

# 11. supporting someone who uses substances



This module explores the principles and methodologies around the harm reduction approach to substance use disorders and some of the history around the criminalization of substance use.

1. welcome

2. gratitude

3. about this training

4. table of contents

5. our focus

6. core values

7. life application story

8. walking alongside someone who's using substances

9. what is harm reduction?

10. harm reduction in b.c.

11. person- first language & anti-oppressive practice

12. the importance of self-compassion within substance use

13. the good samaritan drug act & naloxone

14. recovery with the lens of harm reduction

15. other substance use perspectives & programs

16. prohibition & the “war on drugs”

17. the criminalization of people who use

18. core values assessment

19. summary

20. next steps

21. module references

EXIT the module

# 1. welcome

---

welcome to  
**WHERE WE ARE AT**  
supporting  
someone  
who uses  
substances



Welcome to **Where We Are At**, a training course for Provincial Peer Support Workers. We're glad you're here! This course is made up of 16 modules, all designed to support your training in peer support work."

The purpose of module **11. supporting someone who uses substances** is to give you a broad view of the impact of loss and the process of grief that comes along with that.

---

**We recognize that this module is potentially more complex than many others in this training – not because of the content but because it’s likely to inspire impassioned conversations and debate, and we celebrate that.**

**In that spirit, we encourage you to add your voice, perspectives and innovations to the content. Whether you’re taking this training online, as an individual or as part of a group, we encourage you to remix and adapt this material.**

Any of the modules in this training can stand alone, but you’ll notice they are very interconnected. All of the concepts and core values have many layers, and they will look a little different when you see them through the lens of different topics. For example, self-determination, one of the core values that is essential for peer support work, will look a little different when we look at it through the lens of learned helplessness, grief and loss, or goal planning, but the main message will always be the same.

You will get to experience all of those layers and intersections when you move through each module of the training. Feel free to navigate back and forth between modules as you move along since learning never has to be linear. There will be references to other modules intersected throughout.

**Thank you** for joining us on this educational journey!

## 2. gratitude

---



**Before we begin this  
new *learning* journey, we ask that you  
reflect on the following question:**

# What am I grateful for today?

**We know that taking time to reflect can give us the clarity and strength to do what can sometimes be difficult emotional work.**

**Download the [reflection journal](#) below and use it to record your thoughts. Please don't rush. Take all the time you need. This journal will be used for several questions throughout the module.**



M11\_reflection-journal.pdf  
54.5 KB

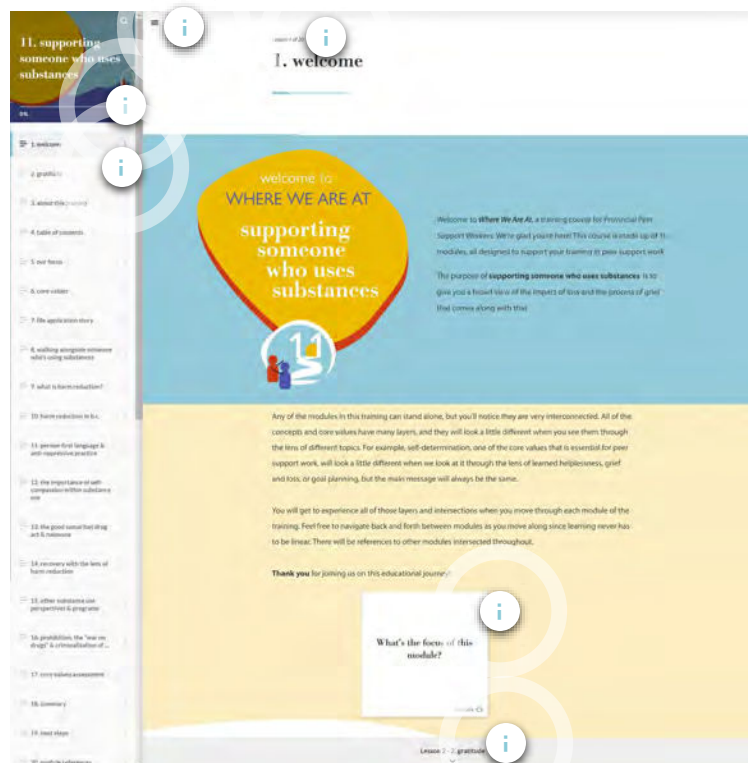


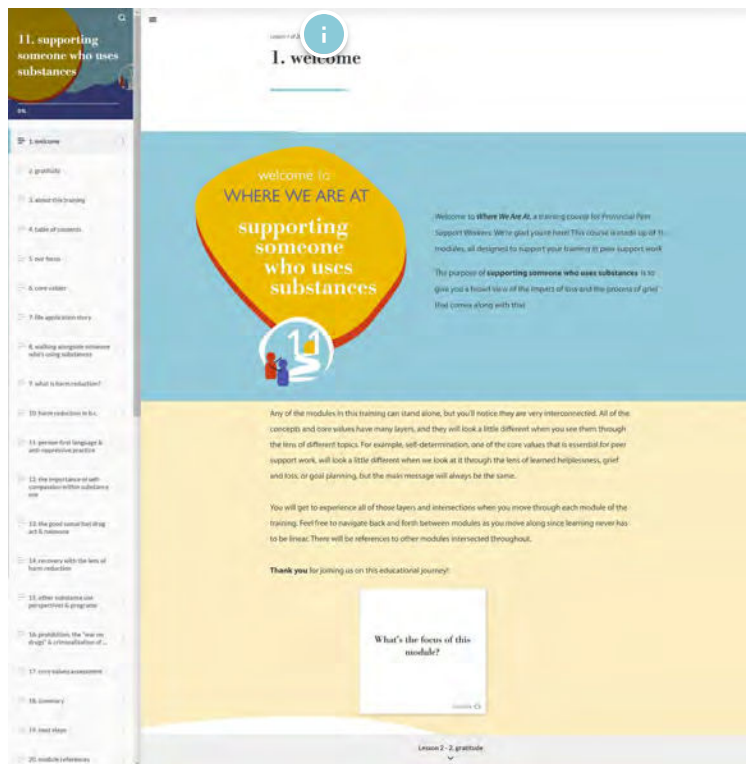
## 3. about this training

**The course content has been guided by consultations that were held with peer support workers. It's with the utmost respect for their experience and wisdom that we share these learnings.**

## course navigation

You may have questions on how to use this course. We designed an interactive diagram to give you the chance to explore the different functions on the screen. Click the buttons below to learn more.





## Lesson titles

*Lesson 1 of 20*

Above each lesson title, the lesson count is shown.

CONTINUE

# reflection journal

As you discovered in the previous section, included in this training is a reflection journal. The journal is designed for you to use throughout the training. It's full of reflective questions related to the topics being explored that will get you engaging in the world around you with curiosity.



Feel free to use the journal in a way that works for you:

- 1 You can print it off and write in it or just use it to support reflective processing
- 2 You can use the fillable PDF version and complete it online
- 3 You can write in your own journal, using the questions as guides

We encourage you to find a safe, comfortable spot to engage with these questions.

CONTINUE

## where we are at

### provincial peer support worker training curriculum

The *Where We Are At* educational curriculum includes 16 modules. You'll find a brief description of each below.

#### 1. the foundations

An overview of all the practices and knowledge that will be transferable to all of the modules in this training.

## **2. peer support & wholeness**

Provides an introduction to peer support work and explores differences between the peer support role and other roles within the mental health and substance use systems.

## **3. categories & containers: unpacking our biases**

Helps you understand how and why we judge.

## **4. self-determination**

Looks at self-determination, the theory of self-determination and how peer support workers can support creating an ecology where people trust their own inner wisdom.

## **5. cultural humility**

Explores how to approach your peer support work through the lens of cultural humility and helps you understand how culture (and the destruction of culture) shapes our lives.

## **6. understanding boundaries & what it means to co-create them**

Examines boundary creation within the context of peer support, grounded in the core value of mutuality.

---

## **7. connection & communication**

---

Focuses on cultivating compassion and empathy, listening deeply to understand, and asking powerful questions to increase reflection and connection.

---

## **8. healing-centred connection: principles in trauma-informed care**

---

Brings together all the learnings from previous modules to support the creation of environments and relationships that are safe and trauma-informed.

---

## **9. social determinants of health**

---

Explores the social determinants of health and how social, economic and other factors lead to better or worse health outcomes.

---

## **10. supporting someone who is grieving**

---

Examines how to understand grief and loss in order to support someone who is grieving, without trying to “fix” or “save” them.

---

## **11. substance use & peer support**

---

Explores the principles and methodologies around the harm reduction approach to substance use disorders and some of the history around the criminalization of substance use.

## **12. mental health & supporting those in crisis** —

Explores the mindset shift necessary to support someone through a crisis.

## **13. goal planning** —

Focuses on how peer support relationships can support the creation and meeting of goals.

## **14. building personal resilience** —

Explores ways to build resiliency, create wellness plans and practice self-compassion.

## **15. family peer support** —

Explores family peer support work and how, by working from a place of shared lived experience, family peer support workers can create positive change for families by building long-term relationships based on trust with those supporting loved ones.

## **16. working with youth & young adults** —

Explores the unique application of peer support principles to working with youth and young adults.

## 4. table of contents

---

Below you'll find a short overview of the topics you'll find in this module.

As you move through these topics, please remember you can always return to this page to revisit the main ideas being explored in each lesson.



### life application story —

A lived experience first-hand story of substance use.

### what is harm reduction? —

Examines the history of harm reduction, harm reduction modalities and core harm reduction principles.

## **person-first language & anti-oppressive practice**

Outlines specific person-first language and anti-oppressive practice in respect to substance use.

## **the importance of self-compassion within substance use**

Explores self-compassion as a core tenet of substance use.

## **naloxone & the good samaritan drug act**

Examines naloxone as well as the legal implications of assisting someone during an overdose.

## **recovery with the lens of harm reduction**

Provides ways to examine recovery through a harm reduction lens.

## **other substance use perspectives & programs**

Outlines abstinence, 12-step models, cultural approaches and other perspectives on substance use.

## **prohibition & the “war on drugs”**

—

Looks at the history of prohibition and the “war on drugs.”

**criminalization of people who use** —

Examines the criminalization and decriminalization of people who use drugs.



## 5. our focus

---

**What's the focus of this module?**

1 of 1

The province of British Columbia takes a harm reduction approach to substance use. There are many layers of complexity that comes with substance use. Because of our history going back to prohibition, the War on Drugs, and the criminalization of people who use drugs, it's very easy to dehumanize those who struggle with substances.

It's essential that people who use substances are treated with the respect that they deserve. This module will walk you through some of the history, and we'll cover some of the principles and methodologies around the evidence-based harm reduction approach and how it connects to lived experience and peer support work. We'll also share some other approaches that people have benefited from.

**after reviewing this module, you'll be able to...**





**Explain the principles of harm reduction and why B.C. has adopted this approach.**



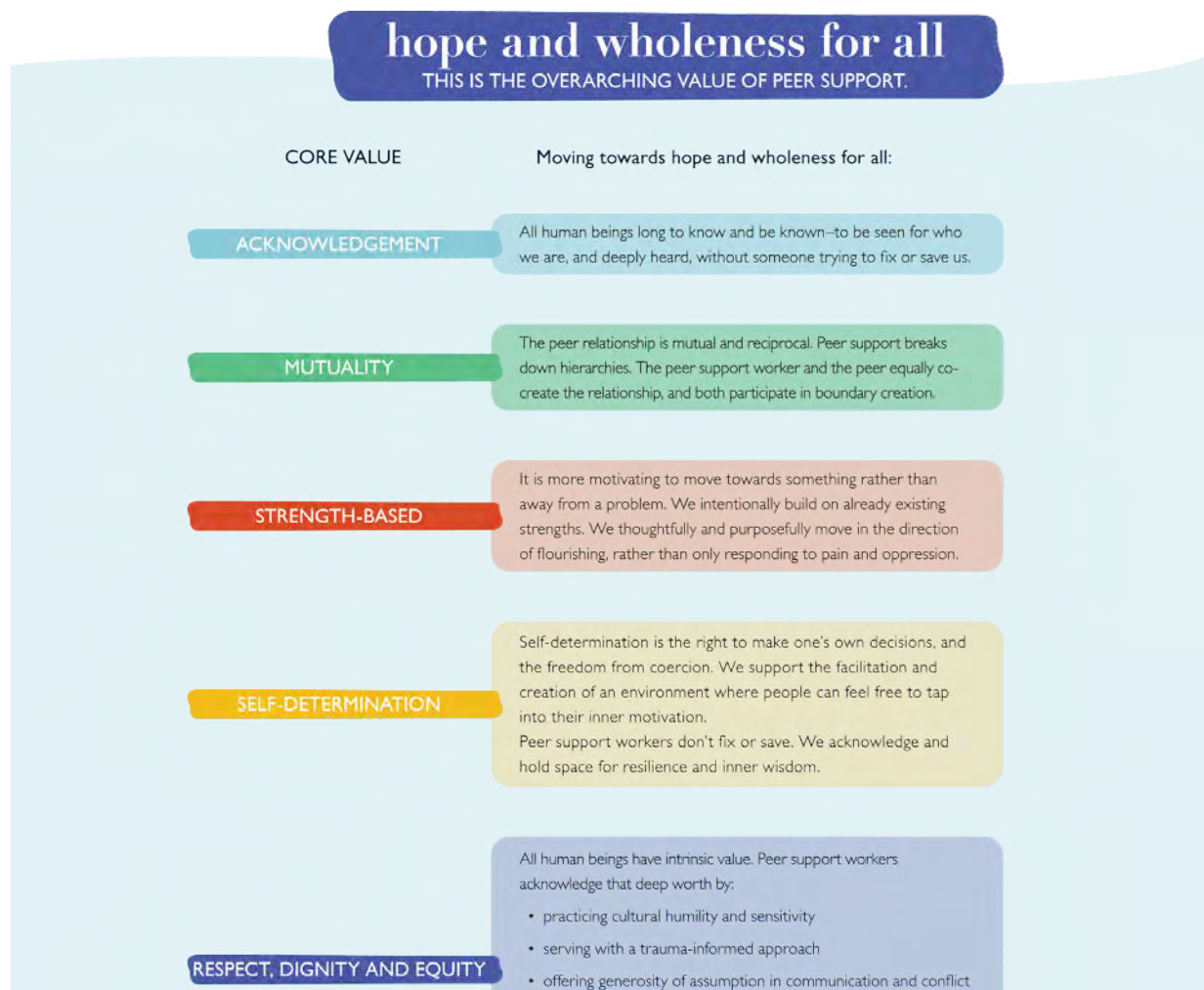
**Apply the knowledge from other modules to reduce the harms arising from systemic oppression/stigma/prohibition and to promote hope inducing strategies in service users.**



**Challenge the myths around substance use, substance use disorders and dependence.**

## 6. core values

The following core values are essential for peer support work. At the end of this module, you'll be asked to decide which ones are key to this topic.



- mindfully addressing personal biases

Peer support is about meeting people where they are at and serving others with a knowledge of equity.

## BELONGING AND COMMUNITY

Peer Support acknowledges that all human beings need to belong and be a part of a community. Peer support recognizes that many people have barriers that keep them from developing community. We actively work towards deconstructing those social blockades that prevent inclusion and acceptance. Peer support workers serve with a social justice mindset, and intentionally practice empathy, compassion & self-compassion.

## CURIOSITY

We are always intentional about how curiosity and inquiry support connection, growth, learning and engagement.

This curiosity isn't fueled by personal gain but by a genuine interest in connection. We encourage curiosity while respecting the boundaries and protecting the privacy of the people we support.

We are continually curious, but not invasive, while challenging assumptions and narratives. We ask powerful questions. We offer generosity of assumption to those who think differently than we do. We know that listening and asking questions are more important than providing answers.

**\*Note on the meaning of the term "generosity of assumption" from the glossary of terms:** Assumptions happen when we don't know the whole story, and allow our brains to fill in the blanks. Often we make negative assumptions about people or situations. Generosity of assumption means that we extend someone the most generous interpretation of their intent, actions, or words.

## 7. life application story

---

Charlene shares her first-hand lived experience as a person who uses substances and as a peer support worker.

### charlene's story

"I was a housewife for 18 years. I was a privileged, white, middle class mother of two and was a stimulant user, very controlled, and then towards the end of my marriage when things turned into chaos with my husband's mental health, I kind of took a nosedive and was using to stay alive. Normally I only used when my children were in bed, and it was really controlled in a lot of ways, and then I lost that control just to save my own mental health in a sense. And then I left the marriage, and I went to treatment, and I'm still an active substance user.

I'm presently the person with lived and living experience and the stakeholder engagement lead at the British Columbia Centre for Disease Control (BCCDC), and I'm a provincial peer coordinator with the Compassion, Inclusion and Engagement project, which is a collaboration with BCCDC and First Nations Health Authority (FNHA). I also founded CSUN – the Coalition of Substance Users of the North, which is still to this day the only well-established drug user organization that's providing service in community so... my work has just ebbed and flowed, and this is who I am today."

### **What was the "Aha" moment that led to you finding increased stability and improved mental health?**

"I think it was an evolution. Sitting with other people with lived and living experience and hearing the amazing things they had to say... it wasn't really an 'aha' moment but at some point, I said to myself, actually I'm not the problem. The system is the problem. And that's what I try to teach to other people is that you're not junkies and crackheads and all these other things; you're a person who uses substances who should be fighting to get equality and equity in healthcare provision and supporting people to reduce the harms in their own lives. If that means still using substances, just ensuring that you're reducing the harms as best you can and letting you... have autonomy to drive your own bus and make those decisions for yourself. And stop having the system tell you that 'I will help you if you do what I tell you to do, if you follow our path.' "

### **What led to you becoming a peer support worker and how do you best support others?**

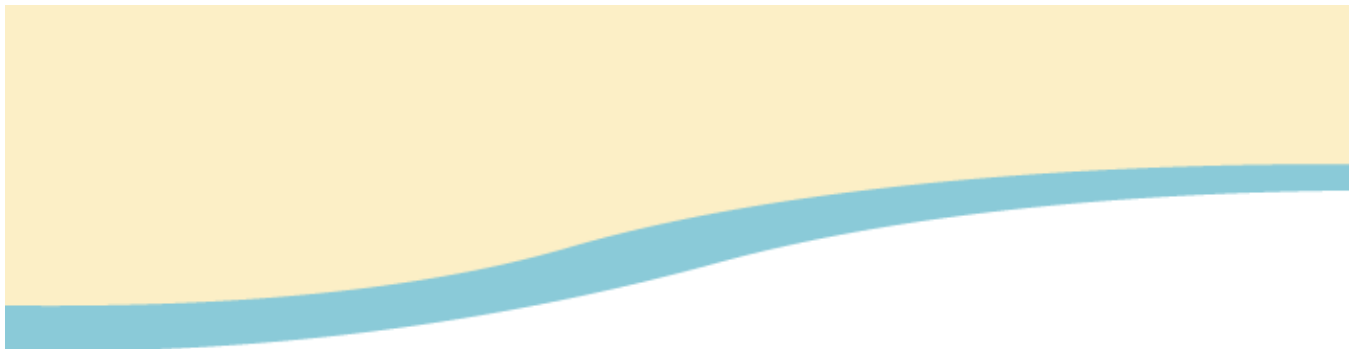
"I think it was empathy. I'd been in a really low place and knowing the system and knowing all the stuff that feeds into this inertia of this overdose crisis and the constant... preventable loss of life... I don't know if I chose this work or this work somehow chose me.

Part of it is teaching people what I have learned about recognizing that it's the system that's failed you, you haven't necessarily failed yourself. And that the messaging that we quite often get from family, friends, community is the problem. You need to find within yourself what is it that you want. If abstinence and sobriety is your goal, then there are options for you. If maintaining a healthy relationship or a healthier relationship with drugs is where you want to be, what do you think you could do to minimize those harms and have a better relationship with substances and with community and family?

I always encourage others to make the decisions for themselves. What can I do to support you, not what can I do for you? Because building resiliency within yourself is the only way you're going to have a successful overall approach. It's about being there for people and supporting them in the way that you can and recognizing that you have to have boundaries in that as well.

It's about finding a place where I know I'm wanted, and I'm supporting people and people walk away from me not feeling stigmatized and they may feel better about themselves, that is the part of the work that I really love. I don't want to be someone's voice for them. I want to help you strengthen your own voice and be able to stand up for yourself. And if that's coming back to an advocate and having that advocate assist you while you learn that process and learn to advocate for yourself, that's really important work.

Peers do that for each other every day."



## 8. walking alongside someone who's using substances

---

**“There are lots of positive reasons for using drugs like having fun socially, good sex, going to a music festival, helping someone cope with life issues. So even though we may use because we are grieving, or have gone through trauma, for some of us drugs helped us to cope. Myself, I was suicidal at times, and if I didn't**

**use, I probably would have gone through with it. Some of us just feel normal when we use. It is the criminality, and health risks, that cause much of the heartache, not so much the drug use itself.”**

J.M, Peer Support Worker

Like J.M. says above, there are many reasons someone may use substances, whether it's recreationally, to cope with grief and loss, or due to generational trauma; pain relief; poverty; [structural violence](#); living with a mental health diagnosis; physical, emotional or sexual abuse; or loneliness to name just a few.

As peer support workers with our own rich, lived experience, we're uniquely placed to meet someone where they're at on their substance use journey and to build trusting, positive, genuine relationships that are deeply rooted in empathy and connection. Our goal is to help those seeking our services to rebuild a sense of control and empowerment through what we share and in how we support them.





---

## Your relationships are activism.

As peer support workers, we often work outside of our formal jobs to build equity, but it's in our relationships with those seeking our services that we can actually deliver on that dream of equity by encouraging those who use substances to feel like they have the power to make decisions about their own lives and to support them in doing just that.



**“Peer recovery support focuses on long-term recovery and is rooted in a culture of hope, health, and wellness.**

**The focus of long-term peer recovery support goes beyond the reduction or elimination of symptoms to encompass self-actualization, community and civic engagement, and overall wellness.”**

Substance Abuse and Mental Health Services  
Administration (SAMHSA)

CONTINUE

**“People who use drugs are not expendable—they are human beings who come from families who love them.”**

Harm Reduction: A British Columbia Community Guide



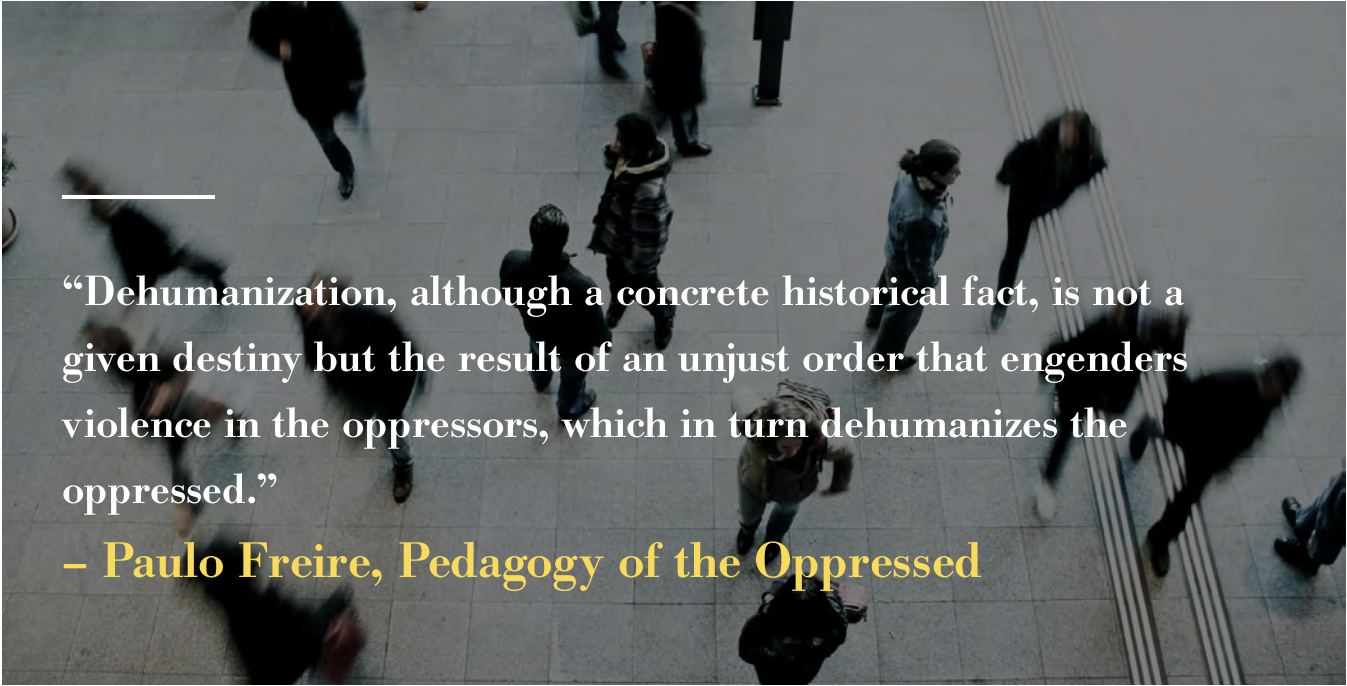
## humanizing recovery

Our focus as peer support workers needs to be on **humanizing recovery**.

What do we mean by this?

At its heart, the idea of humanizing recovery is simple: dead people don't recover. Deeper than that is the fact that when people are marginalized and oppressed, they face additional barriers to recovery. Our work as peer support workers is to support those who've been marginalized to find their voices in whatever way works for them. We can work together to mend some of these harms, so that people can be guided to a place where they can use self-determination to make choices about their own lives.

By humanizing substance use, we support equity, which in turn supports those who use substances to recognize and feel like they have the power and skills to make decisions about their own lives. The strength we bring is in the relationships we build and the trust and bonds created with peers.



“Dehumanization, although a concrete historical fact, is not a given destiny but the result of an unjust order that engenders violence in the oppressors, which in turn dehumanizes the oppressed.”

– Paulo Freire, *Pedagogy of the Oppressed*

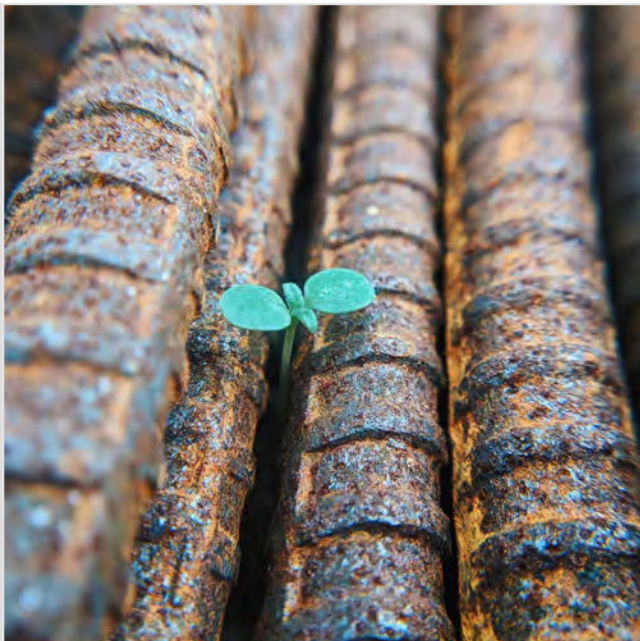
# questions for reflection

Answer these questions in your reflection journal.



**When supporting someone with a substance use disorder, what are some ways you can work to build a trusting relationship?**

1 of 3



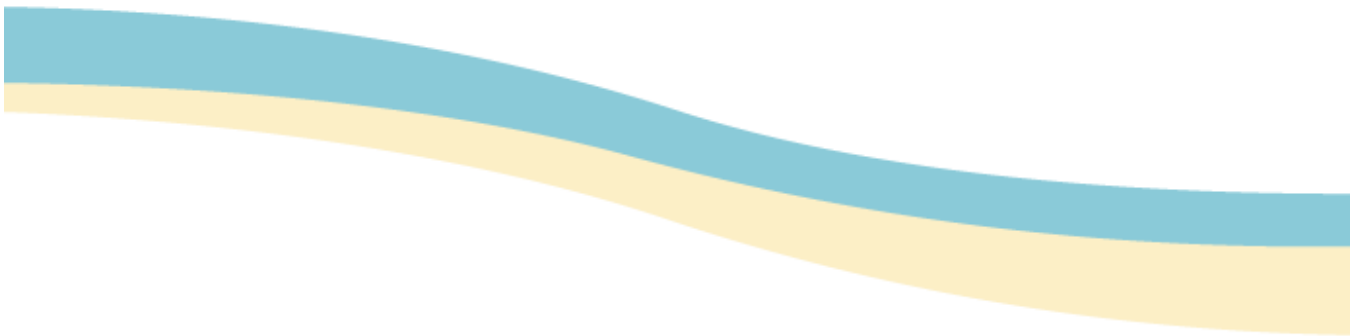
**What other ideas or core values you've learned about in other modules also feel important when supporting someone who uses substances?**

2 of 3



**What might you share about  
your own story or experience  
(within your comfort levels) that  
may help move a peer towards  
hope and possibility?**

3 of 3



## 9. what is harm reduction?

---



Let's first look at the term "harm reduction."

A very simple way to look at harm reduction is to think of it in terms of reducing the potential harm of injury or death from things that are preventable.

Most of us practice this basic principle every day. For example, when we choose to use seatbelts in a car, we're reducing the harm that can come from a car accident. When we wear sunscreen, we're reducing our potential harm from the effects of sun. When we wear a helmet on a bike ride, we're reducing the potential for brain injury

or death in the case of an accident. We accept that some degree of risk exists in our day-to-day activities and attempt to reduce the potential for harm.

The International Harm Reduction Association (2002) describes harm reduction as:

**“Policies and programs which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individual drug users, their families and communities, without requiring decrease in drug use.”**

Harm reduction is, in essence, the act of reducing the risks of any behaviour to create better outcomes for individuals and communities alike. In a substance use context, harm reduction can be practices like drug testing kits, supervised injection sites or carrying a naloxone kit.

**Healthlink BC’s Understanding Harm Reduction: Substance Use (2020) expands on this idea:**

---

**“Harm reduction is a public health approach that aims to reduce harms related to substance use. Harm reduction includes many options and approaches. It may include abstinence, or not using substances at all. Stopping all substance use isn’t required before receiving care. It meets people wherever they are in their substance use journey. Evidence shows that harm reduction does not increase or encourage substance use.**

**Harm reduction strategies and services can lessen the consequences associated with substance use. The consequences include social, physical, emotional and/or spiritual concerns. It may include access to safer sex and safer substance use supplies and/or take home naloxone. It also involves outreach and support programs and referrals to health and support services. Harm reduction helps ensure services are non-judgmental and available to all.**

**Harm reduction treats people with respect. It helps people connect with others and develop healthy relationships. It involves working directly with people and their communities. The service helps individuals; families and friends learn harm reduction skills. People can learn about the resources and supports in their communities.”**





## where did harm reduction come from?

Harm reduction is now a well accepted public health approach, but where did it start?

When most folks think of harm reduction they usually picture a safe consumption site with harm reduction supplies like rigs, cookers, rubber ties, water, matches, candles and everything that someone who uses substances might need in order to use safely and not be at risk of blood borne diseases.

But where did the idea for creating safe spaces for people who use drugs/substances even come from? What about the idea of having someone witness someone else using illicit substances in order to respond to a potential overdose? Where did the idea to package up those harm reduction materials (many of which were previously used for entirely different things) for people to use substances safely come from?

In short, where did the idea for places like Insite (which we discuss in more detail later in the module) begin?

---

**It came from you. Harm reduction belongs to you.**

The information that we see used by health authorities as an expert medical response to substance use is borrowed from marginalized communities such as people who use substances, people who engage in sex work, LGBTQ+ communities and other oppressed groups. These ideas and these materials were then turned into services that have been delivered in a way that's often ended up further stigmatizing and creating more barriers for the very community where those ideas came from.





We offer this perspective not to blame health authorities (people with lived experience of substance use are rightfully proud of the fact that these ideas live in safe consumption sites throughout the world). Instead, we want to remove the idea that expertise comes only from those with medical training. We also want to point out that those with lived experience of using prohibited substances have been the main contributors to some of the most effective responses to the harms they face as individuals and communities.

**“When we talk about harm reduction, we often reduce it to a public health framework, one of reducing risks. That’s harm reduction with a small h-r. Harm reduction is meeting people where they’re at but not leaving them there. But harm reduction with capital H and R – this is the movement, one that shifts resources and power to the people who are most vulnerable to structural violence.”**

CONTINUE

## a brief history of harm reduction

**i** NOTE: As the quote by Monique Tula above shows, **Harm Reduction** (capitalized) refers to the philosophical and political movement focused on shifting power and resources to people most vulnerable to structural violence, whereas **harm reduction** (lower case) refers to the approach and fundamental beliefs in how to provide the services.

---

Harm Reduction is a movement that has been led by peers and driven by oppressed and marginalized groups since it began. It still belongs to us. It's something we can be proud of and draw strength from.



The [National Harm Reduction Coalition website](#) explains that, like the peer support movement, Harm Reduction has its origins in multiple peer-driven movements, strategies and activism that began in the 60s, 70s and 80s. In the U.S., activist response to the AIDS crisis, the women's health movement, feminist activism and acupuncture programs for people who use heroin in the South Bronx were just some of the early inspirations.

In the late 80s, Canada became an early pioneer of harm reduction approaches in response to rising HIV infection rates among people who use intravenous substances. Peer-led and informal syringe distribution began in Vancouver, Toronto and Montreal in 1988. Today, most of the country has syringe distribution programs.



Federal support for harm reduction continued until the mid-2000s and included

- Recognition of harm reduction as one of the central pillars of federal drug policy



- Two temporary legal exemptions to allow for the opening of [Insite](#), North America's first supervised injection facility, without risk of criminal prosecution under federal drug laws
- Attempts to decriminalize cannabis possession
- Implementation of Canada's first heroin-assisted treatment clinical trial

Unfortunately, in 2007, the Government of Canada removed harm reduction as an official pillar of the federal drug strategy, but municipal and provincial governments continue to develop harm reduction services together, recognizing the value of harm reduction as we try to deal with an overdose crisis and other instances where people are engaged with problematic substance use.

In 2020, B.C. became the first province to offer prescribed safer supply. Safer supply options provide people who use drugs with access to clean, regulated drugs in a safe and supportive environment. These options are designed to reduce the harms associated with drug use, such as overdose and transmission of infectious diseases like HIV and hepatitis C. They include programs like Opioid Agonist Treatment (OAT), Overdose Prevention Sites (OPS) and drug checking services. Safer supply options are a crucial harm reduction strategy in B.C. and have helped reduce overdose deaths in the province.





In 2023, the Province of British Columbia took a significant step towards harm reduction by decriminalizing the possession of small quantities of drugs for personal use. This means that people 18 years or older caught with a small amount of drugs will no longer face criminal charges or be subject to incarceration. Instead, they will be directed towards health services and support to address substance use disorders. This move is aimed at reducing the stigma around drug use and providing individuals with the help they need, rather than punishing them. It is hoped that this change in policy will improve the health outcomes of people who use drugs and reduce the burden on the criminal justice system.

This means that people 18 years or older 'who are carrying' a small amount of drugs will no longer face criminal charges or be subject to incarceration.

---

**We need to keep in mind that while harm reduction has been incorporated into healthcare systems and has become a political issue in many ways, we made harm reduction happen. It's grounded in *our***

experiences, and we have valuable insights that have and will continue to shape what harm reduction looks like in action.

CONTINUE

## harm reduction approaches

**Between January 1, 2020 and December 31, 2022, 6,263 people died in B.C. from toxic drug overdoses. B.C. has been in a state of public health emergency since 2016, and overdose numbers continue to rise.**

---

**Let's be clear: dying from overdose  
is preventable.**

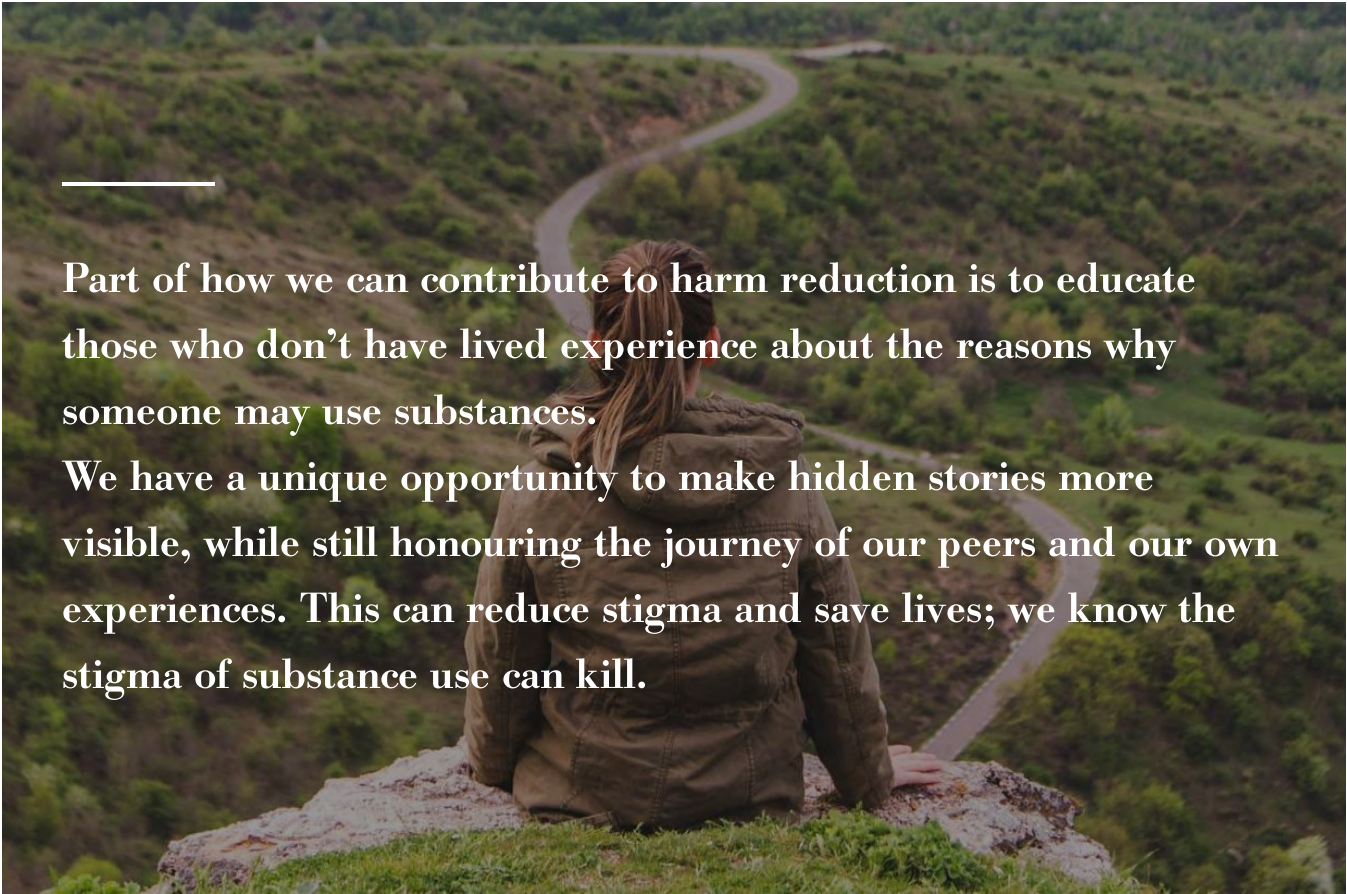
Harm reduction aims to meet people where they're at, promoting safety and support that's free from judgement. As peer support workers with lived experience, we bring our own understanding of what this means and how we can bring hope, compassion and a more human-focused lens to all aspects of harm reduction.

The foundation of harm reduction is that there's never been a drug-free society. Strategies that reduce the potential harm that can come from drug use ask that we suspend any judgement around drug use and work

instead to reduce its impacts.

Harm reduction can involve many different approaches and supports. These supports can include needle distribution, safe disposal, supervised consumption services (SCS) and overdose prevention sites (OPS), medication-assisted treatment, safer supply and overdose treatments like naloxone.

There's no one approach. What works for some, may not work for others. The list above includes just some of the ways harm reduction is manifested in services. In fact, it's important to note that harm reduction is not a set of services but rather an underlying philosophy of care that belongs in every care setting.

A photograph of a person with long brown hair tied in a ponytail, wearing a dark jacket, sitting on a large rock. They are looking out over a vast, green valley with a winding road that curves through the landscape. The scene is captured from behind the person, emphasizing the journey ahead.

Part of how we can contribute to harm reduction is to educate those who don't have lived experience about the reasons why someone may use substances. We have a unique opportunity to make hidden stories more visible, while still honouring the journey of our peers and our own experiences. This can reduce stigma and save lives; we know the stigma of substance use can kill.

CONTINUE



# the principles of harm reduction

(adapted from [Harm Reduction: A British Columbia Community Guide](#))

## realistic approach —

Harm reduction takes a realistic view of substance use. As we've mentioned, harm reduction accepts the fact that the non-medical use of mood altering or psychoactive substances happens almost worldwide. Harm reduction therefore acknowledges that, although there are risks, substance use also gives the person who uses benefits that have to be taken into account. Harm reduction also recognizes that drug use is complex and includes a range of behaviours from chronic dependence to abstinence. There are also different degrees of harm to individuals and communities.

## human rights —

Personal choice, self-management and taking responsibility are key components of harm reduction. It respects the rights and basic dignity of people who use substances and accepts their decision to use as fact, without judgement. There's no move to either support or condemn substance use – 'it is what it is'. Harm reduction supports informed decision making when it comes to active drug use and recognizes an individual's right to freedom of choice and self-determination – a core value we continue to explore in this work.

## focus on harms —

As the name suggests, harm reduction places emphasis on the harms of substance use over how much the person uses or the fact of their substance use. Priority is given to decreasing any negative consequences of substance use – both to the person who uses and others – rather than attempting to decrease the substance use itself. While harm reduction encourages safer practices and patterns of substance use, it also doesn't exclude a longer term goal of abstinence. In this way, harm reduction complements the abstinence model of addiction treatment.

### maximize intervening options —

Harm reduction acknowledges that people who use substances can benefit from a variety of approaches and treatments; there's no "right way" to do it, no single treatment or one type of prevention option that works across the board. People are kept safe and alive through easy, early access to a range of interventions and the ability to choose. Involving both individuals and communities impacted by substance use in the co-creation of effective harm reduction strategies is also key.

### priority of immediate goals —

Harm reduction starts with where a person is at in their substance use, with a focus on their most immediate concerns or needs as the starting point. Harm reduction then establishes achievable goals or steps that, taken one at a time and gradually built on, can lead to a fuller, healthier life for people who use substances.

### involvement of people who use drugs —

Harm reduction places people who use substances at the centre of treatment and all related approaches. It recognizes both their freedom and their ability to make their own choices. They're acknowledged as the best source of information about their own drug use, and the focus is on empowering them to work with service providers to determine what may work best in terms of interventions to reduce harm.



CONTINUE

**“Harm reduction can help move a person from a state of chaos to a state of control over their own life and health.”**

Harm Reduction: A British Columbia Community Guide

---

**We’ve mentioned self-determination here, but how do the other core values of peer support connect to these harm reduction principles?**

## 10. harm reduction in b.c.

---



B.C. is recognized both locally and internationally as a pioneer in the development of innovative harm reduction strategies, with much of that work being built on the foundations originally laid by substance user activist groups. People with lived experience continue to lead the way in creating low barrier, community-based approaches such as Overdose Prevention Sites (which were first pioneered in Vancouver) and in reducing stigma.

Let's take a closer look at some of these supports and services.

**NOTE: Please be aware that these services are constantly evolving, adapting and changing and you are encouraged to always confirm information about available services online.**

CONTINUE

## supervised consumption sites

Supervised consumption sites (SCSs) are legally exempt/legally sanctioned, medically supervised facilities where people can use substances they've bought off-site. They offer a safe, clean environment and supervision from trained staff. As Vancouver Coastal Health explains, the goal of these sites is “to decrease the [negative] health, social and economic consequences of drug use without requiring abstinence from drug use.” SCSs serve an important role in harm reduction by providing immediate response to overdoses, increasing people's access to and use of health care and social services, and reducing issues associated with public substance consumption.

The majority of SCS users tend to be the most socially disadvantaged and marginalized people who use injection drugs and who face challenges such as housing insecurity, poverty and a history of involvement with the criminal justice system.

Some B.C.-based SCSs are outlined below, including Insite – the first legal supervised consumption site in North America.

### The Harbour

[The Harbour](#) is located in Victoria, Vancouver Island and has ten consumptions booths, a waiting/reception and post-use areas, as well as a mental health counselling room, a nurse clinic room and a medication room.

In addition to oversight and clinical services provided by Island Health, contracted service partner harm reduction staff provide supervision and education to ensure safer drug consumption, deliver crisis intervention

and manage harm reduction supplies. Contracted service partner SOLID Outreach Society's team of peer harm reduction workers also provide supervision and education, as well as support and advocacy.

## Insite —

**“They teach us how to properly inject ... It’s changed my way of thinking, the way I use drugs, the amount I use ... Before InSite, I didn’t care whether I OD[ed] or not. I didn’t care whether I died. Now I am starting to care about myself more, I have more self respect. Just because of InSite. Now that I’ve somewhere to go and someone to talk to about it, I don’t use as much.” – Dan, Insite Client and research study participant**

[Insite](#), located in the heart of Vancouver’s Downtown Eastside, first opened its doors in 2003 after receiving an exemption from Health Canada to avoid prosecution under federal drug laws. Using a harm-reduction model, Insite offers people who use substances access to a variety of services, including clean equipment for drug consumption to reduce the spread of infectious diseases such as HIV and Hepatitis, as well as drug contents testing.

Insite also provides

- Immediate overdose response services
- Clinical care (e.g., wound treatments and vaccinations)
- Connections to addiction, healthcare and other community services

There is also space for people who use substances to connect with peer support workers with lived experience and who are there to listen and guide them to a range of staff and supports or services, including housing needs or referrals to treatment services.

Referrals are also available from staff for the detox and recovery support offered by Onsite, located just above Insite.

**“There have been more than 3.6 million visits to inject illicit drugs under supervision by nurses at Insite since 2003. There have been 48,798 clinical treatment visits and 6,440 overdose interventions without any deaths.” – Vancouver Coastal Health (VCH)**

## Johnson St. Community – Supervised Consumption Site (JSC SCS) —

Based on Vancouver Island, [JSC SCS](#) opened in 2016 as a temporary Overdose Prevention Site (OPS) in response to the overdose crisis in B.C. It was unique as it was an early OPS located in a housing project and only for use by residents and their guests. A year after opening, it received a Health Canada exemption as a SCS.

JSC SCS was the first permanent SCS on Vancouver Island and is currently the only one located in a housing site, remaining a key service for residents and guests. People can access harm-reduction supplies (including clean equipment), are monitored by staff for signs and symptoms of overdose and can recuperate in a post-use area that includes monitoring and engagement. The site also has other services like an on-site medical clinic, harm reduction education and connection to other services and supports, including treatment.

### Powell Street Getaway

[Powell Street Getaway](#) offers “a variety of structured and unstructured peers programs to encourage people to participate in social and life skills development” (Lookout Housing + Health Society) with a focus on peer support. In 2017, it incorporated a SCS which, like Insite, operates under a Health Canada exemption from prosecution. Service users are monitored for any signs and symptoms of overdose, staff teach them safer injection practices and they can be referred to services like substance use treatment and counselling.

CONTINUE

# overdose prevention sites & services

Overdose prevention services (OPS) are a key aspect of harm reduction. Different sites offer different ranges of services, but in general, OPS provide people who use substances with a clean, welcoming, and culturally safe environment; harm reduction supplies; and witnessed safer drug consumption. Unlike SCSs, OPS don't need to apply for legal exemptions to be able to operate. Another key difference is that most OPS are staffed by community members with lived experience. As the B.C. government explains, OPS "are uniquely positioned as a low-barrier point of introduction to health and/or social services for people with substance use issues."

The first OPS to open in B.C., as a community-led response to fentanyl poisoning, was the [Overdose Prevention Society](#). It began its life as a tent in an alley in Vancouver's Downtown Eastside in 2016. The OP Society provides harm reduction and overdose prevention services and is staffed by dedicated peer volunteers.

---

**Having those with lived experience as staff, and who are trained to recognize and reverse overdoses and provide additional support and resources, is vital to effectively supporting those who use substances.**

Beyond fixed locations, other ways that OPS services are delivered include portable/mobile OPS vans that provide on-the-spot support for those who need witnessed injections as well as needle exchanges and other services; women's only services (for example, [SisterSpace](#)); and peer witnessing services that are embedded in supportive housing projects.

A great example of mobile OPS serving communities outside the Vancouver or Vancouver Island areas are the Kelowna and Kamloops mobile units. These offer harm reduction supplies, counselling, referrals to treatment programs, other medical services, and outreach to surrounding rural communities.





---

One of the powerful impacts of peer-centred OPS is that community members have been able to witness active people who use substances and people on their recovery journey becoming leaders in a movement and saving lives. This is a powerful form of harm reduction in itself, showing that there's value in lived experience, and that anyone can find purpose in using their experiences to provide hope – not just to their community but to themselves.

CONTINUE

# needle distribution programs

As *Harm Reduction: A British Columbia Community Guide* says about needle distribution programs, “[they] are an established international best practice in health.” Many came from grassroots efforts by people who use to protect themselves and others. Whether peer or health-care system provided, the goal of needle distribution is the same: to provide sterile equipment for every injection in order to decrease the risk of blood-borne diseases like HIV, hepatitis or bacterial infections.



Needle distribution programs are also shown to reduce the number of discarded needles in public places and the risk of needle-stick injuries. They also act as an entry point for people who use substances to access other health or social services, including referrals to treatment services if these are wanted and are available in many places across B.C.

As we've mentioned, OPS services and SCSs often provide needle exchange and safe, clean equipment, but needle distribution also exist as services outside of OPS or SCSs, like in supportive housing sites or from mobile delivery services.

CONTINUE

## drug checking & early warning systems

Illegal drugs aren't subjected to the same controls as legal drugs in terms of production, storage or distribution, and this has led to many harms including contamination, adulteration (e.g., through the addition of cutting agents) and dangerously high purity levels. A harm reduction-focused response to these issues includes drug checking as well as early warning systems that are intended to get the message out to both health officials and people who use substances about contaminated batches or unusually high purity levels that could lead to overdoses.

An example of drug checking is the [fentanyl drug testing strips](#) that VCH has made available for take-home use. Staff make sure that those who request the strips know how to use them. According to VCH, "At Insite, clients who checked prior to consuming the substance, and got a positive result for fentanyl, were 10 times more likely to reduce their dose and clients who reduced their dose were 25% less likely to overdose."

Another example is the [Vancouver Island Drug Checking Project](#), which provides free, confidential drug checking (including a drop off-pick up service). Multiple drug checking instruments are used to figure out the sample's main active ingredients, cutting agents or fillers, any unexpected drugs and any presence of fentanyl.

CONTINUE

---

**New initiatives, services and sites are cropping up all over B.C.  
all the time; take some time to familiarize yourself with what's  
available in your area.**

---

## other initiatives

Some other B.C.-based harm reduction initiatives include:

- ☐ Public education campaigns to promote better understanding in the community regarding substance use disorders, stigma and other related issues
- ☐ Partnerships with local businesses, enforcement, community and municipal governments to institute 'sharps container' programs
- ☐ Education for children and youth on safe needle disposal
- ☐ User-initiated, peer-led groups (some of which have since become formal organizations) such as [Kelowna Area Network of Drug Users \(KANDU\)](#) and [Society of Living Intravenous Drug-Users \(SOLID\)](#).
- ☐ [PEERS](#) Victoria drop-in program that provides access to harm reduction supplies and information
- ☐ [Indigenous Harm Reduction Team \(IHRT\)](#) is a group of Indigenous folks who do harm reduction by and for Indigenous people

**“When you see how nurses are running to save lives, you can imagine yourself being saved if you OD’d too. In fact, I can remember the last overdose. The guy suddenly dropped. Boom, right away, the nurses Narcaned him. One nurse was holding his hand, telling him that he was going to be OK ... Or how they treat you as human beings; it does make you feel good. When I come to InSite, I don’t feel that I’m a junkie anymore.”**

**Ayatollah, Insite service user and research study participant**

## 11. person-first language & anti-oppressive practice

---

“I am learning to remove the stigma around my addiction and drug use. I am an empathetic, loving, caring, strong warrior of a woman and I love myself, and I won’t allow anyone to shame or guilt me due to what I choose to put in my body. ”

BeeLee Lee



## CONTINUE

As we've explored in other modules, most of the time when we use person-first language, we use language that communicates deep respect for the people we support, whether or not they're there with us at the time. It's about honouring and respecting people outside of the labels imposed on them by others.

When we think of person-first language and substance use, it means challenging old ways of speaking. We say "a person who uses drugs" as opposed to calling someone "an addict" or "junkie," which can be dehumanizing terms. We know that dehumanization is sneaky and dangerous – it spreads until people are robbed of their dignity and complexity, and it leads to self-stigma as well as other negative consequences.

Research shows that use of the terms "drug abuse" and "drug abuser" also negatively impacts perceptions and judgements about people with substance use disorders, including whether they should receive punishment or incarceration over medical and other interventions.

Some person-first language to use (based on guidelines from The Office of National Drug Control Policy):

CONTINUE

## **a note about language use & self-determination**

We generally recommend using person-first language when developing your peer relationships, but we also encourage you to check in with peers about what language feels good for them. You can ask what words they use to describe their identities, as well as their relationships to substances or mental health challenges. You can ask if it is ok for you, as the peer support worker, to use that same language in reference to them or what it is that they prefer.

As your relationship with the peer develops, you might find opportunities to shift the language being used and to move towards options that reflect their worth, dignity and humanity. An example might be that when you're first developing a relationship with a peer, they may describe themselves as a "junkie", a "user" or an "addict." As your relationship develops, you can invite a conversation about how it feels if/when others use those words for/about them, and if there are other ways they like to have their relationship to substances described. This may be a good place to discuss person-first language and how it fits with anti-oppressive practice.





CONTINUE

## questions for reflection

Answer these questions in your reflection journal.



**Can you think of any terms you may still use that may be harmful to yourself or others from a person-first perspective and that you want to stop using?**





**How might you work on helping others to stop using these types of terms?**

2 of 3



**When you think about these person-first terms in relation to substance use, how do you think they change the way the person being referred to is characterized?**

3 of 3

“People who have mental health and substance use disorders are friends, colleagues, family and neighbours. They are us.”

Government of B.C., *Pathways to Hope*

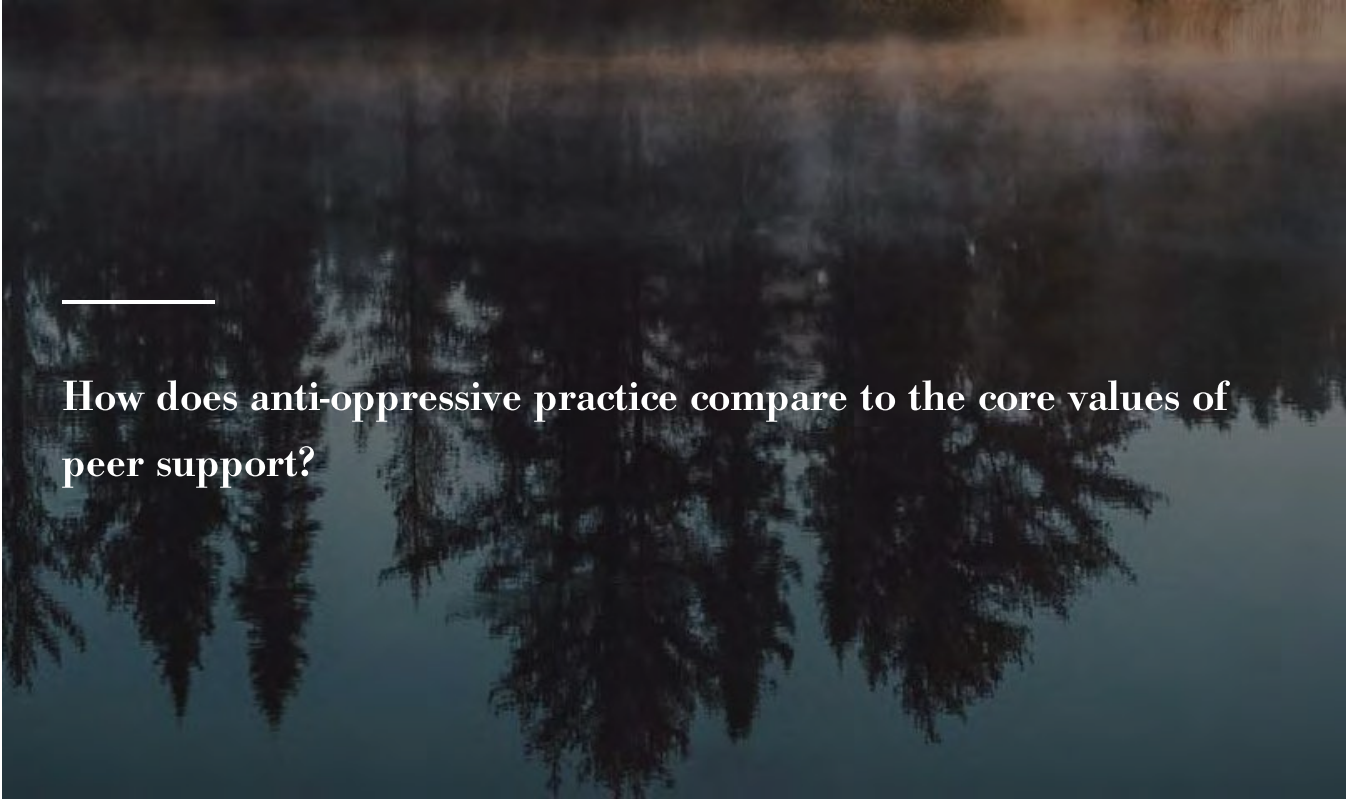
Person-first language in the context of substance use is a form of anti-oppressive practice. Anti-oppressive practice should be part of everything we do in our peer support work, as it seeks to prevent or lessen the exclusion of certain social groups from social equity, rights and social justice.

We’ve discussed stigma before, but it’s worth noting that in [\*A Pathway to Hope: A roadmap for making mental health and addictions care better for people in British Columbia\*](#), the Government of B.C. mentions that people with substance use disorders and/or people living with a mental health diagnosis report that judgement by others is a major barrier to their recovery. Stigma can stop people from seeking help, because they’re scared of what others might say or think about them. Person-first language is a way we can help combat stigma.

---

**It’s important that we acknowledge and challenge any oppressive worldviews, judgements or biases when we support people using substances. Practicing this kind of anti-oppression work in this very concrete way is about confronting societal bigotry as well as confronting ourselves and our own roles of power and oppression in our communities.**

---



How does anti-oppressive practice compare to the core values of peer support?

## 12. the importance of self-compassion within substance use

---

We'll be doing a deep dive into self-compassion in module **14. building personal resilience**, but it's important to briefly examine it here in the context of substance use.

Self-compassion can be defined as the practice of offering compassion, kindness and tenderness towards oneself.

When we practice self-compassion, we become more aware of the common humanity that unites us all. We recognize that struggle and failure is a part of the human condition, and when we mess up, we respond in kindness, rather than choosing to beat ourselves up. The practice also invites us to be mindful of our pain. Ignoring our pain, or fixating on our pain and getting caught in self-pity, can keep us stuck.





---

**The only way out of our pain is through it.**



CONTINUE

One of the things that people often misunderstand about self-compassion is that they think it “lets us off the hook” – that somehow by choosing compassion for ourselves, we’re taking the easy way out. However, there has been a lot of research done around self-compassion that says otherwise. Researcher Dr. Kristin Neff notes that people who practice self-compassion are actually more likely to practice taking personal responsibility for the results of choices they made that were in their control and outside of systemic issues.

In *Does Self-Compassion Mean Letting Yourself Off the Hook?* (2015), Dr. Neff says:

**“Another study by Mark Leary and colleagues found that when participants were instructed to be self-compassionate when thinking about a past mistake, humiliation or failure, they were more likely to accept personal responsibility for what happened rather than blaming things on outside people or events. Other studies have found that self-compassionate people are more likely to feel guilt (a sense of remorse and the desire to make amends) rather than shame (a negative evaluation of one’s worth as a person) about past offenses, and are also more likely to apologize for their mistakes.”**





Consider how “all or nothing” thinking when it comes to substance use can actually create a cycle of “stuckness.” When someone has a setback and their “fall off the wagon” is viewed as a major failure, that essentially erases the progress they’d made. This can undo all of the good work the person has done to support their wellness and recovery, sending them into cycles of shame. It can remove the person’s ability to offer themselves self-compassion.

However, if a person is actively practicing self-compassion, they can offer themselves kindness and tenderness through the ups and downs that happen in regular life. If a bigger setback happens, they’ll be far more likely to exercise personal responsibility, which empowers them to continue their growth journey rather than become stuck in shame.

---

## Self-compassion is at the root of the philosophy of harm reduction.

CONTINUE



“Being cut off from our own natural self-compassion is one of the greatest impairments we can suffer. Along with our ability to feel our own pain go our best hopes



for healing, dignity and love. What seems nonadaptive and self-harming in the present was, at some point in our lives, an adaptation to help us endure what we then had to go through. If people are addicted to self-soothing behaviours, it's only because in their formative years they did not receive the soothing they needed. Such understanding helps delete toxic self-judgment on the past and supports responsibility for the now. Hence the need for compassionate self-inquiry.”

Dr. Gabor Maté

CONTINUE

**Think about a situation where you're working with a peer who has a substance use disorder. They may be in crisis and have been experiencing dehumanizing interactions with the general public or government red tape or other setbacks all day. They see you at a time when they're full of anger and shame and frustration, and it's boiling over.**

**Now think about what you'd hope someone might say to you or has said to you when you've been in a similar situation. Sometimes just something simple like "can I grab you a glass of water, and we can sit and talk?" can cut through the anger, shame and blame, opening up a conversation because you're recognizing the humanity of that person and holding space for them.**



## 13. the good samaritan drug act & naloxone

---

**“This is people on the ground helping each other... A lot of people are seeing people die and they are doing something about it [with Naloxone]... It is an easy thing to do to save lives.”**

**Sarah Blyth, Overdose Prevention Society**



## the good samaritan drug overdose act

Due to ongoing stigma and criminalization of drugs, many people are concerned about whether to call paramedics or 9-1-1 when someone overdoses for fear of legal issues, especially because police are usually dispatched during suspected overdose situations. In order to encourage people to call for help, the Good Samaritan Drug Overdose Act (an amendment to the Canadian Controlled Drugs and Substances Act) was introduced in 2017 to provide some legal protection for people who experience or witness a drug overdose and call 9-1-1 for help.



The Act means a person won't be charged for possession or get charged related to the violation of certain conditions if they seek emergency medical or law enforcement help for themselves or someone else who's overdosing on a controlled substance. The Act also protects the person who gets help, whether they stay or leave from the overdose scene before that help arrives, as well as anyone else who's at the scene when help arrives.

CONTINUE

## **naloxone**

When you give Naloxone (also known by the brand name NARCAN®) to someone experiencing an opioid overdose, it temporarily blocks the body's opioid receptors, reversing the overdose and restoring their breathing and consciousness. We strongly encourage peer support workers to get training in how to administer naloxone

and to carry a treatment kit with them in the event their peer experiences an overdose. Naloxone kits are usually available for free.

Note that Naloxone doesn't help for overdoses caused by

- ☐ Alcohol
- ☐ Stimulants like amphetamines or ephedrine
- ☐ Benzodiazepines (drugs used to treat seizures, anxiety and other diseases)
- ☐ Sleep medications

However, it won't do any harm to someone who's overdosed from these types of substances, so it's okay to give them naloxone if you aren't certain of exactly what caused the overdose.

You can find online naloxone training information at [Toward The Heart](#).



## 14. recovery with the lens of harm reduction

---



**Recovery is a journey, not an end goal.**

The term “recovery” in substance use doesn’t have the same meaning as it does in mental health. It’s important to address this difference. The term “recovery” has a long history and has often been associated with a more



abstinence-based paradigm.

For this training, while we choose to use the word recovery, we've redefined it to align with a harm reduction approach.

CONTINUE

## pathways to recovery

From the Standards of Practice (SOP) document:

**“It’s very important to highlight that recovery doesn’t mean the absence of pain, struggle or setbacks. The BC peer support project takes a harm reduction approach to substance use. That means that recovery isn’t dependent on the absence of using substances. People can use substances and be engaged in recovery. Also, people can use substances and still provide peer support services.”**



We likely know through our own lived experience and peer support work that there are multiple pathways to recovery. Different people need different supports and have different access needs based on their particular relationship to substance use. Someone may not be ready, willing or able to stop using substances; however, a person can still get help and make positive changes in their lives and set recovery goals, beginning their recovery journey in a way that works for them.

Recovery-oriented care and harm reduction are closely linked. A recovery-oriented approach uses strategies to empower people to use their strengths and skills to help them lead the life that they choose when experiencing substance use.

## **a note about harm reduction & sobriety**

Harm reduction and sobriety are not opposites, and harm reduction and sobriety communities are not in opposition to one another.

Harm reduction is anything that reduces the harm of a behaviour. Harm reduction includes practices like carrying a naloxone kit, fresh supplies and drug contents testing kits.

Sobriety is the decision to refrain from substance use entirely. This is a type of harm reduction that works for some people.

Some people move back and forth between sobriety and harm reduction approaches. Some people need to remain totally sober. Some people need access to harm reduction services to make using safer.

Sobriety is not morally superior to substance use, nor is it a judgement on substance use.

Different people need different supports and different access needs based on their particular relationship to substance use.

Regardless of our own needs, full decriminalization of all drugs and widespread access to harm reduction practices would make things safer for everyone.



CONTINUE

## recovery goals & journeys

Let's look closer at what we mean by recovery goals and recovery journeys (based on the Mental Health Commission of Canada's definitions):

### RECOVERY GOAL

A recovery goal is an individually defined goal focused on a person living a life that's satisfying and hopeful, even if they're experiencing ongoing symptoms of substance use or a substance use disorder, or are living with a mental health diagnosis. As we've mentioned, a person's recovery goal may or may not include abstinence.

### RECOVERY GOAL

A recovery journey is the process of change a person experiences on the way to reaching their recovery goal. The journey includes increased personal responsibility and control and a broad range of activities that are person-centred, promoting self-compassion, hope and resilience.

### RECOVERY JOURNEY

## setting recovery goals

Setting mental-health related recovery goals is an important step towards achieving better mental well-being. To set these goals, it is essential to first assess your current mental state and identify areas that need improvement. From there, you can set specific and achievable goals that align with your personal values and priorities. It is important to break down these goals into smaller, more manageable steps and create a timeline for achieving them. You should also consider seeking support from mental health professionals or loved ones to help you stay on track and navigate any challenges that may arise. Finally, it's important to celebrate your successes and acknowledge that setbacks are a natural part of the recovery process. By setting realistic and meaningful goals and taking consistent action towards them, you can build a more positive and fulfilling recovery journey.

## examples

There are many mental-health related recovery goals that one can set depending on their individual needs and circumstances. Here are a few examples:



**Developing coping strategies for managing anxiety:** This could involve learning deep breathing exercises, practicing mindfulness or engaging in activities that help you relax.



**Building a support network:** This could involve reaching out to friends or family members for emotional support, joining a support group or finding a therapist to talk to.



**Improving self-esteem:** This could involve setting achievable personal goals, practicing self-compassion or challenging negative self-talk.



**Increasing physical activity:** This could involve setting a goal to exercise for a certain amount of time each week or finding ways to incorporate physical activity into your daily routine.



**Establishing healthy sleep habits:** This could involve setting a regular sleep schedule, creating a relaxing bedtime routine or avoiding screens before bedtime.



**Setting boundaries:** This could involve learning to say no to activities that are overwhelming or stressful, or setting limits on time spent on social media or other activities that may negatively impact your mental health.





**Finding purpose and meaning:** This could involve exploring new hobbies or interests, volunteering for a cause you care about or setting career goals that align with your values and passions.

---



Recovery goals and journeys are self-determined and self-defined. That means these will always look different from one person to the next.

CONTINUE



# questions for reflection

Answer these questions in your reflection journal.



**Do any of the core principles of harm reduction stand out for you more than others in relation to recovery and substance use?**

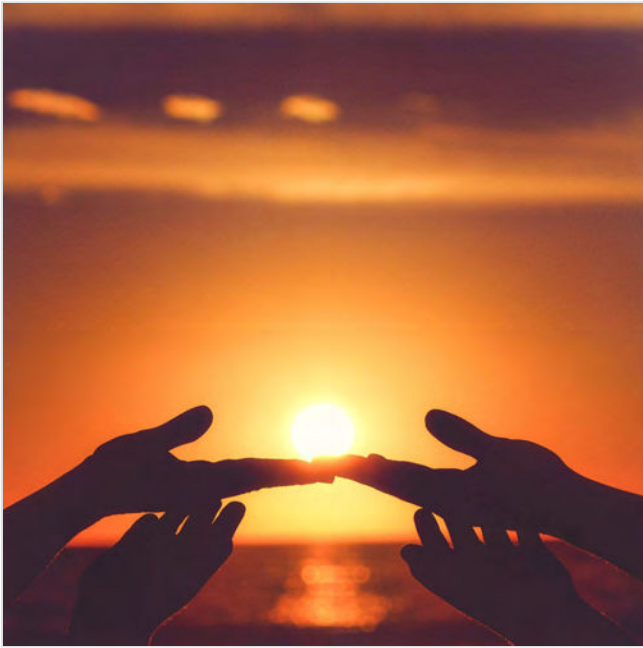
1 of 3



**How do these intersect with the core values of peer support?**

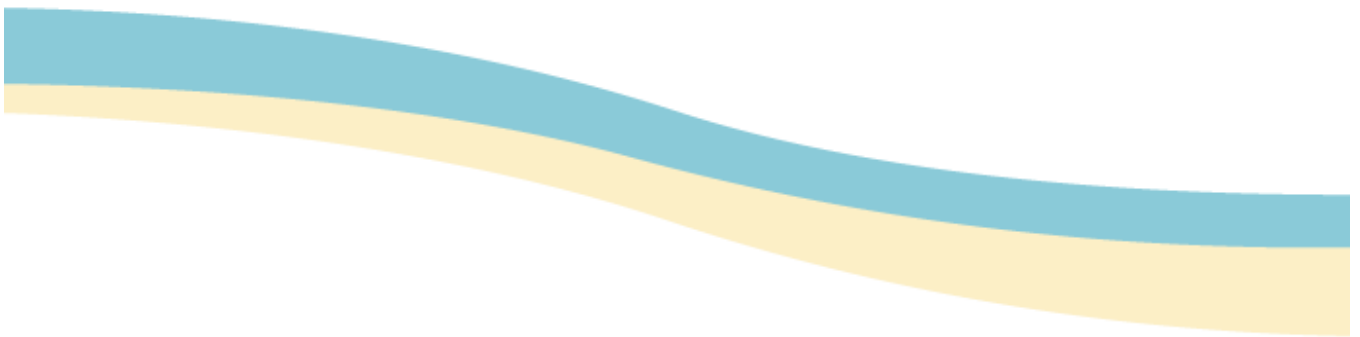
2 of 3





**How might you support a peer who is on their own recovery journey?**

3 of 3



## 15. other substance use perspectives & programs

---

---

**We acknowledge the importance of each person discovering their own path to wellness. There are several different peer-based programs out there that people have found work for them.**



CONTINUE

**“You don’t just ‘treat addiction.’ You end up treating anxiety, depression, PTSD, loneliness, rage, despair, toxic secrets, regret, undiagnosed head trauma, untreated ADHD. Then you realize addiction is someone’s best attempt to cope when they don’t see other options”**

Dr. Glennon Doyle

CONTINUE

Within peer support services, we create space for people to engage in the paths and techniques that resonate for them. Even if the people we support engage in programs that don’t work for us, we choose to suspend our worldview and support them in their self-determined journey.

There are many different approaches to substance use treatment – many of which integrate harm reduction and others that take a different path. These can take place in:

- ☐ Long- or short-term residential treatment programs
- ☐ Outpatient treatment programs
- ☐ Individual and group counselling
- ☐ Criminal justice-involved intervention and treatment – whether before, during, after or instead of incarceration

For example, sobriety is the decision to refrain from substance use entirely. This is a form of harm reduction that works for some people. Others will move between sobriety and harm reduction approaches depending on their needs. Sobriety is not morally superior to substance use, nor is it a judgement on substance use.

CONTINUE

**“One of the most well-known and commonly used types of recovery support is the 12-Step model. Just about everyone has heard of these meetings or of the organization that originated the idea.”**

Alcoholics Anonymous

## abstinence & 12-step programs —

The basic concept of the 12-step model is that abstinence is the best and only way to address substance use, and that, together, people can help each other achieve and maintain complete abstinence. Central to the program, too, is that healing can't happen unless people with substance use disorders surrender to a "higher power." The program consists of group meetings in which people share their experiences and a sponsorship model where they support each other in the ongoing effort to abstain from substance use.

A number of non-religious 12-step groups have modified the steps to fit a secular model to help those who are agnostic or atheist practice the program without needing to focus on religion or the "higher power" concept.

Other abstinence-based approaches include [Self Management and Recovery Training](#) (SMART Recovery) and [LifeRing](#).

## cultural frameworks —

**"Indigenous Harm Reduction is a process of integrating cultural knowledge and values into the strategies and services associated with the work of harm reduction. Indigenous knowledge systems are strongly connected to spirituality, holism, and the natural environment." – [First Nations Health Authority](#)**

In Canada, Australia, the U.S. and other countries, there has been an increasing effort to integrate cultural and traditional interventions into substance use programs or as an alternative to those programs. Many of these approaches address wellness in a holistic sense and may combine Western-style elements and treatments with traditional cultural interventions and teachings that make sense to members of that culture. For example, in Canada, many First Nations, Métis and Inuit groups have used this approach. Interventions can include sweat lodge ceremonies, access to Elders, land-based activities and other ceremonial practices.

Some groups have combined elements of the Narcotics Anonymous or Alcoholics Anonymous 12-step model with more culturally relevant practices. For example, some Native American groups in the U.S. have combined the 12 Steps with the concept of the Medicine Wheel to create a program designed specifically to help Indigenous Americans who struggle with substance use.

### **moderation management™ (MM)**

Focused on alcohol use, MM (sometimes called “controlled drinking”) is a guided self-help approach that is in essence part of the harm reduction model. It focuses on meeting people where they’re at and motivating them to reduce their alcohol use or to abstain, based on what they feel will work for them. MM isn’t for those with an alcohol use disorder, but rather for those wanting to reduce their use of alcohol because they may feel they’re on the path to a disorder.

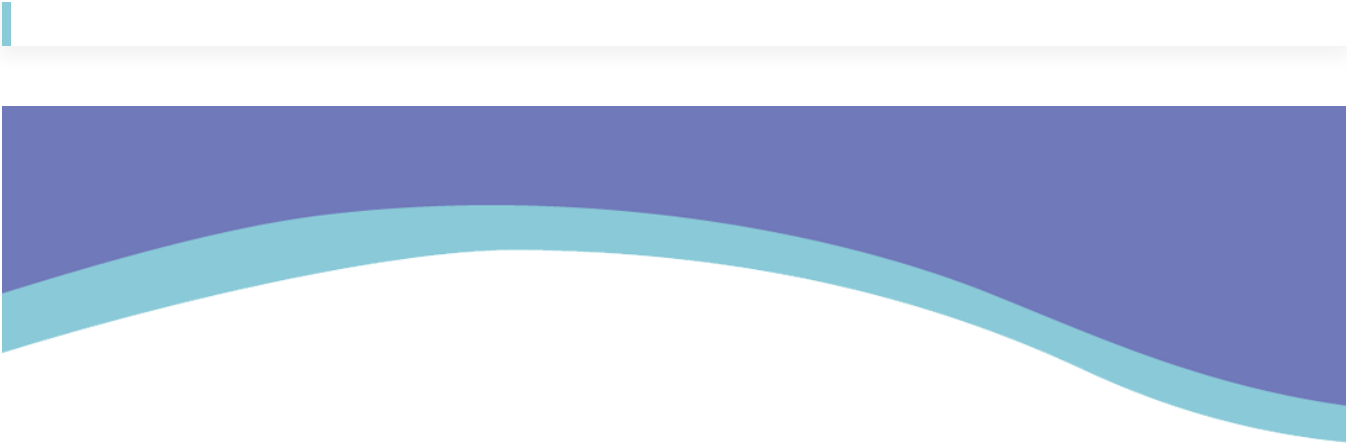
Moderation programs focus on encouraging people to reflect on their behaviour and come up with their own system and goals. The idea is to help people create goals and personal drinking limits.

### **faith-based recovery**

A faith-based recovery program is a type of addiction treatment program that incorporates spiritual beliefs and practices into the recovery process. These programs often involve a focus on prayer, meditation and fellowship with other believers in a supportive community. Participants in faith-based recovery programs are encouraged to turn to a higher power for strength and guidance as they work to overcome their addiction. Many faith-based recovery programs are based on Christian principles, but there are also programs that incorporate the teachings of other religions or spiritual practices. The aim of these programs is to provide a holistic approach to addiction recovery that addresses not only the physical and psychological aspects of addiction but also the spiritual dimension of the individual.

### **psychedelic-based recovery**

Psychedelic-based recovery programs have gained attention as a promising approach to treating addiction and other mental health conditions. These programs use substances like psilocybin, ayahuasca, ibogaine, ketamine and LSD in a controlled, therapeutic setting to facilitate deep introspection, emotional processing and personal growth. Research has shown that these substances can help individuals break free from negative thought patterns, increase self-awareness and reduce symptoms of anxiety, depression and PTSD. However, it is important to note that psychedelic-based recovery programs are still in their early stages of development, and more research is needed to fully understand their efficacy and potential risks.



Positive change will take time and  
healing and recovery may happen when  
you're not there.

We never know how our words and our  
actions are affecting anyone, but if we  
practice these with good intent, then we  
know we're doing our best work.



Note: If you'd like to learn more about other ways of thinking and approaching substance use, we highly recommend taking a look at Canadian psychologist Bruce Alexander's [Dislocation Theory of Addiction](#) and his insights into harm reduction, isolation and how it influences substance use, Indigenous perspectives and more. The work of Canadian addictions specialist [Dr. Gabor Maté](#) on compassion, trauma, mental illness and substance use, as well as his experiences working with people who use is also an excellent place to find more valuable information that you may want to apply in your peer support work.



## 16. prohibition & the “war on drugs”

---

**“Prohibition of substances which give pleasure to people does not work. Addiction is a health problem, not a moral one, and there are many proven strategies which can reduce its burden.”**

Vikram Patel

CONTINUE

**i** Note: “History of Prohibition” from BCCDC Compassion Inclusion and Engagement is included in our training repository.

In the past, practices like prohibition and criminalization of people who use drugs have been used by governments with the goal of reducing illicit drug use. Instead, these practices have produced the opposite results and have shown to increase both drug use and overdose deaths – something we’re especially mindful of in the opioid crisis both in B.C. and globally.

Prohibition is a zero-tolerance approach to illegal drug use and law enforcement. We know that these policies don’t actually reduce drug use, and that the “war on drugs” (which we’ll discuss in more detail later) mindset obstructs the evidence-based approach of reducing the harm caused by substance use.

The following is an excerpt from a speech by Dr. Bonnie Henry, B.C. Provincial Health Officer (2019):

**“We need to find the ways to provide safer alternatives to the unregulated and highly toxic drug supply and to end the stigmas associated with criminalization of people who use drugs... we need to connect people who use drugs with the supports they need rather than sending them to the criminal justice system.”**

CONTINUE

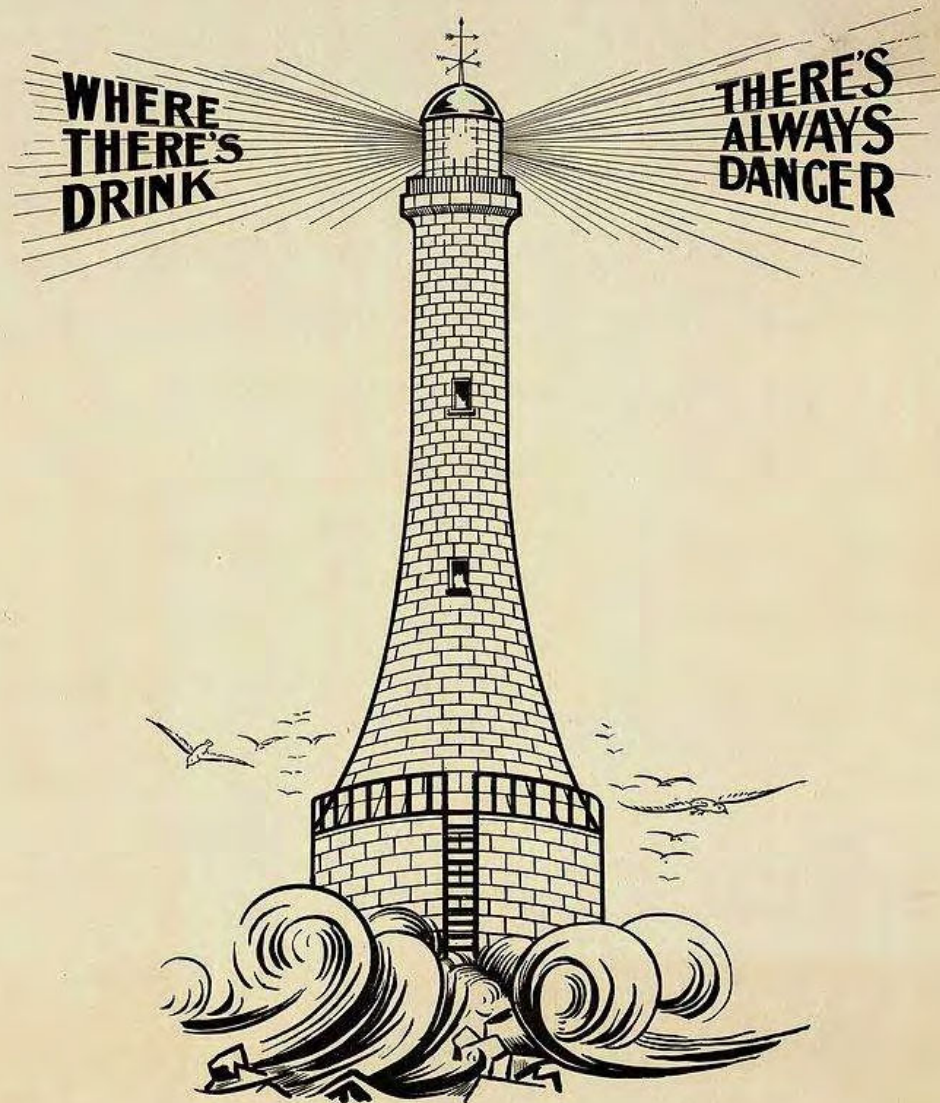
# prohibition in canada & the u.s.

Prohibition was the result of generations of effort by the temperance movement, a social movement that started in the 1800s, to stop the consumption of alcoholic beverages. Temperance activists and their allies strongly believed that alcohol (especially hard liquor) created barriers to moral and religious purity, as well as to economic success and social unity.

In Canada, Prohibition first began in the early 1900s and continued through the First World war and into the 1920s. Legal drinking establishments were closed and alcohol sales, alcohol possession and alcohol consumption became illegal. This criminalization of alcohol created a market for dangerous substitutes; the consumption of substances like cocaine and opioids, for example, increased.

Illegal alcohol consumption levels stayed about the same as pre-Prohibition but a big difference was safe supply – the removal of quality control created dangerous problems with alcohol quality and potency. In addition to the “normal” rate of alcohol-related deaths, roughly 1000 Americans died each year during Prohibition from tainted or poisoned alcohol and, in general, crime, corruption and homicide rates also increased wherever prohibition was instituted.

# CHARACTER



## PREVENTION IS BETTER THAN CURE

**It is more glorious to build a Lighthouse  
than man a Life-Boat**

A 1912 Temperance poster published by the Dominion Scientific Temperance Committee (from the Provincial Archives of Alberta)

---

**It's obvious that Prohibition as a form of 'harm reduction'  
ultimately had the opposite effect to what it intended,  
creating further inequities and harms to people who used  
substances.**

---

CONTINUE

## the war on drugs

“Although crack cocaine had not yet hit the streets when the War on Drugs was declared in 1982, its appearance a few years later created the perfect opportunity for the Reagan administration to build support for its new war.

Drug use, once considered a private, public-health matter, was reframed through political rhetoric and media imagery as a grave threat to the national order.”

Michelle Alexander,

[\*The New Jim Crow: Mass Incarceration in the Age of\*](#)

## Colorblindness

The “war on drugs” is an ongoing set of drug policies intended to discourage the production, distribution and use of psychoactive drugs that participating governments and the United Nations (UN) have declared illegal. Since the mid 1970s, and led by the U.S. federal government, the focus of the “war on drugs” has been on dramatic increases in prison sentences for both people who use substances and dealers. In essence, it has served to further dehumanize and oppress people who use substances, particularly among racialized peoples.

### *the 60s*

In the 1960s during the hippie and Civil Rights movements, drugs became associated with rebellion, political dissent and social change. In 1970, the Controlled Substances Act (CSA) came into law, regulating certain drugs and other substances; this was when the supposed “evils” of drug use began to take up more space in the media in North America and across the globe.



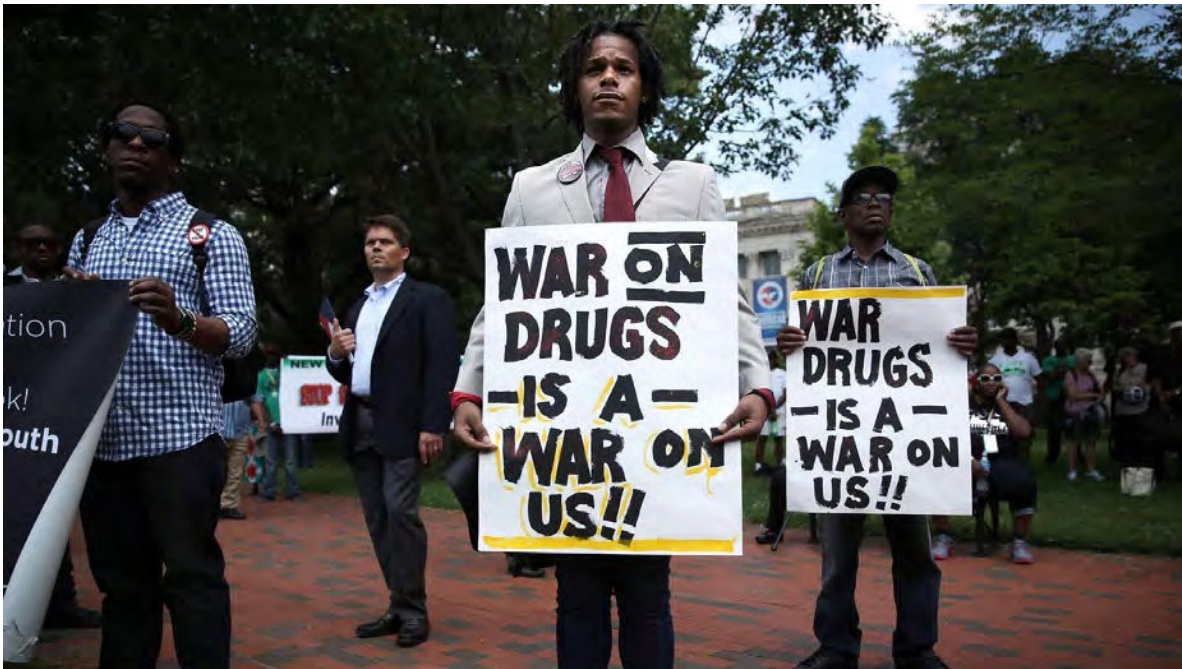
### *the 70s*

In mid-1971, the phrase “war on drugs” was popularized by Richard Nixon, when he also stated that drug abuse was “public enemy number one.”

As part of this “war,” the U.S. began to significantly increase the size and presence of federal drug control agencies, pushing through several related policies including mandatory sentencing and [no-knock warrants](#). This impacted Canada’s drug laws as well as the treatment of those who use substances too.

We’ll look at the criminalization of those who use substances later in the module.





### *the 80s*

Public concern about illegal drug use began to build throughout the 1980s, largely due to continued political hysteria as well as media portrayals of people addicted to crack (the smokeable form of cocaine). This set the stage for the zero tolerance policies implemented in the mid-to-late 80s.

Interestingly, in 1985, the proportion of Americans polled who saw drug use as the country's "number one problem" was only 2-6 percent but a few years later, the number had increased to 64 percent and was one of the most intense reactions by the American public on any issue in polling history.

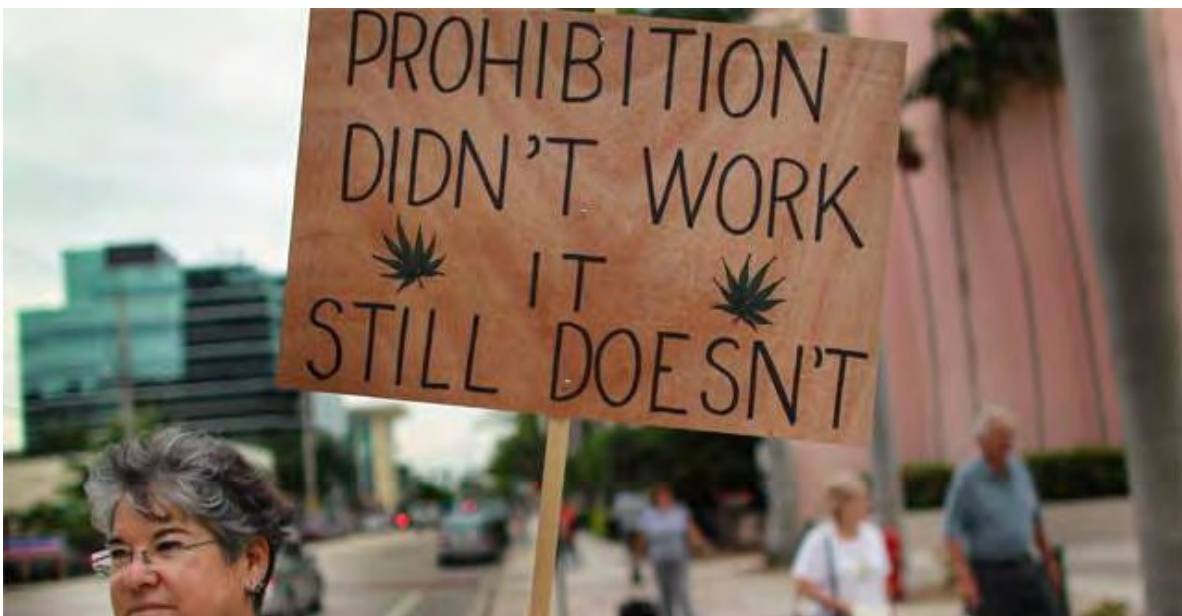




### *the 90s and beyond*

The “war on drugs” continued throughout the 90s and received a further boost when George W. Bush took office in 2001. Bush’s Director of the White House Office of National Drug Control Policy was a vocal opponent of drug decriminalization and legalization, as well as medical marijuana. During this period, illicit drug use rates stayed steady, but overdose death increased dramatically.

In parallel with the “war on drugs” in the late 80s and early 90s, an opposition movement emerged in many countries. It began pushing for new approaches to drug policy. Activists, scholars, policy makers and others began – and continue – to push for reform that includes an expansion of harm reduction and health-based approaches.



## **the opium act of 1908 & other canadian drug policies**

Canada was one of the first countries to ban opiates for non-medicinal/personal use. The Opium Act of 1908 made it an offence to sell, import, manufacture or possess opium for non-medical reasons (though initially it was not an imprisonable offence). In the same year, the Canadian government prohibited the use of cocaine in medicines and required pharmaceutical companies to include if heroin, morphine, or opium were part of a medicine on the label.

When we look at what else was going on at the time in Canada, it becomes clear that the Opium Act was passed in response to not just moral panic about drug use but the effects it was seen to have on race mixing and gender roles. It also tied in to an active public campaign to exclude Chinese people from immigrating to Canada and other racist or exclusionary policies. For example, in 1907 in Vancouver, anti-Asian sentiment had led to violent, racist riots against Chinese and Japanese workers. With this as a backdrop, the opium trade was then used to portray the Chinese community as a threat; the ban on opium was seen as a response to the “Chinese problem” and, internationally, Canada was seen as leading the way on the “opium problem.” Although opium was being consumed by all races, the majority of the arrests made under the Act were against Chinese people.

Not surprisingly, the 1908 Act created a black market for opium, and this then led to the harsher Opium and Drugs Act of 1911, which increased penalties, including imprisonment, and expanded the list of prohibited drugs to include cocaine and morphine. Cannabis was added to the Act in 1923.

Here are a few other key drug-related policies since the opium act of 1908:





Boarded up shop windows on Carrall Street in Vancouver's Chinatown, 1907 after racist rioters targeted Chinese businesses and workers



**Narcotics Control Act of 1961:** This was an amendment to the Opium and Drug Act, which added controls over other narcotics, such as cocaine, heroin and marijuana. The act made it illegal to possess or sell these drugs, except for medicinal purposes.



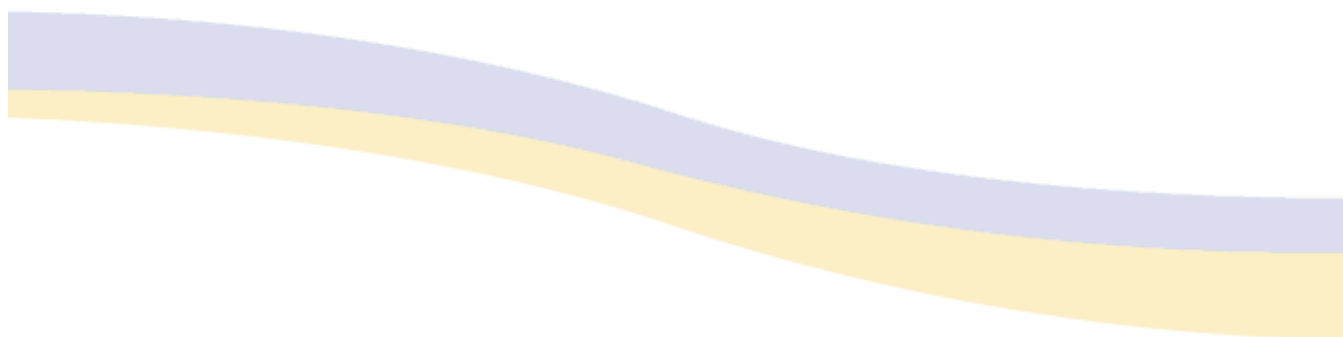
**Controlled Drugs and Substances Act of 1996:** This act replaced the Narcotics Control Act and modernized Canada's drug laws. It established four schedules of controlled substances, ranging from Schedule I (drugs with a high potential for abuse and no recognized medical use) to Schedule IV (drugs with a lower potential for abuse and recognized medical use).



**Medical Marijuana Access Regulations of 2001:** This was a response to court challenges that argued that denying sick people access to medical marijuana violated their rights. The regulations established a framework for Canadians with a prescription to access medical marijuana from licensed producers.



**Cannabis Act of 2018:** This act legalized and regulated the production, distribution and sale of recreational marijuana in Canada. It allows adults to possess up to 30 grams of marijuana and to grow up to four plants for personal use. The act also established a licensing system for commercial producers and retailers.



## 17. the criminalization of people who use

---

---

Public support for the “war on drugs” has declined in recent decades and despite ongoing regulations and laws, public opinion in many countries has shifted to more sensible reforms that include reducing the role of criminalization in drug policy. We’ve seen many reforms in Canada, including marijuana reform and growing support for safe injection sites, and recently Oregon voters passed the U.S.’s first all-drug decriminalization measure.

CONTINUE

## criminalization of people who use substances

“We cannot incarcerate ourselves out of addiction. Addiction is a medical crisis that—when it comes to nonviolent offenders—warrants medical interventions, not incarceration. Decades later, data unequivocally

illustrates that this war [on drugs] has been a massive failure. It has not only failed to reduce violent crime, but arrest rates—throughout its tenure—have continuously ascended even when crime rates have descended.”

— Dominique DuBois Gilliard,

*Rethinking Incarceration: Advocating for Justice That Restores*

We know that substance use is a multi-layered health issue with impacts not just on individuals but also on community, the economy and public safety. When aggressive policing and imprisonment are the defaults for dealing with it, even when we know or have seen that it can be tackled in other ways, this leads to a culture of **mass criminalization**.

International drug laws, including Canada’s, are heavily influenced by the policies of both the UN and the U.S., both of which focus more on criminal justice than a health-oriented or recovery-oriented approach to substance use, which has led to the increased criminalization of people who use substances.

According to the Drug Policy Alliance:

“The criminalization of drugs is frequently how people first encounter the criminal justice system. People are stopped by police on drug-related pretexts as part of ‘stop and frisk,’ or because an officer claims to smell



**marijuana, or simply because they look poor and are in an area associated with drug use.**

**Relying on the criminal justice system to address issues with drugs wastes money, creates a toxic relationship between the police and the communities they are supposed to protect, and does nothing to address problematic drug use.”**

Across the globe, mass criminalization has been shown to create inequitable outcomes for communities of colour – particularly for Indigenous and black communities. Overly strict prison sentencing and drug policies that don't take a harm reduction approach are also generally seen to target the poor as well as people of colour.

For example, in Canada, studies show that Indigenous people, African Canadians and people from multiracial backgrounds are all significantly overrepresented in the federal corrections system. According to Akwasi Owusu-Bempah (2014), although Indigenous people represent 3.8 percent of population, they make up “almost one-fifth (18.5 percent) of offenders under federal supervision. Similarly, blacks represent only 2.5 percent of the Canadian population, but almost one-tenth of all federally supervised offenders.”



Research has also shown that stricter prison sentencing for drug offenses has not made an impact on substance use rates, overdose deaths or drug arrests anywhere in the world.

Activists have pointed to the need to prioritize harm reduction over imprisonment, as well as destigmatizing substance use and decriminalization. Ultimately, if we want to keep communities – including those who use substances – safe, then focus needs to be on finding better, non-criminalizing ways to address these issues in community, involving those with lived experience.

---

**Prohibition, the “war on drugs” and mass criminalization have all served to further entrench structural violence, marginalization, stigma, trauma**

**and many of the other paths that lead people to use substances in the first place.**

CONTINUE

## **why bother with the history?**

Why is it important for a peer support worker to know about the history of prohibition? How can this history help us support those seeking our services in their moments of greatest need?

We know that the transformative power of working from a place of lived experience is all about acceptance and understanding. So, if as peer support workers we know a little bit about the history of prohibition, we might better be able to truly see the people who we work alongside everyday and how many of the difficulties they face in their lives are a result of the arbitrary criminalization of their substance of choice.





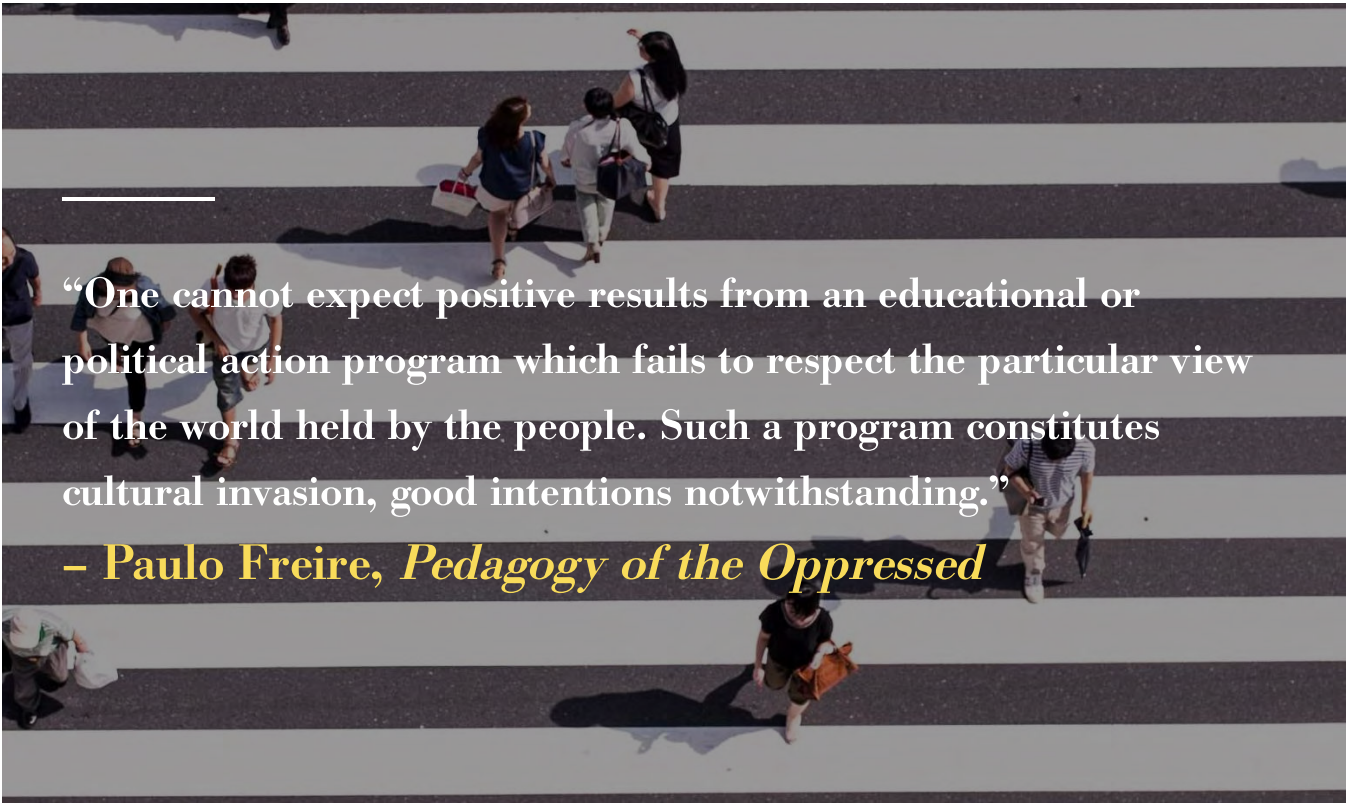
**Imagine you're supporting a couple that you know from your work at an overdose prevention site. Maybe you've been working with them to support their attempts to**

pursue recovery or access safe supply, but perhaps one of them uses alcohol while the other uses fentanyl.

As a support worker you may get frustrated that one of them is continually missing appointments or not staying in hospital when they may need to, but if we understand that because of the arbitrary prohibition of heroin and its illicit derivatives, the burden of that structural violence lands much more heavily on the person who uses heroin (who may encounter accusations of 'drug seeking' when they're trying to go to hospital or may be incarcerated more often than their partner), then we're better able to truly meet those folks where they're at – whether that's at an OPS, a safe supply clinic, a recovery program or even via family support.

---

Knowledge leads to understanding and understanding leads to acceptance.



“One cannot expect positive results from an educational or political action program which fails to respect the particular view of the world held by the people. Such a program constitutes cultural invasion, good intentions notwithstanding.”

– Paulo Freire, *Pedagogy of the Oppressed*

## decriminalization

**“I want equity and equality in healthcare from my government. I want to be able to access my drug of choice through a regulated system and get what I pay for and not put myself at risk around criminalization and all those other components that are part of this inertia of the failed war on drugs, which is really just a war on people who use drugs.”**

Charlene

An understanding of decriminalization begins by recognizing that it's not one single approach, but a range of policies and practices that can include non-criminal penalties like fines instead of prison time being issued for things like substance use, possession of controlled substances and the possession of drug-related equipment like syringes. Many advocates have proposed decriminalization as a way to reduce harms associated with the current opioid crisis.

The reason legalization is something we want to work towards is because, although on the face of it a fine appears less harmful than prison to those who use substances, it's still a punishment and one that disproportionately impacts the poor.

**i Note: Legalization is different from decriminalization; with decriminalization, it's still illegal to possess and use drugs, and selling or manufacturing drugs still carries criminal penalties. With legalization, all penalties for possession and personal use are removed but regulatory controls can still apply like with alcohol and tobacco.**

There are many benefits to decriminalization, including:

- ☐ Reducing the number of people arrested, imprisoned or caught up in the criminal justice system; allowing people, their families and communities to avoid the harms and stigma connected to substance arrests, imprisonment and the burden of a criminal record
- ☐ Removing barriers to implementing programs and services that reduce the potential harms of substance use, including supervised injection sites, needle distribution programs, and drug screening
- ☐ Reducing the racial, ethnic and income-based inequities in the criminal justice system
- ☐ Redirecting resources from the legal system to improve public treatment options
- ☐ Creating space for people who use substances to more actively seek treatment
- ☐ Improving relationships between law enforcement and the communities they serve

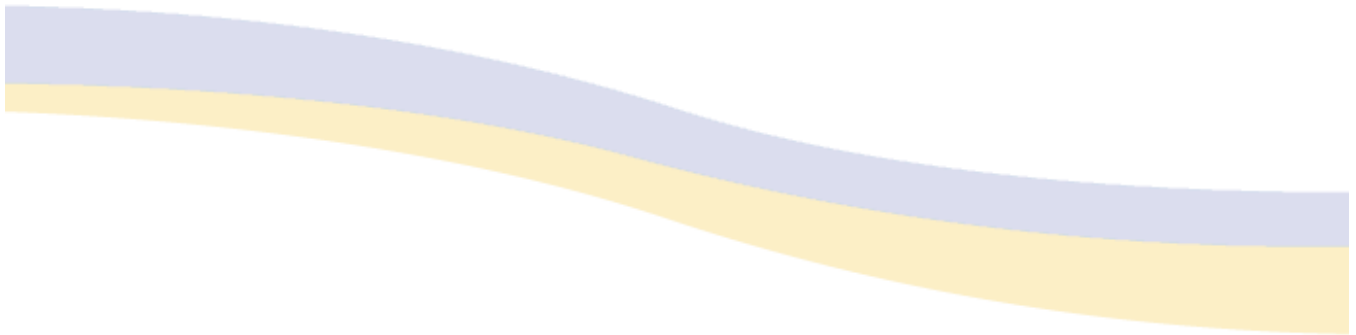
Decriminalization has slowly started to take place in many countries, with encouraging results. For example, Portugal decriminalized drug possession in 2001 and studies show that while drug use has stayed about the same, the rates of overdoses, arrests, disease, incarceration and other harms are all down.



---

**Regardless of the legal implications of substances, as we know, using a harm reduction framework acknowledges that substance use is part of society. Whatever our own needs, full decriminalization of all drugs and widespread access to harm reduction practices would make things safer for everyone. Minimizing the harmful effects of substance use, rather than ignoring or condemning them, is what we need to focus on.**

People with lived experience provide unique expertise and perspectives on substance use and should be meaningfully involved in developing policy and practice to address it. Our hope is that through our peer support work, we can move closer to this.

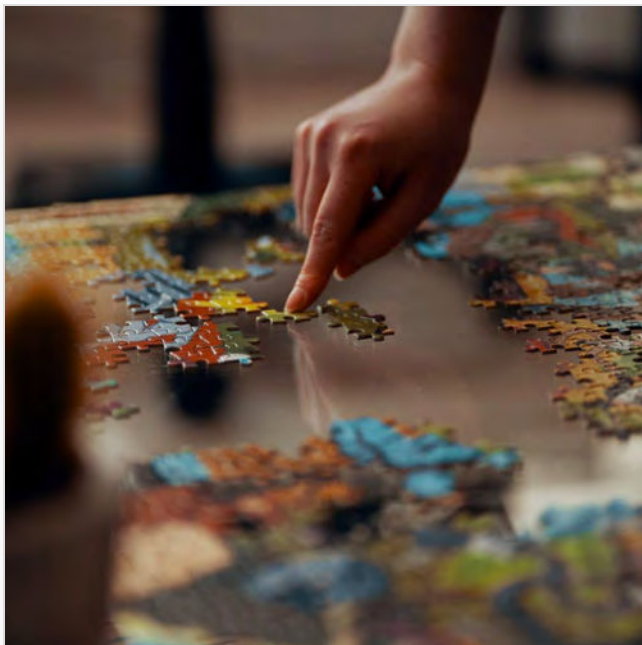


## 18. core values assessment

---

### question for reflection

Answer this question in your reflection journal.



**In what ways have the core values (see list below) intersected with the topic of substance use and peer support?**

1 of 1

CONTINUE

# core peer support values

## acknowledgement —

All human beings deserve to be seen for who they are.

**IN ACTION:** Peer support strives to acknowledge – and deeply hear – people where they are in their journey.

**PSWs SUGGEST:** Asking open-ended questions and actively listening to the PSW to see if they feel comfortable sharing their experience. Ask: “What do you think about that situation?” “Is there a coping strategy that you have used in a previous similar experience that worked for you?”

## mutuality —

All healthy relationships are mutual and reciprocal.

**IN ACTION:** Peer support relationships are co-created, with all parties participating in boundary creation.

**PSWs SUGGEST:** Having a conversation about what is and isn’t okay to discuss with the PSW.

“...Even though I am a PSW, it’s painful for me to make eye contact with people. Hopefully, clients will see that if I’m looking away that it actually means that I am deeply listening to them. Being vulnerable and open seems to allow the other person to do their version of the same, building trust and respect and co-creating the relationship.”

## strength-based —

Every human being has strengths.

**IN ACTION:** Peer support intentionally builds on existing strengths. It thoughtfully and purposefully moves in the direction of flourishing, rather than only responding to pain and oppression.

**PSWs SUGGEST:** Finding things that the PSW feels really confident about and expanding on those areas or delving into those areas and supporting their choices.

## self-determination —

Motivation works best when it's driven from within.

**IN ACTION:** Peer support encourages self-determination and acknowledges and holds space for resilience and inner wisdom.

**PSWs SUGGEST:** Support the PSW in making decisions and doing things on their own – based on their wants, needs and goals.

## respect, dignity & equity —

All human beings have intrinsic value.

**IN ACTION:** Peer support honours human value by

- Practicing cultural humility and sensitivity
- Serving with a trauma-informed approach
- Offering generosity of assumption
- Addressing personal biases mindfully
- Meeting people where they are
- Serving with a knowledge of equity

**PSWs SUGGEST:** Treat PSWs as you would like to be treated and expect to be treated. Learn about them on a personal level and treat them as equals.

## belonging & community —

All human beings need to belong and be a part of a community.

**IN ACTION:** Peer support recognizes that many people have barriers that keep them from developing community and it actively works towards deconstructing those social blockades that prevent inclusion and acceptance. Peer support encourages a social justice mindset, and intentionally promotes empathy, compassion and self-compassion.

**PSWs SUGGEST:** Help PSWs feel wanted and cared about. Help them find resources that foster a sense of community and belonging.

“My quality of life improves immensely when I am surrounded by one or a community of people who understand me. I don’t feel alone. I can be myself among people who I know understand me on a deeper level. When I feel like I can be myself, I feel more confident and able to take positive risks, thus improving the quality of my life. The root of this is connection and being able to be seen for who I truly am. Peers can help people be seen in a real way.”

## curiosity —

Curiosity and inquiry support connection, growth, learning and engagement.

**IN ACTION:** Peer support

- Is continually curious
- Challenges assumptions and narratives
- Asks powerful questions
- Offers generosity of assumption to those who think differently
- Knows that listening and asking questions is more important than providing answers

**PSWs SUGGEST:** Ask questions and be engaged in learning about your PSWs. Find out about their culture and explore with them.



## 19. summary

---

**Let's review some of the key concepts covered in this module.**

☐

At its core, harm reduction is the act of mitigating risk to create better outcomes for individuals and communities alike.

☐

Peer driven, informal harm reduction strategies spread through Canada until they became part of policy both provincially and federally.

☐

Harm reduction aims to meet people where they're at, promoting safety and support that's free from judgement.

☐

Harm reduction can involve many different modalities and supports including needle exchange programs (NEP), supervised consumption services (SCS) and overdose prevention sites (OPS).

☐

Person-first language in a substance use context can help focus on humanizing those who use substances

☐

Self-compassion empowers us to continue our growth journey rather than become stuck in shame, no matter the ups and downs of that journey.

☐

Naloxone is used to reverse opioid overdoses, and it's an important training for all peer support workers to have.

☐

The Good Samaritan Drug Overdose Act was enacted to encourage people to call 9-1-1 for help in the event of an overdose as it offers some legal protection for people who experience or witness a drug overdose.





A recovery-oriented approach uses strategies to empower people to use their strengths and skills to help them lead the life that they choose when experiencing substance use.



Along with harm reduction, there are many different approaches to substance use, including the 12-step model and other programs and perspectives.



## 20. next steps

---

We want to thank you for taking the time to walk alongside peer support workers on a shared path of learning from lived experience.

You are now ready to visit another module of the Peer Support Worker training curriculum!

Please head home to <https://peerconnectbc.ca> where you will find the individual training modules and facilitation guides. You will also find a [resource page](#) at that site to continue your learning about peer support work and the issues surrounding it.

---

### **A Project of BCcampus, Funded by B.C. Ministry of Mental Health and Addictions**

**Released July 2021**

**Curriculum Developer and Writer: *Jenn Cusick***

**Project Manager: *Jonathan Orr***

**Consultant and Former Project Manager: *Corey Ranger***

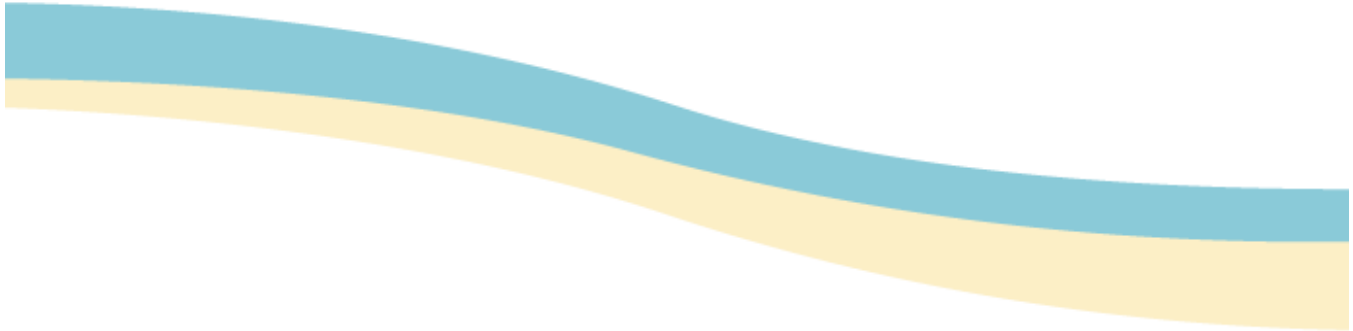
**Life Application Story Writer: *Robyn Thomas***

**Editor: *Annie Brandner***

**Graphic Designer: *Jeseye Tanner***

**Peer Portraits: *Jesse Winters Photography***

**Instructional Design & Development: *PathWise Solutions Inc.***



## 21. module references

---

The following sources were used  
for this module:



Alberta Health Services *Harm Reduction: Recovery-oriented care*, available at

<https://www.albertahealthservices.ca/assets/info/hrs/if-hrs-recovery-oriented-care.pdf>

BC Coroners Service. (2020, July 16). *Illicit Drug Toxicity Deaths in BC January 1, 2010 – June 30, 2020* .

<https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicit-drug.pdf>

Brown, Tarnell. (2020, August 26). *A Brief Look at Why Prohibition Laws Don't Work*, available at <https://www.econlib.org/a-brief-look-at-why-prohibition-laws-dont-work/>

Canadian Centre on Substance Use and Addiction available at <https://www.ccsa.ca/sites/default/files/2019-04/CCSA-Decriminalization-Controlled-Substances-Policy-Brief-2018-en.pdf>

Canadian Drug Policy Coalition, available at <https://www.drugpolicy.ca/our-work/issues/harm-reduction/>

CBC/Radio Canada. (2019, February 7). *B.C.'s top doctor calls for regulated opioid supply after almost 1,500 overdose deaths in 2018* | CBC News. CBCnews. <https://www.cbc.ca/news/canada/british-columbia/bonnie-henry-opioid-deaths-1.5009950>

Colebourn, John. (2016, November 10). *Training clinic on using Naloxone offers hope to drug users, advocates say*, Vancouver Sun, available at <https://vancouversun.com/news/local-news/training-clinic-on-using-naloxone-offers-hope-to-drug-users-advocates-say>

Drug Policy Alliance, available at <https://drugpolicy.org/issues>

Hallowell, Geraldine. (2013, August 12). *Prohibition in Canada*, available at <https://www.thecanadianencyclopedia.ca/en/article/prohibition>

*Harm Reduction: A British Columbia Community Guide*, available at <https://www.health.gov.bc.ca/library/publications/year/2005/hrcommunityguide.pdf>

Hyshka, E., Anderson-Baron, J., Karekezi, K. et al. *Harm reduction in name, but not substance: a comparative analysis of current Canadian provincial and territorial policy frameworks*. Harm Reduct J 14, 50 (2017). <https://doi.org/10.1186/s12954-017-0177-7>

Jozaghi, Ehsan. (2012). *"A Little Heaven In Hell": The Role Of A Supervised Injection Facility In Transforming Place* Simon Fraser University, available at <http://www.sfu.ca/~palys/Jozaghi-2012-ALittleHeavenInHell.pdf>

National Harm Reduction Coalition, available at <https://harmreduction.org/>

Neff, K. (2015, February 21). *Does Self-Compassion Mean Letting Yourself Off the Hook? Self-Compassion*, available at <https://self-compassion.org/does-self-compassion-mean-letting-yourself-off-the-hook/>.

Owusu-Bempah, Akwasi. (2014). *Race, Crime, and Criminal Justice in Canada*, available at [10.1093/oxfordhb/9780199859016.013.020](https://doi.org/10.1093/oxfordhb/9780199859016.013.020).

Phelps, C. L., Paniagua, S. M., Willcockson, I. U., & Potter, J. S. (2017). The relationship between self-compassion and the risk for substance use disorder. *Drug and Alcohol Dependence*, 183, 78–81.  
<https://doi.org/10.1016/j.drugalcdep.2017.10.026>

Rowan, M., Poole, N., Shea, B. et al. Cultural interventions to treat addictions in Indigenous populations: findings from a scoping study. *Subst Abuse Treat Prev Policy* 9, 34 (2014). <https://doi.org/10.1186/1747-597X-9-34>

Substance Abuse and Mental Health Services Administration Bringing Recovery Supports to Scale Technical Assistance Center Strategy, available at <https://www.samhsa.gov/brss-tacs>

The Anti-Oppression Network *What is Anti-Oppression?* available at <https://theantioppressionnetwork.com/what-is-anti-oppression/>

The Pew Charitable Trusts. (2018). *More Imprisonment Does Not Reduce State Drug Problems*, available at <http://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2018/03/more-imprisonment-does-not-reduce-state-drug-problems>

*Understanding Harm Reduction: Substance Use*. HealthLink BC. (2020, April 1).  
<https://www.healthlinkbc.ca/healthlinkbc-files/substance-use-harm-reduction>

“War on drugs” (n.d.) In Wikipedia, available at [https://en.wikipedia.org/wiki/War\\_on\\_drugs](https://en.wikipedia.org/wiki/War_on_drugs)

# EXIT the module

---

**You've completed this module.**  
**Click the button to EXIT.**

EXIT MODULE