GUIDELINES TO DESTIGMATIZE HARM REDUCTION: HOW STIGMA AND MISPERCEPTIONS IMPEDE BENEFITS OF EVIDENCE-BASED DRUG POLICY

By

Lorraine Schembri

B. A., Simon Fraser University, 2011

PROJECT SUBMITED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF EDUCATION
IN
COUNSELLING

UNIVERSITY OF NORTHERN BRITISH COLUMBIA

March 2019

Abstract

Despite the wealth of literature supporting a harm reduction approach to substance use, it remains challenging to implement evidence into policy. As Canada expands its harm reduction services, it is important to address that controversial community perceptions of harm reduction and substance use negatively impact the goals of this work.

This project is based on a literature review on community perceptions of harm reduction and people who use drugs. Health professionals and clients have identified stigma in health care, and in broader society, as a barrier to optimal service provision. The project addresses this problem with a set of guidelines for health professionals on destigmatizing harm reduction work. The guidelines clarify misperceptions about harm reduction, outline the harmful impact of stigma on health outcomes, and promote actions associated with reduced stigma and enhanced health outcomes. Such actions include self-care, reflection on ethics, and supporting the dignity and autonomy of clients.

Table of Contents

List of Tables

List of Figures

Acknowledgements

The completion of this project included the input and support of a number of people whom I am deeply grateful for, and would like to acknowledge.

My project supervisor, Dr. Linda O'Neill, has been supportive and accommodating throughout this journey. She encouraged me to choose an education path, research topic, and process, that most inspires and works for me. Her guidance has been enriching beyond the scope of this project. My project committee members, Dr. Joanna Pierce and Dr. John Sherry, were invaluable in providing thoughtful feedback that strengthened both the academic writing and the practical application aspects of this project. Their time and expertise elevated my work.

My friend, Kate, has been walking this path with me through countless study sessions, making the good times more fun than research should be, and growing with me through the hard times. My friends, Lauren and Pawel, helped me edit and organize my thoughts and ideas. My partner, Lucian, grounded my life apart from my project. He reminds me where my heart is.

Finally, my mom and dad have provided endless love and support. Throughout my academic life, my dad always came through with printer support at inconvenient times, and my mom has read all my papers since grade school without protesting the late nights or early mornings she's put in to help me meet deadlines. My love and gratitude are immeasurable.

Part One: Introduction

The opioid crisis in Canada has brought urgency to reevaluating our country's response to drug use. The traditional model of drug control, enforcement and criminalization, has failed to deter drug use (UK Home Office, 2014; Zábranský, 2004) and has had the perverse effect of increasing harms associated with drug use (Beletsky et al., 2014; Global Commission on HIV and the Law, 2012; Kerr, Small & Wood, 2005; Werb et al., 2011). Thousands of preventable deaths indicate that efforts to reduce the harms associated with drug use are lacking. Experts in health and policy, such as the World Health Organization, the United Nations Office on Drugs and Crime, the Joint United Nations Program on HIV/AIDS, the Global Commission on Drug Policy, and the Global Commission on HIV and the Law, are calling for a shift from a criminal model of drug policy to a harm reduction model (Global Commission on Drug Policy, 2016; Global Commission on HIV and the Law, 2012; WHO, UN Office on Drugs and Crime & UN Joint Programme on HIV/AIDS, 2012). Harm reduction services like needle and syringe programs (NSP), opioid agonist treatment (OAT) and safe injection facilities (SIF) have been effective in decreasing injection drug related rates of human immunodeficiency virus (HIV) and hepatitis C virus (HCV) (Fernandes et al., 2017; MacArthur et al., 2012; MacArthur et al., 2014; Palmateer, 2014; Turner et al., 2011). Such services have also decreased risk behaviours associated with injection drug use such as syringe sharing, syringe reuse, and injecting in public spaces (MacArthur et al., 2014; Potier, Laprévote, Dubois-Arber, Cottencin & Rolland, 2014). Furthermore, harm reduction decreases rates of overdose, increases access to treatment, and has shown economic benefits with savings in health care and social justice systems (Hughes & Stevens, 2010; McCollister & French, 2003; Potier et al., 2014; Wilson, Donald, Shattock,

Wilson & Fraser-Hurt, 2015; WHO, UN Office on Drugs and Crime & UN Joint Programme on HIV/AIDS, 2004).

Despite the substantial evidence base that supports harm reduction, researchers and health professionals have expressed concern around the lack of implementation of evidence into drug policy and health care practice (Eggertson, 2013; Reuter, 2001). Research identifies political agendas, and stigmatizing attitudes towards drug use and people who use drugs (PWUD) as key barriers to the much-needed expansion of harm reduction practices (Canadian Nurses Association, 2012; Coomber, 2010; Kerr, Mitra, Kennedy & McNeil, 2017; Singleton & Rubin, 2014). Health professionals report that negative community attitudes towards PWUD, even among their colleagues, impede optimal provision of harm reduction services in their communities (Hobden & Cunningham, 2006; Pauly, 2008a; Shepard, 2013). Discrimination towards PWUD is reported as a barrier for accessing treatment, and for practicing safer drug use strategies (Boucher et al., 2017; Bozinoff, 2017). Stigma and discrimination reported within harm reduction and health care services is especially concerning as it violates the human right of equal access to health care services (Pauly, 2008a; Van Boekel, Brouwers, Van Weeghel & Garretsen, 2013). If negative perceptions of PWUD are limiting the benefits of harm reduction, this is a problem that needs to be addressed in order to optimize health service outcomes and effectively respond to the opioid crisis.

Significance of the Project

Research suggests that further training or education opportunities can better equip health professionals for ethical challenges they face in their work, such as systemic discrimination of PWUD (Van Boekel et al., 2013). Although useful instructions on upholding the principles of harm reduction in health care settings are available (Hawk et al., 2017), they do not address how

the values of harm reduction are undermined by normalized societal stigma towards PWUD. This means well-intentioned health professionals may accept the guiding philosophy of harm reduction without examining or understanding the ways in which systemic stigma and personal biases conflict with the ethics of their work, and negatively impact client care and health outcomes.

This project is a guidebook for addressing and decreasing stigma in harm reduction work. It includes a set of guidelines based on research findings on stigma and discrimination towards PWUD. The intention is to raise awareness about the ways that societal stigma impacts health and wellness outcomes for PWUD. The guide is written for people who work in the field of substance use and addiction under a harm reduction framework. The guidelines confront stigmatizing beliefs, and address misperceptions about harm reduction and PWUD in order to facilitate anti-oppressive health service environments. Organizations or individuals may use it as an education, training, or professional development tool. The guidelines include the perspectives of PWUD, researchers, and health professionals. The over-arching goal of the project is to decrease stigma in health care and in society at large to better support evidence-based drug policy and wellness outcomes for PWUD.

Background of the Project

Graduate studies brought me to Northern B.C., where I became interested in understanding how harm reduction practices are received by northern communities, especially in contrast to larger urban cities, such as Vancouver, where I completed my undergraduate studies. When I finished my literature review on the topic of community perceptions of harm reduction and PWUD, I found that there was a rich amount of information on the topic of addressing the

stigma and misperceptions that surround harm reduction, and I decided to make this the project focus.

The project began to take shape after completing my workplace orientation that gave new staff members a basic overview of the values and principles of harm reduction within our organization. These guiding principles such as being respectful, non-judgmental and maximizing client options are integral to harm reduction work. However, they do not go as far as directly challenging commonly held stigmatizing perceptions towards harm reduction and PWUD that are pervasive in society and health care settings. It is important that professionals in substance use work are prepared for addressing this ethical issue.

Researcher Positioning

During my undergraduate studies, my involvement in the Canadian Students for Sensible Drug Policy alerted me to the lack of research involved in drug policy. It is unacceptable that in the context of drug control, peoples' prejudice about illicit drug use and PWUD impacts policy more than research and evidence. Currently, my work in mental health motivates me to combat stigma, and promote understanding around mental health issues. From a feminist counselling theory approach, understanding people and their motivations requires an examination of their surrounding social systems. We cannot condemn an individual for their addiction without being critical of the social systems that support, and may perpetuate, their behaviour. Feminist theory defines the goals of counselling as creating change for individuals that supports their personal goals, and changing society through challenging the constraints of socialized roles, discrimination and oppression (Corey, 2013). This proposed project is an opportunity for me to live the values of my practice, and advocate for basic human rights of human dignity and health care for PWUD.

Clarification of Terms

Drug use and people who use drugs. Many people use drugs for reasons that are social, health-related, performance enhancing, and for coping with the pains and struggles of life. Many drugs that have high potential for addiction or misuse require a prescription, with obvious exceptions such as caffeine, alcohol, and nicotine, while others have been deemed illicit substances, thereby criminalizing those who use them. The term 'people who use drugs' includes most people in society, but for the purposes of this paper, it will be used to refer to people who use illicit drugs. In the same way, the term 'drug use' will mainly refer to use of illicit drugs.

Harm reduction. The practice of harm reduction is another common part of many peoples' lives. Use of seatbelts, helmets, condoms, and sunscreen, are practices that reduce risk of harm. Community harm reduction services are typically aimed at reducing risk of harms from legal and illegal sexual activity, and substance use. Since this proposed research is focused on harm reduction pertaining to substance use, the term will be used to refer to substance use harm reduction.

Overview of the Project

As Canada is expanding its harm reduction services and responding to the opioid crisis, the stigma and misperceptions about harm reduction that create barriers to evidence-based drug policy are problematic. This project addresses harmful and misinformed views of harm reduction and PWUD. It will summarize recommendations from research on this topic into a guidebook for decreasing the stigma around harm reduction work. The guide will be written for people who work in the field of harm reduction and substance use services.

What follows in part two will be a literature review on harm reduction that begins with an overview of the research on harm reduction service outcomes, which will be contrasted with law

enforcement drug control, to highlight the importance of rethinking the way society responds to drug use. Next, it will summarize the challenges involved in raising awareness of the benefits harm reduction, and implementing evidence-based drug policy. It will then provide an overview of the research on community perceptions of harm reduction, drug use and PWUD. The literature review will end with examining the implications of stigma on health outcomes among PWUD, and recommendations for addressing stigma in health services settings.

Part three will outline the proposed project plan. It will outline the project format, the target audience, and the step-by-step process of summarizing the research into guidelines.

Part Two: Literature Review

The history of stigma associated with illicit drug use and PWUD continues to negatively impact the quality and availability of evidence-based harm reduction services (Kulesza, Teachman, Werntz, Gasser, & Lindgren, 2015; Pauly, 2008a; Van Boekel et al., 2013; Wild, et al., 2017). The benefits of harm reduction are well documented (Fernandes et al., 2017; MacArthur et al., 2014; Potier et al., 2014). Harm reduction has been endorsed as best practice response to problems associated with substance use by prominent international organizations (WHO et al., 2012). In order to optimize harm reduction strategies, especially in response to the current fentanyl crisis, it is important to review how stigma and misperceptions about harm reduction, drug control, and substance use, are impacting service provision. Part two will provide a review of the research on harm reduction services for substance use. It will begin with an examination of both criminalization and harm reduction as responses to problematic substance use. Next, it will outline why evidence-based drug policy has been met with resistance from governments and communities. It will then examine the role of public perceptions in the provision and expansion of harm reduction services. The final part of this section will outline recommendations for decreasing stigma, and increasing positive attitudes towards harm reduction and PWUD in health care settings.

Harm Reduction, Criminalization and Enforcement Drug Policy

Harm reduction, as it pertains to substance use, can be defined as a policy, program or intervention with the prime directive of reducing drug related harms on PWUD and the broader community. Rather than targeting drug use, harm reduction targets risks associated with drug use. This means that decreasing or eliminating drug use is not a requirement of successful harm reduction, however, these actions may be considered a form of harm reduction in cases where

they are part of individuals' goals for reducing risk and promoting health (Lenton & Single, 1998). Harm reduction can be misunderstood as condoning drug use, and thereby opposing the prohibition of drugs. However, the philosophy of harm reduction is neutral on moral and legal assessments of drug policy, and instead assesses the impact that policy has on health, social, and economic problems, associated with drug use (Erickson, 1995; Harm Reduction International). Harm reduction and law enforcement drug control, to some extent, share the same goal of reducing the harmful consequences of drug use. Striking differences between enforcement and harm reduction are that enforcement is not based on evidence or cost-benefit analysis (Singleton & Rubin, 2014), it targets drug use rather than the harms of drug use, and it includes punitive measures that create social and legal harms for PWUD.

Decreasing harms of illicit drug use. In 1998, a UN General Assembly Special Session on Drugs was held around the theme, "A Drug-Free World – We can do it". This assembly endorsed law enforcement drug control and criminalization of illicit drug possession, production and trafficking (Csete et al., 2016). Almost twenty years later, the 2017 UN World Drug Report shows that rates of drug use and opium field production have remained stable (United Nations Office on Drugs and Crime, 2017). Though world-wide statistics are often too general to extrapolate useful information from, what is clear is that efforts to eradicate substance use have been futile. In 2014, the United Kingdom government reviewed specific drug policies in eleven countries ranging from highly punitive criminal justice models to decriminalization. There was no relationship found between levels of drug use and the severity of criminal justice enforcement (UK Home Office, 2014). Furthermore, research on the impact of incarceration on drug use cessation shows no change in rates of drug use before and after a period of incarceration among people incarcerated for drug use. The same study found incarceration to be negatively correlated

with drug use cessation whereas methadone treatment was positively correlated with drug use cessation (DeBeck et al., 2009).

In the Czech Republic, 1998, the government commissioned a team of academic researchers to review the impact of their strict prohibition drug policy. Six years later, the team found that rates of problematic drug use, and the availability of drugs, were not impacted. They also noted the high cost of increased policing and incarceration. As a result of their findings, the Czech Republic organized a team of drug policy planners, including people with firsthand experience in health and social services with PWUD, to develop a more effective drug policy framework. This resulted in decriminalization of use and possession of illicit drugs below a defined amount (Zábranský, 2004).

Decreasing or eradicating drug use has been shown to be futile over human history. The Russian Tsars in the 1600s tortured and threatened to execute people for tobacco use, but even these harsh measures were not able to dissuade use (Starks & Krementsov, 2017). While drug use seems to be a human behaviour that is here to stay, the problems and harms associated with drug use are changeable.

Harm reduction practices such as needle and syringe programs (NSP), safe injection facilitates (SIF) and opioid agonist treatments (OAT) have been successful in decreasing infectious diseases such as human immunodeficiency virus (HIV), hepatitis C virus (HCV) and tuberculosis (TB) (Aspinall et al., 2014; Fernandes et al., 2017; Grenfell et al., 2013; MacArthur et al., 2014). Meta-analyses demonstrated that OATs and NSPs reduce risk of HIV transmission among people who inject drugs by roughly 50% (MacArthur et al., 2012; MacArthur et al., 2014). Harm reduction programs have also been found effective at reducing risk behaviours associated with injection drug use such as syringe sharing, syringe reuse, public injecting, and

publicly discarded needles (European Monitoring Centre for Drugs and Drug Addiction, 2016; MacArthur et al., 2014; Potier et al., 2014; Wood et al., 2004). In a community surrounding an Australian NSP, there were fewer reports of public nuisances related to drug use (Salmon, Thein, Kimber, Kaldor & Maher, 2007). In Vancouver, following the opening of North America's first SIF, overdose deaths dropped by 35% (Marshall, Milloy, Wood, Montaner, & Kerr, 2011). A meta-analysis found that no deaths by overdose have ever taken place within the reviewed SIFs (Potier et al., 2014).

The benefits of harm reduction are not just reduction of negative consequences, but increases in positive results such as more people seeking treatment for substance dependence (Hughes & Stevens, 2010; Potier et al., 2014). Research on Vancouver's SIF showed that 18% of people who used the facility took part in a detoxification program (Wood et al., 2006), 57% started addiction treatment, and 23% stopped using injection drugs (DeBeck et al., 2011). Additional benefits include increased opportunities for social connection, support and feelings of belonging, all of which contribute to better treatment outcomes and overall quality of life for PWUD (Boucher et al., 2017; Lago, Peter & Bógus, 2017)

Increased harms associated with drug use. Punitive drug policy increases the harmful risks associated with drug use. Risk of arrest, a criminal record, and social marginalization are not caused by drugs but by social rules and attitudes about drugs (Global Commission on Drug Policy, 2016). Criminalization and enforcement drug control have been found to exacerbate problems and harms associated with drug use and the illicit drug market. Systematic reviews on the impact of enforcement on drug markets show that increased enforcement is associated with increased violence and volatility among PWUD and drug dealers, and increased homicide rates in the drug market (Kerr, Small & Wood, 2005; Werb et al., 2011). Increased enforcement

intensifies marginalization and 'hardening' of PWUD (Coumans et al., 2006). Additionally, when enforcement removes key participants from the illicit drug market, rather than permanently hurting the market, it creates turnover and opens profitable opportunities (Werb et al., 2011).

Another negative effect of enforcement is that it can deter PWUD from using harm reduction strategies. When PWUD fear police interactions, they are more likely to use drugs in isolated, unsafe places. In their haste, they are more likely to skip important steps like using NSPs and sterilizing the injection site (Beletsky et al., 2014; Bozinoff et al., 2017; Kerr et al., 2005). A United Nations report stated that criminalization, discrimination and punitive law enforcement practices discourage people who are dealing with HIV and substance dependence from accessing HIV and health care services, thereby perpetuating the spread of HIV (United Nations General Assembly, 2011).

Harm reduction, by its philosophy, does not include practices that increase risk to individuals and communities. Critics of harm reduction express concern that it enables or promotes drug use (Potier et al., 2014). However, in communities where SIFs have opened, evidence shows that there have been no increases in crime, drug use, drug trafficking, the number of people who use drugs, and the number of people switching from non-injection drug use to injection drug use (Potier et al., 2014; Wodak & Cooney, 2005). Moreover, research following the opening of Vancouver's SIF found no evidence of increased injection drug relapse rates, and no change in drug use cessation rates (Kerr et al., 2006). Harm reduction has not increased the drug related problems of PWUDs and surrounding communities as tough-on-crime drug laws have.

Economics. In the few instances where enforcement and criminalization drug control models have been reviewed, they have been found costly and ineffective at reducing problematic

drug use (UK Home Office, 2014; Zábranský, 2004). A consequence of scaling up enforcement as a means of drug control in the U.S. has been the immense increase in prison populations and the resulting high cost on taxpayers (Werb et al., 2011). Countries and states that have decriminalized cannabis saved substantial amounts in criminal justice costs (Global Commission on Drug Policy, 2016). Portugal reduced social costs by 18% over ten years after decriminalizing all substances, partly due to PWUD being able to continue working rather than being incarcerated (Goncalves, Lourenco & da Silva, 2015).

Cost benefit analysis of harm reduction programs have shown them to be highly cost effective. HIV prevention strategies such as NSPs, SIFs and OATs, cost less than HIV treatment (Pinkerton, 2011; WHO et al., 2004). Due to their impact on reducing illicit opioid use, OATs contribute to additional savings by decreasing relapse, incarceration, and enforcement costs (WHO et al., 2004; Wilson et al., 2015). Reductions in criminal activity and health care costs are the greatest economic benefits of harm reduction services (McCollister & French, 2003).

Social justice and human rights. In 2015, after completing a study on the impact of the world drug problem on human rights, the UN High Commissioner for Human Rights concluded that drug policy, law and enforcement have led to a number of human rights violations such as discrimination and unjust treatment of PWUD, and excessive arrests, detention and incarceration for minor drug offences. He also denounced inhumane treatment of PWUD in institutional settings, denial of life-saving health care for PWUD, and restrictive access to opioids for pain and health management among PWUD (UN High Commissioner for Human Rights, 2015). Such violations of human rights damage respect for the rule of law and create contempt, suspicion and fear of those who enforce it (Chaney & Robertson, 2013).

Human rights considerations are the core of harm reduction services. Harm reduction does not aim to criminalize or stigmatize human behaviour, rather it seeks to empower people by supporting autonomy in managing their levels of risk. In 2011, when the federal government wanted to shut down Canada's only operating SIF, Insite, the Supreme Court ruled unanimously that doing so would be a violation of human rights to life, liberty and security (Canadian HIV/AIDS Legal Network et al., 2015). The court stated that the government's decision to refuse an exemption to Insite undermined the health and safety mandate of Canadian drug laws because the health benefits that the facility provides to PWUD and the surrounding community outweigh any benefits of upholding prohibition laws. The court further ruled that access to prevention services and life-saving services cannot be denied for the sake of upholding prohibition laws, and that to do so would be an inexcusable violation of rights to people most in need of public services (Canadian HIV/AIDS Legal Network et al., 2015).

Disproportionate negative outcomes. An unacceptable problem evident in the research on enforcement drug control is that it disproportionately punishes certain demographics. Between 2007 and 2016 the federal prison population in Canada increased by less than 5%, while the Indigenous prison population increased by 39%. Furthermore, Indigenous people account for less than 5% of the Canadian population, but comprise 26.4% of the federal inmate population (Office of the Correctional Investigator of Canada, 2017). These grossly disproportionate statistics are directly impacted by drug policy. As the Office of the Correctional Investigator of Canada (2013) reports, the high incarceration rates of Aboriginal peoples is associated with systematic discrimination, substance use and intergenerational trauma, among other factors.

America's black population accounts for 13% of the population, uses drugs at comparable rates as other populations, make up 29% percent of those arrested for drug law violations, and account for 40% percent of the federal inmates with drug-related charges. Latinos comprise 18% percent of the American population, 47% percent of all federal court drug offence case, and 38% percent of federal inmates arrested for drug-related offences (Drug Policy Alliance, 2018)

These statistics understandably cause suspicion around whether the aim of the war on drugs was ever to deter harmful drug use, or whether it offered a convenient way to disempower certain groups. Harm reduction, on the other hand, is anti-oppressive in that it seeks to empower people with education and choices regarding their substance use.

Barriers to Evidence Based Drug Policy

Despite the clear evidence in support of harm reduction, it remains a contentious issue globally and in Canada. International coverage of harm reduction services remains low where there is urgent need to scale up (Mathers et al., 2010). Harm Reduction International (2016) estimates that there is significant injection drug use in 158 countries, but only 90 with operational NSPs. Countries with little to no harm reduction services in Eastern Europe and Asia continue to see rising HIV rates from injection drug use while global incidences of HIV infection have been on the decline (UNAIDS, 2015).

A 2017 study by the Canadian Harm Reduction Policy Project reviewed the status of harm reduction services in Canada and concluded that provinces and territories are lacking consistent comprehensive governance outlines for optimal use of harm reduction strategies. (Wild, et al., 2017). Health service providers have criticized the lack of effective harm reduction

in legislation and note that there is too much political, as opposed to evidence-based, influence on public health issues (Canadian Nurses Association, 2012).

A question that comes up repeatedly in the literature is that with all the supporting evidence demonstrating the effectiveness and cost effectiveness of harm reduction, as well as the evidence outlining the harms and deficiencies of enforcement drug control, why is it so challenging to shift towards a better model of drug policy? Outlined below are explanations of the unique challenges around moving towards evidence-based drug policy.

Public opinion, politics and press. Understanding why evidence bears so little influence on drug policy requires an examination of the interactions between politics, the media, and the public. Public opinion has a significant impact on policy (Burstein, 2003). With politically salient issues, public opinion has greater influence than evidence (Monroe, 1998; Page & Shapiro,1983). When it comes to harm reduction, political motivation to institute and maintain these services is significantly swayed by public perceptions of harm reduction (Rapid Response Service, 2012). However, public opinion is largely influenced by the media, and by politics through the media (Blendon & Young, 1998; Millhorn et al., 2009; Shanahan, Mcbeth & Hathaway, 2011). The U.S. government has been found to have spent over a billion dollars on years of media propaganda effort that justify tough, drug war policy (Boyd, 2002). Governments and media have been fueling the need for a war on drugs for over a century by vilifying the illicit drug scene and painting those involved as evil predators seeking to destroy lives of the young and innocent (Benso, 2010; Coomber, 2010).

The philosophy of harm reduction that humanizes PWUD, and seeks to decrease the harms of their behaviors, is at odds with the historic view that they deserve punishment through tough-on-crime law enforcement. It is understandable, though problematic, that dated narratives

ingrain ways of thinking that become inflexible to conflicting evidence, and strengthened by ongoing misinformation. For instance, the president of the U.S. has recently claimed that countries with harsher, tough-on-crime drug control have had the most success dealing with the problem of drug use (Meza, 2018). His sentiment was likely taken as fact by millions of people despite it being in direct opposition with the evidence.

Canada's changing political climate since the 2015 election is more favourable towards evidence-based drug policy, but politics continue to counter evidence. The Prime Minister has expressed support for SIFs (Lupick, 2015) and the government has changed legislation to make legality issues around SIFs less restrictive (Kerr, 2017). However, the federal government's moves towards evidence-based drug policy continues to be fought by the opposition who have been accused of perpetuating the controversy and fear surrounding drug policy as a platform to gain votes (Kassam, 2018).

Morality policy. Wild et al. (2017) offered an explanation to the question around the difficulty of translating evidence to policy, suggesting that the contested nature of harm reduction is an issue of morality policy, or policy that is based on core values and notions of right and wrong. They explain that this morality context of drug policy is what makes it resistant to arguments based on health and economics research. Reuter (2001) reasoned in the same vein that drug use has historically been presented as a problem of crime and morality, so the logic in treating it as a problem of health and addiction is lost in justice considerations of right and wrong. In a morality policy context, research for effectiveness and cost benefit analysis are irrelevant if the aim of enforcement is to bring criminals to justice. Blendon and Young's (1998) research on American attitudes towards the war on drugs support this concept. They found that most Americans do not think the war on drugs has been successful, but they do not wish to

change these efforts. Furthermore, they see drug use as a moral issue, not a health issue. Research from the U.K. suggests that polarizing moral issues around drug policy prevent productive discourse about the goals of drug policy, and therefore prevent new directions for drug policy reform (Singleton & Rubin, 2014).

Dismissed Evidence. Evidence that is not seen or understood can have little impact on policy. The research team in Toronto that was responsible for assessing the need for SIFs had established a thorough evidence base on the positive health and social benefits of SIFs, but the main discussion around drugs in the media was on the rapid increase in fatal opioid overdoses during the ongoing opioid crisis (Bayoumi & Strike, 2016). A U.K. review on good governance of drug policy found that public debate on drug policy, as fuelled by the media and questionable evidence, is focused on disagreement over the harms of illicit substances as opposed to a sensible response to these harms. It further stated that expert opinions of the Advisory Council on the Misuse of Drugs is often rejected, highlighting a problem of undervaluing research in policy decisions (Singleton & Rubin, 2014).

Even when the general population is exposed to research that supports harm reduction, their preexisting notions about illicit drug use, and lack of experience with health research can skew their understanding of the information. Reuter (2001) explains that a 25% decrease in future heroin use may be a promising reason for researchers to endorse a given treatment program, but the lay observer may be put off by the fact that the immediate beneficiary of the program will be people who are criminals due to their drug use. Additionally, the public may note that most people using the program will continue to use drugs in some capacity, a result that may seem problematic without a background understanding of the economic and health benefits of harm reduction.

Public Perceptions

A reoccurring topic in the literature on the barriers to implementing evidence-based policy is public perceptions of drug use and drug policy. It is widely accepted that politicians are avoidant of endorsing research that contrasts with the prevailing views of the press and public within their support base (Monroe, 1998; Page & Shapiro,1983; Singleton & Rubin, 2014). However, the literature on public support is unclear because statistics show high support for harm reduction, yet the stigma that exists towards PWUD is well documented. The general stigma towards drugs and PWUD may be diminishing existing support for harm reduction, and negatively impacting the provision of harm reduction services.

Public support. In Canada, surveys and studies completed between 2003 and 2007 on public perceptions and support for harm reduction show a majority support for harm reduction programs. These polls, surveys and studies were from B.C., Quebec, Ontario, and nation-wide, and they include support for NSPs, and heroin-assisted treatment (HAT) (Rapid Response Service, 2012). A 2013 study of public attitudes towards safer drug use practices in B.C. found 76% support for harm reduction in general, 72% for NSP, 65% for NSP in their local community, and 52% for safer inhalation equipment (Tzemis et al., 2013). Cruz et al. (2007) completed a study of public opinions towards harm reduction practices, and found 60% support for SIFs and HATs in Ontario. Survey results posted in 2017 show the differences in community support for SIFs in major Canadian cities. Vancouver, Ottawa, Toronto and Montreal show majority approval ratings. The three lowest levels of approval came from the prairies with roughly 40% approval, 40% disapproval and 20% unsure in Calgary, Saskatoon and Regina (Duggan, 2017). A 2016 study in Ontario showed a different perspective. When given the options to strongly agree, strongly disagree, or somewhat agree and disagree that certain harm

reduction services should be made available, the majority expressed the ambiguous response. 60% of respondents somewhat agreed and disagreed with SIF availability and 64% expressed the same for supervised smoking facilities (SSF). For SIFs, 28% strongly agreed, and 12% strongly disagreed, compared with 20% that strongly agreed, and 16% that strongly disagreed with SSFs (Strike, Rotondi, Watson, Kolla & Bayoumi, 2016). This study examined public support for different goals of harm reduction such as safer drug use, reduction of infectious diseases, reduced drug-related neighbourhood problems, or increased contact between PWUD and health and social services. Support was strongest when the goals of the facilities were about reducing drug-related problems in the neighbourhood. In this case, 56% strongly agreed with SIFs, and 46% strongly agreed with SSFs. Another result from Strike et al. (2016) was that the lack of harm reduction services available for inhaled stimulates, such as crack cocaine and methamphetamines, compared to the services available for injection drug use, was parallel with how many Ontarians were aware of SSF models - 20%, compared with about 60% awareness of SIF services. The outcome of this research suggests that raising awareness of the benefits of harm reduction services, especially those relevant to the broader community, may increase support and expansion of services.

Internationally, a 2012 review of public opinions and perceptions of harm reduction found that most studies and surveys were from Canada, the U. S., the U.K., and Australia, and the results show a majority in support of various harm reduction services (Rapid Response Service, 2012). In Sydney Australia, businesses and residents located within the vicinity of NSPs indicated 83% support for NSPs in general, and 77% support for local NSPs. Support for a newly established syringe automatic dispensing machine was slightly lower at 67% in general and 60% locally. When asked about common concerns about harm reduction services, less than

half of the participants endorsed concerns such as increased number of injection drug users, and increased number of drug-related crime in the neighbourhood. Five years after the establishment of a SIF in Sydney, local residents and businesses reported seeing less public injection drug use, less publicly discarded needles and less drug-related public nuisances. There was no significant trend in amount of residents who were offered drugs for purchase in the streets (Salmon et al., 2007). Both of these studies show that a majority of the local residents and businesses who took part in this research see the benefits of harm reduction in their local neighbourhood and do not endorse fears about increased drug-related problems.

In the U.S., a 2015 study showed 81% of participants somewhat to strongly supported NSPs, and 60% somewhat to strongly supported SIFs (Kulesza et al., 2015). Two decades ago, Blendon and Younge (1998) researched American attitudes towards policies established under the war on drugs mentality. They found a slight majority support for NSPs when told that these services were endorsed by the American Medical Association. It is important to note that results on the topic of harm reduction are influenced by wording, design, and the organization commissioning the study (Hopwood, Brener, Frankland, & Treloar, 2010). Surveys conducted by organizations with a public health mandate were more likely to show results that support NSPs than surveys run by organizations with a family values focus (Vernick et al., 2003). The one study included in this literature review that found a minority support for harm reduction was one that framed the concept of support in terms of willingness to pay. The response showed 43.2% in favour of allocating tax dollars to NSPs, and 39.4% towards methadone treatment (Matheson, 2014).

Public resistance. The statistics in public perceptions outlined in the section above are mostly positive, yet harm reduction remains a highly contentious topic that receives vocal

political and public opposition. Tzemis et al. (2013) noted that even in municipalities in B.C. that responded with a majority support for harm reduction, the policies did not reflect supportive attitudes. They noted that some municipalities in the Fraser Health Authority region had bylaws in place prohibiting harm reduction services despite respondents from this region showing 69% support. Another municipality on Vancouver Island with a 78% support response within their health authority had recently closed down a twenty-year-old NSP. These findings suggest that the policy makers in these two cases may have been responding to a vocal minority whose views may have been generalized to the broader public. White et al. (2016) noted a similar situation in Sidney Australia wherein national data indicated majority support for harm reduction, yet the implementation of their first syringe automatic dispensing machine was met with apparent community opposition in media reports. Likewise, Salmon et al. (2007) found that businesses and residents in Sidney expressed awareness of the benefits that a local SIF brought to the community while political controversy surrounding the opening of the SIF was ongoing.

Stigma and discrimination. Perhaps it is not surprising that public opposition, even a minority, would be so strong since stigma around drug use remains prevalent. The stigma towards drug use and PWUD is a major factor in public support for harm reduction (Cruz et al., 2007; Kulesza et al., 2015). Common concerns about harm reduction services include attracting more PWUD to the areas of service availability, increasing drug-related crime and public nuisances, and the belief that harm reduction promotes or condones drug use (Potier et al., 2014; Wodak & Cooney, 2005). When describing opposition to a methadone clinic in Toronto, Smith (2010) summarized community concerns by likening the body of an 'addict' to an infection, and the clinic to a site of contagion. Blendon and Young (1998) reported that among America's highest concerns about illicit drug use are increased crime rates and a diminished national image.

Criminalization of certain substances and the war on drugs have made stigma and marginalization of PWUD socially acceptable (Ahern, Stuber & Galea, 2007; Earnshaw, Smith & Copenhaver, 2013). Discrimination against those seen as deviant or criminal is so normalized in society that it can go unnoticed. In a study on "not in my back yard" patterns of resistance towards harm reduction, the authors termed the stigma and discrimination that they found towards PWUD an "inequitable exclusion alliance" wherein these oppressive attitudes towards vulnerable populations is institutionalized by politicians and the law (Tempalski, Friedman, Keem, Cooper & Friedman, 2007).

Surveys and vignette design studies provide evidence that PWUD are seen as unpredictable and dangerous. Their willingness to engage in risky behaviour is seen as immoral. Their dispositions are seen as their fault, and therefore their suffering is self-inflicted and perhaps deserved. This stereotypic perception of PWUD is associated with less pity and helping behaviour, and more avoidance, fear and anger (Corrigan, Kuwabara & O'Shaughnessy, 2009; Crisp, Gelder, Rix, Meltzer & Rowlands, 2000; Lee & Rasinski, 2006; Sattler, Racine & Göritz, 2017). Even family members of people with substance use disorders endure blame and social shame for their perceived role in the matter (Corrigan, Watson & Miller, 2006). Stigma around drug use justifies more punitive rather than help-based responses to people with substance use disorders. Lee and Rasinski's (2006) research on the American social justice system found that the amount of blame and moral judgment put on PWUD for their drug use or addiction was positively correlated with the severity of sanctions. (Lee & Rasinski, 2006).

PWUD have been known to avoid health and social services because of the discrimination and abusive law enforcement practices they may encounter in certain public spaces (United Nations General Assembly, 2011). A 2017 Canadian participatory research study

explored the preferences, experiences, and reasons for engaging in harm reduction among PWUD. The most commonly noted barrier that was not specific to service parameters, such as rules and availability, was the "pervasive anti-drug discrimination and stigmatization in society at large" (Boucher et al., 2017, p.11). Vancouver's Downtown Eastside has a number of harm reduction services available including the only operating SIF in Canada for 15 years, until recent changes in legislation allowed more SIFs to open in 2017 (Kerr et al., 2017). Street-involved youth reported wanting to leave or avoid this area because of the stigma associated with it, even though this meant engaging in higher risk drug use (Bozinoff, 2017). This is in line with Anstice, Strike and Brands' (2009) research with clients of Canadian methadone clinics who reported concern about being seen entering or leaving clinics. Some clients said they preferred using pharmacies for this reason, yet respondents also described feeling more stigma and embarrassment at pharmacies than at methadone clinics because the later was seen as more catered towards PWUD.

In health care, negative perceptions of PWUD are common and problematic. PWUD have reported that despite their efforts to adopt harm reduction practices into their routines, they felt negative judgment, disrespect, condescension, and rejection from health service providers (Boucher et al., 2017). The most common stereotypes endorsed by nurses regarding PWUD are that they have weak character and are violent, dangerous, unhygienic, infected and contagious (Natan et al., 2009). Pauly (2008a) identified what he called value tensions among nurses. The tensions were about not being able to "fix" people with addiction problems, and believing that PWUD were at fault for their addiction and inability to recover. These tensions resulted in PWUD being seen as a waste of time and resources, and being less deserving of care than patients with health issues that have less personal responsibility ascribed to them (Pauly, 2008a).

These kinds of attitudes are in direct conflict with the ethical responsibility to provide equal care to all in need (Canadian Nurses' Association, 2008). A systemic review of stigma towards PWUD among health professionals found that common stigmatizing beliefs in health care are that PWUD can be violent, manipulative, untrustworthy, and poorly motivated. Holding these negative views of clients resulted in professionals feeling frustration, resentment, and powerlessness, and they reported less motivation and job satisfaction when working with PWUD (Van Boekel et al., 2013).

Implications of Stigma on Health and Well-Being

Stigma towards PWUD is a normative and accepted part of our culture, largely due to the criminalization of illicit drug use. As long as PWUD are perceived as criminals, they will be more likely to be seen as deviants of society, untrustworthy, dangerous, unpredictable and undeserving, as many of the studies in this review have shown (Ahern et al., 2007; Corrigan et al., 2009; Crisp et al., 2000; Earnshaw et al., 2013; Lee & Rasinski, 2006; Sattler et al., 2017; Tempalski et al. 2007). The implications of stigma on health, social worth and self-concept are reviewed below.

Suboptimal health care outcomes. The negative attitudes of health professionals outlined in Van Boekel et al. (2013) resulted in more avoidant delivery of services to PWUD compared to other patients. This meant shorter visits, less empathy, diminished personal engagement, a more task-oriented approach, and reduced collaboration between professionals and patients. The lack of trust in PWUD is exemplified in the account of a research participant who had her prescription for stabilizing pain medication, which she had been taking for years, withheld from her because other drugs had been found in her system (Boucher et al., 2017). Pauly (2008a) found evidence that care was being rationed so that less time was spent with

patients considered more to blame for their health concerns and less deserving of care due to their social status. This tangible difference in treatment can reduce client self-esteem and empowerment, thereby negatively impacting treatment retention and outcomes (Anstice, Strike & Brands, 2009; Curtis & Harrison, 2001). The takeaway finding from research on this topic is that stigma and discrimination in health care contributes to suboptimal delivery of care to PWUD.

Decreased health and well-being. Meta-analyses show that stigma and discrimination are associated with increased prevalence of mental health challenges among stigmatized groups (Mak, Poon, Pun & Cheung, 2007; Pascoe & Richman, 2009). The stigma and discrimination related to having a devalued social identity, such as having a substance use disorder, can feel threatening to the individuals impacted. As a result, perceived or anticipated stigma can lead to heightened physiological and behavioural stress reactions which negatively impact performance (Blascovich, Mendes, Hunter, Lickel & Kowai-Bell, 2001), and are related to increased unhealthy coping and decreased healthy coping behaviours (Pascoe & Richman, 2009). Among people in treatment for substance use, perceived stigma was associated with poor sleep, increased depression and anxiety, and lower self-esteem (Birtel et al., 2017). PWUD report a high amount of stigma from those closest to them, friends and family (Earnshaw, Smith & Copenhaver, 2013). Perceived stigma from close connections diminishes the quality of interpersonal relationships and decreases perceived social support, which is integral to recovery and wellbeing (Gyarmathy, & Latkin, 2008; Thoits, 2011).

Oppression and inequality. Corrigan and Wassel (2008) describe three ways of experiencing stigma, and forms of discrimination and oppression that each result in. Their research on three forms of stigma are outlined below.

Public Stigma. For some PWUD, their addiction is visible. A disheveled appearance is a common stereotype. Even those in recovery who may have limited access to housing and hygiene may receive judgment from others who assume they are a "junkie". Stigma for visible traits that are associated with addiction can lead to missed opportunities such as access to housing, jobs, social services, insurance coverage and treatment (Corrigan & Wassel, 2008). Common disadvantages experienced by PWUD include social rejection and isolation, psychological distress, inadequate health care, difficulty finding employment, and denial of important responsibilities by employers (Crisp et al., 2000; Earnshaw et al., 2013).

Self-stigma. When a person is aware of the negative judgments and stereotypes put on them due to a devalued social identity, they are more likely to internalize these stereotypes as indicators of decreased worth. Perceived stigma negatively impacts mental health by confirming and strengthening self-stigma (Birtel et al., 2017). Loss of self-esteem and self-efficacy can decrease motivation, and lead to a defeated disposition towards wellness and opportunities. (Corrigan & Wassel, 2008). Lago et al. (2017) argued that internalized stigma decreases self-trust, and that without self-trust, a person cannot experience complete autonomy. In these ways, stigma towards mental health and substance use disorders is a barrier to personal growth and life aspirations.

Label Avoidance. Prejudice and discrimination associated with labels, such as diagnosis or perceived mental health problems, can motivate people to avoid situations where they may be labeled. This can mean avoiding professional assessment and treatment that may confirm a label or make it visible to others (Corrigan & Wassel, 2008). It may also lead to keeping an addiction, or other mental health challenge, private. Strategies for privacy can lead to isolation and

diminished social support due to avoidance of social interactions, and increased negative coping behaviours for dealing with stigma (Link et al., 1989).

The socially accepted stigma towards PWUD is not just punitive for perceived criminal behaviour, it is oppressive of their growth, identity and quality of life.

Addressing Stigma in Harm Reduction and Health Services

The experience of stigma in health care settings contradicts goals of health and wellness. The unequal power dynamics between those providing services and those seeking services is increased when those seeking services are a socially devalued group. Unequal power dynamics strengthen the negative impact of stigma on the disadvantaged group (Johnson, 2006). The result is a health care system that plays a role in perpetuating diminished hope and motivation towards wellness for people with substance use disorders. This form of institutionalized oppression is challenging, but possible, to change.

Awareness of the benefits of harm reduction, especially those relevant to the community as a whole, increases community support for harm reduction practices (Strike et al., 2016). Changing stigmatizing beliefs about PWUD can both reduce discrimination against this group, and allow for meaningful discussions about evidence-based harm reduction strategies (Kulesza et al., 2015). Lago et al. (2017) recommend public educational initiatives on the social systems that oppress PWUD, as well as continuing education for health professionals on ethical practice around this topic. Anstice et al. (2009) reported that reducing stigma in harm reduction service environments may improve meaningful service accessibility, and improve treatment outcomes.

The research included in this review on community perceptions of harm reduction and PWUD has been assembled into an educational guidebook for destigmatizing harm reduction (see Appendix for guidebook). It incorporates research findings on the experiences of PWUD,

common stigmatizing beliefs, and suggestions for reducing stigma. The guidelines and a rational for each one are outlined below.

People who use drugs are deserving of services, their lives have value. This section addresses the issue of PWUD being seen as social problems who are less deserving of care than other patients (Boyd, 2017; Pauly, 2008a; Van Boekel et al., 2013). It addresses the human right of equal access to health care. Kulesza et al. (2015) found that shifting perceptions of PWUD to being deserving of help rather than punishment increased positive attitudes towards harm reduction. When challenging stigma towards PWUD, it is important to not only target negative beliefs, but to highlight positive attributes. This section highlights the activism work that PWUD have contributed to drug policy and human rights issues.

Successful harm reduction does not require healing addiction. A problem identified in health care is an ideology of "fixing" that causes health professionals to give up on patients whose mental health and substance use issues are complex and not easily remedied (Pauly 2008a). Many people engage in a range of harm reduction practices for reasons such as prevention or management of infectious disease, reducing risk behaviours, social support from staff and peers, counselling service availability, and a comfortable welcoming space (Boucher et al., 2017). Understanding that decreasing risk and enhancing support in service environments is successful work that promotes ongoing service use may decrease frustration and resentment among health care providers (Pauly 2008a; Van Boekel et al., 2013).

Be critical of social contexts that oppose goals for positive change. Corrigan and Wassel's (2008) work on different forms of stigma provides an outline on how societal stigma, internalized stigma and stigmatized labels impact options and opportunities for housing, employment and treatment. They also illustrate how the experience of stigma reduces social

support, self-worth and motivation towards change. Lago (2017) argues that when internalized stigma leads to self-trust issues, it limits full autonomy of the individual to make and follow through with positive choices. Understanding more about how normalized negative perceptions of PWUD impact client care and well-being may help health professionals redirect critical beliefs about their clients towards critical thought about the social oppressions that limit clients, as well as their professional role in that process.

Strengthen decision-making capacity, and avoid persuasion. When client goals differ from those of health professionals, tensions and judgments may arise. Research in a drug treatment setting found that health professionals were unintentionally imposing their beliefs, values and prejudices on clients in their care, and that doing so had a disempowering effect on clients (Curtis & Harrison, 2001). To counter disapproving attitudes towards clients, nurses focused on a common goal of enhancing client decision-making capacity. They recognized clients' responsibility for their choices but also recognized the limitations many clients' life circumstances provided for developing decision-making capacity (Pauly, 2008a).

Support general life goals, as well as managing risk behaviours. PWUD reported that when the focus of harm reduction services and health professionals is restricted to mediating risk behaviours, it feels as though the services are for public interest in reducing disease transmission and discarded needles, rather than for the individuals using the services. They expressed having additional reasons, beyond the mainstream focus on public safety issues, for choosing harm reduction practices. Their reasons include maintaining social relationships, accessing social services, counselling support, and the pursuit of general life goals (Boucher, 2017). When harm reduction is focused only on risk management, and not social support, it is insufficient at meeting

the needs of clients who face intersectional inequalities such as poverty, homelessness, and limited access to health care (Pauly, 2008b).

Harm reduction is not supporting substance use, it supports people and communities. The Ontario HIV Treatment Network made a list of recommended educational efforts to change negative opinions about harm reduction and PWUD (Rapid Response Service, 2012). Among their recommendations was the importance of making sure the public understands that harm reduction does not equate to condoning or promoting drug use. This section of the guidebook illustrates the benefits of harm reduction for PWUD and communities. Especially when contrasted to the harms of criminalization and enforcement, harm reduction practices are the best evidence-based strategies available for decreasing problems associated with substance use. Understanding this may decrease problems of low motivation and morality issues experienced by professionals working with PWUD.

Harm reduction is not a waste of tax dollars and health services. Misperceptions about harm reduction lead to common concerns about allocating money and resources towards drug use (Matheson, 2014). Research outlining the economic benefits of harm reduction, especially in contrast with social justice costs, may decrease concerns about misperceptions that PWUD are draining health care resources.

Support, trust and advocacy are valued and impactful. Research on the benefits of supportive relationships on health care outcomes for PWUD, as well as appreciation expressed from PWUD about their positive experiences with services providers, may decrease feelings of powerlessness, resentment, low motivation, and low satisfaction among health professionals working with this demographic (Van Boekel et al., 2013). Perceived social support is associated with higher self-esteem, better sleep, and lower depression and anxiety among PWUD (Birtel et

al., 2017). This guideline is meant to inspire qualities such as warmth and understanding that contribute to positive and meaningful relationships between services providers and PWUD (Earnshaw et al., 2013).

Take care, debrief and seek support. Harm reduction and health care work with PWUD is known to be challenging on professionals for reasons including burnout, secondary trauma and discouragement (Shepard, 2013; Van Boekel et al., 2013). Work environments impact health professionals' attitudes towards PWUD. Organizational support such as supervision and consultation opportunities contribute significantly to increased job satisfaction and willingness to work with PWUD. Additionally, supportive work environments increased self-esteem, perceived knowledge and feelings of empowerment among care providers (Van Boekel et al., 2013). This guideline encourages health professionals to utilize their supports, and to optimize their work and home environments.

Summary of Part Two

Despite the wealth of research supporting harm reduction drug policy, outdated drug control measures, as well as stigma around drug use and PWUD, have been major barriers in shifting drug policy towards evidence-based practices in Canada. Stigmatization and discrimination of PWUD have led to harm reduction service avoidance, treatment avoidance, subpar delivery of health care, and ongoing oppression of this group that limits their access to a range of personal wellness aspirations. Research on community attitudes towards PWUD brings attention to specific stigmatizing beliefs such as the perception that they are more deserving of punishment than help, and that they are more at fault for their health issues than other people, thereby less deserving of treatment and support. Research also identifies negative beliefs and misperceptions about harm reduction such as the fact that it's using tax dollars to support

criminals. Suggestions for decreasing societal stigma towards PWUD include shifting from punishing substance use towards decreasing harms of substance use, focusing on the common values of human rights rather than moral differences, and accepting the reality that substance use is a societal issue and not just an individual problem. Since research is not often widely reviewed by the public at large, or even accessible to them, a summary of this information has been made into a guidebook that can be used as a practical tool to combat stigma in health care settings and in the broader community.

Part Three: Project Description

The following project is a guidebook on destigmatizing harm reduction work. It includes guidelines that challenge stigmatizing beliefs about PWUD, and misperceptions about harm reduction. It is based on recommendations for addressing stigma from a literature review on public perceptions of harm reduction and PWUD. Part three will provide an overview of the guidebook target audience, its goals and objectives, and a step-by-step process of how it was made. See Appendix for the complete guidebook.

Target Audience

Since research identifies discrimination and stigmatization in health care as a barrier to optimally making use of harm reduction services, the target audience for this project will be people who work in the field of addiction and substance use services under a harm reduction mandate. This includes a range of health care professionals such as people working in hospitals, clinics, pharmacies, mental health services, needle exchanges, safe injection facilities, and people doing outreach work.

This guidebook may be used by organizations that offer addiction and harm reduction services as part of staff orientation, training, or as optional educational material. It may also be used by students in relevant fields of study such as social work, phycology, and political science. Additionally, it may be distributed to the general public by any organizations or individuals such as addiction services, doctor's offices and activist groups that are interested in supporting harm reduction and PWUD.

Guidebook Goals and Objectives

The main goal of this project is to decrease stigma towards PWUD in harm reduction health care services. A secondary goal is to increase job satisfaction for health care providers in

the field of harm reduction and addiction. These goals are based on the problem of stigma and discrimination towards PWUD in health care services, and a contributing factor to this problem, the negative attitudes of health professionals towards PWUD (Anstice et al., 2009; Pauly, 2008a; Van Boekelet al., 2013). The project offers a set of guidelines for meeting these goals. See Table I below for the complete list of guidelines.

Table I

Guidelines for Destigmatizing Harm Reduction

People who use drugs are deserving of services, their lives have value.
Successful harm reduction does not require healing addiction.
Be critical of social contexts that oppose goals for positive change.
Strengthen decision-making capacity, and avoid persuasion.
Support general life goals, as well as managing risk behaviours.
Harm reduction is not supporting substance use, it supports people and communities.
Harm reduction is not a waste of tax dollars and health services.
Support, trust and advocacy are valued and impactful.
Take care, debrief and seek support.

The guidebook has five objectives, the first of which is confronting stigmatizing beliefs and discriminating actions directed at PWUD. Second, it aims to raise awareness and

understanding of how stigma impacts health and wellness outcomes. The first two objectives are met by outlining research findings on the topic of public perceptions towards people who use drugs. Case examples are included to exemplify the problems each guideline aims to address. The third objective is to increase understanding of what harm reduction is and whom it serves. It does this by challenging common misperceptions about harm reduction with evidence of effectiveness. Fourth, the guidelines promote behaviours that decrease stigma, and support health and wellness outcomes for PWUD. The final objective is to empower service providers towards actions associated with improved job satisfaction. The guidebook meets the last two objectives by including 'Take-away Message' sections that suggest ways of applying each guideline to health care work.

How it was Made

This project is based on a literature review on the topic of community attitudes towards harm reduction. The stigmatizing beliefs and practices identified in the literature review, as well as the recommendations for decreasing stigma, have been organized into guidelines for the purpose of creating an evidence-based guidebook on how to destigmatize harm reduction work. A step-by-step process for how it was made is outlined in Table II below. A screenshot of an excel spreadsheet is shown in Figure 1 to exemplify how excel was used in step two to organize research notes.

Table II

Steps Included in Making the Guidebook

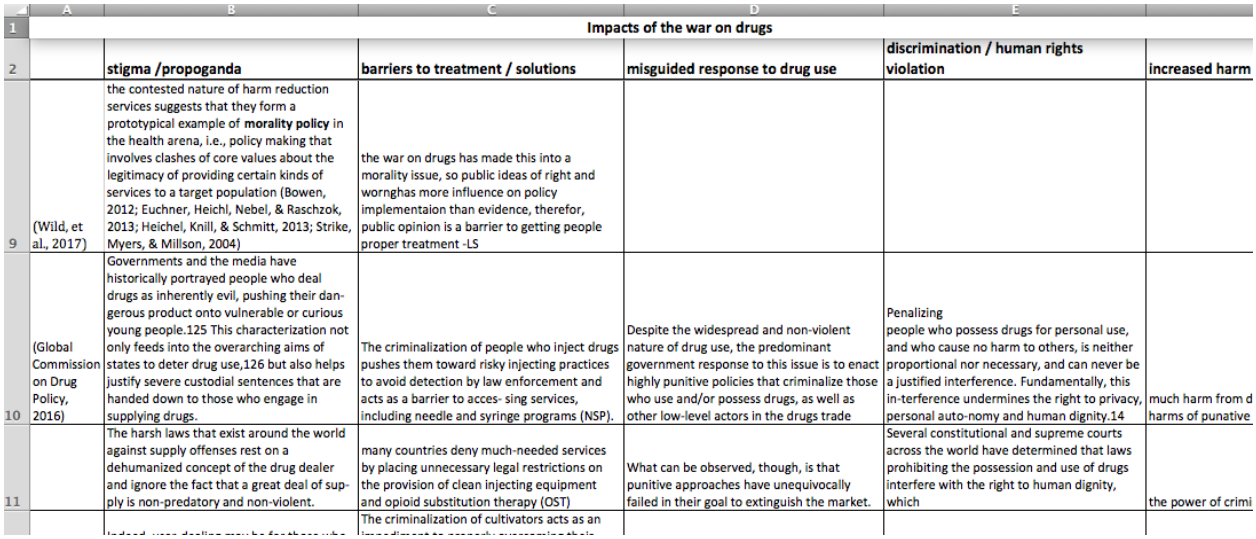
Step 1	Literature review was completed on community attitudes towards harm reduction and PWUD
Step 2	Collected research findings that: • identify misinformed perceptions of harm reduction

	• identify stigmatizing beliefs about addiction and people who use drugs • recommend strategies for increasing support for harm reduction • recommend strategies for decreasing stigma towards harm reduction and people who use drugs
Step 3	• Organized the research from step two into categories using Excel spreadsheets. • Refined notes by collapsing similar themes and removing those not relevant to the goals of the project. • Summarized the research findings into a set of nine guidelines for destigmatizing harm reduction work.
Step 4	An explanation of each guideline was written and organized into four sections: • Key issue – to describe the purpose of the guideline • Background information – to provide a rational for the guideline and outline the research it's based on • Case examples – to provide scenarios that exemplify the problem being addressed by the guideline. • Take-away message – to suggest ways of applying the guideline to health services
Step 5	Completed additional aspects of the guidebook including: • cover page • dedication • introduction • references

Overview of Part Three

The outcome of this project is a guidebook on destigmatizing harm reduction that is based on a literature review on public perceptions of harm reduction and PWUD. The goals of

the guidebook are to decrease stigma in health care settings, and increase job satisfaction among health care professionals. A summary of the research findings that identify stigmatizing perceptions of harm reduction and PWUD, as well as recommendations for decreasing this stigma, have been written into a set of guidelines for destigmatizing harm reduction work. The guidebook is relevant for people who work in the field of addiction and substance use, as well as members of the general public. Organizations and individuals may distribute the guidebook as a tool for challenging commonly held stigmatizing perceptions of harm reduction and PWUD. The overall purpose of the project is to better support harm reduction service provision and evidence based drug policy, a critical need as Canada responds to the current opioid crisis.



	A	B	C	D	E	
1		Impacts of the war on drugs				
2		**stigma /propoganda**	**barriers to treatment / solutions**	**misguided response to drug use**	**discrimination / human rights violation**	**increased harm**
9	(Wild, et al., 2017)	the contested nature of harm reduction services suggests that they form a prototypical example of **morality policy** in the health arena, i.e., policy making that involves clashes of core values about the legitimacy of providing certain kinds of services to a target population (Bowen, 2012; Euchner, Heichl, Nebel, & Raschzok, 2013; Heichel, Knill, & Schmitt, 2013; Strike, Myers, & Millson, 2004)	the war on drugs has made this into a morality issue, so public ideas of right and worngha s more influence on policy implementaion than evidence, therefor, public opinion is a barrier to getting people proper treatment -LS			
10	(Global Commission on Drug Policy, 2016)	Governments and the media have historically portrayed people who deal drugs as inherently evil, pushing their dan- gerous product onto vulnerable or curious young people.125 This characterization not only feeds into the overarching aims of states to deter drug use,126 but also helps justify severe custodial sentences that are handed down to those who engage in supplying drugs.	The criminalization of people who inject drugs pushes them toward risky injecting practices to avoid detection by law enforcement and acts as a barrier to acces- sing services, including needle and syringe programs (NSP).	Despite the widespread and non-violent nature of drug use, the predominant government response to this issue is to enact highly punitive policies that criminalize those who use and/or possess drugs, as well as other low-level actors in the drugs trade	Penalizing people who possess drugs for personal use, and who cause no harm to others, is neither proportional nor necessary, and can never be a justified interference. Fundamentally, this in-terference undermines the right to privacy, personal auto-nomy and human dignity.14	much harm from d harms of punative
11		The harsh laws that exist around the world against supply offenses rest on a dehumanized concept of the drug dealer and ignore the fact that a great deal of sup- ply is non-predatory and non-violent.	many countries deny much-needed services by placing unnecessary legal restrictions on the provision of clean injecting equipment and opioid substitution therapy (OST)	What can be observed, though, is that punitive approaches have unequivocally failed in their goal to extinguish the market.	Several constitutional and supreme courts across the world have determined that laws prohibiting the possession and use of drugs interfere with the right to human dignity, which	the power of crimi
			The criminalization of cultivators acts as an			

Figure 2: Example of Excel Spreadsheets used in Step 3

References

Ahern, J., Stuber, J., & Galea, S. (2007). Stigma, discrimination and the health of illicit drug users. *Drug and Alcohol Dependence*, *88*(2–3), 188–196. http://doi.org/10.1016/j.drugalcdep.2006.10.014

Anstice, S., Strike, C. J., & Brands, B. (2009). Supervised methadone consumption: Client issues and stigma. *Substance Use and Misuse*, *44*(6), 794–808. http://doi.org/10.1080/10826080802483936

Aspinall, E. J., Nambiar, D., Goldberg, D. J., Hickman, M., Weir, A., Van Velzen, E., … Hutchinson, S. J. (2014). Are needle and syringe programmes associated with a reduction in hiv transmission among people who inject drugs: A systematic review and meta-analysis. *International Journal of Epidemiology*, *43*(1), 235–248. http://doi.org/10.1093/ije/dyt243

Bayoumi, A. M., & Strike, C. J. (2016). Making the case for supervised injection services. *The Lancet*, *387*(10031), 1890–1891. http://doi.org/10.1016/S0140-6736(16)30308-7

Beletsky, L., Heller, D., Jenness, S. M., Neaigus, A., Gelpi-Acosta, C., & Hagan, H. (2014). Syringe access, syringe sharing, and police encounters among people who inject drugs in New York city: A community-level perspective. *International Journal of Drug Policy*, *25*(1), 105–111. http://doi.org/10.1016/j.drugpo.2013.06.005

Benso, V. (2010, September). User-dealer, those who have been forgotten by harm-reduction. *Suchtmagazin*, *5*, 34–36. Retrieved from http://www.talkingdrugs.org/sites/default/files/drug-user-report-benso.pdf

Birtel, M. D., Wood, L. & Kempa, N. J. (2017). Stigma and social support in substance abuse: Implications for mental health and well-being. *Psychiatry Research, 252*, 1-8. http://dx.doi.org/10.1016/j.psychres.2017.01.097

Blascovich, J., Mendes, W. B., Hunter, S. B., Lickel, B., & Kowai-Bell, N. (2001). Perceiver threat in social interactions with stigmatized others. *Journal of Personality and Social Psychology*, *80*(2), 253–267. http://doi.org/10.1037/0022-3514.80.2.253

Blendon, R. J., & Young, J. T. (1998). The public and the war on illicit drugs. *Journal of the American Medical Association*, *279*(11), 827–832. http://doi.org/10.1001/jama.279.11.827

Boucher, L. M., Marshall, Z., Martin, A., Larose-Hébert, K., Flynn, J. V., Lalonde, C., … Kendall, C. (2017). Expanding conceptualizations of harm reduction: results from a qualitative community-based participatory research study with people who inject drugs. *Harm Reduction Journal*, *14*(1), 18. http://doi.org/10.1186/s12954-017-0145-2

Boyd, S. (2002). Media constructions of illegal drugs, users, and sellers: A closer look at Traffic. *International Journal of Drug Policy*, *13*(5), 397–407. http://doi.org/10.1016/S0955-3959(02)00079-8

Boyd, S., Murray, D., & MacPherson, D. (2017). Erratum to: Telling our stories: heroin-assisted treatment and SNAP activism in the Downtown Eastside of Vancouver. *Harm Reduction Journal*, *14*(1), 36. http://doi.org/10.1186/s12954-017-0161-2

Bozinoff, N., Small, W., Long, C., DeBeck, K., & Fast, D. (2017). Still "at risk": An examination of how street-involved young people understand, experience, and engage with "harm reduction" in Vancouver's inner city. *International Journal of Drug Policy*, *45*, 33–39. http://doi.org/10.1016/j.drugpo.2017.05.006

Burstein, P. (2003). The Impact of Public Opinion on Public Policy: A Review and an Agenda. *Political Research Quarterly*, *56*(1), 29. http://doi.org/10.2307/3219881

Canadian HIV/AIDS Legal Network, CDPC, BC Civil Liberties Association, VANDU, CAAN,

PASAN, … CATIE. (2015). Drug Policy and Human Rights: the Canadian Context. Retrieved from https://www.ohchr.org/Documents/HRBodies/HRCouncil/DrugProblem/CanadianHIVAIDsLegalNetwork.pdf

Canadian Nurses Association. (2012). Public health issues should trump politics, advocates of safe injection sites urge. *The Canadian Nurse*, *108*(6), 8–9. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/22866565

Canadian Nurses' Association (2008). *Code of ethics for registered nurses: Canadian Nurses' Association*. Ottowa, ON: Canadian Nurses Association

Chaney, C., & Robertson, R. V. (2013). Racism and Police Brutality in America. *Journal of African American Studies*, *17*(4), 480–505. http://doi.org/10.1007/s12111-013-9246-5

Coomber, R. (2010). Reconceptualising drug markets and drug dealers — the need for change. *Drugs and Alcohol Today*, *10*(1), 10–13. http://doi.org/10.5042/daat.2010.0122

Corey, G. (2013). *Theory and practice of counseling and psychotherapy*. California: Brooks/Cole,Cengage Learning

Corrigan, P. W., Watson, A. C., & Miller, F. E. (2006). Blame, shame, and contamination: The impact of mental illness and drug dependence stigma on family members. *Journal of Family Psychology*, *20*(2), 239–246. http://doi.org/10.1037/0893-3200.20.2.239

Corrigan, P. &Wassel, A. (2008). Understanding and influencing the stigma of mental illness. Journal of Psychosocial Nursing and Mental Health Services, 46, 42–48. doi:10.1007/s10597-007-9084-9

Corrigan, P. W., Kuwabara, S. A., & O'Shaughnessy, J. (2009). The public stigma of mental illness and drug addiction: Findings from a stratified random sample. *Journal of Social Work*, *9*(2), 139–147. http://doi.org/10.1177/1468017308101818

Coumans, M., Knibbe, R. A., & van de Mheen, D. (2006). Street-Level Effects of Local Drug Policy on Marginalization and Hardening: An Ethnographic Study Among Chronic Drug Users. *Journal of Psychoactive Drugs*, *38*(2), 161–171. http://doi.org/10.1080/02791072.2006.10399841

Crisp, A., Gelder, M., Rix, S., Meltzer, H., & Rowlands, O. (2000). Stigmatisation of people with mental illnesses. *British Journal of Psychiatry*, *177*, 4–7. http://doi.org/10.1192/bjp.177.1.4

Cruz, M. F., Patra, J., Fischer, B., Rehm, J., & Kalousek, K. (2007). Public opinion towards supervised injection facilities and heroin-assisted treatment in Ontario, Canada. *International Journal of Drug Policy*, *18*(1), 54–61. http://doi.org/10.1016/j.drugpo.2006.12.001

Csete, J., Kamarulzaman, A., Kazatchkine, M., Altice, F., Balicki, M., Buxton, J., … Beyrer, C. (2016). Public health and international drug policy. *The Lancet*, *387*(10026), 1427–1480. http://doi.org/10.1016/S0140-6736(16)00619-X

Curtis, J. & Harrison, L. (2001). Beneath the surface : collaboration in alcohol and other drug treatment . An analysis using Foucault ' s three modes of objectification. *Journal of advanced nursing, 34*(6), 737-744. http://doi/epdf/10.1046/j.1365-2648.2001.01803.x

Davidson, P. J., & Howe, M. (2014). Beyond NIMBYism: Understanding community antipathy toward needle distribution services. *International Journal of Drug Policy*, *25*(3), 624–632. http://doi.org/10.1016/j.drugpo.2013.10.012

DeBeck, K., Kerr, T., Li, K., Milloy, M. J., Montaner, J., & Wood, E. (2009). Incarceration and drug use patterns among a cohort of injection drug users. *Addiction*, *104*(1), 69–76. http://doi.org/10.1111/j.1360-0443.2008.02387.x

DeBeck, K., Kerr, T., Bird, L., Zhang, R., Marsh, D., Tyndall, M., … Wood, E. (2011). Injection drug use cessation and use of North America's first medically supervised safer injecting facility. *Drug and Alcohol Dependence*, *113*(2–3), 172–176. http://doi.org/10.1016/j.drugalcdep.2010.07.023

Drug Policy Alliance (2018). The drug war, mass incarceration and race. Retrieved from http://www.drugpolicy.org/sites/default/files/drug-war-mass-incarceration-and-race_01_18_0.pdf

Duggan, K. (2017, Jan 18). Poll shows where Canadian cities stand on supervised injection sites. *Politics*, Retrieved from https://ipolitics.ca/2017/01/18/where-canadian-cities-stand-on-supervised-injection-sites-poll/

Earnshaw, V., Smith, L., & Copenhaver, M. (2013). Drug Addiction Stigma in the Context of Methadone Maintenance Therapy: An Investigation into Understudied Sources of Stigma. *International Journal of Mental Health and Addiction*, *11*(1), 110–122. http://doi.org/10.1007/s11469-012-9402-5

Eggertson, L. (2013). Legislation ignores benefits of safe injection sites, say doctors. *CMAJ : Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne*, *185*(12), 555–557. http://doi.org/10.1503/cmaj.109-4536

Erickson, P. G. (1995). Harm reduction: what it is and is not. *Drug and Alcohol Review*, *14*(3), 283–285. http://doi.org/10.1080/09595239500185361

European Monitoring Centre for Drugs and Drug Addiction. (2016). *European Drug Report*

2016: Trends and Developments. *European Monitoring of Drugs and Drugs Addiction*. http://doi.org/10.2810/88175

Fernandes, R. M., Cary, M., Duarte, G., Jesus, G., Alarcão, J., Torre, C., … Carneiro, A. V. (2017). Effectiveness of needle and syringe programs in people who inject drugs: An overview of systematic reviews. *BMC Public Health*, *17*(1), 309. http://doi.org/10.1186/s12889-017-4210-2

Global Commission on Drug Policy (2016). *Advancing drug policy reform: A new approach to decriminalization*. Retrieved from http://www.globalcommissionondrugs.org/wp-content/uploads/2016/11/GCDP-Report-2016-ENGLISH.pdf

Global Commission on HIV and the Law (2012). *HIV and the law: risks, rights, and health*. New York, NY: United Nations Development Programme. Retrieved from https://hivlawcommission.org/wp-content/uploads/2017/06/FinalReport-RisksRightsHealth-EN.pdf

Goncalves, R., Lourenco, A., & da Silva, S. N. (2015). A social cost perspective in the wake of the Portuguese strategy for the fight against drugs. *International Journal of Drug Policy, 26*, 199–209. http://doi.org/10.1016/j.drugpo.2014.08.017

Grenfell, P., Baptista Leite, R., Garfein, R., de Lussigny, S., Platt, L., & Rhodes, T. (2013). Tuberculosis, injecting drug use and integrated HIV-TB care: A review of the literature. *Drug and Alcohol Dependence*, *129*(3), 180–209. http://doi.org/10.1016/j.drugalcdep.2012.11.013

Gyarmathy, V. A., & Latkin, C. A. (2008). Individual and Social Factors Associated With Participation in Treatment Programs for Drug Users. *Substance Use & Misuse*, *43*(12–13), 1865–1881. http://doi.org/10.1080/10826080802293038

Harm Reduction International. *What is harm reduction? A position statement from Harm Reduction International*. Retrieved from https://www.hri.global/what-is-harm-reduction

Harm Reduction International. (2016). *The Global State of Harm Reduction 2016*. Retrieved tim,

K. L., & Cunningham, J. A. (2006). Barriers to the dissemination of four harm reduction strategies: a survey of addiction treatment providers in Ontario. *Harm Reduction Journal*, *3*, 35. http://doi.org/10.1186/1477-7517-3-35

Hawk, M., Coulter, R. W. S., Egan, J. E., Fisk, S., Friedman, M. R., Tula, M., & Kinsky, S. (2017). Harm reduction principles for healthcare settings, 1–9. http://doi.org/10.1186/s12954-017-0196-4

Hopwood, M., Brener, L., Frankland, A., & Treloar, C. (2010). Assessing community support for harm reduction services: Comparing two measures. *Drug and Alcohol Review*, *29*(4), 385–391. http://doi.org/10.1111/j.1465-3362.2009.00151.x

Hughes, C. E. & Stevens, A. (2010). What can we learn from the Portuguese decriminalization of illicit drugs? The British Journal of Criminology, 50(6), 999-1022. https://doi.org/10.1093/bjc/azq038

Johnson, A. (2006). *Privilege, power, and the difference (2nd ed.)*. New York: McGraw-Hill

Kassam, A. (2018, April 16). Canada's Liberal party considers decriminalization of all illicit drugs. *The Guardian*, Retrieved from https://www.theguardian.com/world/2018/apr/16/canada-liberal-party-considers-decriminalization-all-illicit-drugs

Kerr, T., Small, W., & Wood, E. (2005). The public health and social impacts of drug market

enforcement: A review of the evidence. *International Journal of Drug Policy*, *16*(4), 210–220. http://doi.org/10.1016/j.drugpo.2005.04.005

Kerr, T., Mitra, S., Kennedy, M. C., & McNeil, R. (2017). Supervised injection facilities in Canada: past, present, and future. *Harm Reduction Journal*, *14*(1), 28. http://doi.org/10.1186/s12954-017-0154-1

Kulesza, M., Teachman, B. A., Werntz, A. J., Gasser, M. L., & Lindgren, K. P. (2015). Correlates of public support toward federal funding for harm reduction strategies. *Substance Abuse Treatment, Prevention, and Policy*, *10*(1), 25. http://doi.org/10.1186/s13011-015-0022-5

Lago, R. R., Peter, E., & Bógus, C. M. (2017). Harm reduction and tensions in trust and distrust in a mental health service: A qualitative approach. *Substance Abuse Treatment, Prevention, and Policy*, *12*(1), 12. http://doi.org/10.1186/s13011-017-0098-1

Lee, R. D., & Rasinski, K. A. (2006). Five grams of coke: Racism, moralism and White public opinion on sanctions for first time possession. *International Journal of Drug Policy*, *17*(3), 183–191. http://doi.org/10.1016/j.drugpo.2006.02.001

Lenton, S., & Single, E. (1998). The definition of harm reduction. *Drug and Alcohol Review*, *17*(2), 213–219. http://doi.org/10.1080/09595239800187011

Link, B. G., Cullen, F. T., Struening, E., Shrout, P. E., Dohrenwend, P., Link, B. G., … Shrout, P. E. (1989). A modified labeling theory approach to mental disorders : An empirical assessment. *American Sociological Association*, *54*(3), 400–423. doi: 10.2307/2095613

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27, 363–385. doi:10.1146/annurev.soc.27.1.363

Lupick, T. (2015, March 5). Justin Trudeau tells UBC students he wants supervised injection

sites across Canada. *The Georgia Straight*, Retrieved from https://www.straight.com/blogra/404631/justin-trudeau-tells-ubc-students-he-wants-supervised-injection-sites-across-canada

MacArthur, G. J., Minozzi, S., Martin, N., Vickerman, P., Deren, S., Bruneau, J., … Hickman, M. (2012). Opiate substitution treatment and HIV transmission in people who inject drugs: systematic review and meta-analysis. *Bmj*, *345*(oct03 3), e5945–e5945. http://doi.org/10.1136/bmj.e5945

MacArthur, G. J., van Velzen, E., Palmateer, N., Kimber, J., Pharris, A., Hope, V., … Hutchinson, S. J. (2014). Interventions to prevent HIV and hepatitis C in people who inject drugs: A review of reviews to assess evidence of effectiveness. *International Journal of Drug Policy*, *25*(1), 34–52. http://doi.org/10.1016/j.drugpo.2013.07.001

Mak, W. W. S., Poon, C. Y. M., Pun, L. Y. K., & Cheung, S. F. (2007). Meta-analysis of stigma and mental health. *Social Science and Medicine*, *65*(2), 245–261. http://doi.org/10.1016/j.socscimed.2007.03.015

Marshall, B. D., Milloy, M. J., Wood, E., Montaner, J. S., & Kerr, T. (2011). Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: A retrospective population-based study. *The Lancet*, *377*(9775), 1429–1437. http://doi.org/10.1016/S0140-6736(10)62353-7

Mathers, B. M., Degenhardt, L., Ali, H., Wiessing, L., Hickman, M., Mattick, R. P., … Strathdee, S. A. (2010). HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage. *The Lancet*, *375*(9719), 1014–1028. http://doi.org/10.1016/S0140-6736(10)60232-2

Matheson, C., Jaffray, M., Ryan, M., Bond, C. M., Fraser, K., Kirk, M., & Liddell, D. (2014). Public opinion of drug treatment policy: Exploring the public's attitudes, knowledge, experience and willingness to pay for drug treatment strategies. *International Journal of Drug Policy*, *25*(3), 407–415. http://doi.org/10.1016/j.drugpo.2013.11.001

McCollister, K. E., & French, M. T. (2003). The relative contribution of outcome domains in the total economic benefit of addiction interventions: A review of first findings. *Addiction*, *98*, 1647–1659. https://doi.org/10.1111/j.1360-0443.2003.00541.x

Meza, S. (2018, January 6). *President Trump says countries that had success dealing with drugs chose to be 'very harsh'*. Newsweek U.S. Edition. http://www.newsweek.com/trump-says-countries-are-harsh-drugs-have-less-difficulty-773168

Millhorn, M., Monaghan, M., Montero, D., Reyes, M., Roman, T., Tollasken, R., & Walls, B. (2009). North Americans' attitudes toward illegal drugs. *Journal of Human Behavior in the Social Environment*, *19*(2), 125–141. http://doi.org/10.1080/10911350802687075

Monroe, A. D. (1998). Public opinion and public policy, 1980-1993. *Public Opinion Quarterly, 62*(1), 6-28. https://doi.org/10.1086/297828

Natan, M. Ben, Beyil, V., & Neta, O. (2009). Nurses' perception of the quality of care they provide to hospitalized drug addicts: Testing the Theory of Reasoned Action. *International Journal of Nursing Practice*, *15*(6), 566–573. http://doi.org/10.1111/j.1440-172X.2009.01799.x

Office of the Correctional Investigator of Canada (2013). Aboriginal Offenders – A critical situation. Retrieved from http://www.oci-bec.gc.ca/cnt/rpt/oth-aut/oth-aut20121022info-eng.aspx

Office of the Correctional Investigator of Canada (2017). *Annual Report of the Office of the*

Correctional investigator 2016-2017. Retrieved from http://www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20162017-eng.aspx#s5

Page, B. I., & Shapiro, R. (1983). Effects of public opinion on policy. *The American Political Science Review, 77*(1), 175-190. https://doi.org/10.2307/1956018

Palmateer, N. E., Taylor, A., Goldberg, D. J., Munro, A., Aitken, C., Shepherd, S. J., … Hutchinson, S. J. (2014). Rapid decline in HCV incidence among people who inject drugs associated with national scale-up in coverage of a combination of harm reduction interventions. *PLoS ONE*, *9*(8). http://doi.org/10.1371/journal.pone.0104515

Pascoe, E. A., & Richman, L. S. (2009). Perceived Discrimination and Health: A Meta-Analytic Review. *Psychological Bulletin*, *135*(4), 531–554. http://doi.org/10.1037/a0016059

Pauly, B. (2008a). Shifting moral values to enhance access to health care: Harm reduction as a context for ethical nursing practice. *International Journal of Drug Policy*, *19*(3), 195–204. http://doi.org/10.1016/j.drugpo.2008.02.009

Pauly, B. (2008b). Harm reduction through a social justice lens. *International Journal of Drug Policy*, *19*(1), 4–10. http://doi.org/10.1016/j.drugpo.2007.11.005

Potier, C., Laprévote, V., Dubois-Arber, F., Cottencin, O., & Rolland, B. (2014). Supervised injection services: What has been demonstrated? A systematic literature review. *Drug and Alcohol Dependence*, *145*, 48–68. http://doi.org/10.1016/j.drugalcdep.2014.10.012

Pinkerton, S. D. (2011). How many HIV infections are prevented by Vancouver Canada's supervised injection facility? *International Journal of Drug Policy*, *22*(3), 179–183. http://doi.org/10.1016/j.drugpo.2011.03.003

Rapid Response Service (2012). *Rapid Response: Public Perception of Harm Reduction Interventions*. Toronto, ON: Ontario HIV Treatment Network; December 2012

Reuter, P. (2001). Why does research have so little impact on Amerian drug policy? *Addiction*, *96*(3), 373–376. http://doi.org/10.1080/09652140020054437

Salmon, A. M., Thein, H. H., Kimber, J., Kaldor, J. M., & Maher, L. (2007). Five years on: What are the community perceptions of drug-related public amenity following the establishment of the Sydney Medically Supervised Injecting Centre? *International Journal of Drug Policy*, *18*(1), 46–53. http://doi.org/10.1016/j.drugpo.2006.11.010

Sattler, S., Escande, A., Racine, E., & Göritz, A. S. (2017). Public Stigma Toward People With Drug Addiction: A Factorial Survey. *Journal of Studies on Alcohol and Drugs*, *78*(3), 415–425. http://doi.org/10.15288/jsad.2017.78.415

Shanahan, E. A., Mcbeth, M. K., & Hathaway, P. L. (2011). Narrative policy framework: The influence of media policy narratives on public opinion. *Politics and Policy*, *39*(3), 373–400. http://doi.org/10.1111/j.1747-1346.2011.00295.x

Shepard, B. C. (2013). Between harm reduction, loss and wellness: on the occupational hazards of work. *Harm Reduction Journal*, *10*(1), 5. http://doi.org/10.1186/1477-7517-10-5

Singleton, N., & Rubin, J. (2014). What is good governance in the context of drug policy? *International Journal of Drug Policy*, *25*(5), 935–941. http://doi.org/10.1016/j.drugpo.2014.03.008

Smith, C. B. R. (2010). Socio-spatial stigmatization and the contested space of addiction treatment: Remapping strategies of opposition to the disorder of drugs. *Social Science and Medicine*, *70*(6), 859–866. http://doi.org/10.1016/j.socscimed.2009.10.033

Starks, T. A., & Krementsov, S. (2017). A Revolutionary Attack on Tobacco : Bolshevik Antismoking Campaigns in the 1920s. *American journal of Public Health*, *107*(11), 1711–1718. http://doi.org/10.2105/AJPH.2017.304048

Strike, C., Rotondi, N. K., Watson, T. M., Kolla, G., & Bayoumi, A. M. (2016). Public opinions about supervised smoking facilities for crack cocaine and other stimulants. *Substance Abuse Treatment, Prevention, and Policy*, *11*(1), 8. http://doi.org/10.1186/s13011-016-0052-7

Tempalski, B., Friedman, R., Keem, M., Cooper, H., & Friedman, S. R. (2007). NIMBY localism and national inequitable exclusion alliances: The case of syringe exchange programs in the United States. *Geoforum*, *38*(6), 1250–1263. http://doi.org/10.1016/j.geoforum.2007.03.012

Thoits, P. A. (2011). Mechanisms linking social ties and support to physical and mental health. *Journal of Health and Social Behavior*, *52*(2), 145–161. http://doi.org/10.1177/0022146510395592

Turner, K. M. E., Hutchinson, S., Vickerman, P., Hope, V., Craine, N., Palmateer, N., … Hickman, M. (2011). The impact of needle and syringe provision and opiate substitution therapy on the incidence of hepatitis C virus in injecting drug users: Pooling of UK evidence. *Addiction*, *106*(11), 1978–1988. http://doi.org/10.1111/j.1360-0443.2011.03515.x

Tzemis, D., Campbell, J., Kuo, M., & Buxton, J. A. (2013). A cross-sectional study of public attitudes towards safer drug use practices in British Columbia, Canada. *Substance Abuse Treatment Prevention, and Policy*, *8*, 40. http://doi.org/10.1186/1747-597X-8-40

UK Home Office (2014), Drugs: International Comparators, UK Government, 47. Retrieved From https://assets.publishing. service.gov.uk/government/uploads/system/ uploads/attachment_data/file/368489/DrugsInternationalComparators.pdf

UN High Commissioner for Human Rights (2015). *Study on the impact of the world drug problem on the enjoyment of human rights*. Human Rights Council, 30th session. Retrieved from

http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session30/Pages/ListReports.aspx

UNAIDS. (2015). How AIDS Changed Everything. *Journal of Chemical Information and Modeling*, *53*(9), 1689–1699. http://doi.org/10.1017/CBO9781107415324.004

United Nations General Assembly (2011).*United to end AIDS: achieving the targets of the 2011 Political Declaration – Report of the Secretary-General*. Retrieved from http://files.unaids.org/en/media/unaids/contentassets/documents/document/2012/20120402_UNGA_A-66-757_en.pdf

United Nations Office on Drugs and Crime. (2017). *World drug report 2017: Global overview of drug demand and supply*. *World Drug Report 2017*. Retrieved from https://www.unodc.org/wdr2017/field/Booklet_2_HEALTH.pdf

Van Boekel, L. C., Brouwers, E. P. M., Van Weeghel, J., & Garretsen, H. F. L. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. *Drug and Alcohol Dependence, 131*, 23–35. doi:10.1016/j.drugalcdep.2013.02.018

Vernick, J. S., Burris, S., & Strathdee, S. A. (2003). Public opinion about syringe exchange programmes in the USA: An analysis of national surveys. *International Journal of Drug Policy*, *14*(5–6), 431–435. http://doi.org/10.1016/S0955-3959(03)00144-0

Werb, D., Rowell, G., Guyatt, G., Kerr, T., Montaner, J., & Wood, E. (2011). Effect of drug law enforcement on drug market violence: A systematic review. *International Journal of Drug Policy*, *22*(2), 87–94. http://doi.org/10.1016/j.drugpo.2011.02.002

White, B., Haber, P. S., & Day, C. A. (2016). Community attitudes towards harm reduction services and a newly established needle and syringe automatic dispensing machine in an

inner-city area of Sydney, Australia. *International Journal of Drug Policy*, *27*, 121–126. http://doi.org/10.1016/j.drugpo.2015.05.010

WHO, UN Office on Drugs and Crime & UN Joint Programme on HIV/AIDS (2004). *WHO/UNODC/UNAIDS position paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*. Retrieved from http://www.who.int/substance_abuse/publications/en/PositionPaper_flyer_English.pdf

WHO, UN Office on Drugs and Crime & UN Joint Programme on HIV/AIDS. (2012) *WHO, UNODC, UNAIDS, Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*. Retrieved from http://www.unaids.org/sites/default/files/sub_landing/idu_target_setting_guide_en.pdf

Wild, T. C., Pauly, B., Belle-Isle, L., Cavalieri, W., Elliott, R., Strike, C., … Hyshka, E. (2017). Canadian harm reduction policies: A comparative content analysis of provincial and territorial documents, 2000–2015. *International Journal of Drug Policy*, *45*, 9–17. http://doi.org/10.1016/j.drugpo.2017.03.014

Wilson, D. P., Donald, B., Shattock, A. J., Wilson, D., & Fraser-Hurt, N. (2015). The cost-effectiveness of harm reduction. *International Journal of Drug Policy*, *26*(S1), S5–S11. http://doi.org/10.1016/j.drugpo.2014.11.007

Wodak, A., & Cooney, A. (2005). Effectiveness of sterile needle and syringe programmes. *International Journal of Drug Policy*, *16*(SUPPL. 1). http://doi.org/10.1016/j.drugpo.2005.02.004

Wood, E., Kerr, T., Small, W., Li, K., Marsh, D. C., Montaner, J. S. G., & Tyndall, M. W. (2004). Changes in public order after the opening of a medically supervised safer injecting

facility for illicit injection drug users. *Cmaj*, *171*(7), 731–734. http://doi.org/10.1503/cmaj.1040774

Wood, E., Tyndall, M.W., Zhang, R., Stoltz, J.-A., Lai, C., Montaner, J.S., Kerr, T., (2006). Attendance at supervised injecting facilities and use of detoxification services. The New England Journal of Medicine, 354(23), 2512-2514. doi: 10.1056/NEJMc052939

Zábranský, T. (2004). Czech drug laws as an arena of drug policy battle. *Journal of Drug Issues*, *34*(3), 661–686. http://doi.org/https://doi-org.prxy.lib.unbc.ca/10.1177/002204260403400309

Appendix

Destigmatize Harm Reduction Guidebook

Destigmatize Harm Reduction

GUIDELINES FOR HEALTH PROFESSIONALS
TO ENHANCE CLIENT OUTCOMES
AND JOB SATISFICATION

Guidelines at a glance…..

People who use drugs are deserving of services, their lives have value.

Successful harm reduction does not require healing addiction.

Be critical of social contexts that oppose goals for positive change.

Strengthen decision-making capacity, and avoid persuasion.

Support general life goals, as well as managing risk behaviours.

Harm reduction is not supporting substance use, it supports people and communities.

Harm reduction is not a waste of tax dollars and health services.

Support, trust and advocacy are valued and impactful.

Take care, debrief and seek support.

Dedication

Special acknowledgement to peer groups engaging in harm reduction work and advocacy such as :

BC / Yukon Association of Drug War Survivors

Canadian Association of People Who Use Drugs

L'ADDICQ – Association pour la Défense des Droits et L'Inclusion des personnes qui Consomment des drogues du Québec

MANDU – Manitoba Area Network of Drug Users

Méta d'Âme - Association pour dépendants aux opioïdes

SNAP - SALOME/NAOMI Association of Patients

SANSU - Surrey Area Network of Substance Users

Toronto Drug Users Union

VANDU - Vancouver Area Network of Drug Users

Those doing peer outreach work

Your work and advocacy are progressing evidence-based drug policy, supporting human rights, and saving lives.

Table of contents

Guidebook Introduction

What is it?

This is a guidebook for addressing and decreasing stigma in harm reduction work.

It is based on recommendations of research findings on stigma and discrimination towards people who use drugs in health care and harm reduction settings.

It includes the perspectives of researchers, health professionals and people who use drugs.

It addresses misperceptions and stigmatizing beliefs about harm reduction and people who use drugs, and includes a set of guidelines to facilitate anti-oppressive health service environments.

Why is it needed?

Stigma and discrimination towards people who use drugs is prevalent in society [1,2] and in health services. [3,4,5] Although useful instructions on upholding the principles of harm reduction in health care setting are available, [6] they do not address how the values of harm reduction are undermined by normalized societal stigma towards people who use drugs.

When people work in harm reduction within a society that normalizes stigma towards people who use drugs, they may hold beliefs and biases that oppose the values of their work, and negatively impact client outcomes. [3,4,5]

This book is meant to raise awareness of the ways that societal stigma impacts health and wellness outcomes for people who use drugs.
The guidelines confront stigmatizing beliefs, and promote actions to decrease stigma.

Who is it for?

This guide is for people who work in the field of substance use and addiction under a harm reduction mandate.

This includes a range of health professionals such as people working in hospitals, clinics, pharmacies, mental health services, needle exchanges, safe injection facilities, outreach workers, and more.

If your place of work subscribes to the values and practices of harm reduction, and you want the best outcome for your clients, these guidelines are to help examine and address the role of stigma in your work.

Vision

For substance use to be met with support and understanding in health care, social services and society at large.

Objectives

- Confront stigmatizing beliefs and discriminating actions directed at people who use drugs.
- Increase awareness and understanding of how stigma impacts health and wellness outcomes.
- Increase understanding of what harm reduction is, and whom it serves.
- Promote behaviours that decrease stigma, and support health and wellness outcomes.
- Empower service providers towards actions associated with improved job satisfaction.

Guidebook Layout

Each guideline will be presented with the following sections:

Key Issue: 	This part will highlight the purpose of the guideline.
Background information: 	This part will provide a rational for the guideline, and summarize the research it is based on.
Case examples: 	This part will provide short scenarios: ☒ One will exemplify a problem the guideline is addressing. ☑ One will exemplify use of the guideline. ? Each case includes a thought question or two. Most cases are based off real experiences, and use false names.
Take-away message: 	This part will suggest ways of applying the guideline to your work.

People who use drugs are deserving of services, their lives have value.

Key Issue:

A common negative perception of people who use drugs is that they are seen as responsible for their disposition, and therefore less deserving of help, or worse, deserving of punishment rather than help.

Stigma and discrimination in health care undermine the human right of equal access to health care, and contradict the ethical responsibility of health professionals.

Background information:

Studies on public perceptions show that stereotypes of people who use drugs include:

- They are unpredictable, dangerous and immoral.
- They are responsible for their disposition and deserving of punishment.
- Patients with drug use problems are often perceived as manipulative, aggressive, rude and poorly motivated to take responsibility for their health. [1,2,3,7,8]

Decades of media and political propaganda have promoted and legitimized stigma towards people who use drugs, [9,10] making it easy for bias, discriminatory treatment of this group to go unnoticed, or accepted in social and professional settings.

Endorsement of negative stereotypes leads to:

- less helping and more avoidant response from the general public
- feelings of frustration, resentment and powerlessness among health professionals
- **discrimination in health care services:**
  - → Health professionals show lower regard, and less motivation for working with patients with substance use disorders as indicated by shorter visits and less empathy when providing care for this demographic, as though care is rationed to those seen as less deserving.
  - → There's been evidence of reduced collaboration between health professionals and patients with substance use disorders. [1, 3]

All of the above can lead to feelings of disempowerment and heightened anxiety that negatively impact mental and physical health care outcomes among this demographic. Discrimination perpetuates unhealthy behaviours and discourages change towards healthy behaviours. [11,12]

Contrary to the stereotypes, people who use drugs contribute to society.

- Drug user groups, such as the Vancouver Area Network of Drug Users and the SALOME/NAOMI Association of Patients, participate in activism and advocacy, and have successfully fought for human rights.
- People who use drugs volunteer as peer outreach workers to support others, foster community building, and clean up discarded syringes.
- In areas known for high rates of street drugs and homelessness, people in the neighbourhood report a sense of strength and community. These healing social relationships are some peoples' reasons for engaging in harm reduction.
- Their resilience in surviving and overcoming horrific circumstances, such as societal marginalization, family dysfunction, abuse, neglect, traumatic injury and loss, is a testament to the human spirit . [13,14,15,16,17]

Case examples:

☒ Kate has been on pain medication for 14 years for injuries from a car accident. When she was trying to get into an opioid replacement program that required drug screen testing, her pain medication prescription was cancelled because other illicit drugs were found in her system. She was labeled with the negative characterization of people with addiction having hidden motives for seeking medication, and her history of relatively stable use of pain medication was disregarded.

She learned that because she is addicted to opioids, she will not have her health needs met without suspicion, reluctance or withholding of practical pain medication.

☑ When Kate's drug screen shows illicit drugs in her system, the doctor is concerned about potential for misuse of her prescription. The doctor has experience with clients with substance use disorders who have been known to exaggerate pain symptoms in order to get access to prescription drugs.

Rather than making assumptions about her intentions, he consults with her the same way he would with any other patient. After consulting with her about her use of this medication and how it supports her needs, he may decide that it is negatively impacting her addiction, and discuss alternative options for pain management, or he may give her a short trial prescription.

? What concerns do you have about the impact of stigma on client care?

How do you prevent negative thoughts about clients from impacting the quality of care you provide them?

Take-away message:

- The lives of people who use drugs have meaning and value.
- Whether negative stereotypes are true or not, human rights and ethical obligations of health care professionals endorse equal access to quality of health services.
- Stigma increases impatience with clients, and decreases empathy and overall quality of care.
- Because society has legitimized stigma towards people who use drugs, it is important to examine how this may impact your work with this group.

Reflective questions:

- How were you taught to perceive people who use drugs?
- How do you perceive people who use drugs today?
- When do you notice feelings of frustration, resentment, or avoidance towards clients?
- When have you felt more, or less, inclined to work with certain people or groups?
- How do you check in with your biases and ethical standards?

Successful harm reduction does not require healing addiction.

Key Issue:

This guideline is to emphasize that harm reduction may be meeting the needs of clients, and benefiting the community, even when it does not include reducing or stopping drug use.

Health professionals may feel frustrated in their work, themselves, or their clients, when it seems that little positive change is being made. This guideline is a reminder that while harm reduction services may not relieve the circumstance surrounding substance use, it's meant to provide people the best possible options for managing those circumstances. In some cases this means that providing options, again and again if need be, is successful work in itself.

Background information:

A problem identified in health care is an ideology of fixing people and their problems. [4]

This ideology can be at odds with the complex needs of people who use drugs, and it can create tension, distrust and stigma in health care settings . [17]

Patients report feeling like health professionals give up on them when their addiction, mental health and social needs are too complex to be efficiently met. [4]

Health professionals report feeling like they've failed people when their services cannot resolve the social and health needs of clients with substance use problems. [4]

When you want your clients to "get better", it can be disheartening when they don't seem to be making progress. However, people report using harm reduction strategies for a range of reasons other than reducing drug use or treating addiction.

Reasons for using harm reduction include:

- Decreasing negative impacts of drugs use on themselves and others
- Prevention or management of infectious disease
- Reducing risk behaviours such as using unsterile equipment and no supervision
- Substituting high risk drugs such as heroin with more manageable drugs like methadone or buprenorphine
- Social support from staff and peers
- Mental health and social service availability
- Community and comfort [18]

Case examples:

☒ Kai is a nurse in an emergency department where there is high pressure to "fix" people as efficiently as possible, and move on to the next person to prevent congestion. He takes pride in his ability to efficiently address the acute needs of those in his care. When Stu comes in needing care for abscesses associated with injection drug use, Kai knows what to do. He gives Stu antibiotics, treats his wounds, and briefly discusses strategies and resources for lower risk injection drug use.

When Stu comes back a second time for the same reason, the visit goes the same way. When Stu comes back a third time with overdose symptoms, Kai feels frustrated because Stu is not making choices that support his health. Kai feels that Stu is not taking responsibility for his health and is wasting his time. Kai is short with Stu, does not review the strategies they discussed during their last two visits and implies with his tone that he is fed up with Stu.

Kai feels frustrated and helpless that there is not much more he can do for Stu. Stu feels shame for disappointing a nurse who was kind to him, and he avoids treating his wounds the next time he needs care.

☑ When Stu comes in to treat his wounds associated with injection drug use, Kai's main focus is addressing Stu's immediate needs, and providing information to help Stu reduce risks associated with his drug use.

When Stu comes back a third time, Kai, rather than feeling disempowered in his ability to realistically help Stu, focuses on providing quality services and being a safe person for Stu.

Kai is not frustrated because he has not set unrealistic goals for himself or for Stu. He has given Stu some practical options for managing risks while using drugs.

Stu has had a positive interaction with a health professional who made him feel like a human being instead of a waste of time. He feels more trusting of health services and more likely to engage in harm reduction support that Kai continues to recommend.

? What feelings come up for you when working with clients who seem stuck in their patterns?

Have you ever felt that someone could not be helped? Is there another way of seeing the situation that allows for more hope?

Take-away message:

- The goal of reducing harm decreases stress and burnout for care providers. [4]
- Shifting the focus of your work from fixing, healing or resolving, to providing options and reducing harm, can relieve pressure on you and your clients. [35]
- Under a harm reduction philosophy, any service that includes support and options for reducing risk and/or enhancing quality of life can be considered successful.
- Practicing with a harm reduction mandate may increase trust, improve relationships and enhance job satisfaction. [17]
- See the table on page 14 for an overview of "Harm Reduction Principles for Healthcare Settings" as presented in the research of Hawk et al. 2017. [6]

Harm Reduction Principles for Healthcare Settings

Hawk et al. 2017 [6]

Principle	Definition	Approaches
Humanism	Clients are seen as human beings. Care providers seek to understand the human need driving their behaviours.	Acceptance of clients' choices. Approachable for clients' needs. Withholding judgments and grudges.
Pragmatism	Clients are held to realistic standards of health. Care providers account for the way that societal norms contribute to client health.	Abstinence or decreasing drug use should not be prioritized or assumed to be the ultimate goal. Decisions are based on level of harm to clients rather than moral or societal standards.
Individualism	Everyone has unique needs, strengths, and experiences. Interventions offered reflect client diversity and individuality.	Care providers offer flexible interventions appropriate to individuals' needs and experiences. Not relying on universal protocols.
Autonomy	Respect for individuals' rights to make their own choices.	Professionals offer options, education and suggestions while respecting client input and decisions.
Incrementalism	Appreciation of each small effort. Acknowledgement that change takes time and includes set-backs.	Highlight all positive client effort and strengths. Set realistic goals. Reassure that setbacks are a normal part of moving forward.
Accountability without termination	Holding people responsible for the consequences of their behaviour without shaming, punishing or trying to change their minds.	Help clients understand the impacts of their choices. Do not penalize choices you disapprove of.

Be critical of social contexts that oppose goals for positive change.

Key Issue:

This guideline encourages health professionals to redirect critical beliefs about their clients towards critical thought about the social oppressions that limit clients, and critical thought on their own professional role in that process.

"Harm reduction falls short of shifting the context from one of personal responsibility to social responsibility for reducing inequities" *(19 p.202)*

Background information:

There are times when it can be hard to withhold judgement of the choices clients make towards their recovery.

A common problematic belief is that people who use drugs have a choice and are making the wrong choice. Therefore they are seen as less deserving of help than those who don't have a choice in their ailments. [3]

In reality, inequalities and negative life experiences can limit options and decrease individuals' decision-making capacity. [4,16,18,19]

Circumstances that are obstacles to realistic positive change include:

- **Discrimination, stigma and marginalization**
- **Poverty**
- **Unstable or low quality housing options**
- **Physical and mental health challenges**
- **Severe trauma**
- **Lack of social engagement and support**
- **Lack of education opportunities**
- **Decreased employment opportunities**

3 Types of Stigma and Oppressive Outcomes

Corrigan & Wassel's research outlines different ways that social stigma can counter health and wellness goals of people who use drugs. [20]

Type of Stigma	Definition	Oppressive Outcome
Public stigma	Negative stereotypes and judgments from society	Social rejection Mistreatment & discrimination Limited access to housing, employment, social services, insurance and treatment
Self Stigma	Internalization of negative stereotypes and judgments from society	Low self-esteem Low self-efficacy Defeated outlook Decreased motivation Psychological distress
Label Stigma	Prejudice and discrimination associated with labels such as diagnoses or derogatory terms.	Incentive to avoid treatment or social situations that confirm or draw attention to a label Isolation Private suffering Diminished relationships

Case examples:

☒ Ann regularly visits a methadone clinic for safe injections that help manage her opioid addiction. She has been addicted to opioids for years, and suffers with poverty and mental health challenges. Sometimes she spends time with people who use street heroin despite her efforts to stop using street heroin.

When she visits her family doctor, her doctor feels pity for her. The doctor knows about her troubled past and sees how unlikely it is that Ann may make a full recovery from drug use. She knows that the methadone clinic is positive for Ann, but when she sees Ann suffering from her depression and addiction, she wonders how useful it is to extend her life with harm reduction when there is little hope for improvement.

Ann's doctor means well but is unintentionally taking part in systemic stigma that undervalues the lives of people with substance use disorders. Even if she does not voice her thoughts to Ann, she may otherwise indicate the hopelessness and pity she feels towards Ann's circumstances. The doctor's attitude is more likely to confirm than reduce the stigma that Ann lives with.

☑ Ann's doctor feels compassion for the struggles she has seen Ann endure over the years due to her depression and addiction. When she wonders why Ann bothers going to the methadone clinic, she asks Ann about it. Ann tells her that when she is able to commit to the clinic for periods of time, it makes her life easier because she can manage her addiction without having to hustle all day.

Ann's doctor sees the value in these temporary periods of positive change that Ann is able to achieve, and she acknowledges Ann's efforts. The doctor recognizes that Ann values herself enough to make small, if not life-changing, steps to reduce the problems in her life associated with her addiction. She commends the positive choices Ann makes, thereby conveying support rather than hopelessness.

? In what ways might someone in your role contribute to the systemic stigma experienced by people you work with?

When making care plans or setting goals, how do you acknowledge barriers a client may face?

Take-away message:

- People with substance use disorders received enough judgment, reproach and blame from themselves and society at large.
- If you feel critical of your clients, be critical of their surrounding social systems that may be obviously or subtly disempowering them from positive change.

- When promoting client autonomy and empowerment, it is important to:

  → realistically consider life circumstances and inequalities that limit client options

  → recognize clients' resilience and commend their participation in harm reduction despite the challenges they may be living with

- **CAUTION!**
  → Awareness of social context does not mean assuming that all people who use drugs are oppressed. For some, drug use it is a choice and a lifestyle they are accustomed to.
  → When practicing awareness of social systems, convey **respect, not pity**, for the way people navigate their circumstances.

Strengthen decision-making capacity, and avoid persuasion.

Key Issue:

This guideline offers client-centered directions for working through tensions that can arise when client goals differ from goals of health professionals.

Background information:

Studies show that when health professionals intentionally or unintentionally impose their goals, values, and beliefs on clients, it has a disempowering impact that undermines client goals, and limits collaboration and cooperation in health service settings. [4,21]

Actions that are persuasive, coercive or imposing on clients include:

- Assuming clients' ultimate goals involve decreasing or ceasing drug use
- Trying to convince clients they should decrease or cease drug use
- Implying people are less deserving of care because they create their own problems
- Conveying moral or value-driven judgement

When it appears that clients have differing goals than health professionals, it can bring up common stereotypes about people who use drugs that characterize them as uncooperative, poorly motivated and not taking responsibly for their health.

To decrease stigma and frustration towards clients, some health professionals actively acknowledge that unknown personal experiences, and symptoms of addiction, can limit:

- realistic options
- decision-making capacity
- self-worth
- self-trust

When health professionals disagree with clients' decisions, such as discontinuing antiviral medication, binging after detox, or missing an appointment, rather than labelling clients as noncompliant, reckless or poorly motivated, they can remain client-centred and focus on strengthening clients' capacity to make decisions about their health. [4,17]

Case examples:

Karen is a nurse in a primary care setting that follows a harm reduction philosophy of care. Karen values the services she provides, but at times runs into situations that challenge her harm reduction principles.

☒ When a pregnant woman came in asking for injection supplies, Karen found that her first instinct wanted to say "You know you shouldn't be using while pregnant!". But, she knew that withholding harm reduction supplies may put the baby at greater risk by exposing it to HIV, or motivating the mother towards drugs more harmful for the baby than heroin. Karen also knew that if she gave her the supplies reluctantly or with a comment about how she is harming her baby, the mother would feel judged and less likely to engage in further health services for herself or her baby.

☑ Karen decided that the best way to reduce harm in this case was to support the mother's harm reduction efforts and preserve her trust in health services. Karen knew from experience that respectful relationships with clients better support their health, self-worth, and chances of continuing to use services that promote positive changes in their behaviour.

? What's it like for you when you see clients repeatedly using services without making positive changes you'd like to see in their lives?

When you disapprove of a client's behaviour, how do you strive to keep your interactions empowering to them?

Take-away message:

Actions that support autonomy and strengthen decision-making capacity :

- Provide options
- Promote collaboration rather than cooperation
- Balancing encouragement with clients' right to say 'no'
- Acknowledge obstacles and help reduce them when possible
- Promote self-worth and self-esteem
- Consider all forms of harm reduction and symptom management to be worthwhile goals and productive work

Caution:

→ This guideline is not saying that you can't be sincere with your clients and let them know when you disagree with them. It's saying that your goal is not to convince them to do what you want, but to provide them with the best possible support in making their own informed decisions.

→ In cases when conditions are life-threatening, it's ok to tell clients that they must act or their lives could be at risk.

Support general life goals, as well as managing risk behaviours.

Key Issue:

People are more than their addiction. When the focus of health service is reducing risk behaviours without acknowledging general wellness, it can feel dismissive to clients, and it misses opportunities for supporting overall quality of life that surrounds the substance use issues.

Background information:

Participants of harm reduction programs report that when harm reduction goals focus only on proper disposal of needles and reducing transmission of disease, it feels as though the services are more for public interests then the needs of participants. [18]

Participants expressed having reasons for choosing harm reduction practices beyond the mainstream focus on public safety issues. [14,18]

Their reasons include:

- Maintaining social relationships
- Access to mental health and social services
- Pursuit of general life goals such as:
    - → Stable housing
    - → Steady income
    - → Development self-esteem and self-efficacy

People who use drugs outlined some activities that increased their self-esteem and self-efficacy:

- Reconnecting with family
- Receiving provincial social or disability support
- Finding employment
- Education or job skill opportunities
- Improving their appearance
- Community service opportunities
- Seeing the value of their lived experiences [14,18]

Case examples:

☑ Tim was referred to community nursing services for substance use, mental health and medical challenges. He was reluctant for services at first but his nurse, Chris, made multiple outreach visits to develop a relationship with him, and to collaborate on how they could meet his needs. Eventually, Tim became interested in making use of harm reduction services, and attended an addiction program meet and greet.

Because Chris took the time to get to know Tim, he knew that a major stressor in his life was unstable housing and risk of eviction due to disorderly house keeping and behaviour. Chris referred Tim to a life skills worker who was able to help Tim maintain his housing and prevent greater harm of being evicted and homeless.

☒ If Chris' main objective was to manage Tim's risk behaviours rather than seek to understand Tim's perspective of his needs, at worse, Tim may never have agreed to any services due to feeling coerced into something that does not serve his interests. At best, Tim may have agreed to engage in basic harm reduction strategies, but a major risk to his health and safety, eviction from his home, may have been missed.

? What client needs are important for you to know about in your work?

How do you seek opportunities to better understand what's important to a client besides your common harm reduction goals?

Take-away message:

- Sustaining harm reduction and health goals is challenging and unrealistic when basic needs like support from loved ones and secure housing are not met.
- When possible, provide service options that address housing, financial, social and basic needs of clients.
- When possible, show interest in clients' lives outside of their service needs. Ask them what's important to them.
- Create and sustain supportive environments that convey interest in serving the needs of clients, not just interest in upholding policy mandates.

Harm reduction is not supporting substance use, it supports people and communities.

Key Issue:

A common misperception that decreases public support for harm reduction is that it's condoning illicit drug use and that it will increase problems associated with drugs. [22]

Background information:

Studies show that harm reduction has not been found to:

- Increase drug use or relapse rates
- Increase drug trafficking and crime
- Increase the number of people who use drugs in surrounding communities
- Decrease motivation to engage in treatment or to reduce substance use [23,24,25]

In contrast, research shows that enforcement drug control models:

- Are not evaluated or based on evidence of effectiveness
- Do not decrease or deter drug use
- Increase violence and volatility in the illicit drug market
- Disproportionately target and punish certain demographics
- Conflict with human rights [26,27,28,29,30,31]

Benefits of harm reduction services:

Decreased disease rates (HIV, HCV, TB) [26,27,32-36]
A meta-analysis demonstrates that opioid agonist therapies and needle syringe programs reduce HIV transmission among people who use injection drugs by 50% . [33]

Decreased risks associated with drug use such as:

- Syringe sharing
- Syringe reuse
- Public injecting
- Discarded needles in public spaces [23,35,37,38]

Decreased overdoses and overdose mortalities

- Overdose deaths dropped 35% after the opening of a safe injection facility. [39]
- A meta-analysis shows no death by overdose has occurred inside of a safe injection facility. [23]

Decrease in drug-related crime

- Significantly lower rates of drug-related crime was found among people with substance use disorders who took part in harm reduction programs and training. [40]
- Opioid agonist treatments are effective at reducing participation in the illicit drug market. [36]

Increase in people seeking treatment

Among people who used a safe injection facility:

- 18% started a detox program [41]
- 57% started addiction treatment, and 23% stopped using injection drugs [42]

Improved quality of life for people with substance use disorders

Additional benefits for people who use harm reduction programs include increased opportunities for social connection and support, feelings of belonging, and improved attitudes toward their addiction, all of which contribute to better treatment outcomes and overall quality of life. [17,18,43]

Note: It is important to note that some harm reduction programs include drop-in centers, access to counselling and social services, and hot meals. These additional services resolve some basic needs of people with substance use disorders and likely contribute to the positive outcomes outlined above such as reductions in drug use and drug-related crime. [40]

Case examples:

☒ A good example of misperceptions and misrepresentations of harm reduction is shown in this news headline below regarding opioid agonist treatment.

When misinformed comments like these go unchallenged, it feeds negative propaganda about substance use that the media and government have historically supported. Stigma and misinformation about drug use decreases public support for evidence-based drug policy that people with substance use problems need.

☑ When you encounter comments such as these in your place of work, or elsewhere, you can support harm reduction and people who need it by correcting the misunderstanding. It can be as simple as pointing out that research supports harm reduction, or as involved as going through the benefits of harm reduction as compared to the harms of enforcement as outlined previously. Perhaps you have experiences from your work, or stories from your clients that provide more accurate information about what harm reduction really means.

? Can you think of common misperceptions about your clients or your work?

How would you like to address these misperceptions?

Take-away message:

- Harm reduction is the most effective strategy researched thus far for decreasing problems associated with drug use, both for people who use drugs, and the broader community.
- **Raising awareness works!** Research shows that awareness of the benefits of harm reduction increases public support for harm reduction. [44,45]
- **Health care professionals can be highly influential** in impacting public perceptions. [44] It is important that people in the field understand what harm reduction is, and correct misleading representations. People may find your experience more relatable than research that contradicts their worldviews.

Harm reduction is not a waste of tax dollars and health services.

Key Issue:

A common negative notion about harm reduction is that it's spending tax dollars and health service resources on helping criminals use drugs.

Background information:

It is not uncommon for health and social services to be understaffed, underfunded and at capacity.

In harm reduction and substance use work, the opioid crisis has required a heightened response from health services and substantial health care funding that may never seem like enough for those working on the front line.

Funding pressures, combined with efficiency pressures, contribute to the stigma and discrimination experienced by people who use drugs in service settings. [4]

Health providers have expressed concern about the financial burden of repeat visits for drug-related problems, a concern that may impact notions about some people being more or less deserving of time and care. [4]

However, cost benefit analyses of harm reduction programs have shown them to be highly cost effective.

Savings in health care

- HIV prevention strategies such as needle syringe programs, supervised injection facilities and opioid agonist treatments are less costly than HIV treatment.
- By preventing 5-6 HIV infections per year, Vancouver's supervised injection facility averts more than $1,000,000 in lifetime treatment services of HIV-related medical costs. [36,46]

Savings in social justice and enforcement

- Harm reduction services are less costly than enforcement and incarceration.
- Study estimates report that every $1 put into opioid agonist treatments may result in savings between $4-$7 on costs of drug-related crime, criminal justice services, and theft. [36,46]

Case examples:

☒ A group of health professionals are sharing a table in the cafeteria. Jen expresses her concern about dumping money into the opioid crisis when there are people dying of illnesses they did not choose to have. Karen mentions that harm reduction services are lifesaving and cost effective. Ron says that even though all the money and training going into naloxone kits is saving lives, he wonders if it's worth it when he sees the same people overdose multiple times. Mark says that the money being put into naloxone distribution should be put into insulin coverage for people with diabetes.

The case above highlights how daily experiences at work, such as seeing clients overdose or pass away, and seeing more negative than positive outcomes, can bring up concerns and tensions about how best to allocate time and resources.

Although, it's ok to have differing opinions and explore controversial views, it's problematic when bias views and moral judgments lead to discriminatory client care.

☑ A group of health professionals are sharing a table in the cafeteria. Mark comments on a post on social media stating that people addicted to heroin get free methadone while people with diabetes have to pay for their insulin. Some at the table express discomfort with the way this idea suggests that certain groups are more deserving of care than others. Karen comments on how misleading it is to compare different circumstances in this simplistic way, and expresses concern that this post may represent public understanding of harm reduction. Jen says the financial burden faced by some people with diabetes is unfair, but she refrains from comparing this to addictions issues.

The case above illustrates people sharing concerns about health care while being careful not to discriminate against any particular health needs or circumstances.

? How would you like to respond to situations like the one above?

Take-away message:

- The benefits of harm reduction in prevention of infectious disease treatment costs, and social justice costs, are not always obvious in the day-to-day work.

- As a health professional, you are in an influential position to:
  - → prevent the spread of misinformation that diminishes public support for your work and your clients
  - → share your knowledge of evidence-based health services

Support, trust and advocacy are valued and impactful.

Key Issue:

When health professionals feel uncertain that their work is effective, this guideline is a reminder that clients benefit from their genuine support and respect.

Background information:

Clients notice and appreciate supportive interactions void of stigma.

When describing stigma and discrimination in health service settings, people who use drugs were quick to defend health professionals by pointing out positive interactions that lacked stigma, or displayed warmth, support and understanding. [47]

Harm reduction participants described more positive interactions in health settings than they did when talking about stigma in other settings, such as among family, friends, and co-workers. [47]

Research on Supportive Interactions:

Perceived social support is associated with higher self-esteem, better sleep and lower depression and anxiety. Supportive uplifting interactions may combat the detrimental impact of internalized stigma and shame on mental health. [11]

Research on positive health service interactions identified common characteristics among health professionals such as:

- Positive views on treatment interventions and harm reduction practices
- Rejection of moral stereotypes about this patient demographic [3]

How people who use drugs describe positive and negative interactions:

Positive interactions that stood out to clients were described as meeting fundamental human needs such as safety, nutrition, hydration, medicine, hygiene, relationships, recreation, occupation, and emotional support.

"There were people with whom I could share ideas." [17 p.4]

Negative interactions that stood out were described as dehumanizing; verbal and non-verbal messages implying unworthiness of services, and feelings of being treated like "garbage" or "a piece of shit".

"Those who were street involved described wanting to be treated as a real person when they accessed health care" [4 p.200]

Case examples:

☒ When Tom approached a team of outreach health care providers in a neighborhood known for high drug use, he told them he had symptoms of pain and thought he should go to the hospital. The ambulance driver said sarcastically "Do you really want to go to the hospital?" implying that Tom was likely just attention seeking to obtain pain medication.

☑ A psychiatric nurse on the outreach team that Tom approached found a place to sit down with Tom, and ask more about his symptoms. She realized Tom was dehydrated and gave him a couple juice boxes. She asked Tom question about his health other than those related to his pain symptoms and drug use, such as whether he is getting enough sleep. Tom, having been to busy emergency rooms before, was not used to having health professionals give him much time once they treat his immediate needs. He appreciated that this nurse was willing to listen to his concerns and did not make negative assumptions about his intentions.

? In what ways, large or subtle, do you demonstrate to clients that they have worth to you?

Take-away message:

- Your clients remember and value your compassion, support and advocacy.
- Supportive interactions promote better mental health for your clients.
- Helping clients connect with and utilize social support in their lives can combat internalized stigma and shame that damages their health and well-being.
- Supportive interactions reject negative stereotypes of people who use drugs, and value harm reduction work.

Take care, debrief and seek support.

Key Issue:

Harm reduction and healthcare work with people who use drugs is known to be challenging on professionals for reasons including burnout, secondary trauma and discouragement. [4,48]

Background information:

A major part of health care professionals' work involves establishing and maintaining relationships of trust while caring for others. It is not uncommon for the emotional toll of empathic engagement to go unnoticed among care providers. [49,50]

Compassion fatigue is the emotional cost of providing care, compassion and empathy to people who have experienced trauma. [49]

When care providers experience compassion fatigue, their quality of client care and job satisfaction decrease. [49]

Compassion fatigue and feelings of burnout may result from:

- Pro-longed or frequent experiences of empathizing with clients or their families
- Desire to absorb or alleviate suffering of others
- Feelings that the demands of the job cannot be met [49]

Work environments impact job satisfaction and staff moral in the field of substance use and addiction .

- Organizational support, supervision, training and team collaboration opportunities contribute to significantly increased job satisfaction and willingness to work with people experiencing substance use problems.

- Supportive work environments and shared team values increased self-esteem, perceived knowledge and feelings of empowerment among care providers.

- Research suggests that when professionals feel well supported, well trained, and knowledgeable of resources that support themselves and their clients, their client care improves, as does their ability to empower clients. [3,4]

Case examples:

☒ When Meg began working as an addiction counsellor at a non-profit organization, she was immediately overwhelmed with her caseload, and was not yet familiar with local resources. The organization was goal-oriented and their funding relied on clearly documented goals and progress reports. Meg found it really challenging to set goals with some clients who were feeling hopeless about what they could do to improve their situation. She started to feel insecure in her role, and resentful towards the clients she was having trouble working with. She wrote in some of their progress notes that they were not ready to engage in counselling services.

☑ Meg knew that her stress was impacting the quality of her work and her perception of her clients. She also knew that the organization she worked for could not offer more training, and that their funding would decrease if she lessened her case load. Feeling helpless to improve her work situation, she focused on the quality of her personal life.

She scheduled herself relaxation time, and talked to trusted friends about her work stress. One friend encouraged her to talk to her supervisor. Meg was afraid to share her insecurities with her supervisor, but decided it was more professional to confront the issue than avoid it.

Meg's supervisor was able to support her by suggesting common starting goals for clients who are not sure what they need. Her supervisor's advice to focus more on her relationship with clients and less on the goals helped Meg feel more natural in her new role. The supportive interaction with her supervisor made her feel less alone in dealing with her job stressors.

? How can you tell when you're overwhelmed? Think of all the options you have to alleviate or manage these feelings.

Take-away message:

In harm reduction work, it is important that professionals:

- Seek out and utilize support resources at work and in their personal lives.
- Be kind to yourself and practice self-care that nourishes your body, mind and spirit.
- Check in with yourself regularly about any changes in your stress levels, well-being, relationships and ways of thinking and relating to people.
- Do not compensate for shortcomings of work environments, such as lack of support, training and staffing, by overworking yourself.
- Do not set unrealistic expectations for yourself or your clients.
- Know that positive regard and support is one of the best things you can provide your clients and coworkers.

References

1 Corrigan, P. W., Kuwabara, S. A., & O'Shaughnessy, J. (2009). The public stigma of mental illness and drug addiction: Findings from a stratified random sample. *Journal of Social Work*, *9*(2), 139–147. http://doi.org/ 10.1177/1468017308101818

2 Sattler, S., Escande, A., Racine, E., & Göritz, A. S. (2017). Public Stigma Toward People With Drug Addiction: A Factorial Survey. *Journal of Studies on Alcohol and Drugs*, *78*(3), 415–425. http://doi.org/ 10.15288/jsad.2017.78.415

3 Van Boekel, L. C., Brouwers, E. P. M., Van Weeghel, J., & Garretsen, H. F. L. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. *Drug and Alcohol Dependence, 131*, 23–35. doi:10.1016/j.drugalcdep. 2013.02.018

4 Pauly, B. (2008). Shifting moral values to enhance access to health care: Harm reduction as a context for ethical nursing practice. *International Journal of Drug Policy*, *19*(3), 195–204. http://doi.org/10.1016/ j.drugpo.2008.02.009

5 Anstice, S., Strike, C. J., & Brands, B. (2009). Supervised methadone consumption: Client issues and stigma. *Substance Use and Misuse*, *44*(6), 794–808. http://doi.org/10.1080/10826080802483936

6 Hawk, M., Coulter, R. W. S., Egan, J. E., Fisk, S., Friedman, M. R., Tula, M., & Kinsky, S. (2017). Harm reduction principles for healthcare settings, 1–9. http://doi.org/10.1186/s12954-017-0196-4

7 Crisp, A., Gelder, M., Rix, S., Meltzer, H., & Rowlands, O. (2000). Stigmatisation of people with mental illnesses. *British Journal of Psychiatry*, *177*, 4–7. http://doi.org/10.1192/bjp.177.1.4

8 Lee, R. D., & Rasinski, K. A. (2006). Five grams of coke: Racism, moralism and White public opinion on sanctions for first time possession. *International Journal of Drug Policy*, *17*(3), 183–191. http://doi.org/10.1016/j.drugpo.2006.02.001

9 Boyd, S. (2002). Media constructions of illegal drugs, users, and sellers: A closer look at Traffic.*International Journal of Drug Policy*, *13*(5), 397–407. http://doi.org/10.1016/S0955-3959(02)00079-8

10 Coomber, R. (2010). Reconceptualising drug markets and drug dealers — the need for change. *Drugs and Alcohol Today*, *10*(1), 10–13. http://doi.org/10.5042/daat.2010.0122

11 Birtel, M. D., Wood, L. & Kempa, N. J. (2017). Stigma and social support in substance abuse: Implications for mental health and well-being. *Psychiatry Research, 252*, 1-8. http://dx.doi.org/10.1016/j.psychres.2017.01.097

12 Pascoe, E. A., & Richman, L. S. (2009). Perceived Discrimination and Health: A Meta-Analytic Review. *Psychological Bulletin*, *135*(4), 531–554. http://doi.org/10.1037/a0016059

13 Boyd, S., Murray, D., & MacPherson, D. (2017). Erratum to: Telling our stories: heroin-assisted treatment and SNAP activism in the Downtown Eastside of Vancouver. *Harm Reduction Journal*, *14*(1), 36. http://doi.org/10.1186/s12954-017-0161-2

14 Bozinoff, N., Small, W., Long, C., DeBeck, K., & Fast, D. (2017). Still "at risk": An examination of how street-involved young people understand, experience, and engage with "harm reduction" in Vancouver's inner city. *International Journal of Drug Policy*, *45*, 33–39. http://doi.org/10.1016/j.drugpo.2017.05.006

15 http://www.vandu.org/

16 Mate, G. (2008). *In the realm of hungry ghosts.* Toronto, ON: Vintage Canada

17 Lago, R. R., Peter, E., & Bógus, C. M. (2017). Harm reduction and tensions in trust and distrust in a mental health service: A qualitative approach. *Substance Abuse Treatment, Prevention, and Policy*, *12*(1), 12. http://doi.org/10.1186/s13011-017-0098-1

18 Boucher, L. M., Marshall, Z., Martin, A., Larose-Hébert, K., Flynn, J. V., Lalonde, C., … Kendall, C. (2017). Expanding conceptualizations of harm reduction: results from a qualitative community-based participatory research study with people who inject drugs. *Harm Reduction Journal*, *14*(1), 18. http://doi.org/10.1186/s12954-017-0145-2

19 Pauly, B. (2008). Harm reduction through a social justice lens. *International Journal of Drug Policy*, *19*(1), 4–10. http://doi.org/10.1016/j.drugpo.2007.11.005

20 Corrigan, P. &Wassel, A. (2008). Understanding and influencing the stigma of mental illness. Journal of Psychosocial Nursing and Mental Health Services, 46, 42–48. doi:10.1007/s10597-007-9084-9

21 Curtis, J. & Harrison, L. (2001). Beneath the surface : collaboration in alcohol and other drug treatment . An analysis using Foucault ' s three modes of objectification. *Journal of advanced nursing, 34*(6), 737-744. http://doi/epdf/10.1046/j.1365-2648.2001.01803.x

22 Rapid Response Service (2012). *Rapid Response: Public Perception of Harm Reduction Interventions*. Toronto, ON: Ontario HIV Treatment Network; December 2012

23 Potier, C., Laprévote, V., Dubois-Arber, F., Cottencin, O., & Rolland, B. (2014). Supervised injection services: What has been demonstrated? A systematic literature review. *Drug and Alcohol Dependence*, *145*, 48–68. http://doi.org/10.1016/j.drugalcdep.2014.10.012

24 Wodak, A., & Cooney, A. (2005). Effectiveness of sterile needle and syringe programmes. *International Journal of Drug Policy*, *16*(SUPPL. 1). http://doi.org/10.1016/j.drugpo.2005.02.004

25 Kerr, T., Small, W., & Wood, E. (2005). The public health and social impacts of drug market enforcement: A review of the evidence. *International Journal of Drug Policy*, *16*(4), 210–220. http://doi.org/10.1016/j.drugpo.2005.04.005

26 Global Commission on Drug Policy (2016). *Advancing drug policy reform: A new approach to decriminalization.* Retrieved from http://www.globalcommissionondrugs.org/wp-content/uploads/2016/11/GCDP-Report-2016-ENGLISH.pdf

27 Csete, J., Kamarulzaman, A., Kazatchkine, M., Altice, F., Balicki, M., Buxton, J., … Beyrer, C. (2016). Public health and international drug policy. *The Lancet*, *387*(10026), 1427–1480. http://doi.org/10.1016/S0140-6736(16)00619-X

28 Singleton, N., & Rubin, J. (2014). What is good governance in the context of drug policy? *International Journal of Drug Policy*, *25*(5), 935–941. http://doi.org/10.1016/j.drugpo.2014.03.008

29 UN High Commissioner for Human Rights (2015). *Study on the impact of the world drug problem on the enjoyment of human rights.* Human Rights Council, 30th session. Retrieved from http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session30/Pages/ListReports.aspx

30 Office of the Correctional Investigator of Canada (2017). *Annual Report of the Office of the Correctional investigator 2016-2017*. Retrieved from http://www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20162017-eng.aspx#s5

31 Drug Policy Alliance (2018). The drug war, mass incarceration and race. Retrieved from http://www.drugpolicy.org/sites/default/files/drug-war-mass-incarceration-and-race_01_18_0.pdf

32 Aspinall, E. J., Nambiar, D., Goldberg, D. J., Hickman, M., Weir, A., Van Velzen, E., … Hutchinson, S. J. (2014). Are needle and syringe programmes associated with a reduction in hiv transmission among people who inject drugs: A systematic review and meta-analysis. *International Journal of Epidemiology*, *43*(1), 235–248. http://doi.org/10.1093/ije/dyt243

33 Fernandes, R. M., Cary, M., Duarte, G., Jesus, G., Alarcão, J., Torre, C., … Carneiro, A. V. (2017). Effectiveness of needle and syringe programs in people who inject drugs: An overview of systematic reviews. *BMC Public Health*, *17*(1), 309. http://doi.org/10.1186/s12889-017-4210-2

34 MacArthur, G. J., van Velzen, E., Palmateer, N., Kimber, J., Pharris, A., Hope, V., … Hutchinson, S. J. (2014). Interventions to prevent HIV and hepatitis C in people who inject drugs: A review of reviews to assess evidence of effectiveness. *International Journal of Drug Policy*, *25*(1), 34–52. http://doi.org/10.1016/j.drugpo.2013.07.001

35 Grenfell, P., Baptista Leite, R., Garfein, R., de Lussigny, S., Platt, L., & Rhodes, T. (2013). Tuberculosis, injecting drug use and integrated HIV-TB care: A review of the literature. *Drug and Alcohol Dependence*, *129*(3), 180–209. http://doi.org/10.1016/j.drugalcdep.2012.11.013

36 WHO, UN Office on Drugs and Crime & UN Joint Programme on HIV/AIDS (2004). *WHO/UNODC/UNAIDS position paper: Substitution maintenance therapy in the management of*

opioid dependence and HIV/AIDS prevention. Retrieved from http://www.who.int/substance_abuse/publications/en/PositionPaper_flyer_English.pdf

37 European Monitoring Centre for Drugs and Drug Addiction. (2016). *European Drug Report 2016: Trends and Developments*. *European Monitoring of Drugs and Drugs Addiction*. http://doi.org/10.2810/88175

38 Wood, E., Kerr, T., Small, W., Li, K., Marsh, D. C., Montaner, J. S. G., & Tyndall, M. W. (2004). Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users. *Cmaj*, *171*(7), 731–734. http://doi.org/10.1503/cmaj.1040774

39 Marshall, B. D., Milloy, M. J., Wood, E., Montaner, J. S., & Kerr, T. (2011). Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: A retrospective population-based study. *The Lancet*, *377*(9775), 1429–1437. http://doi.org/10.1016/S0140-6736(10)62353-7

40 Sadeghi, H., Habibi, Z., Haghrangbar, F., & Madanipour, K. (2013). The Effectiveness of Harm Reduction Programs on Reduce Crimes of Addicts Referred the Drop in Centers (DIC). *Procedia-Social and Behavioral Sciences*, *84*, 496–500. http://doi.org/10.1016/j.sbspro.2013.06.591

41 Wood, E., Tyndall, M.W., Zhang, R., Stoltz, J.-A., Lai, C., Montaner, J.S., Kerr, T., (2006). Attendance at supervised injecting facilities and use of detoxification services. The New England Journal of Medicine, 354(23), 2512-2514. doi: 10.1056/NEJMc052939

42 DeBeck,K.,Kerr,T.,Bird,L.,Zhang,R.,Marsh,D.,Tyndall,M.,...Wood,E.(2011).Injectiondruguse cessation and use of North America's first medically supervised safer injecting facility. *Drug and Alcohol Dependence*, *113*(2–3), 172–176. http://doi.org/10.1016/j.drugalcdep.2010.07.023

43 Habibi, Z., Sobhi-Gharamaleki, N., & Bermas, H. (2011). Effectiveness of harm reduction program on addicts' attitudes. *Procedia - Social and Behavioral Sciences, 30,* 1545-1548. http://doi.org/10.1016/ j.sbspro.2011.10.300

44 Blendon, R. J., & Young, J. T. (1998). The public and the war on illicit drugs. *Journal of the American Medical Association*, *279*(11), 827–832. http://doi.org/10.1001/jama.279.11.827

45 Strike, C., Rotondi, N. K., Watson, T. M., Kolla, G., & Bayoumi, A. M. (2016). Public opinions about supervised smoking facilities for crack cocaine and other stimulants. *Substance Abuse Treatment, Prevention, and Policy*, *11*(1), 8. http://doi.org/10.1186/s13011-016-0052-7

46 Pinkerton, S. D. (2011). How many HIV infections are prevented by Vancouver Canada's supervised injection facility? *International Journal of Drug Policy*, *22*(3), 179–183. http://doi.org/10.1016/j.drugpo. 2011.03.003

47 Earnshaw, V., Smith, L., & Copenhaver, M. (2013). Drug Addiction Stigma in the Context of Methadone Maintenance Therapy: An Investigation into Understudied Sources of Stigma. *International Journal of Mental Health and Addiction*, *11*(1), 110–122. http://doi.org/10.1007/s11469-012-9402-5

48 Shepard, B. C. (2013). Between harm reduction, loss and wellness: on the occupational hazards of work. *Harm Reduction Journal*, *10*(1), 5. http://doi.org/10.1186/1477-7517-10-5

49 Sorenson, C., Bolick, B., Wright, K., & Hamilton, R. (2017). An Evolutionary Concept Analysis of Compassion Fatigue Data Sources and Sample for Data, (c), 557–563. http://doi.org/10.1111/jnu.12312

50 Dattilio, F. M. (2015). The Self-Care of Psychologists and Mental Health Professionals : A Review and Practitioner Guide, *50*(April), 393–399. http://doi.org/10.1111/ap.12157