CANADIAN ABORIGINAL AIDS NETWORK

HARM REDUCTION IMPLEMENTATION GUIDE

used in complement to:

Walk With Me - Pathways To Heath
Harm Reduction Service Delivery Model

CAAN

The Canadian Aboriginal AIDS Network (CAAN) was established in 1997. CAAN is a national, not-for-profit organization that represents more than 340 member organizations from all regions of Canada – coast to coast to coast. Every year CAAN holds an Annual General Meeting and national forum for Aboriginal People Living with HIV/AIDS and member organizations to express their needs and concerns. Part of CAAN's mandate is to provide relevant, accurate and up-to-date information on issues facing Aboriginal people living with and affected by HIV/AIDS in Canada. CAAN is governed by a thirteen member national Board of Directors and operated by a four member executive committee.

CAAN Mission Statement

As a key national voice of a collection of individuals, organizations and provincial/territorial associations, CAAN provides leadership, support and advocacy for Aboriginal people living with and affected by HIV/AIDS. CAAN faces the challenges created by HIV/AIDS in a spirit of wholeness and healing that promotes empowerment, inclusion and honours the cultural traditions, uniqueness and diversity of First Nations, Inuit and Métis people regardless of where they reside.

CAAN Vision Statement

A Canada where First Nations, Inuit and Métis people, families and communities achieve and maintain strong, healthy and fulfilling lives free of HIV/AIDS and related issues where Aboriginal cultures, traditions, values and Indigenous knowledge are vibrant, alive, respected, valued and integrated into day-to-day life.

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1 INTRODUCTION

2 WILL HARM REDUCTION WORK IN MY COMMUNITY?

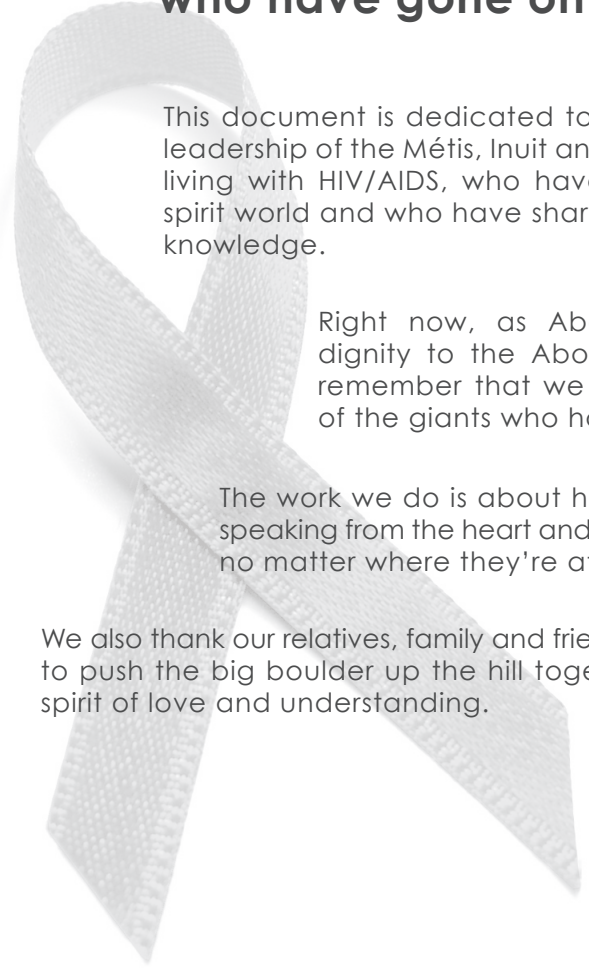
3 WORKING WITH DIFFERENT AUDIENCES

02 INTRODUCTION

05 WILL HARM REDUCTION WORK IN MY COMMUNITY?

21 WORKING WITH DIFFERENT AUDIENCES

Dedication to our brothers and sisters who have gone on to the spirit world



This document is dedicated to the hard work and leadership of the Métis, Inuit and First Nations people living with HIV/AIDS, who have passed on to the spirit world and who have shared their experiential knowledge.

Right now, as Aboriginal people respond with dignity to the Aboriginal HIV/AIDS epidemic, we remember that we are standing on the shoulders of the giants who have come before us.

The work we do is about helping our communities, speaking from the heart and walking with our relatives no matter where they're at.

We also thank our relatives, family and friends helping to push the big boulder up the hill together in the spirit of love and understanding.

1 INTRODUCTION

The harm to Aboriginal individuals, families and communities resulting from substance use is immense – reaching across and through families, communities and generations. There are many ways harm from drug use is experienced including the break-down of relationships and families, violence, loss of financial security, disease, and death; these harms are significant. Hepatitis C and HIV infection through injection drug use is happening very rapidly in Canadian Aboriginal communities – most call it a health crisis, some people even called it an epidemic. Our communities need to be able to respond to these issues in meaningful, culturally appropriate and community specific ways. Most Aboriginal people can agree that it is honourable and practical to work towards reducing the harms associated with substance use for both individuals and communities.

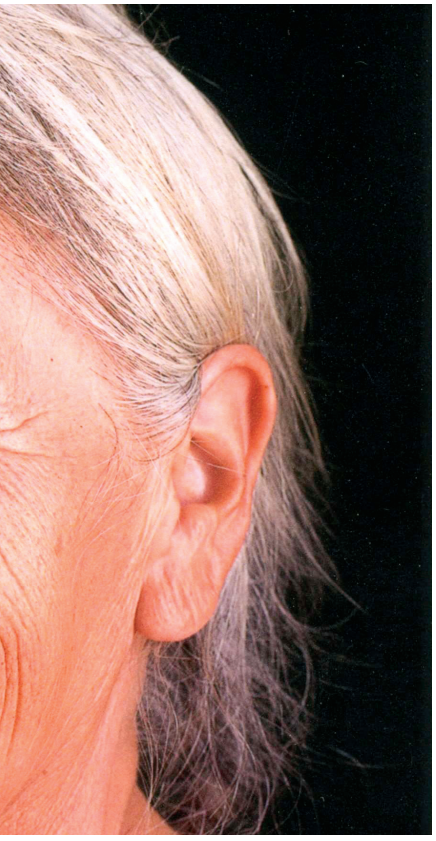
This Implementation Guide hopes to compliment and enhance the *Walk With Me – Pathways to Health Service Delivery Model* (Canadian Aboriginal AIDS Network, 2007). It is not within the scope of this resource to discuss and describe everything there is to know about the vast landscape of Aboriginal harm reduction. There are many pathways to health and each person is free to choose the path for themselves. As service providers and/or supporters of our relatives, it is our job to walk with our relatives; to actively listen in a non-threatening and non-judgmental way to get to know where they are at right now on their path. This is about 'doing' harm reduction and how to move your group or community towards the goal of harm reduction across all services. It's a big job but the point of this implementation guide is to get ALL Aboriginal people thinking and talking about harm reduction and how they might be able to apply it in their setting (community, workplace, school, home, etc.). To do this, it is important to establish trust.

Trust is developed by spending time together and establishing a relationship. In order for people to reach out and ask for help, we have to instill trust. Creating safe spaces where relationships can be fostered between those who provide services and those who are seeking or requiring services is very important. In many cases for Aboriginal people most at risk, culturally safe services are often the only point of contact these individuals might have with the health care system and other support services.

There are many opinions about how Métis, Inuit and First Nations communities should move forward in responding to this issue. But it is important to remember that the patterns and modes – the drug(s) of choice and preferred manner of consumption – of substance use differ from region to region and from community to community. Yet, some communities have celebrated successes in their interventions and responses – we can learn from their experience and help get communities ready to adapt it to fit their own realities. We must share our experiences and lessons with each other because there are still many communities struggling with how to meaningfully address substance use. Each community requires it's own culturally appropriate response to its home-grown issues. We hope that this guide will provide you with new tools to assist in normalizing harm reduction approaches in your community as one means of acknowledging and working to reduce the incidence of HIV/AIDS and Hepatitis C.

1.1

Why an Implementation Guide?



It is possible that harm reduction provides a place – an approach, a philosophy – where we can come together and create a strategic response. In order to put harm reduction into action in any community environment, it is essential that one on one and group discussions on the issues take place. This preparation for and planning of actions for change can happen step by step according to where a community is at with the issue and the possible responses.

How ready is your community or agency to implement harm reduction? The reality is that 67% of the new Aboriginal HIV infections are attributed to injection drug use. HCV rates of infection in Aboriginal people through injection drug use are even higher. This Implementation Guide will focus on injection drug use but also on other harm reduction programming. This Implementation Guide is about presenting options for delivering services to Aboriginal people who are at risk of harm due to their substance use and other social behaviours.

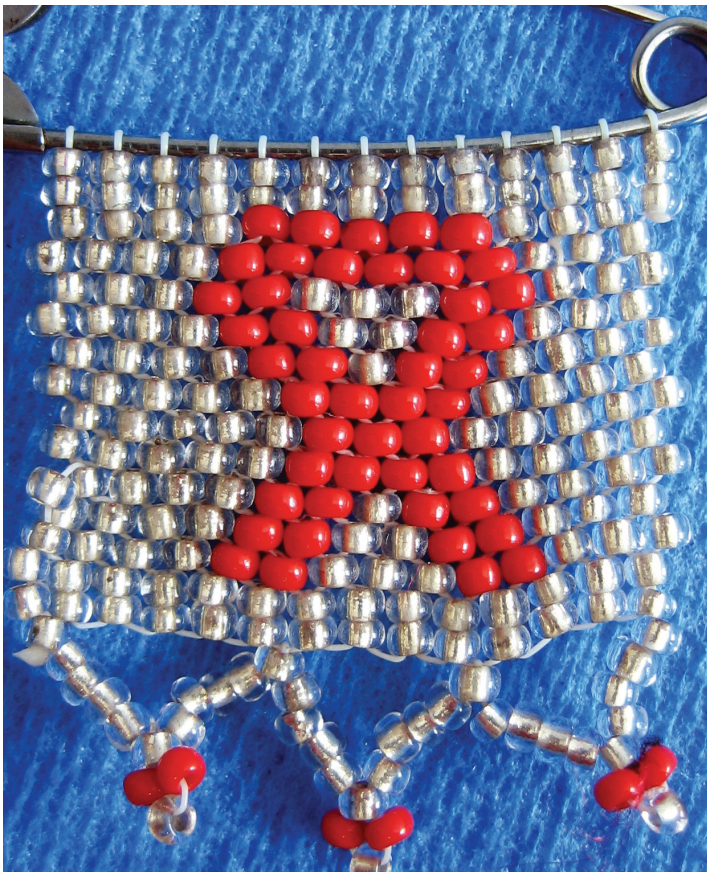
Many of the Aboriginal individuals most at risk for harm, like contracting HIV and/or HCV, as a result of their drug use usually have little or no contact with the health care system. Grounded in principles of non-judgment, harm reduction approaches are proven to engage Aboriginal people who use injection drugs and other drugs with prevention programming, care, treatment and support. Harm reduction is one way to respond to the gaps in services for Aboriginal people who use substances. The Walk With Me model is grounded in seven Aboriginal values: wisdom, respect, humility, honesty, bravery, love, and truth. We hope this complimentary resource to Walk With Me demonstrates how harm reduction principles blend well or match with our cultural values, and therefore can facilitate culturally appropriate, community-based responses to complex substance use circumstances.

1.2

Making of This Resource

During the course of this Harm Reduction project, training sessions were delivered across Canada on the Walk With Me model. Aboriginal participants who attended the training were from a wide range of health and social service providers and service users. They were at all levels of understanding of harm reduction – from no knowledge at all to highly trained professionals working exclusively in HIV/AIDS. It was a challenge to come up with a concept flexible enough to be developed into an implementation guide for such a wide and diverse spectrum of Aboriginal audiences, who are from communities at different stages of development and with different assets.

The intention of this resource is to highlight ways you can decide how best to introduce harm reduction approaches in your community. During Walk with Me workshop presentations, participants presented diverse community scenarios that illustrated how each community is in a different 'place' with respect to how they feel about harm reduction. Sometimes a little public awareness will make all the difference, but in other circumstances, there is a lot of resistance to change and lots of support for abstinence-only programming. How then can one model work in each situation? Well, it won't – unless it is adapted appropriately and the right strategies are used for the situation based on how 'ready' the community is. This resource outlines why harm reduction is important to communities, how to work to address the issue of harm reduction in your community, and present community readiness models as a tool in your journey towards delivering comprehensive (or simple) harm reduction services in your community.



Although, various community readiness initiatives exist, the most extensively developed (and tested in Aboriginal communities) is the Community Readiness Model produced by the Tri-Ethnic Center for Prevention Research housed at Colorado State University:

The Community Readiness Model is an innovative method for assessing the level of readiness of a community to develop and implement prevention programming. It can be used as both a research tool to assess distribution of levels of readiness across a group of communities or as a tool to guide prevention efforts at the individual community level.

www.triethniccenter.colostate.edu/communityreadiness.html

We know there are Aboriginal communities where harm reduction has influenced policy change and the implementation of harm reduction strategies – even needle exchange programs. However, simply duplicating a successful program from one Aboriginal community in another often does not work. Like individuals, communities need to want to change and be ready to take the necessary steps to do so. In other words, communities need to be ready to implement change on any given issue – just because one community was ready, it does not mean the one next door is.

There are a number of Aboriginal communities and agencies in Canada who are currently approaching harm reduction from a community readiness perspective. Assessing a community's stage of readiness is key in preparing and planning to implement a strategic response to a given issue. As resistance to and unfamiliarity with harm reduction is often a major barrier to its implementation, gauging community readiness is a wise and necessary process.

2

WILL HARM REDUCTION WORK IN OUR COMMUNITY?

The idea or discussions of Aboriginal harm reduction can create community conflict if poorly introduced and facilitated; it can be a hot topic. Drug use is difficult to talk about for lots of reasons, including the fact that many people are hurting from the devastating effects – in both families and communities. It is impossible to say whether harm reduction will work in your community; however, throughout this resource we hope to remind you about how you can look at the cultural strengths, resources, and leadership you have in your community in a way that you can build on. This is the way to determine what is right for your community and to develop a model of harm reduction for your local issues.

Methadone is an oral opiate-based drug used for pain relief and to treat opiate (e.g., heroin) addiction; methadone maintenance therapy prevents opiate withdrawal symptoms by administering small doses of methadone on a regular (e.g., daily) basis.

It is important to realize that broad-based harm reduction strategies are already working in ALL of our communities. Designated driver programs, condom distribution, addictions and harm prevention outreach and education activities and even AA programs, while encouraging sobriety, do not insist on abstinence in order to be involved – while often people attend these meetings to 'get sober', sobriety is not a required to attend meetings or participate in general. Yet some Aboriginal communities and agencies have acknowledged that initiatives like needle exchange programs (NEP) may never be implemented in some of our Aboriginal communities. So what is the alternative?

An inclusive approach is needed for addressing the harms resulting from problematic substance use. *The Walk With Me model* is designed to accommodate cultural diversity Harm reduction is a way of working with our people in a safe, non-judgmental and culturally appropriate way and will only work if it supported by the community. Decisions we make now affect our future generations, who can be the ones who will benefit from successful initiatives aimed at reducing harm in Aboriginal communities. While remembering and honouring our Aboriginal values, we can strategically create positive change in our world.

Our communities can address gaps in services for the most at-risk people in our communities and reduce the harms associated with problematic substance use including the transmission of HIV and HCV. Harm reduction approaches can provide services that address the needs of people who otherwise may not have contact with health services – for example, homeless and street-involved people, our people who feel stigmatized by their life circumstances. Whether a community wants a formal Needle Exchange Program or not, workers can get educated about where to get clean needles (pharmacies); how to discard of them safely (sharps containers); how to educate community for what to do if used needles are found. Without harm reduction initiatives as a choice these individuals would be left with few services to provide for their needs. In many cases, harm reduction outreach is the only point of contact with the health system for at-risk sectors of the Aboriginal population.

2.1

What is Harm Reduction?

Harm reduction is a philosophical approach to addressing the complex issues presented by and motivating substance use. Harm reduction is really about substance use – even legitimately prescribed medications – and reducing the harms associated with it, for everyone, regardless of whether their use is 'chaotic', recreational, experimental, regular, or once a year. There is no one drug using 'group' who benefits from harm reduction; we all can as individuals and communities. In particular, harm reduction is demonstrated to be one of the most useful means of addressing harmful drug use for those who have become entrenched in a using lifestyle.

The focus of harm reduction is not on the drugs. Instead, it focuses on the potential harms of different drugs, ingestion methods, side effects, and so on, and attempts to counter the harms with prevention interventions. Sometimes it's as simple as providing clean water. Sometimes part of reducing harm includes discussing alternative means of using, for example, smoking instead of injecting, or ingesting orally instead of snorting. Sometimes a person who injects drugs needs to be taught to rotate injection sites so infections do not occur so readily. Sometimes it could involve suggesting someone drink home brew instead of mouthwash (or other alternative products containing alcohol) to reduce liver damage. Harm reduction happens when the client is interested in talking about it – high, sober, drunk, needing a fix, experimenting, relapsing, withdrawing, or when they are 'dope sick'. Focussing on the harm is a tool in addressing individuals' substance use; the point where they identify their use as being problematic in their opinion is where the conversation can start.

Most often harm reduction programs focus on teaching people how to be safe when they use drugs or have sex. Stopping the behaviour is not necessarily the focus, but some people have used harm reduction programs as a first step towards considering whether their behaviour is something they want to change.

Abstinence also reduces harm and works for some people. Abstinence programs focus on completely stopping behaviours that could put people at risk of harm (e.g., drinking, drugging, sex work, etc.) These programs encourage people to stop certain behaviours altogether. Stopping completely is often an underlying principle of abstinence programs. However, we know that not everyone is in a place where they can stop completely, so we need other ways of responding which respect an individual's right to choice AND the right to appropriate social and medical services.

The Ontario Aboriginal HIV/AIDS Strategy defines harm reduction in relation to drug use this way:

There are no moral, legal or medical judgments made about drug use. There are no moral judgments made about the people who inject drugs because drug use is not seen as immoral or irresponsible. The dignity and value of all human beings is respected. The concern is the potential harm from injection drug use.

The focus is the problem of reducing the potential for HIV [and HCV] infection among people who inject drugs. The Harm Reduction approach provides options in a non-judgmental and non-coercive way. The focus is not on abstinence. Harm reduction accepts that people who inject drugs may continue to use drugs.

Abstinence can be part of the program for people who inject drugs who want to quit using drugs, but it is not the goal: reducing harm from drug use IS the goal.

Harm reduction recognizes that people who inject drugs are competent to make choices and change their behaviours.

2.2

Harm Reduction Guiding Principles

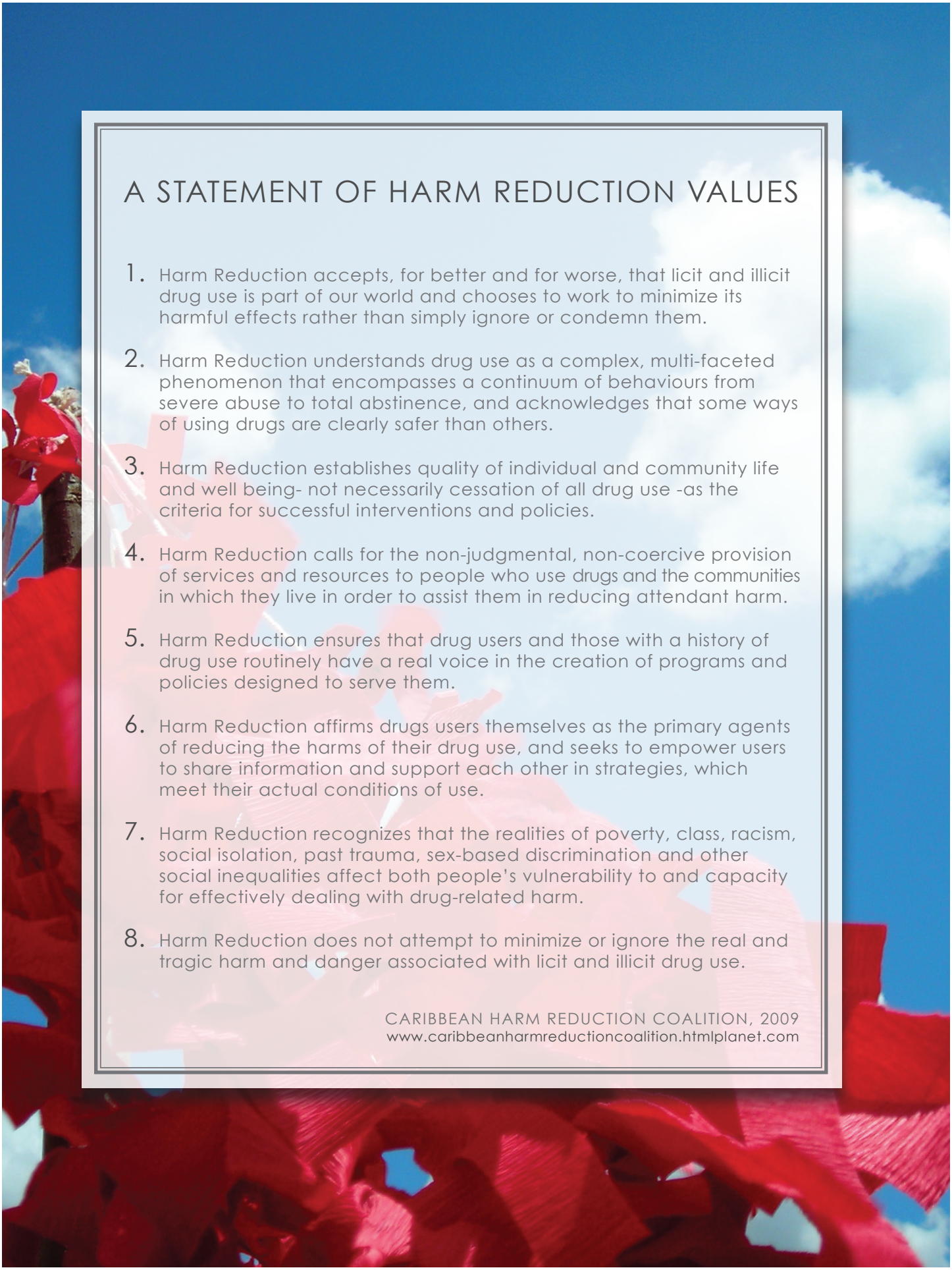
Harm reduction is grounded in non-judgment and pragmatism – it is about starting with people 'where they're at' – working with them to take care of themselves and those around them while they are using. In many cases it is difficult to understand how someone can persist in using something that is clearly harmful to their well being – where they are wasting away and doing all kinds of things they never thought they would in search of and because of the next fix. Harm reduction is about community health and the health of individuals. Non-judgmental approaches are proven to be key in developing relationships between service providers and at-risk populations who otherwise would be unlikely to be in contact with health professionals.

Regardless of what harm reduction intervention is talked about or whether any behaviour change occurs, there is value in creating opportunities for people who are engaged in harmful behaviours to speak to service providers and medical professionals about how to keep safe. Respectful conversations are effective; people who are substance using and exploring how they feel about themselves and their decisions about their using need to have people to talk to. If people feel pushed or coerced toward a particular change, it is less likely that the effort will succeed. Allow individuals autonomy in their decision-making and recognize that they are the only ones who can decide to change; this is empowerment. It's all about choice; the choice belongs to the individual. It is essential that a person be ready for any particular intervention in order for it to succeed.

When people live marginalized, 'secret', and dangerous substance using lives, there are few people they can trust. Meeting a service provider who is interested in building a relationship can be the difference between thinking about change or staying entrenched in their current behaviour. Non-judgment is the foundation to building and achieving these relationships; listening is key to appreciating the complexity of the lived experience. Through non-judgmental and respectful exchanges, there is room to develop new, 'less pressure than cold turkey' options for intervention.

It is of paramount importance that service providers recognize how life experience can influence substance use behaviours. Only in doing so may we be able to find a space where people who are severely entrenched in using can begin to imagine a different life. People who succeed in addressing harmful substance use usually develop a relationship with a service provider who is invested in their wellbeing. Having someone else care about your wellbeing when you do not (or cannot) is powerful and hopeful – everyone needs that – unfortunately, many people do not have any positive relationships with service providers. Indeed, a service provider's attitude can make all the difference in engaging an Aboriginal person who uses drugs. Trust is built by meeting face-to-face and getting to know each other. Harm reduction is getting to know the people who you are intending to serve. Sometimes an individual who is caught up in substance use just needs someone to talk with them for a while. This can help to build trust and familiarity with what services might be available to support them in moving towards less harmful substance use.

All human beings have a right to receive services even if they are high. As Aboriginal communities, families and service providers, we have a responsibility to provide services no matter where a person is on their path in life. Our relatives who are injecting drugs are most at risk for harm, especially if they are sharing contaminated or dirty drug equipment such as syringes, pipes and other paraphernalia. For example, many people know that using a dirty syringe is high risk for HIV and HCV but do people who smoke drugs from a hot glass or metal pipe know that HCV can be transmitted this way? We are obligated to respond; people who use drugs have a right to prevention messaging, care, treatment, and support services as much as anyone else. This is harm reduction.



A STATEMENT OF HARM REDUCTION VALUES

1. Harm Reduction accepts, for better and for worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.

2. Harm Reduction understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviours from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.

3. Harm Reduction establishes quality of individual and community life and well being- not necessarily cessation of all drug use -as the criteria for successful interventions and policies.

4. Harm Reduction calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.

5. Harm Reduction ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.

6. Harm Reduction affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies, which meet their actual conditions of use.

7. Harm Reduction recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.

8. Harm Reduction does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

CARIBBEAN HARM REDUCTION COALITION, 2009
www.caribbeanharmreductioncoalition.htmlplanet.com

Continuum of Drug Use

It is important that when we talk about people who use drugs that we always remember that they are people first. The terms 'Aboriginal addict', user, drug user, junky, drunk, drug abuser, and so forth are stereotypes that serve to further stigmatize substance use and the people who are using and addicted to substances. Though the terms drug abuse and drug abuser are still widely used, even by some service providers who provide harm reduction services, it is less judgemental to simply say "people who use drugs" or "people who inject drugs."

A drug is defined as:
Any substance, other than food, which is taken to change the way the body and/or mind function. Mood altering drugs (psychoactive drugs) are drugs that can change or affect the way a person thinks, feels or acts. The effects of a drug are influenced by how it is taken and by factors such as the age and gender of the person who uses the drugs.
(for more information please see Health Canada's Straight Facts About Drugs & Drug Abuse, 2000)

The continuum of drug use ranges from no use to dependence. Harmful drug use relates to a person experiencing negative consequences of drug use, for example, health problems, problems with family, problems with school, work problems, legal problems, and so forth. Drug dependence occurs when a drug is used excessively and the use continues despite the person experiencing serious problems. A person may be both physically and psychologically dependent on a drug or drugs.

Drug Use Continuum (Health and Welfare Canada and Addiction Research Foundation, 1991)

Non-use	Never used a particular drug.
Experimental use	Has tried a substance once or several times. Use is motivated by curiosity about the drug effect, and peer influence.
Occasional use	Use is infrequent and irregular, usually confined to special occasions (holidays, birthdays, etc.) or when opportunities present themselves directly. Availability, accessibility and affordability influence use.
Regular use	Use has a predictable pattern, which may entail frequent or infrequent use. The user actively seeks to experience the drug effect, or to participate in the drug taking activities of the peer group. Usually he or she feels in control of the drug use (e.g., he or she can take it or leave it).
Dependence use	Use is regular and predictable and usually frequent. The user experiences a physiological and/or psychological need for the drug. He or she feels out of control vis-à-vis its use, and will continue to use despite adverse consequences. Drugs are often used alone and daily activities may be planned around drug use.

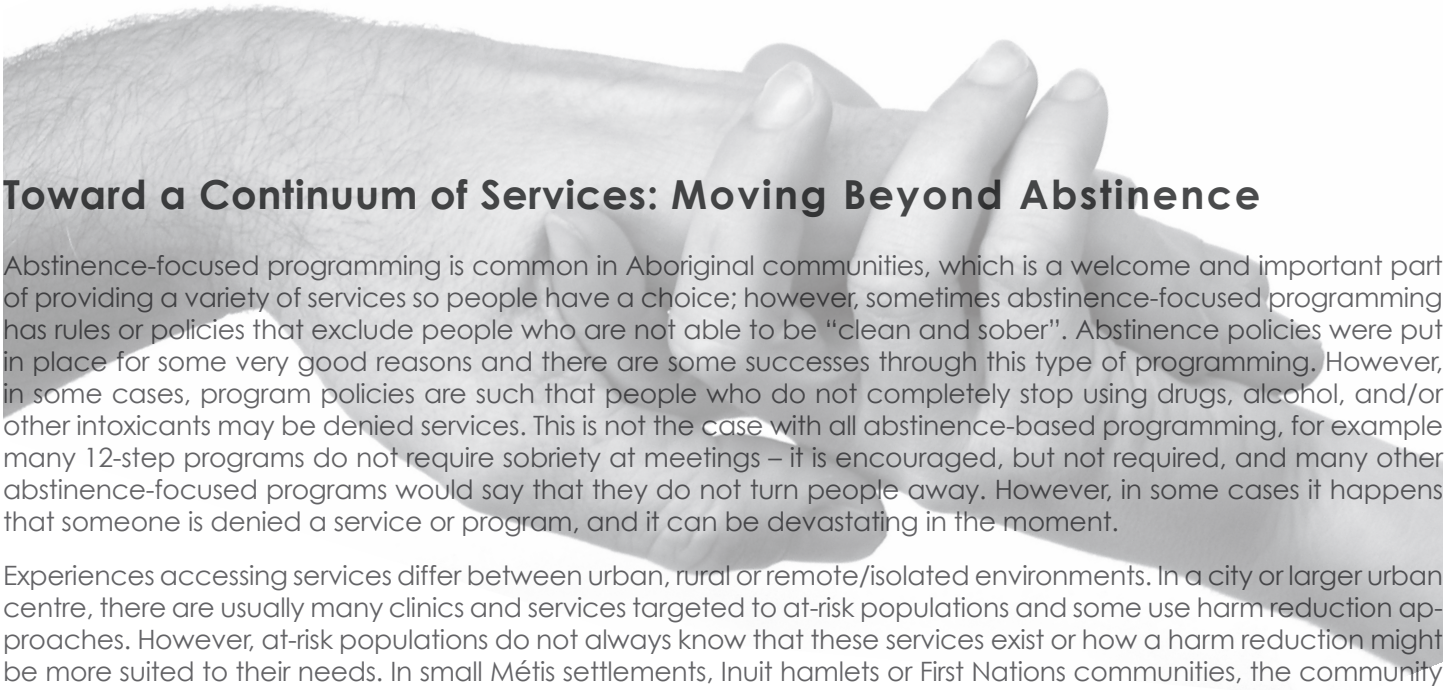
There are specific safety and health hazards caused by individual psychoactive drugs, especially a strong desire or craving to use. Cravings or the desire to use a drug may be triggered by internal cues (for example, restlessness, 'jones', physical pain, emotions, or personal crisis) or external cues (such as seeing injection equipment, seeing other people using, seeing pictures of paraphernalia in a presentation and so on). Further, illegal drug use has another set of risks as drug dealers may not know (or reveal) exactly what they are selling. As a result, many bad drug reactions including fatal over doses have occurred because people were under the impression that they were getting one thing, but then really, it was something else or the potency of the substance turned out to be far stronger than they are accustomed to. Not knowing what is being sold (for sure) is dangerous for all people who use drugs, but this can be particularly dangerous for people who combine drugs to enhance the effect or to counteract undesirable side effects of another drug – in these cases, the hazards are often compounded. A mixture of cocaine and heroin is an example of drugs that are often used together with harmful effects; also, it is common for people to mix other legal drugs either with alcohol or each other (e.g. Gravol and Tylenol 1s – both available over-the-counter). Combining substances can have catastrophic effects. Many substance users know this; yet, they often cannot imagine ever stopping completely. This is why it is so important to provide a continuum of service around substance use prevention, care, treatment, and support.

A facility sign could say,

> "If you become disruptive or threatening, then you will be asked to leave",

instead of,

> "if you are under the influence you will be asked to leave."



Toward a Continuum of Services: Moving Beyond Abstinence

Abstinence-focused programming is common in Aboriginal communities, which is a welcome and important part of providing a variety of services so people have a choice; however, sometimes abstinence-focused programming has rules or policies that exclude people who are not able to be "clean and sober". Abstinence policies were put in place for some very good reasons and there are some successes through this type of programming. However, in some cases, program policies are such that people who do not completely stop using drugs, alcohol, and/or other intoxicants may be denied services. This is not the case with all abstinence-based programming, for example many 12-step programs do not require sobriety at meetings – it is encouraged, but not required, and many other abstinence-focused programs would say that they do not turn people away. However, in some cases it happens that someone is denied a service or program, and it can be devastating in the moment.

Experiences accessing services differ between urban, rural or remote/isolated environments. In a city or larger urban centre, there are usually many clinics and services targeted to at-risk populations and some use harm reduction approaches. However, at-risk populations do not always know that these services exist or how a harm reduction might be more suited to their needs. In small Métis settlements, Inuit hamlets or First Nations communities, the community health centre may be the only place where Aboriginal people can get services. If there is a requirement for people to be sober in order to receive services at their community health centre, where are they going to go if they are always under the influence of a substance?

Sobriety is extremely difficult, impossible, or undesirable for some people, and abstinence-centred policies become a barrier to accessing programming for people who cannot or will not stop using their substance of choice. People are at various stages within the continuum of substance use, and they are always moving back and forth within it or around it – rarely is it a straight-line process. Individuals have a right to receive services at all stages within this continuum, at all points along their journey. As there is a continuum of substance use, there also should be a continuum of services to address substance use. 'Backsliding' or relapsing into patterns of substance use is not seen as a failure but as a learning experience. Abstinence falls under the umbrella of and is captured within the continuum of the harm reduction approach; however, the goal of harm reduction is not abstinence unless the individual decides that is their goal.

People seeking recovery or to reduce the harm they experience from substance use need a continuum of programs and services to choose from – there is no one solution or order of treatment that will work for everyone. Harm reduction approaches can also provide a safe space for people who are experimenting but are embarrassed, ashamed, or scared to speak to their regular care provider about their substance use or the newly diagnosed HIV+ or HCV+ person who need some sensitive guidance about how to change substance using to be less harmful for themselves, their partner, and so forth.

Without harm reduction guiding some initiatives, the most marginalized people in our communities would often not get the services they require and would likely only access emergency room services when health issues become severe or life threatening. In many cases, harm reduction outreach services are the only contact our most marginalized community members will have with the health system.

We know there is more than one path away from harmful substance use. And we know that one program rarely meets everyone's needs as the causes and complexities of substance use are diverse. Harm reduction may not be for everyone, abstinence may not be for everyone, and some people may use some of each at various times in their journey. Harm reduction provides the flexibility to adapt to diverse needs and any kind of substance. The approach encourages practitioners to intervene at all stages of substance use and with various strategies – or 'levels of intervention' – an individual could consider.

Because people change and grow and evolve at different stages in their lives, they need different types of harm reduction services and messaging. For some people, the real harm reduction for them is to be abstinent and that is what they are working toward. Regardless, behind both approaches is the individuals' right to choose and whatever their choice, they should still be offered services. Aboriginal communities need a continuum of interventions and strategies to adequately address the diversity of the issue of substance use; harm reduction can be part of your community's response.

2.2 Normalizing Harm Reduction

Talk about harm reduction in ways that have nothing to do with substance use.

We are all at risk for something – even the flu can be deadly. Encouraging frequent hand washing is a basic public health response to 'flu epidemics' and preventing sickness. As increasing hand washing is normalized as a response to the threat of flu season, it is important to normalize the concept of harm reduction as a response to harms resulting from social behaviours like substance use. As we increase the number of organizations, communities and leaders who address high-risk behaviors, we decrease the number of people who experience irreparable harm.

Talk about the harms of the substance use, not the using alone – it's about the harm, not the substance use.

Some people believe that harm reduction is about supporting or promoting substance use – this is absolutely not the case. Harm reduction does not condone substance use, but rather attempts to address harms in a respectful, practical, non-judgmental way to improve individuals' health and to protect the broader community.

Talk about harm reduction as one way to involve and empower families and loved ones who experience the pain and grief of harmful substance to protect themselves and create a better community-wide response.

We are talking about Aboriginal harm reduction for a lot of reasons. Many of us have lost family members and loved ones to a variety of preventable situations, illnesses, and injury – there is much grief, yet, we often do not change the way we offer programming in any meaningful way to change outcomes.

Talk about harm reduction as a tool for positive community change.

This implementation guide is one way that the Canadian Aboriginal AIDS Network seeks to provide tools and understanding to help foster positive change in the community. We talk about harm reduction in the Aboriginal HIV/AIDS Movement because we know that many of our people have become infected with HIV through injection drug use and unprotected sex. We work with our people to understand what might have made the difference for them when they were involved in harmful behaviours – we ask them what we can do now. Harm reduction approaches are often named as key to building the relationships necessary to support people to protect themselves from harm. We will keep talking about harm reduction as it is a key aspect of preventing the spread of HIV/AIDS and everyone is at risk.

Talk about how we have taken on controversial issues in the past and worked out our community difficulties in the best interests of the community.

We have implemented programs and services in response to community issues in the past. For example, a few decades ago in the 60s and 70s, Aboriginal communities and agencies began condom distribution as one way of responding to high rates of teen pregnancies and sexually transmitted infections (STI) like chlamydia, gonorrhea, and syphilis. In the late 80s, 90s and onward, condom distribution as a prevention effort was expanded to include the prevention of the 'new' STIs: HIV and HCV (although HCV is spread primarily through other contact with substance use paraphernalia, like sharing needles or straws).

Creating and implementing condom distribution programs was not without controversy! In the early days many people objected on to making condoms readily available. Many battles were fought in many communities – not just Aboriginal ones – around condom distribution and whether this practice would 'encourage' people (young people, in particular) to have sex or be promiscuous. This was morally objectionable at the time. However, these days, condom distribution is accepted or at least recognized as a "normal" way to address issues related to the prevention of sexually transmitted infections and unwanted pregnancies. We need to learn from the past and use similar approaches – or small steps – to achieving an environment or atmosphere where harm reduction approaches are normal community responses to substance use and other potentially harmful social behaviours.

Talk about how harm reduction accommodates and 'fits' with most cultures and can work in your community too.

In order for harm reduction to be practiced in any Métis, Inuit or First Nations organization, community or family the concept needs to be presented and confirmed as a positive, effective, and evidence-based step towards addressing substance use and the harms associated with it – both community and individual harms. Often discussions of harm reduction turn controversial since substance use is a can be a very sensitive topic; however, this is not a reason to stop talking about it. We need to acknowledge and work through our discomfort with these issues – we need to normalize substance use as a reality, not an 'uncommon' or 'community specific' or 'a few bad apples' issue – if we are to meaningfully intervene and reduce the harms associated with substance use.

Talk about harm reduction as a traditional concept lived out in the current reality.

Through engaging in discussions on the diversity of Aboriginal people, sharing stories about our culture and experiences can we begin to explore the issues around substance use and addictions. By inviting all community members to participate in the circle, including our women, our young people, our family members who are or have been in prison, and our two-spirit people, communities can create meaningful harm reduction programming and services to meet the needs and rights of individuals "where they are at." It is only through ongoing communication processes – like community discussions, town hall meetings, working with leadership, bringing in the voice of Elders and youth – that communities can begin to explore harm reduction as a means to develop their own ways to address their local issues. We call this the point at which a community 'buys into' harm reduction.

Talk about community wellbeing as the heart of harm reduction.

Protecting community health is a traditional Aboriginal value, and principles of non-interference are found in many of Canada's Aboriginal communities. Non-interference is about respecting individuals', their journeys, and their relationship to the creator – offering advice or telling someone how they should live their life is inappropriate in this context. Harm reduction is compatible with and grounded in principles of protecting community/public health and non-interference. Perhaps if we can situate harm reduction as a traditional concept of interrelatedness we can move towards normalizing services that address substance use harms without demanding abstinence.

2.3

Aboriginal Culture: First Nations, Métis, Inuit, and Beyond

In Canada, the Aboriginal population is very diverse. There are three formal groups recognized by the federal government: First Nations, Métis, and Inuit. That said, these three designations do not in anyway represent the diversity within each group, and these designations cannot convey the full scope of Aboriginal identities in Canada. The diversity of Aboriginal people and the communities we live in must be respected and incorporated into the services developed and implemented.

Inuit and remote or isolated hamlets are very different than the urban environments where people may migrate. Not all Inuit see themselves represented in all the resources considered "Aboriginal". Often, our attempts at being "pan-Aboriginal" fail to capture the uniqueness and distinctness of Inuit culture and reality. Aboriginal people from these northern communities often have difficulties adapting to a foreign environment where life-skills learned back home do not transfer to the cities or southern living. Aboriginal modes of communication, body language, eye contact and other cultural ways can often be misunderstood in the mainstream Canadian culture. Food, clothing, language and drug culture or substance using cultures are different in the south than in the north.

Métis people also have distinct cultures that vary from community to community. Like individual people, each community is not the same. Often, when light-skinned Aboriginal people access health services, it is assumed that they are "white" and the approach to them can in many cases be culturally inappropriate and inadequate. In other cases, it may be assumed by service providers that darker-skinned Aboriginal person is naturally 'well-steeped' in Aboriginal culture. That also is often not the case. Nearly half of all Aboriginal people live in urban settings in Canada and experience varying levels of acculturation. Some are estranged from their culture and want to know more. Anyone hoping to provide services to Aboriginal people needs to learn the essential skills of listening. We must walk with that person to find out where they are at before knowing which kind of approach is most appropriate for any Aboriginal person.

Often, when someone appears to be Aboriginal it is assumed that they are First Nations. While it's true that a majority of Aboriginal people in Canada are of First Nations heritage, using a pan-Aboriginal approach to our people will not work in many cases. First Nations people are also very diverse. Each community's history is different and each treaty has different terms. Also, it is important to realize that urban Aboriginal people experience a vastly different environment than do their cousins back "on the rez." Further, many Aboriginal people were raised in the foster care system. Some remember their early childhood and living with their biological parents, while others have few threads that connect them to their heritage and Aboriginal culture. Some have had no access to our vast Aboriginal cultural knowledge. There are also Aboriginal people who have been raised "by the system" or institutionalized since early childhood; this experience will be distinct as well. It is clear that we are diverse peoples – which require diverse responses. We must evolve and change with the current environment, as our ancestors did, to ensure our survival.

Always Evolving According to the Environment

Just as each individual is different, so is each community. Culture can be described as our current way of living. Tradition is how we used to live at any given moment in the past. Culture is ever-changing and therefore cannot be lost; practicing and adapting our culture is how our communities have survived to see the present day. Our culture adapts to changing environments and some of those changes have been very painful and traumatic for Aboriginal people. Aboriginal culture has been constantly changing, in the context of government and institutional attempts to assimilate our people. Many of our customs and traditions were lost to us through these policies.

Our diverse communities dealt with the historical changes in our lives in different ways. There is no right or wrong way and each community must work within its own cultural norms of today. Culturally appropriate interventions and responses are grounded in understanding community and the local cultural imperatives or ways. Being culturally appropriate or culturally competent may include learning about local values, customs, beliefs and practices, as well as the history of the land, location, or things that a community experienced as a people that affect their current conditions. Because of our histories and also our different worldview, each Aboriginal community must take stock and see what their strengths are. Then, we can use our cultural resources to take steps forward – together.

Aboriginal specific services create space for culturally relevant programming. Often, Aboriginal people may relate better to interventions and programming that are holistic in nature and throughout the prevention, care, support, and treatment service cycle.

A FEW COMMON CANADIAN ABORIGINAL VALUES

Earth-based spirituality:	Attached to and identify with the land.
We are all related:	Interconnected to plants, animals, sea-dwellers and winged ones.
Creator has a purpose:	People born different were believed to be made that way for a reason.
Family-based cultures:	Extended family systems, clans, and relations were part of identity.
Everyone belonged:	All community members had a role or 'place' in the community.
Health is broadly defined:	Includes collective ability to respond to, as well as the absence of, illness.
Non-interference model:	Individual responsibility for actions – Creator will intervene as necessary.

Cultural Resources

In many ways, our culture is our mainstay – it is through our culture that we have managed to survive as a people despite facing circumstances that worked directly against our identities, our ways, our languages, and our practices. While some practices, languages, and in some cases whole groups have been lost, we still have many strengths to draw on. We can be proud of our modern day influence, which often goes unacknowledged, on the ongoing development and shaping of Canadian Society.

Our influence on the values of government and constitutional law in both Canada and the United States are legacies to our historical governance structures. There are many examples of contributions to biomedicine and pharmacology through sharing Indigenous medicinal knowledge about the healing properties of local flowers, plants, herbs, and trees. Our commitment to family and community keeps our culture alive and allows our contemporary identity to grow and evolve in meaningfully ways either through our arts, our good humour, our politics, our ability to respond to community crisis, our integration of traditional healing with 'modern medicine'. We have much strength to draw on in our communities. We must take stock of our community and use our strengths to strategize and rally around the current substance use crisis that is in our communities.

We can do more than tell people it is 'bad' or 'a war on drugs'. There is more to the story. We know people are substance using for a wide variety of reasons and often due to traumas they have experienced – this does not make harmful using acceptable; however, positioning people who are substance using as 'self-medicating' or 'abusing' or [insert stereotype here] is usually unhelpful in light of the multiple issues that usually accompany harmful use. Increasingly, there is a relationship drawn between individuals with post-traumatic stress disorder and/or experiences of child abuse, and experiences with harmful drug use patterns. Many of our cultural resources, such as story-telling, are still used by Aboriginal people as powerful tools. **Our traditional Aboriginal stories have lessons for people at all stages; and creating space for people who have lived traumatic lives to tell their stories – to spend time with Elders – can be healing**. But not everyone can access traditional experiences or those who hold the knowledge.

Healing is what is needed; however, this process tends to be very individual. Our culture and the lessons from our Elders teach us that – we are each on our own journey. In general, Aboriginal cultures are grounded in wellbeing. The theory was that if everyone in the community was provided for, everyone would be healthy. Individuals were responsible for their own wellbeing, but in that, they were expected to contribute to the wellbeing of everyone else through their practices. This is harm reduction, really – except that the service delivery aspect is about making it possible for people to take care of themselves and their community by providing what is required to do so (e.g., needle exchange, drive-home program, condom distribution, etc.). We have many resources we can draw on to help us make harm reduction a reality in our communities.

Traditional Cultural Resources

Traditional Cultural Tools:	Elders Ceremony Songs & Dances – our Prayers Traditional Teachings Arts and Crafts 'Moccasin Telegraph' The Land Spirituality concepts	Recent Cultural Tools:	Community Centres Bingo halls Sports clubs Webpages Aboriginal-specific services Friendship Centres Powows Churches

Thinking About YOUR Cultural Resources

- What are your cultural strengths?
- How can they be used to do harm reduction work?
- Are there any barriers? (e.g. needing to be abstinent for 4 days before participating in ceremony)
- Do community Elders know enough about HIV/AIDS and HCV?
- Who can inform them about these issues?

Harm Reduction Values and Cultural Values

Non-judgment in service provision, much like concepts of non-interference in some communities, is the cornerstone behind harm reduction. Accessing care, treatment or support services is difficult enough without someone sitting behind a desk and seeming judgmental. We live our lives according to our own values and beliefs. There are common values shared by most Aboriginal people however, as professional service providers, it is not reasonable to expect those who we serve to have the same set of values and beliefs as we do. Therefore, the choices or conclusions that others come to in their decision-making may be very different. Finding common ground on the idea of shared values and the relationship between practitioners/organizations and clients, is important. *The Walk with Me* document centres on working together with the guiding values that most could comfortably agree were important; wisdom, respect, humility, honesty, love, bravery, and truth as the fundamentals of the harm reduction service delivery model. By keeping focused on these core values of *the Walk with Me model* while doing our work, we can begin to develop a practice of non-judgmental service delivery.

GUIDING VALUES

Wisdom – Experience -

Traditional teachings, indigenous education, awareness sessions, use of Elders, generations of experience, and history combine to provide the capability of teaching others how to live a healthy balanced life

Respect – Acknowledging Power -

This includes viewing people as equals, with their own gifts to share, practicing kindness towards others, regardless of their health status, sexual orientation, race, etc., while being appreciative of and caring for each other

Humility – Remembering our Place -

Recognizing that leadership, para-professionals, community, service organizations and clients understand and realize that all people have their own journey to follow in life.

Honesty – Walking the Walk -

Providing a trusting environment for clients, with accurate, informative materials to advance the Harm Reduction approaches in Canada. It includes providing an atmosphere for clients where they may receive assistance regardless of risky behaviors that they may engage in, without judgement.

Bravery – Assessing Risk & Taking Action -

Honouring the bravery of clients who come forward to mobilize against the continued spread of the HIV/AIDS and Hepatitis C (HCV) virus, by engaging in Harm Reduction initiatives. Promoting the bravery that is required for HIV and HCV testing. To have the courage and strength to make healthy choices that will influence your life, and the life of your family.

Love – threads which hold together the universe -

Using positive energy to provide a loving environment to help people who may not have been shown love in their lives. Showing affection, kindness, and caring to everyone that you greet through out your day.

Truth – speaking from the heart -

To be sincere, and to speak your truth, be who you are and be proud.

Respecting Diverse Community Views: Working with Opposition to Harm Reduction

It may be difficult for communities to come to terms with some of the substance using behaviours that they know are going on. It is often an issue that seems too complex to address, particularly at a time when there are many pressing needs. Stigma towards the issue exists, and there are not adequate resources to respond. Yet, every community has strengths that can be built on. Harm reduction is about caring for everyone through preventing the spread of disease and providing services to people who may need support, education, and treatment to do their part in caring for themselves and their community.

Despite whether everyone agrees on how to respond to substance use in our communities, the reality is, substance use continues to exist.

The real question is how do we deal with this reality?

Aboriginal people, as other people in Canada, including those who use drugs have a right to health care and social services. Not only is this is a right of citizenship in Canada but many Aboriginal people have a Treaty right to health care through Medicine Bundle or Medicine Chest provision clauses found in some Treaties – the Canadian government has a fiduciary responsibility to provide healthcare and services to Aboriginal people. Harm reduction is a health intervention – specifically, a public health intervention. It is about protecting the broad community and individuals who are substance using.

Moral panic related to harm reduction can create conditions that prevent programs and interventions from occurring (or even being discussed) in institutions, communities, and organizations. It can be intense feeling expressed by a large number of people about 'others' who use drugs or people living with HIV/AIDS who are perceived to threaten the social order. The panic is primarily based on emotions of fear. This response to harms from drug use is not based on facts but on emotion and stigma. It's actually quite a common and normal first response.

It can take a long time for a person or a community to begin to understand and appreciate the successes of broad-based harm reduction strategies and targeted harm reduction interventions. Often, it is politically advantageous to play on the fear of harm reduction through public accusations that harm reduction encourages more drug use. The research and data around the issue simply do not support this 'distracting from the real issue' accusation. Harm reduction has been proven to work all over the world when it is adapted by the local community. The reality is NOT everyone who use substances can stop using and we need programs and services for them in order to protect our people and communities most at risk for harm.

Community dialogue is extremely important to building understanding with those in opposition to harm reduction. It will be important to build some consensus around how harm reduction will be defined in your community – people and groups who are known to oppose harm reduction must be invited to discuss their concerns and participate in decision-making so that all issues can be discussed. In some cases, implementing a service delivery model can only occur and evolve as quickly as the opposition is supportive of the idea and witnesses positive outcomes. However, harm reduction approaches, when implemented at an appropriate level of intervention to 'fit' with the level of opposition, are proven to be successful in bringing people otherwise not in contact with healthcare and social support systems into relationships with professionals who can work with them to help prevent HIV and Hepatitis C.

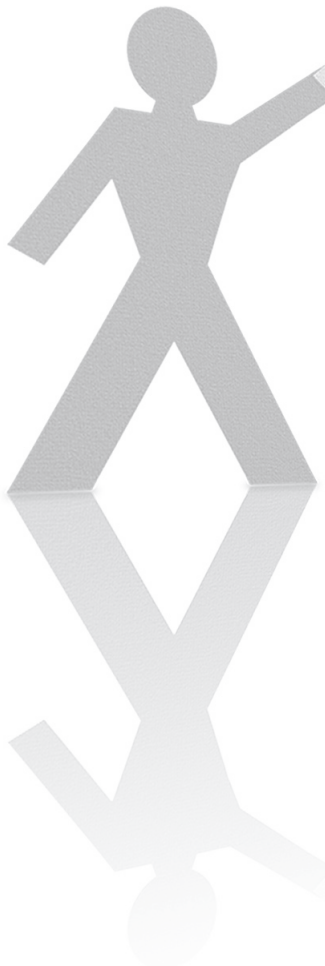
Prevent the Spread of Disease: Hepatitis C & HIV

Although the funding for this project comes from Aboriginal HIV/AIDS funding, we refer to Hepatitis C often as well. We recognize that where there is HIV risk, there is usually Hepatitis C risk. But really Hepatitis C is much more prevalent than HIV. Close to 70% of most populations and/or communities of people who inject drugs are living with Hepatitis C. While rates for HIV infection in injection drug using communities are high, Hepatitis C is more prevalent. The Public Health Agency of Canada (2005) reports in their national cohort study of people who injection drug use that 65.7% of people who agreed to participate in their study and who inject drugs have Hepatitis C. This reflects the infection rate among the general population of people who injection drug use, not just Aboriginal people. According to the HIV/AIDS EpiUpdates (November 2007, data from between 2002 and 2005), the prevalence of HIV in injection drug using communities ranged from 1.2% to 23.8%, depending on the I-Track Sentinel research site.

What the statistics do not reveal is that depending on conditions in a community, the percentage could be higher on-reserve, in cities and towns, or in isolated communities where sharing could be much more common or likely. However, it's really less about statistics and more about risk. If communities can understand that there are risks, even when isolated (and sometimes more so because of isolation) they may be able to respond more compassionately and appropriately. Harm reduction approaches are proven to reduce transmissions, harms, and costs.

HIV is transmitted through bodily fluids (i.e., semen, blood, and breast milk) to sexual partners. As well, women who are pregnant need to know their HIV status as HIV can be transmitted to babies during natural birth (a process where mom and baby often 'exchange' body fluids), and there have been some cases where breast fed infants have become infected through breast feeding.

Hepatitis C is also a blood-borne disease. Any blood, including blood from cuts and nosebleeds, and small amounts of blood found on razors, toothbrushes, earrings, needles used for body piercing, tattooing or acupuncture, or nasal blood found on straws used for snorting substances can carry the virus and be a source of infection. Further, many people believe that if they have hepatitis C, they cannot 'get it again', but they CAN become infected with other (sometimes 'harder-to-treat') strains. However, in order to become infected with hepatitis C, you must have an open sore or cut that needs to come into direct contact with blood that has the hepatitis C virus. For most people, hepatitis C is not a concern, but for people who participate in certain substance use behaviours (e.g., snorting or injecting drugs) there are many hidden risks for the substance user and their significant and intimate friends and family. This is why we need comprehensive ways of addressing substance use. It almost seems like some diseases, like hepatitis C and HIV, exploit the service gaps created by philosophical differences (and indifference) in how to intervene.



Our Aboriginal people are becoming infected with and living with HIV and hepatitis C at alarming rates. These are our people. Sharing substance use equipment is the most efficient way to spread these blood born diseases. In terms of injection drugs use, a harm reduction approach would be less concerned about whether someone injects drugs with needles, but more concerned about whether they "share" paraphernalia (like filters, spoons, water, razors, and so on) as it is through sharing these instruments that HIV and hepatitis C are passed. An effective harm reduction approach would not simply give out clean needles and a 'safer using pack', they would connect with the person, make sure they feel safe, welcome, understand the risks, and when showing harms to their selves, offer them compassionate services that relate to how they are using, including treating minor health issues like skin infections, listening in a supportive way, and acknowledge the individuals resilience despite such evident struggles. This is harm reduction.

3 WORKING WITH DIFFERENT AUDIENCES

Engaging in discussions about harm reduction implementation from the perspective of your own community is essential. Communities need to be ready and willing to look at themselves through a clear lens. Sometimes it is hard to take stock and remain objective when assessing our own selves and our own communities. Harm reduction can most certainly be used as a means of intervention, but only if the personal and community issues are identified and acknowledged through dialoguing with our community members. Further, it would be wise to think ahead about what else might come to the community, even if it's not there yet, and prepare to respond, rather than wait to see if it will be necessary. How will our approaches and decisions influence our people seven generations from now?

Harm reduction can positively benefit everyone: individuals, families and communities. It is part of a public health response that can be adapted to suit the diverse needs of Aboriginal communities; it is only when we work to address the needs of all of the people that we can be whole. Each person's gifts are valuable and should be utilized to the benefit of all. This is a holistic view of community. Each person and each family and each community is unique – comes with strengths and vulnerabilities – and is situated within a spectrum of readiness or preparedness to address issues facing Aboriginal people.

3.1

Community Readiness and Harm Reduction Implementation: A Community Perspective

Community Readiness does indeed help a community to create a shared vision. Referring back to Quinn (1998), vision is like the flowing river. The river wasn't always flowing, but one after another, tiny springs bubbled up and began to flow together – it became a brook, a stream and eventually, a river, awakened and sustained and enhanced entirely by vision.

Vision is the goal, vision pursues the desirable, it doesn't oppose, it proposes, and it opens the way to success.

(Centre on Child Abuse and Neglect, 2000, http://devbehavpeds.ouhsc.edu/assets/pdf/pmm/Comm-Readiness.pdf)

Community readiness refers to how 'ready' a community is to address a particular issue. Community readiness models are noted for guiding communities in effectively addressing many issues – substance use, domestic violence, and cancer prevention initiatives have been under-taken to name a few. That is, a particular issue is looked at (in this guide, we are looking at the issue of harm reduction) from a number of community perspectives, and then based on the perspectives collected, strategic decisions are made about how to create change around the identified issue.

Community readiness is necessary in order to create change, particularly for community issues that create conflict and tension, like substance use or domestic violence. Fortunately, community readiness models are proven to provide guidance in creating responses to complex issues that can be supported by the broader community. That is, creating 'palatable' – or easy to swallow – approaches that even opponents can support. There are a number of community readiness models; you can find many examples of community readiness assessments online.

Most of the 'readiness models' centre on four key processes:

1. **Determining an issue (focusing what you are trying to change),**
2. **Asking questions specific to the issue (community strengths, assets, and challenges documentation),**
3. **Seeking input from a variety of community sources (key informant/key player interviews), and**
4. **Scoring the results on a 'readiness' scale (a scoring tool that usually accompanies a 'model') to determine what next steps would be appropriate for moving the community to a new phase or level of acceptance of an issue and the need to respond.**

Really, any community readiness model you may find reflects a community-centred decision-making process: first awareness of an innovation, changing attitudes, adopting the idea, trying it out, determine where it is used again or discontinued and why, create community interest in the issue (recognition of need), initiate a response (development of alternative solutions among community members who first propose new programs), engage local leaders, lobby for community acceptance of the need for action, decide to act, develop specific, strategic plans with a diverse group of community members), and implement some action.

While there are a number of community readiness models, one of the most developed and tested models was developed by the Tri-Ethic Center (TEC) at Colorado State University. We are introducing the core concepts of their model here, but this introduction will only touch on the major points. We encourage you to check out the TEC's webpage

www.triethniccenter.colostate.edu

You can access your own full copy of the complete TEC guide to their community readiness model – Community Readiness: A Handbook for Successful Change – from the webpage. This comprehensive document outlines, step-by-step, how to adapt and use the TEC community readiness model to suit the needs and issues of your community.

Communities and organizations can access the document through the TEC web page where there is a 'form' to fill out (required before you can access the full document). There they ask you to share how you are using the TEC community readiness model in your community. The TEC values knowing where the model is being used and applied. This is part of their ongoing evaluation activities, but collecting this information also helps the TEC understand what issues and environments are responding well to their model. Because of this kind of engagement with people who are applying the model, TEC can confirm where it is working.

The TEC Community Readiness Model has been demonstrated to be effective in Native American communities, and is receiving endorsements from Canadian Aboriginal communities and organizations as well, like through the Métis Community Services British Columbia who are using the TEC community readiness tool in a project addressing Métis mental health **(http://mcsbc.org).**

Even with multiple passionate stakeholders involved and plenty of fiscal and human resources to support it, a strategy is still only as good as the community is ready for it. The level of acceptance of harm reduction interventions needs to be sorted out from the beginning, as even within harm reduction programs there can be disagreement and tension about how to 'do' harm reduction. Some people will say that one program is 'too loose' others might view the same program as 'too rigid', for example. Even within the 'harm reduction community' there are different levels of acceptance and intervention. However, using the Community Readiness Model will highlight areas needing to be addressed to implement a harm reduction approach and/or intervention. This is why we are supporting, endorsing, and sharing information about the Tri-Ethic Centre's Community Readiness Model – this is a way to determine a path to establishing harm reduction services in your organization and community.The Community Readiness Model is defined by Six Dimensions of Readiness and Nine Stages of Readiness.

Dimensions of readiness are key factors that influence your community's preparedness to take action on an issue. The six dimensions identified and measured in the Community Readiness Model are very comprehensive in nature. The dimensions are useful for 'diagnosing' your community's needs and for developing strategies that meet those needs.

Stages of readiness reflect where a community is 'at' along the continuum of readiness to address a given issue – from no awareness of the issue at all to having a high level of community ownership over the issue. Understanding how ready your community is determines how you might intervene to create change. Each stage of readiness is linked to different strategies that can be used to raise the profile of an issue in your community and to influence how your community views its role in the issue.

Using 'stage appropriate' strategies is very important to the success of your intervention; challenging a community with strategies that are more than what it is ready for may cause tension or division, and will not help create a community climate conducive to change. Especially for sensitive issues, like domestic violence, child abuse, and harm reduction, for example; these issues are very difficult for many people to acknowledge in their communities because there is much pain associated with sharing and discussing these experiences. You do not want to 'trigger' a community with the intervention you plan – meet the community where it is at. The goal of this exercise – using the community readiness model to assess your community's 'readiness' in relation to implementing harm reduction service delivery models like Walk with Me – is to assess how your community views harm reduction, what might be some challenges, what resources in the community are available to help in the response, and given the 'mood' of the community, which strategies might be most appropriate for influencing the creation of a community climate that values harm reduction as a tool in responding to substance use and the harms associated with it.

Dimensions Of Readiness

Community Efforts:

To what extent are there efforts, programs, and policies that address the issue?

Community Knowledge of the Efforts:

To what extent do community members know about local efforts and their effectiveness, and are the efforts accessible to all segments of the community?

Leadership:

To what extent are appointed leaders and influential community members supportive of the issue?

Community Climate:

What is the prevailing attitude of the community toward the issue? Is it one of helplessness or one of responsibility and empowerment?

Community Knowledge about the Issue:

To what extent do community members know about the causes of the problem, consequences, and how it impacts your community?

Resources Related to the Issue:

To what extent are local resources – people, time, money, space, etc. – available to support efforts?

Your community's status with respect to each of these dimensions forms the basis of scoring the overall level of community readiness.

(As developed by Plested, B.A., Edwards, R.W., & Jumper-Thurman, P. (2006).
Community Readiness: A handbook for successful change. Fort Collins, CO: Tri-Ethnic Center for Prevention Research, p. 7)

Stages Of Community Readiness

1. No Awareness

Issue is not generally recognized by the community or leaders as a problem (or it may truly not be an issue).

2. Denial/Resistance

At least some community members recognize that it is a concern, but there is little recognition that it might be occurring locally.

3. Vague Awareness

Most feel that there is a local concern, but there is no immediate motivation to do anything about it.

4. Preplanning

There is clear recognition that something must be done, and there may even be a group addressing it. However, efforts are not focused or detailed.

5. Preparation

Active leaders begin planning in earnest. Community offers modest support of efforts.

6. Initiation

Enough information is available to justify efforts. Activities are underway.

7. Stabilization

Activities are supported by administrators or community decision makers. Staff are trained and experienced.

8. Confirmation/Expansion

Efforts are in place. Community members feel comfortable using services, and they support expansions. Local data are regularly obtained.

9. High Level of Community Ownership

Detailed and sophisticated knowledge exists about prevalence, causes, and consequences. Effective evaluation guides new directions. Model is applied to other issues.

(As developed by Plested, B.A., Edwards, R.W., & Jumper-Thurman, P. (2006).
Community Readiness: A handbook for successful change. Fort Collins, CO: Tri-Ethnic Center for Prevention Research, p. 9)

Engaging People who Substance Use(d) and the GIPA Principles

When aiming for a particular target audience, it is important to meaningfully engage people with lived experience related to the issue in all aspects of the process from concept to completion and evaluation. For example, if you are hoping to reach people who use drugs, then it is very important to engage people who use drugs in the development of your approach.

The Canadian HIV/AIDS Legal Network has published a document, Nothing About Us Without Us — A manifesto by people who use illegal drugs (2008 – available at www.aidslaw.ca). People who use drugs wrote this manifesto. Participants in the project expressed their hope that people who use drugs around the world will either adopt this manifesto, or use it as the basis for creating their own manifesto.

> **"Through collective action, we will challenge existing oppressive drug laws, policies and programs, and work with governments and international agencies to formulate evidence-based policies and programs that respect our human rights and dignity and protect and promote our health."**
>
> **"And we stand in solidarity with our brothers and sisters in other countries who often suffer great abuses of their human rights. We demand that our governments take action in our countries, but also at the international level, so that our health and human rights are respected, protected and promoted, and we are involved in all decisions that affect our lives."**
>
> **(A manifesto by people who use illegal drugs - Canadian HIV/AIDS Legal Network, International HIV/AIDS Alliance, Open Society Institute and International Network of People Who Use Drugs, 2008)**

Harm reduction can provide a process for Aboriginal people who use drugs and Aboriginal people with a history of using drugs as to provide a voice in the creation of programs and policies designed to serve them. That means the meaningful engagement of Aboriginal people who use and/or inject drugs or people have done so can be a key element to community mobilization. Involving an Aboriginal person living with HIV/AIDS and/or HCV would be very helpful as well, especially if they have lived experience to enhance a community's understanding of harm reduction. Further, involving people who have experience(s) with the issue are in the best position to determine next directions. In the HIV/AIDS movement this is called ***the GIPA principle – the Greater Involvement of People living with (HIV)AIDS.*** The purpose of GIPA is to ensure that people living with HIV have direct participation in the decision-making that affects their lives. Another way of saying **GIPA is 'Nothing about us, without us'** – which follows principles of meaningful involvement of target populations will help ensure quality interventions.

Walk with Me presented harm reduction ideas for four target groups: Aboriginal women, Aboriginal youth, Aboriginal people who are or have been in prison, and Two-spirit men. Walk with Me outlines some suggestions for working with these specific groups, however, it is important to remember to include members of the target population you hope to influence on a steering or planning committee for the intervention. They are the most knowledgeable experts of their lived experience – often the simplest interventions are the most effective – members of target populations may be able to suggest easy points of intervention that otherwise would be missed. Be sure to use your target population as a key informant in the development of any strategy as well as the leadership of your community.

Engaging Leadership

Leaders are the ones who walk the walk. Honour is about action; there is no honour in words unless there are honourable actions to back them up. Our leaders can be and are, in many cases, convinced that HIV and hepatitis C are present in our communities. They should know that harm reduction is one way they can respond which offers a continuum of intervention options. The rate of HIV and hepatitis C infections are significant in our communities – our leadership still need to be reminded of these issues on a regular basis and presented with innovative, evidence-based response options they can support. Engaging Aboriginal leaders is one way community based service providers receive the guidance and support they need to develop appropriate programs and services; engaging leadership is also critical to creating a truly community supported approach to the issue. Winning local political support is a first step in the process; elected Aboriginal leaders can be powerful supports and advocates so make sure they are invited into your discussions too! Partnering and collaborating with the leadership in your community can lead to a stronger voice and stronger representation at many levels of government.

Elected Leaders

> *Elected Aboriginal Leaders, as a group, are no more at risk [of becoming infected with HIV] than whatever their sexual orientation, gender, or risk behaviours may be. They are listed here as a group that requires education about all the aspects involved in HIV and AIDS. Whether at the community level, through regional bodies or the national scene, greater work is required to ensure that HIV/AIDS stays on the agenda of political organizations.*
> *Strengthening Ties –Strengthening Communities–*
> *The Aboriginal Strategy on HIV/AIDS in Canada*

There is a critical role that elected Aboriginal leaders play in strategic areas and in the overall struggle to overcome all the challenges of HIV/AIDS. One strategy includes encouraging elected Aboriginal leaders to speak publicly about HIV/AIDS so that Aboriginal communities hear their leaders talking about these issues. Further, Aboriginal leadership can: work to ensure that Aboriginal people living with HIV/AIDS in their communities are not discriminated against; support lobbying efforts to ensure that adequate funding is available to support a response to HIV/AIDS; and simply learn enough about HIV/AIDS so that it gets the proper attention and any misconceptions can be removed.

‘Doing’ Harm Reduction

Some Broad-based Harm Reduction Examples

Medical Marijuana

refers to providing and allowing people with chronic illnesses (e.g., cancer, HIV, Hep C, glaucoma, etc.) to access and use cannabis products as part of a comprehensive treatment program.

Condom Distribution

refers to providing easy pubic access to condoms (like in schools, health clinics and offices, and at relevant organizations) as means of prevention sexually transmitted infections (e.g., Chlamydia, HIV, syphilis, gonorrhea, etc.) and pregnancy.

12-Step and Anonymous Programs

refers to community-based, community-run programs that participants attend voluntarily (and confidentially) with the purpose of reducing or eliminating substance use and/or addiction – most commonly mentioned programs include: Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, and Gambling Anonymous.

Anti-Drinking and Driving Legislation

refers to provincial and federal lobbying for clear laws that respond to harms related to drinking-and-driving with the intention of protecting the broader public and changing social attitudes toward drinking-and-driving (like ‘I drive better after a few drinks’).

Smoking Bylaws

refers to organizational, municipal, provincial, and federal enactment of laws that regulate where a person can smoke tobacco products in an effort to limit non-smokers’ exposure to the harms related to the inhalation of second hand tobacco smoke.

Mandatory Seatbelt Use laws

refers to legislation enacted in response to motor vehicle accidents and the severity of injuries and high rate of deaths associated with them – seatbelts were demonstrated to decrease the level of injury and chance of death associated with these accidents.

Some Specialized or Targeted Harm Reduction Examples

Needle Exchange Programs (NEPs)

refers to programming focused on reducing the harm associated with injection drug use through facilitating and providing the exchange of used or 'dirty' substance use equipment for unused or 'clean' equipment (like needles, spoons, filters, and water among other things). Some NEPs operate on a 'one-for-one' basis where service users are expected to return as many needles as they are requesting (that is, one 'dirty' will get you one 'clean'); other programs focus on access and distribution of clean materials regardless of whether 'dirties' are returned, yet they provide a disposal service, too, but it is not the focus of their initiative.

Safe Injection/Consumption Sites

refers to facilities that substance users can frequent to reduce the harms associated with 'public ingestion' (i.e., interactions with law enforcement, careless disposal of equipment, 'rushed' and did not use 'safely' because of fear of getting caught, etc.). When they need to use but do not want to do so in public, these facilities provide a place where substance users will be supervised as they use (to prevent overdose deaths and injuries), and they can access education and treatment support, should they wish to. Quite common in other countries (like Australia, the Netherlands, Germany, and the UK), Canada has only one (hotly contested) safe injection site – InSite in Vancouver.

Methadone Maintenance

refers to a synthetic drug (developed in Germany after WWI) that mimics opiates and is used for pain relief and to treat opiate dependency (e.g., heroin, dilaudid, morphine, oxycodone, MS Contin, codeine, Demerol, etc.); taken once daily in an oral liquid dose, methadone slowly releases and prevents the harms associated with opiate withdrawal and (when on the 'right' dose for the individual) can prevent psychological cravings. Like the opiates it 'masks', methadone is highly addictive and withdrawal is significant, yet it can be a very effective means of 'interrupting' opiate dependency and reducing the harms associated with the lifestyle of opiate addiction. However, deciding to initiate methadone maintenance treatment requires understanding the long-term commitment (this is not a 'quick fix' to opiate dependency) and consequences (i.e. dependency) of this therapy. Methadone maintenance is ONLY offered under the care of a physician who is certified to prescribe methadone.

Heroin/Alcohol Maintenance

refers to programs that provide service users with small, previously determined doses of a substance to reduce harms and allow them to function. Particularly helpful with chronic alcohol users, this therapy can limit the severity of withdrawal symptoms (e.g., delirium tremens or DTs) through regular 'doses' of alcohol, as well as provide the option of 'weaning', or slowly reducing the 'dose', until a service user is no longer needing the substance at all should they want this.

'Wet' Shelters

refers to temporary shelter services that provide services to people who are actively substance using in an effort to reduce the harms experienced due to 'exposure to the elements' since most shelter services require sobriety or abstinence while people reside with them, yet this is difficult (or impossible) for some people. Wet shelters provide an alternative option.

3.3

Case Scenarios – Thinking It Through

In this section, ideally, the whole story comes together; the need to do community assessments, invite key players to the table, constant communication/ negotiation with the community, and determining a point of intervention that everyone can 'handle' AND that might move the community towards the next step in time. Through processes that respect communities and individuals, real change can and DOES happen; it's been proven and is an evidence-based practice.

Here we present an exercise. The goal of this exercise is also to get people thinking about their 'community' - again, a town, an organization, an office, whatever/wherever - and how 'ready' they might be to respond to the issues in the scenarios. Some questions are included here to start the discussion.

Questions to Consider about a Scenario

- these can be applied to your home community if it is more helpful -

What behaviours would be a 'problem' in terms of connecting them to services and agencies?

What might make them difficult candidates for particular programs?

Identify how your community or agency or program could intervene, using a harm reduction approach, to address pressing concerns.

How would your community respond to this individual?

What are the clear harms to the individual over the short-term?

What are the clear harms to the individual over the long-term?

What might your community or agency be able to do right now?

What if communities got organized and rewrote some policies?

What about 10 years from now?

How would you want your community to be able to respond differently?

These example scenarios are meant to get you thinking about broad-based harm reduction approaches. The scenarios can be used personally or with others; they can be used as a way to start conversations among co-workers, within organizations, and with communities of all stripes. The scenarios reflect a whole number of stereotypical circumstances into a few short stories – they do not reflect any one individual's life and whether they seem 'realistic' or not is not important. The point of the exercise is to consider how you might apply harm reduction in the situation presented.

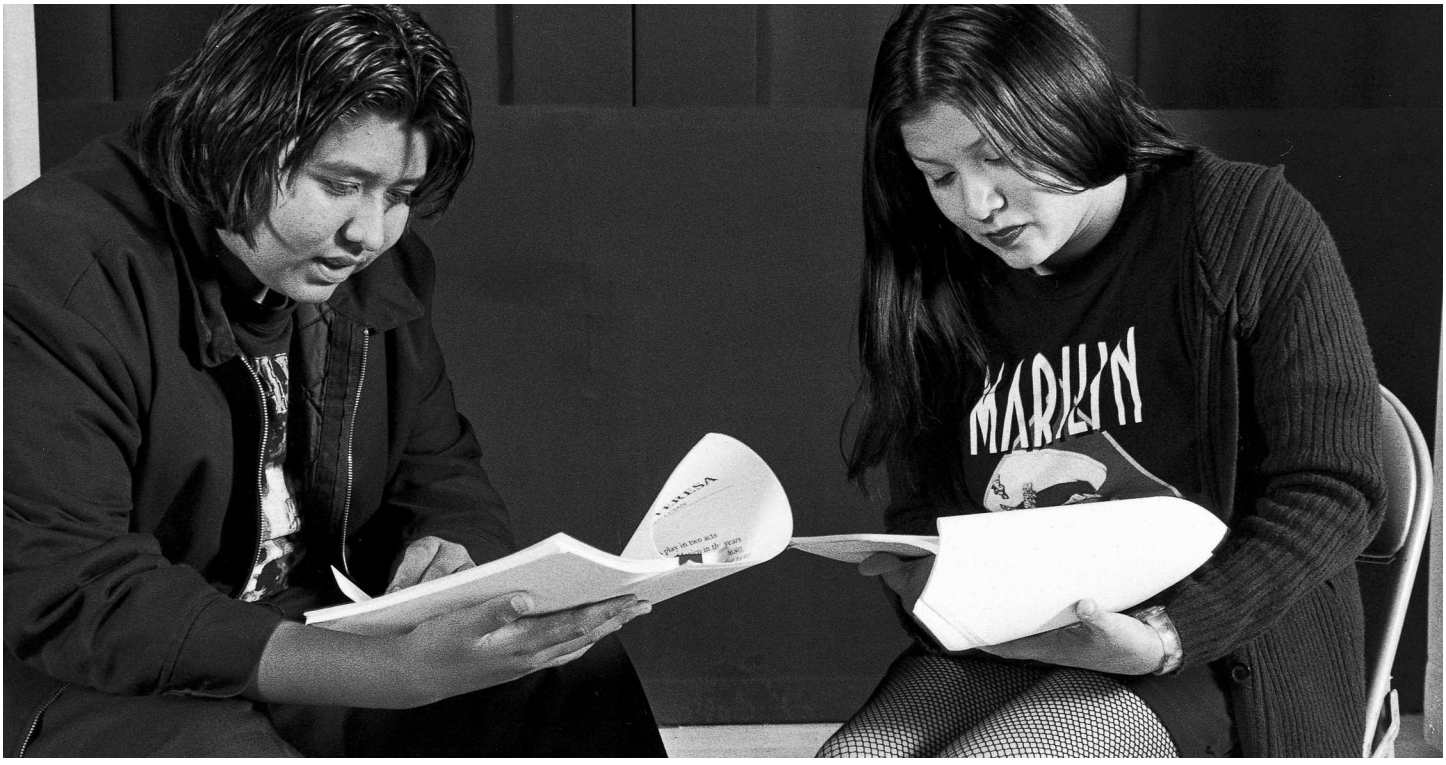
In the Walk With Me – Pathways to Health: Harm Reduction Service Delivery Model on pages 27 to 29 are four more case scenarios to work with.

There is a lot of room for making assumptions about the 'gaps' in the stories presented here. As gaps are noted, try to develop appropriate harm reduction contingency plans to accommodate the imagined circumstances – gaps and all! Being open to all kinds of situations and considering how we might more creatively respond is at the core of 'doing' harm reduction.

When we talk about 'broad-based' harm reduction, we mean that there are many levels at which intervention can take place. This is why assessing community readiness is so important – so you can determine what kind of interventions will suit the community and create change. Sometimes part of getting thinking about harm reduction is remembering some of the common interventions, like medical marijuana for pain treatment, condom distribution, methadone maintenance, 'wet' detox services, Alcoholics Anonymous, needle exchange programs, and safe-use facilities (like InSite in Vancouver). Further, there are plenty of practical and less controversial interventions to be undertaken too, like providing food programs, doing needle and paraphernalia neighbourhood 'sweeps' to pick-up used equipment not disposed of properly, providing easy public access to sharps disposals, supporting street health outreach programs, and lobbying for shelter and temporary harm reduction housing. Hopefully these examples have got you thinking.

Finally, the practice of universal precautions is a great example of a harm reduction measure. 'Universal precautions' refers to the policies that arose out of the 1980s (in response to the emergence of HIV/AIDS) and were entrenched as normal practice in the early 1990s as HIV and other blood borne pathogens became more understood. This is harm reduction for both the medical practitioner AND the person being examined. These seemingly simple changes in our routines can have profound effects and the practice of universal precautions presents a compelling harm reduction example. It is this message that we must get across to leaders, service providers, and those who we are targeting with our harm reduction approach; the value of the approach are the layers or levels of intervention that are available to be considered.

Now, please consider the following scenarios. How do they relate to your community? How do they reflect your organization's experience and your workplace policies? Where does your organization or community or role 'fit' in terms of supporting these Aboriginal persons? And so on. Let your imagination run wild. Let's imagine for a moment that the individuals described below have asked for help around a particular issue and they are not getting it because of their 'competing priorities' (like 'getting their kids back' but being unwilling to 'get clean') how do we work with harm reduction in these cases?



‘Broad based’ examples along the continuum of harm reduction; 6 case scenarios

1. A 22 year old, HIV+ Inuit woman living in an urban centre has 2 children in care and is pregnant with another one. She wants to reduce her alcohol consumption to get her children back. She is sometimes homeless and accesses the shelter or supportive housing system. She is living with diabetes and some cognitive impairment (possibly FASD), in addition to being HIV+. She has a warrant for her arrest for failing to appear to a court hearing for trespassing. Her understanding of English is limited, and she doesn’t feel that the native friendship centre represents her culture or understands her.

2. A 71 year-old Innu elder living in isolated, island, fly-in community is on high dosages of prescription pain medications for a chronic hunting-related injury. He is worried and wants to make sure he can still participate in cultural activities even though he is taking medication. Can he still smoke the pipe? He is a cigarette smoker, with diabetes, heart disease, and gout, and he is inactive except for bingo. His food quality is low as his injury prevents him from hunting. He may soon need dialysis, however, the drugs keep him in an altered state of consciousness but still mobile, with a good sense of humour. He has one daughter who lives in the south with her children. Extended family members provide help in small ways, some land food and home upkeep. He believes he is now ‘drug addicted’ but doesn’t see an alternative. He is hearing people talk and getting a reputation in town for being stoned all the time. Doctor boats in once a month in short summer. Ice road in winter. No access except by helicopter in the slushy fall freeze and spring thaw.

3. A 43 year old HCV+, married, Metis man injects cocaine by choice (and other if 1st choice unavailable). He considers himself a strong Christian. He has a history of physical and sexual abuse, and experience transitioning out of prison. He tried to get methadone while in prision, but was unable to. He was kept in protective custody because of his HIV disclosure and trouble with other people inside. He found and read PASAN’s newsletter inside. He is a person who injects drugs and wants to protect himself and his partner from infection and disease, but does not want to stop using right now…maybe someday. He has not yet told his wife that he got HIV inside prison through sharing injecting equipment

4. How do we respond when a community is divided and integrate the logic of community readiness? The 35 year-old President of the Board (FN woman) and 57 year-old Executive Director (non-Aboriginal woman) of a local friendship centre are community leaders in a town of 15000. They and the Board and membership are divided on how to respond to increasing substance use and careless discarding of used equipment. Half of the Board is trying to implement mandatory drug testing for staff, other half wants to start up NEP in the town. Additionally, there are high rates of Aboriginal teen pregnancy, rape, drug use, arrests, and suicide. The town is close to 3 different reserves, many members move back and forth from town to the rez.

5. A15 year-old two-spirit man is living on-reserve and is experimenting. He can access Ritalin at school among his friends and experiment with drugs; he also bringing his parents’ medications to school to share and he’s figuring out his sexuality and wants to belong. Drug culture in school revolves around sports, steroids, and cigarettes. Has been queer bashed by cousins a few times and gets bullied for being effeminate. All of his friends are girls. Recently he took a bus alone to the nearby city where he managed to sneak in and get served in a local gay bar. At the bar he realized that Aboriginal people were all on one side of the bar and everyone else was on the other side. Many older men propositioned him for sex when he was there exploring the gay scene. He comes into the school counsellor to ask how he can transfer to the school in the city so he can live as an openly gay person but is worried about becoming caught up in the drug culture he discovered there.

6. A non-status urban trans-gender woman of unknown Aboriginal decent, is working in the sex trade and was raised in institutions, including foster care and juvenile detention. She spent some time in provincial detention centre. She is very mobile and splits her time between Winnipeg, Toronto and Vancouver. When she cannot afford cocaine or crack she sniffs glue. She is tremendously artistic and shows off her work – she is a fantastic painter and poet. She has never been tested for HIV but has had other STIs, which were treated in prison. Sometimes she slashes her arms (self-mutilates) but won’t/can’t explain why she cuts herself – but she wants help to stop. Since slashing has become more frequent it is more difficult to camouflage. Sex work clients are asking questions and becoming turned off by it. She wants to change this behaviour.

CONCLUSION

This document was developed to support communities and organizations implement broad based and targeted harm reduction strategies for Aboriginal people who substance use. Learnings from facilitating Aboriginal harm reduction training sessions and community consultations directly influenced the development – the feel and nature of this document – and guided what information was shared.

The *Community Readiness Model* by the Tri-Ethnic Center for Prevention Research at the Colorado State University is the most widely used readiness model. We drew attention to this model to offer communities a place to start talking about harm reduction and what it might 'look like' in your community or in communities where you do your work. This Implementation Guide complements the previous CAAN resource – *Walk with Me – Pathways to Health: Harm Reduction Service Delivery Model* – which highlights how to create harm reduction programming for specific target groups. Together, these resources can create a path for communities to follow as they introduce and establish harm reduction interventions to address their local issues.

Interwoven in the continuums of drug use and harm are life stories. At different points – or moments in time – within this continuum communities themselves can figure out how to intervene. The story line approach in the guide and DVD puts a human face to the issues and challenges harm reduction can address, as well as outlines nine stages of readiness and six dimensions of readiness.

Our Aboriginal communities have experienced multiple traumas over the centuries, including targeted assimilation, residential schooling, and the outlawing of Aboriginal ceremonies and customs. Many of our traditional coping mechanisms were lost or taken away through this legacy leaving people to fend for and find themselves. Culture evolves according to the environment, not always in a positive way. Some of our communities are really hurting; they are seeking new ways to respond to substance use and the harms that can come with it.

This Implementation Guide is about communities looking inward and gauging where they are at. Practically speaking, this guide should inform us that the first step to developing harm reduction initiatives in any community is to see what stage of readiness a community is at for implementing harm reduction. A needle exchange program, for example, is a higher level of targeted intervention which might face more resistance than providing a meal program for people who inject drugs – both can be harm reduction interventions. The process of figuring out what harm reduction might look like in the community can be developed by using this process. Once they 'know where they're at' with respect to harm reduction, communities can look at what has been done and how others have done it.

CAAN will continue to develop harm reduction resources which build on previous work. This particular guide is NOT about 10 easy steps to an NEP or any other particular intervention. **The steps will look different in every community, depending on the stage of readiness and which interventions are appropriate to the stage.** Setting up an NEP is one thing, maintaining it and dealing with issues as they arise is quite another.

CAAN knows that implementing targeted harm reduction strategies can come with a lot of problems; there are often unanticipated situations, opposition, conflict, and consequences – it is difficult to predict. This is why we encourage using the Tri-Ethic Centre's Community Readiness Model as a tool in determining how your community feels about harm reduction, what initiatives or interventions would be supported, and how the community will want the service to be delivered.

The bottom line is that harm reduction will ONLY work in any Aboriginal community, if that community is at a stage of readiness to receive the particular level of intervention.

ACRONYMS

CAAN – Canadian Aboriginal AIDS Network

APHA – Aboriginal Person living with HIV/AIDS

Walk With Me – CAAN Walk With Me – Pathways to Health: Harm Reduction Service Delivery Model

NEP – Needle Exchange Program

SIS – Supervised Injection Site

HIV – Human immunodeficiency Virus

HIV+ - HIV positive – has tested positive for the Human immunodeficiency Virus

HCV – Hepatitis C Virus (often referred to as HepC)

GIPA – Greater Involvement of People with HIV/AIDS

HCV+ - – HCV positive – has tested positive for the Hepatitis C Virus

AIDS – Acquired Immune Deficiency Syndrome

AA programs – Alcoholics Anonymous Programs

IDU – Injection Drug Use

STI – Sexually Transmitted Infections
(sometimes still referred to as STD –Sexually Transmitted Diseases)

Canadian Aboriginal AIDS Network Resources – www.caan.ca –

Walk with Me: Pathways to Healing (2007) was created by CAAN to offer a resource to communities who wanted to develop or expand HIV/AIDS and HCV programming in their community. Using the Medicine Wheel to explain the model, Walk with Me presents tools for working with four target groups: Aboriginal youth, Aboriginal women, Aboriginal people who are or have been in prison, and Two-spirit men. This resource should be used alongside the Implementation Guide and is available, in its entirety, through the CAAN web page.

Take Me To Your Leader (2007) is a strategy document that can guide your efforts to connect with and reach elected and non-elected Aboriginal leaders with messages about HIV/AIDS issues. This CAAN document examines what is needed for reaching leadership and why and points a way forward to addressing how issues related to HIV/AIDS in the Aboriginal population of Canada can be elevated to such a level that people, including governments will be compelled to act with greater emphasis. This resource could help guide some of your work once you have determined what stage of readiness your community is at.

Making it Our Way: A Community Mobilization Model (2006) was created by CAAN to demonstrate one way of engaging communities and leadership in discussions about HIV/AIDS. This model operates from the core belief that if we all work together we can make change. This resource may be helpful in pursuing community readiness and can be accessed online through the CAAN web page.

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Online Resources

Canadian Aboriginal AIDS Network	www.caan.ca	1 888 285 2226
Native Women's Association of Canada	www.nwac-hq.org	1 800 461 4043
Ontario Aboriginal HIV/AIDS Strategy	www.oahas.org	1 800 743 8851
Healing Our Spirit	www.healingourspirit.org	1 866 745 8884
All Nations Hope AIDS Network	www.allnationshope.ca	1 877 210 7622
Healing Our Nations	www.hon93.ca	1 800 565 4255
2-Spirited People of the 1st Nations	www.2spirits.com	1 416 944 9300
Nine Circles Community Health Centre	www.ninecircles.ca	1 888 305 8647
Commission de la santé et des services sociaux des Premières Nations du Québec et du Labrador	www.cssspnql.com	1 418 842 540
Canadian Harm Reduction Network	www.canadianharmreduction.com	1 800 728 1293
Canadian Centre on Substance Abuse	www.ccsa.ca	1 613 235 4048
Pauktuutit Inuit Women of Canada	www.pauktuutit.ca	1 800 667 0749
Metis National Council	www.metisnation.ca	1 800 928 6330
Centre for Addiction & Mental Health	www.camh.net	1 800 463 6273

CANADIAN ABORIGINAL AIDS NETWORK

HARM REDUCTION IMPLEMENTATION GUIDE

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