2007). For example, Whitehorse's outreach van program utilizes territorial funding, funding and support from the Rotary Club, and food and coffee donations from restaurants and coffee shops (CHRN, 2007).

Alternatively, the Atlantic Provinces have had a more neo-conservative approach to harm reduction programs. Although needle exchange programs are permitted to operate, they focus mostly on exchange of syringes; access to other safe injection supplies is limited (CHRN, 2007). There is a prevailing false notion that harm reduction programs act as a disincentive to reduce drug use.

Ontario has led the way in the implementation of needle distribution and crack kits (Cavalieri & Riley, 2012). Though towns and smaller cities tend to be underserved, medium-sized cities throughout Ontario have demonstrated increased awareness and implementation of harm reduction practices. Since 1997, Ontario local boards of health are required by law to



provide access to needle syringe programs as a harm reduction strategy to prevent transmission of blood-borne diseases (Canadian HIV/AIDS Legal Network, 2007).

Toronto has a strong advocacy community for harm reduction, initiated and lead by community activists, front line workers, peers, academics and some city politicians (Cavaliere & Riley, 2012). In 2004, the City of Toronto initiated a Drug Strategy with strong input from community partners and stakeholders, in which harm reduction plays a central role (City of Toronto, 2005). In Toronto, approximately 36 agencies provide harm reduction supplies and methadone is available across the province (City of Toronto, 2012).

DRUG PREVALENCE IN CANADA

Ten percent of all Canadians over the age of 15 report symptoms consistent with alcohol or drug dependence (Government of Canada, 2006). The 2002 Canadian Community Health Survey found that 77% of all adults (aged 15 years or older) consumed alcohol over the course of a one-year period, while 13% (3.1 million people) reported using illicit drugs (Tjepkema, 2004). Youth aged 15 to 24 are the most commonly represented age cohort in substance-use disorders (Health Canada, 2007).

The Canadian Addictions survey (2007) found alcohol to be the most prevalent psychotropic substance used by youth and reported that 90.8% of youth used alcohol at some point in their life, while 82.9% reported using alcohol over the past year. Cannabis was the second most utilized substance; 61.4% of youth reported using Cannabis in their lifetime, and 37% reported cannabis consumption in the past year (Health Canada, 2007). The majority of youth who currently use any illicit drugs also consume cannabis (91.3%) and alcohol (99.6%)



(Health Canada, 2007). Lifetime use of inhalant, steroid and drugs by injection (including heroin) was approximately 1% of youth (Health Canada, 2007).

Current HIV rates among drug users in Canada range between 5 - 30%, with significant overrepresentation of aboriginal communities (Cavalieri & Riley, 2012). Injection drug users represent 17% of all newly transmitted HIV cases annually in Canada (CHRN, 2008). However, this figure grows exponentially when considering adult women: 37.3% of newly transmitted HIV cases among adult women in Canada are due to injection drug use (PHAC, 2012). In addition to HIV transmission, current or former injection drug users represent approximately 70% of all people infected with hepatitis C (CHRN, 2008). Every year, approximately 47 000 Canadian deaths are linked to substance use (Canadian Centre on Substance Abuse, 2012).

THE INTEGRATION OF SOCIAL WORK AND HARM REDUCTION

SOCIAL WORK AND HARM REDUCTION

Harm reduction mirrors the fundamental client-focused values of social work: inherent worth and dignity of persons, mutual participation, collaboration, and client self-determination. As Brocato & Wagner (2003) state that harm reduction is a “peace movement [that] is aligned with the humanistic values around which social work is organized” (p. 117). Informed by ecological, empowerment and strengths-based perspectives, social workers often engage in harm reduction practices with clients by minimizing risks associated with social location, health status and/or behavior, even if they do not define their actions as such (Bigler, 2005; Karoll, 2010). Embracing a structural social work perspective, social workers are natural advocates for marginalized peoples, their families and communities, and recognize the complexity of everyday



lives as determined by ethnicity, culture, gender, sexual orientation, age, socioeconomic status and health (Bigler, 2005).

Structural social work is concerned with the socio-economic and political aspects of society that create unequal relations, distribution of resources, and oppression of various groups. The approach focuses on the interplay between individuals and structures, and how that creates barriers and limitations for those who are disadvantaged, based on class, race, gender, sexual orientation, age, and religion. The theory views society in which problems are a result of competing power, resources and ideological worldviews and examines the way in which inequality is maintained (Weinberg, 2008).

Structural social work seeks to connect people with needed resources, change social structures, help service users negotiate problematic situations, and deconstruct socio-political discourses (Wood & Tully, 2006). Structural social work is a theory and practice that easily aligns with harm reduction, and its commitment to reducing the negative consequences of drug use and promoting human rights and accessibility of resources for people who use drugs.

Harm reduction alone does not adequately address the root cause of the inequalities faced by individuals who use drugs (Pauly, 2008). Embracing the philosophy and values of harm reduction creates a moral context in which structural social work and social justice can address the “harms created by policies that impact problematic substance use such as housing, welfare, and income policies” (Pauly, 2008, p. 5). Working from a structural social work perspective correlates and enhances the effectiveness of harm reduction approaches.

From a structural social work perspective, social work and harm reduction intersect in seven concrete ways (Bigler, 2005):



1) Inherent dignity and worth of all individuals: Social workers primarily work with marginalized and disenfranchised groups, such as people who use drugs. In both social work and harm reduction, all individuals are regarded with acceptance, honesty, openness, genuineness, care, and dignity.

2) Self-determination: In both social work and harm reduction, the recognition of client needs, wants, desires, and perspectives is paramount for facilitating a collaborative therapeutic relationship. Furthermore, in both social work and harm reduction it is understood that clients are the primary agent of change and that this recognition of ability and competence is empowering. Thus, social workers and harm reduction collaborators begin “where the client is,” proceeding incrementally towards client-centred and client-determined goals and objectives.

3) Resources: Social work and harm reduction interventions are dynamic and rely on the provision of a diverse array of resources and social determinants of health, including housing provision, education, counseling, linkages to other service providers, employment opportunities, health-promoting supplies, and wellness training.

4) Social Justice: Social work and harm reduction both serve as humane and responsive actions to people’s identified needs, based upon a humanistic framework. Social workers strive to promote social justice by advocating and facilitating the empowerment of individuals, families, and communities. Similarly, harm reduction helps to promote self-determining behavior without coercion or moralistic ideation. It strives to assist individuals in gaining control over resources to help mitigate against the negative effects of harmful drug-use behaviours.

5) Respect for Diversity: Social work and harm reduction recognize that oppression and discrimination based on gender, poverty, ethnicity, culture, socioeconomic status, and sexual



orientation exists and affects people in all aspects of their lives. Thus, social work and harm reduction provide services without discrimination, promoting equity and fair access regardless of an individual's sexual orientation, gender, socioeconomic status, ethnicity, and culture.

6) Strengths-perspective: Both social work and harm reduction engage in efforts to move away from pathologizing individuals based upon perceived deficits and instead work towards appreciating diverse abilities and assets. A strengths-based perspective promotes empowerment, resilience, healing and wholeness by recognizing that all individuals, families and communities exhibit strengths and a propensity for collaboration if limitations of growth are not assumed.

7) Evidence-based practice: Social work and harm reduction advocate for evidence-based practice and the continual engagement with research and evaluation that is disseminated to broad audiences.

8) Interprofessional collaboration: Due to the nature of social work and harm reduction, interprofessional collaboration is supported and is seen as a source of strength, innovation, and more effective practice. Social workers and individuals engaged with harm reduction activities will work with professionals, academics and clients from diverse backgrounds, all providing important contributions to practice.

SOCIAL WORK CODE OF ETHICS AND HARM REDUCTION PRINCIPLES

The following tables illustrate specific values outlined in both the CASW Code of Ethics and OCSWSSW Code of Ethics that support and parallel harm reduction principles: pragmatism,



human rights, self-determination, priority of immediate goals, client involvement, and appropriate intervention options.

A social worker or social service worker shall maintain the best interest of the client as the primary professional obligation;

1. A social worker or social service worker shall respect the intrinsic worth of the persons she or he serves in her or his professional relationships with them;
2. A social worker or social service worker shall carry out her or his professional duties and obligations with integrity and objectivity;
3. A social worker or social service worker shall advocate for workplace conditions and policies that are consistent with this Code of Ethics and the Standards of Practice of the Ontario College of Social Workers and Social Service Workers;
4. A social worker or social service worker shall promote excellence in his or her respective profession;
5. A social worker or social service worker shall advocate change in the best interest of the client, and for the overall benefit of society, the environment and the global community.

Table 2: *OCSWSSW Code of Ethics*

Value 1: Respect for the Inherent Dignity and Worth of Persons

Principles:

- Social workers respect the unique worth and inherent dignity of all people and uphold human rights.
- Social workers uphold each person's right to self-determination, consistent with that person's capacity and with the rights of others.
- Social workers respect the diversity among individuals in Canadian society and the right of individuals to their unique beliefs consistent with the rights of others.
- Social workers respect the client's right to make choices based on voluntary, informed consent.

Value 2: Pursuit of Social Justice

Social workers believe in the obligation of people, individually and collectively, to provide resources, services and opportunities for the overall benefit of humanity and to afford them protection from harm. Social workers promote social fairness and the equitable distribution of resources, and act to reduce barriers and expand choice for all persons, with special regard for those who are marginalized, disadvantaged, vulnerable, and/or have exceptional needs.

Principles:

- Social workers uphold the right of people to have access to resources to meet basic human needs.
- Social workers advocate for fair and equitable access to public services and benefits.
- Social workers advocate for equal treatment and protection under the law and challenge injustices, especially injustices that affect the vulnerable and disadvantaged.
- Social workers promote social development and environmental management in the interests of



all people

Table 3: CASW Code of Ethics

OCSWSSW AND NASW HARM REDUCTION POLICY GAP ANALYSIS

The OCSWSSW fails to explicitly address harm reduction. The OCSWSSW and CASW lack policy statements, concrete organizational policies, and publications that support the use of harm reduction practices. This gap has been identified by the CHRN and needs to be addressed in order to provide the best possible care for social work clients and best possible support for social work practitioners who provide harm reduction services (Cavalieri, private communication, Oct. 17, 2012). In comparison, the National Association of Social Workers (NASW) in the United States not only supports harm reduction, but has also published literature for its members regarding the efficacy and applicability of harm reduction practices for marginalized communities (NASW, 2012).

The following tables outline the OCSWSSW’s guiding values that can be compared to NASW core values that guide social work practice. Both these values support the use of harm reduction for social work policies; however, there are no statements from either the college and association that explicitly support harm reduction practice in within their values.

<u>OCSWSSW Guiding Values:</u>
Values
We believe that our Mission and Vision statements are realized when the goals and outcomes of the College and the Council reflect the following:
Respect
<ul style="list-style-type: none">• Every individual has the right to be treated with dignity and respect.



- Diversity of perspectives and cultures are recognized and valued.
- Social workers, social service workers and public members are equally represented on Council and their contributions to the College are valued.

Fairness and Transparency

- The College strives to provide services that are accessible and available within Ontario.
- The College's communication with stakeholders is clear.
- Policies and processes are transparent and reflect openness, quality and consistency.

Efficiency and Effectiveness

- Issues are addressed and activities are conducted in an effective, timely and efficient manner.

Leadership and Accountability

- The College offers responsible and responsive leadership.
- The College is guided by a strategic plan and is fiscally responsible in its operations.
- Policies and services are evaluated regularly.
- Council and staff are credible, knowledgeable and consistent in implementing policies that demonstrate accountability to the public.

Ethical Conduct

- Council and staff follow an established code of conduct that is consistent with the ethical values of the professions.

Caring Communities

- The College contributes to creating caring communities through its accountability to the public.

Table 4: *OCSWSSW Guiding Values*

NASW Social Work Core Values:

- **Service:** Social workers are committed to helping people in need and addressing social problems.
- **Social Justice:** Social workers challenge social injustice of all forms.
- **Dignity and Worth:** Social workers value and respect every person, no matter their differences.
- **Relationships:** Social workers recognize the central importance of relationships in human well-being.
- **Integrity:** Social workers value and protect the trust they earn with clients and communities

Competence: Social workers practice within their abilities and work to enhance their professional expertise.

Table 5: NASW Core Values



Despite the exclusion of harm reduction strategies in guiding value statements, NASW has a great amount of literature and publications that support the use of harm reduction policies within social work practice. Additionally, research supported by NASW has found that harm reduction is effective social work practice for working with people who use drugs. The following case example illustrates the research that has been supported by NASW as an example of what the OCSWSSW should strive to incorporate in their association.

NASW Case Example:

In contrast to the general approach that the OCSWSSW takes in regards to harm reduction policies, NASW explicitly supports the use of harm reduction to inform social work practice. The harm reduction literature published on the NASW website explicitly links harm reduction to the core values of self-determination and professional competency within social work practice. Moreover, the NASW's incorporation of harm reduction practice is representative of a shifting of the overall public health system to address harm reduction (NASW, n.d.).

The NASW HIV/AIDS Spectrum Project is an example of another publication that illustrates the integration of harm reduction practice into the social work profession. It utilizes strategies to support persons living with HIV/AIDS and includes substance abuse treatment/reduction, needle exchange programs, and safe injection education (Tomaszewski, 2011). This article, as well as "[Harm Reduction: Starting Where The Client Is](#)," are just two examples of various publications on the NASW website that demonstrate the support by NASW for harm reduction policies to be used in social work practice.

Table 6: NASW Case Example

OTHER GROUPS INVOLVED IN HARM REDUCTION ADVOCACY IN CANADA

Although harm reduction has been practiced in Canada for years now, social workers, for the most part, have been absent in the forefront of its implementation. In fact, nurses have been among the leading advocates for harm reduction. The Canadian Nurses Association (CNA), along with the Registered Nurses' Association of Ontario (RNAO) and the Association of Registered Nurses of British Columbia (ARNBC) presented arguments before the Supreme Court of Canada in support of Insite, Canada's first injection site located in Vancouver (CNA, 2011). In



fact, nurses were strong advocates for harm reduction long before Insite opened its doors in 2003. In the 1960s and 1970s, “street nurses in blue jeans” (Ruiterman & Biette, 1973) took to the streets of Vancouver during the sexual revolution, carrying backpacks and dispensing oral contraceptive pills and sexual transmitted infection treatments. In 1988, the AIDS Prevention Street Nurse Program was created in the Downtown Eastside neighborhood of Vancouver (Hardill, 2007). Street Health Nursing Foundation, founded in 1989, is an early example of harm reduction street provision in Toronto. This initiative was also led by nurses and has grown to be a large organization with many staff. There are more than forty street nurses in Toronto conducting street outreach, providing care from mobile vans and buses (Hardill, 2007).

There is significant literature surrounding harm reduction, nurses and the ethical dilemmas involved. The literature provides information for those working in harm reduction and aims to “assist nurses in providing safe, competent and ethical care” (Pauly, et al., 2007, p. 1). It also demonstrates that the values of harm reduction “are consistent with existing professional and ethical standards of nursing practice” (Lightfoot et al., 2009, p. 18).

The CNA, a federation representing over 140 000 nurses in Canada, released a discussion paper in May of 2011 entitled “Harm Reduction and Currently Illegal Drugs: Implications for Nursing Policy, Practice, Education and Research.” On their website a link is given to this paper and along with an explanation of the importance of the paper to nurses. There have been similar papers written about harm reduction and social work, however these have not been published on the CASW website, nor do they provide access to the article-links through the website. Furthermore, a simple search of “harm reduction” on the CASW website found only three search results, whereas the same search on CNA website produced over ten pages of



results. This illustrates the passivity of governing bodies of social workers regarding harm reduction.

Nurses practicing harm reduction stress the importance of providing material resources, such as condoms and clean needles and providing teaching personal care issues such as vein maintenance. There is also a large emphasis on the importance of developing relationships and building and maintaining trust while working with clients. This work involves “mutual goal setting, using the client’s agenda, and proceeding at a pace acceptable to the client” (Lightfoot et al., 2009, p. 7). These skills are congruent with those of social workers, demonstrating the niche for social workers and their specialized abilities.

DEFICIENCIES IN SOCIAL WORK EDUCATION AND TRAINING

Good training about substance use disorders can positively impact social work practice (Amodeo & Fassler, 2000; Loughran et al., 2010). Amodeo and Fassler (2000) found that social workers with sufficient chemical dependency training had higher caseloads of clients with substance use disorders or substance use disorders plus psychiatric diagnoses. If more social workers were adequately trained to support people who use drugs, this would alleviate the heavy burden placed on the few social workers that have competency in this area. In her study focusing on clinical social workers, Hofschulte (2012) concluded that employment history and training competencies in substance use disorders positively impact social workers’ beliefs toward harm reduction principles and interventions. Despite the relevance of harm reduction to social work practice, evidence demonstrates social workers lack training with individuals who



use drugs (Amodeo & Fassler, 2000; Bigler, 2005; Hofschulte, 2012; Loughran et al., 2010; Mancini et al. 2008; McNeece, 2003).

Harm reduction education is absent from professional programs, producing training deficiencies (Bigler, 2005). McNeece (2003) indicates that out of 420 BSW and 140 accredited MSW programs in social work worldwide there is no agreement on the minimum training required for practice in areas of substance abuse disorders. Due to training deficiencies, social workers often rely on abstinence-only approaches to substance use disorders, which ignore the fact that not all substance use is an addiction. Moreover, these trainings serve to pathologize individual behaviour and support traditional biomedical models of addiction, ignoring the empowerment, strengths and solutions-focused perspectives of social work and harm reduction (Bigler, 2005; Hofschulte, 2012).

Research suggests that with educational and training support, social workers will readily adopt harm reduction principles and strategic interventions while embracing the pragmatism and client engagement offered by harm reduction intervention opportunities (Hofschulte, 2012; Mancini et al., 2008). Social workers must be educated about the differing relationships between mental health, drug use and trauma, which also impact drug use and addiction (Cavalieri, private communication, Oct. 17, 2012). However, if current education trends continue, social workers will be unsuccessful in providing relevant, humane, respectful, cost-effective and evidence-based harm reduction interventions to clients most at need of such services



CONCLUSION

Various agencies and professionals practice harm reduction across Canada and Ontario. It is imperative that social workers and social service workers are trained and able to provide relevant and timely harm reduction services and education, understanding historical and contemporary contexts of drug use and policy. These services should include: safer substance using practices and techniques, safer sex practices, substance use disorder supports, recreational drug use education, supports for marginalized populations, transgender issues and hormone injection practices knowledge, identifying health issues of drug users, and local programs, services and policy development to assist clients in reducing harm in their lives.

With a harm reduction mandate provided by the OCSWSSW social workers and social service workers will be better equipped to deal with marginalized client populations with various intersecting identities. The ideological framework needed to bolster harm reduction principles already exist within social work. Utilizing the strategic approach previously outlined, we recommend an agency wide harm reduction mandate be implemented by the OCSWSSW.




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