JOINT POSITION STATEMENT

Harm reduction

Position

The Canadian Nurses Association (CNA) and the Canadian Association of Nurses in AIDS Care (CANAC) recognize harm reduction as a pragmatic public health approach aimed at reducing the adverse health, social and economic consequences of at-risk activities. Harm reduction is most commonly used in relation to public health programming with people who use psychoactive substances, but it can also be applied to programs that address alcohol use, sexual practices, cycling, driving, gaming and others.

We believe that harm reduction does not require at-risk practices be discontinued while focusing on promoting safety, preventing death and disability, and supporting safer use for the health and safety of all individuals, families and communities.

Harm reduction for those that use drugs

We recognize that inequities in access to health care are prevalent for those who use drugs, and that these disparities are further exacerbated by the social determinants of health, including inadequate housing, poverty, unemployment and the lack of social support.

We believe that harm reduction is part of a comprehensive health-care response to the health and social harms experienced by people who use substances, and that it complements abstinence, prevention and treatment strategies for substance use.

We recognize that many people benefit from the use of harm reduction strategies: those who use drugs and their families, who need supportive health care and social services; nurses and other health-care professionals, who offer harm reduction as an option to their clients; and the public, who enjoy safer communities and a decreased burden on the health-care system.

Harm reduction emphasizes human rights and the importance of treating all people with respect, dignity and compassion, regardless of drug use. It is a non-judgmental approach that accepts the person as they are and their right to make choices.

Policies and programs must be based on best evidence, cost-effectiveness and local needs while involving the participation of those who use drugs in decisions that affect them.[1]

[1] (Canadian HIV/AIDS Legal Network, 2005)

The values of harm reduction are consistent with the primary values in CNA's *Code of Ethics for Registered Nurses* that guide professional ethical nursing practice:[2] (1) providing safe, compassionate, competent and ethical care; (2) promoting health and well-being; (3) promoting and respecting informed decision-making; (4) preserving dignity; (5) maintaining privacy and confidentiality; (6) promoting justice; and (7) being accountable.

Nurses have a responsibility to provide non-judgmental care to individuals and families affected by substance use, regardless of setting, social class, income, age, gender or ethnicity, and they can influence the development of organizational and governmental harm reduction policies related to drug use.

Background

Harm reduction is a public health approach directed toward individuals or groups that aims to reduce the harms associated with certain behaviours. To do so, nurses and other professionals draw on a range of strategies not only in connection with alcohol, legal drugs, illegal drugs and tobacco but also with car driving, bicycle riding and sexual practices. Examples of harm reduction strategies include encouraging low-risk drinking guidelines, reducing second-hand smoke exposure and using seatbelts, helmets and condoms.

When applied to substance use, harm reduction is a pragmatic approach, because it recognizes that both legal and illegal substance use are enduring features of human existence. Harm reduction focuses on decreasing the adverse consequences of substance use while building non-judgmental, supportive relationships.[3] Although it includes abstinence as an option if and when the person is ready, harm reduction recognizes that abstinence is not always realistic for a person with addictions.

Many health and social harms are associated with illegal drug use. Of great concern is the spread of blood-borne diseases such as HIV and hepatitis C. The Public Health Agency of Canada reports that injection drug use accounts for 21.6 per cent of new adult HIV infections in Canada, a figure that rises to 60.3 per cent among Aboriginal Peoples.[4]

Overdose deaths have contributed to increased mortality rates among people who use psychoactive substances. In one Canadian study, close to one in five people who used injection drugs reported an overdose experience in the past six months.[5] Soft-tissue infections such as abscesses and cellulitis are also commonly associated with injection drug use. In addition, law enforcement approaches to illegal drug use have contributed to its harms by increasing prison populations.[6] Compared to the population as a whole, prison populations in Canada and around the world have significantly higher rates of HIV and hepatitis C.

[2] (Canadian Nurses Association [CNA], 2008)

[3] (Pauly, 2008)

[4] (Public Health Agency of Canada, 2010)

[5] (Fischer et al., 2005)

[6] (Drucker, 1999; Friedman et al., 2006; U.N. Global Commission on Drug Policy, 2011; Wood et al., 2012)

Originating in the Netherlands and the United Kingdom in the 1980s, as injection drug use became a key mechanism for the transmission of HIV,[7] the harm reduction movement gained prominence as a more humane approach to the harms associated with drug use than that of law enforcement.[8]

Since that time, many international organizations have embraced the harm reduction approach, such as the World Health Organization, the Joint United Nations Programme on HIV/AIDS, the United Nations Office on Drugs and Crime, the United Nations Children's Fund, the International Federation of Red Cross and Red Crescent Societies[9] and the World Bank.[10]

Harm reduction is an approach to caring for people who use drugs. A useful way of better understanding how it addresses the problems of drug use is by comparing different models. Brickman et al.[11] describes four models of helping people who are experiencing addiction: (1) the moral model; (2) the medical model; (3) the enlightenment model; and (4) the compensatory model.

In the *moral model*, problems people have are taken to be of their own making, and they are seen as responsible for solving them. Continuing problematic drug use is understood as a personal failure in this model, and the individual is to blame for the problems. This view fails to recognize that drug use is exacerbated by social conditions, and also that people do not have access to the same resources to manage or address drug use. The *medical model* focuses on addiction as a disease, seeing people as being prey to an illness and in need of treatment. Individuals are neither responsible for the problems, nor for their solution. People are victims of their circumstances. In the *enlightenment model*, sometimes known as the *spiritual model* or 12-step program, individuals are responsible for their problems while the solutions require surrender to a higher power. The *compensatory model*, in contrast, sees individuals as responsible for solutions but not for the problem.

How does harm reduction fit into these models? Of the four models given, it fits best with the compensatory model, although it can complement other models as well.

Although the results of the extensive research on harm reduction are still mixed, in certain areas the benefits of harm reduction programs are significant. An overview of these benefits can be found in CNA's discussion paper, *Harm Reduction and Currently Illegal Drugs: Implications for Nursing Policy, Practice, Education and Research*,[12] which focuses on the following strategies: needle distribution and recovery programs, peer-based outreach strategies, overdose prevention strategies, methadone maintenance and heroin prescription, supervised injection sites and safer crack use.

[7] (Ball, 2007; Hilton et al, 2001)

[8] (Marlatt, 1996)

[9] (International Federation of Red Cross and Red Crescent Societies, 2003)

[10] (Wodak, 2009)

[11] (Brickman et al., 1982)

[12] (CNA, 2011)

Nurses caring for people at various stages of life in acute care and community settings may encounter situations in which drug use and the circumstances surrounding drug use impacts the health of individuals. Nurses may be the first point of contact for populations vulnerable to the harms of illegal drugs in a variety of settings, such as community health centres, hospitals, prisons and street outreach.

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