Under the Influence

Making the Connection Between HIV/AIDS and Substance Use

A guide for AIDS service organization workers who provide support to persons living with HIV/AIDS

October 1997

The Canadian AIDS Society is a national coalition of community-based AIDS organizations across Canada. CAS is dedicated to increasing the response to HIV/AIDS across all sectors of society, and to enriching the lives of people and communities living with HIV/AIDS.

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Nancy Currie, Project Coordinator
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1.0 Introduction

Background

People living with HIV/AIDS and substance use issues present unique challenges to support service staff in community-based AIDS organizations. In 1994, the Canadian AIDS Society (CAS) began to address concerns about resource development and service delivery to this population through the "HIV, Alcohol, and Other Drug Use Project." The critical barriers identified by this client group were fear of being judged, and fear of having someone try to control their life. The project's final report recommended the development of resources and training with an emphasis on harm reduction strategies. A harm reduction approach to the provision of support enables the client to make decisions and choices about their substance use based on their understanding of the risks involved. The CAS study further identified that some front line workers hold negative attitudes toward people who use drugs and have anxiety about working with this client base because they feel they lack the knowledge and training needed to help them.

The Situation in 1997

Rates of HIV infection in Canada are still increasing.[1] Two risk factors account for the increase in HIV transmission: unprotected sexual behaviours (for example, heterosexual transmission accounts for 2.2% of all AIDS cases before 1990, 5.6% between 1990 and 1995, and 9.2% in 1996) and unsafe injection drug using (IDU) practices (1.5% of all reported AIDS cases before 1990, 4.9% between 1990 and 1995, and 10.3% in 1996). As well, the age is decreasing. Prior to 1983, the average age of a person infected with HIV was 32. Between 1985 and 1990 the age dropped to 23.

One growing trend is the alarming increase of HIV/AIDS infection among women. From 1981 to 1989, women represented 5.5% of the total AIDS cases in Canada, but from 1993 to 1996, the percentage rose to 7.2%. And women with AIDS are disproportionately represented in Quebec (51% of female AIDS cases in Canada are in Quebec). Among adult women, 63% of AIDS cases are due to heterosexual contact, with the remaining cases due to: injection drug use (17%), receipt of blood products (13%), and no identified risk factor (7%). The proportion of HIV/AIDS cases in women aged 15–44 related to injection drug use has increased dramatically, from 10% in 1982–89, to 20% in 1990–92, and to 28% in 1993–96.

One potential consequence of the increase in prevalence among women is an increase in cases among children infected perinatally. As of April 15, 1997, there were 159 cases of AIDS in children in Canada.[2]

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[1] Laboratory Centre for Disease Control. *Epi Updates*. Ottawa: Health Canada. December 1996 and May 1997.

[2] Laboratory Centre for Disease Control. *Quarterly Surveillance Update (to March 31, 1997)*. Ottawa: Health Canada. May 1997.

It is clear that the infected population is getting younger and is no longer identified with a particular group. People living with HIV/AIDS include men, women, transgendered persons, children, gays, straights, lesbians, bisexuals, injection drug users, users of other substances, people who practise unprotected sex, street involved persons — the common denominator is HIV/AIDS.

Community-based AIDS organizations (CBAOs) are well established in communities across Canada and are bearing witness to the changing face of the HIV/AIDS epidemic. These organizations are already providing leading edge services that address contentious and provocative issues. Support workers are serving more and more clients who use substances, and many need and want tools to increase their ability to meet the needs of the growing population.

How This Manual Was Developed

A project entitled "Improving Services for People Living with HIV/AIDS and Substance Use Issues: Skills-building for Support Service Workers in AIDS Service Organizations" was the Canadian AIDS Society's response to the recognized need. It built on the findings and recommendations in "The HIV, Alcohol, and Other Drug Use Project." The goal of the project was to provide support to the changing roles of AIDS support staff. The objective of the project was to produce this manual.

The project undertook research to ensure that the content of this manual would reflect the needs of two groups — the service providers and the service users. A needs assessment survey was undertaken to tap into the voices of the service providers. A diverse cross-section of 49 CAS member groups was surveyed. By region, the responses were: Pacific 40%; Prairies 50%; Ontario 70%; Quebec 50%; and Atlantic 56%. Also, five focus groups were conducted in Toronto, Sydney, Vancouver, Winnipeg and Montreal to hear the needs of the service users (HIV positive people with substance use issues).

A National Advisory Group assisted throughout the development of this culturally sensitive training and resource manual. The committee was made up of support service workers from CBAOs representing the five geographical regions (Atlantic, Quebec, Ontario, Prairies, and Pacific). Other group members included a needle exchange worker, a Health Canada representative, aboriginal and ethnocultural representatives, a peer, and a person from an addiction treatment organization. The Advisory Group met twice during the project and held one teleconference to review and suggest amendments to the manual. The members were committed to the project and generously provided their time, experiences and suggestions toward our goals.

The result of this project is *Under the Influence*, a resource manual for support workers in CBAOs that addresses the changing face of the HIV/AIDS epidemic. *Under the Influence* provides a framework to meet this challenge.

2.0

Skills and Approaches to Providing Support

2.1 Getting Started

This manual was written by service providers for service providers. It honours the skills you bring to your work in a community-based AIDS organization, and offers opportunities to enhance these abilities. You should not be expected to become drug counsellors.

Philosophy

The approach of this manual is client-centred, based on the concepts of mutual respect, harm reduction, and health promotion.

Language

Language is a critical issue which challenges our ability to communicate clearly. The alcohol and drug treatment field speaks with a certain vocabulary, while the HIV/AIDS community uses another language. Though not mutually exclusive, these differences can become problematic. It is important to be aware of the meanings that we and the clients assign to words (when in doubt, ask). Assumptions about definitions can create misunderstandings. Some of the terms and abbreviations used in this book are defined below:

Client: We have chosen to use the word client to refer to service users who are HIV positive and substance using.

Substance: This term refers to drugs, alcohol, and other things like gasoline that people ingest.

ASO: AIDS service organization. This term is commonly used to describe all those organizations that provide services related to HIV/AIDS, including support for people living with HIV/AIDS, prevention, advocacy, public awareness.

CBAO: Community-based AIDS organization. Means the same thing as ASO, but is gaining preference because it more clearly includes organizations of persons living with HIV/AIDS. Both terms are used interchangeably in this manual.

Focus Groups

Five focus group consultations took place. Each group had five to seven members and the participants ranged in age from 21 to 50, the average age being 35. There were 16 males, 12 females and one transgendered person. The sexual orientations were, gay, heterosexual and bisexual. No females identified as lesbian.

Ethnicity (as self-described): Black, Aboriginal, White, Anglo Saxon, Mexican, Canadian, Quebecoise, Acadian and some identified by religion. Serostatus: 83% of participants self-disclosed as HIV positive. Alcohol and drug use: 100% used either currently or in the past. Drugs of choice mentioned most often: cocaine (10); alcohol (9); cannabis (5); heroin (3); prescription medication (2); acid (1); and methadone (1). The most frequently named method of using substances was drinking, followed by injecting, then smoking. Women participated in all five focus groups, but were in the minority. To address the gender differences in both HIV/AIDS and substance use, an all female Francophone focus group was held in Montreal.

Participants spoke about being "shamed, judged and hassled" and an appalling lack of sensitivity, training and education on the part of health care professionals.

Ethnicity

Substance use and HIV/AIDS issues are compounded for people who belong to ethnocultural communities. Racial prejudice and discrimination are part of the social fabric of our country. Support organizations may not be perceived as being friendly to people from diverse ethnic backgrounds. Language and lack of culturally-specific educational resources are barriers to service.

Three agencies working with ethnocultural communities are: Black Coalition for AIDS Prevention (Black CAP), (416) 977-9955; Asian Society for the Intervention of AIDS, (604) 669-5567; and Canadian Aboriginal AIDS Network, (613) 567-1817. (See *Further Reading for Building Bridges, Responding to HIV/AIDS in Ethnocultural and Aboriginal Communities.*)

Rural Issues

HIV/AIDS and substance use are issues in rural areas, though often acknowledged indirectly. Fear, denial, stigmatization and discrimination, lack of privacy or confidentiality, invisibility, travel and transportation issues, and lack of AIDS services and support isolates those who are affected and at risk. Affected individuals can and do migrate to larger urban centres to ensure their anonymity as well as to receive specialized medical care. Initiatives for the city may not be applicable to rural environments.

Examples of smaller communities that are providing services are: AIDS Society of Kamloops (ASK), (250) 372-7585; and Peterborough AIDS Resource Network (PARN), (705) 749-9110.

Women

More women are becoming infected with HIV, particularly women who use injection drugs or whose sexual partners are at increased risk for HIV. Factors

contributing to women's vulnerability are: the economic, social and physical power imbalance, difficulty negotiating safer sex, coerced sex including rape and sexual abuse, and sex trade work. As well, subordination in education, employment, social and legal status limit women already stigmatized by substance use and HIV/AIDS.

These agencies are working with women: Positive Women's Network, (604) 681-2122 ext. 200; Voices of Positive Women, (416) 324-8703; Centre for AIDS Services of Montreal (Women), (514) 989-7997; and Comité Prevention Action Femmes SIDA (PAFS), (514) 934-0354. (See *Further Reading for Women and HIV Projects and Committees Inventory.*)

What's It All About?

Under the Influence is divided into three parts: (1) *Introduction,* (2) *Skills and Approaches to Providing Support,* and (3) *Resources.*

Part 2 includes chapters on seven key topics. *Attitudes, Values, and Beliefs* (Chapter 2.2) is designed to encourage us to reflect on our attitudes, values and beliefs about substance use. Examining our personal experiences around substance use allows us insight into our biases. Exercises in this chapter will challenge your perceptions and fears. *Relationships, Boundaries and Ethics* (Chapter 2.3) examines the necessary conditions for the safety of the client, the worker and the organization. *Listening Skills* (Chapter 2.4) reminds us of our purpose. *Self Care* (Chapter 2.5) addresses the personal, professional, and organizational self care that helps us deal more effectively with work related stress.

Harm Reduction (Chapter 2.6) outlines the concepts of this philosophy and suggests practical applications. Harm reduction is a practical, non-judgmental approach that provides clients the opportunity to make informed decisions and choices about their health. Research has shown that people who use drugs or alcohol will change their behaviour in response to harm reduction education, and that this change is greater if skills training and encouragement are provided.[3] This chapter also looks at the Prochaska-DiClemente *Stages of Changing Behaviour* model to understand how people make change in their behaviour. The model provides the opportunity to consider personal differences, social context and risk-related behaviours with individuals "where they're at." The combination of these two approaches (Harm Reduction and *Stages of Changing Behaviour*) allows the HIV positive person with substance use issues to develop self-efficacy through active participation in the process.

The final chapter in this part, *Policies and Procedures* (Chapter 2.7), examines how policies are required to support all aspects of service provision and need to be creative, culturally sensitive, and consistent regarding people living with HIV/AIDS with substance use issues.

Part 3, *Resources,* contains reference material and sources of further information. Substance Use 101 (Chapter 3.1) which provides basic informa-

[3] Riley, D. *The Harm Reduction Model.* Ottawa: Canadian Centre on Substance Abuse. 1994.

tion about drug and alcohol use and effects, interactions, ways of using, detection periods for various drugs, and drug treatment options. The *Glossary* (Chapter 3.2) is a quick reference to some substance use terms, although street or regional preferences may differ. *Further Reading* (Chapter 3.3) lists useful material to help you gather more information, and finally *Who Do You Call?* (Chapter 3.4) provides a phone list of national and regional resources

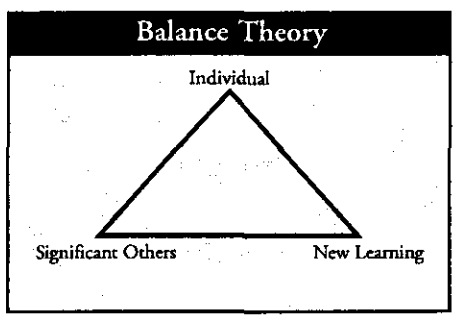
Linking New Learning to Our Work

When we acquire new learning, we have the opportunity to change. Change can manifest itself in all areas of life — professional, organizational, personal. The question then, is, "How do we apply new learning to the many and varied aspects of our lives?" Readers should expect to gain new knowledge, skills, and attitudes from this manual. To help ensure that we retain this learning and incorporate it into our lives, there are a number of exercises and opportunities for reflection throughout the manual.

We must include our significant others (co-workers, clients, supervisor, lover, etc.) in our efforts to link new learning to our lives, or else we risk either losing the significant other or the new learning, and returning to our old ways of doing things. This is known as the Balance Theory.[4] The goals of linking new learning are the following:

- to enhance our awareness of the impact of our new learning on significant others;
- to provide us with the opportunity to plan how we might introduce new learning at work, at home and with significant others.

The Balance Theory encourages us to involve our co-workers in the learning process. For this reason, most of the exercises in this manual are designed to be done with a group. In several chapters you will find *Linking New Learning*



exercises that are also specifically designed to help you reflect on how the material is relevant to your everyday work. If you can not work with a group, you are encouraged to find at least one other person to discuss what you are learning and how you can apply it in a practical way.

[4] Adapted from Fritz Heider. *The Psychology of Interpersonal Relations.* New York: John Wiley and Sons. 1985.

2.2 Attitudes, Values and Beliefs

James Street Credo

All people are equal.
Respect one another's feelings.
People have the right to their own opinions and feelings without the need to defend them.
We strive to have dignity for ourselves and others.
We have the responsibility to ourselves and others to promote a sense of security.
Respect people for who they are.
We each have the responsibility to not tolerate abuse of any kind.
We have the responsibility not to discriminate against gender, sexual preference, nationality, age, religious beliefs, social and economic standing, and the physically and/or mentally challenged.
We must endeavour to understand that there is something to be gained from everyone's special qualities, and that only God (as we understand God) has all wisdom.
In fulfilling my responsibilities, I have the right to be here.

The James Street Recovery Program is a residential drug and alcohol treatment centre in Ottawa, Ontario. After the December 6, 1989 massacre in Montreal, in which 14 women were killed, the residents felt they needed to respond to the tragedy. These young street-involved men and women worked together for several months to craft the *James Street Credo* as a statement of their attitudes, values and beliefs. Their legacy continues today.

The *Credo* is one example of a group's values and beliefs. It sets expectations for the group members to meet that have been discussed and agreed upon by all. In community-based AIDS organizations (CBAOs) we can also define a statement of values to help guide our work. It may look similar to the one above, or it may look quite different. However, it is important to understand what our attitudes, values, and beliefs are, and how they impact on our ability to serve our clients.

Attitudes, Values and Beliefs

Attitude: A way of thinking, behaving, acting or feeling.

Value: An established ideal of life. To esteem, to have a high opinion of something.

Belief: The acceptance of something as true.

We all have attitudes, values and beliefs. They represent the core of our self concept. They can change when influenced by a variety of different forces. They can be as simple as what we like and dislike (food, clothing, music). They operate at both the conscious and the intuitive levels, producing subtle shades of behaviour that we act out without understanding why. They can lead to judgment of others and of ourselves.

Substance use has been a part of history since time began, while HIV/AIDS is a relatively new health crisis. Values, attitudes and beliefs regarding sexuality, substance use, lifestyle and access to health care affect our work in providing support to individuals living with these two issues. People who use substances and are HIV positive challenge us as care givers in unique ways. To effectively deal with substance use and HIV/AIDS as support service workers in CBAOs we need to examine our own attitudes, values and beliefs. This section will support you in examining these relationships.

Recognizing Our Unique Attitudes, Values and Beliefs

Below are four exercises that help illustrate how attitudes, values and beliefs develop in all of us. They make us who we are, and must first be validated. The goals and objectives of these exercises are:

Goals:

1) To assist you in developing self-awareness of how personal attitudes, values and beliefs can influence your work with people who are HIV positive and who use substances.

2) To develop guiding principles which support new ways of working with people.

Objectives:

1) To explore and validate the origins of our attitudes, values and beliefs.

2) To experience feelings and responses with clients who are HIV positive and use substances.

3) To learn how to better manage and understand attitudes, values and beliefs when working with others.

Guidelines for Completing the Exercises

Ideally, all members of staff will participate in this learning. Staff development and training are essential to meet the growing challenges provided by HIV positive people who use substances. A staff person could be designated to facilitate these exercises or an outside facilitator could be brought in. Alternatively, you can do these exercises by yourself. However, there may be feelings, responses, and issues raised that may catch you off guard. Check in with your peers, friends, colleagues, a health care professional — someone you trust — to assist you in discovering what these mean. We have a wide variety of personal and professional experiences that have shaped our views, and we have different levels of awareness of their impact on us.

Below are some ground rules your group may want to use to conduct the exercises. These guidelines can create a safe environment for personal reflection that promotes mutual respect and honours confidentiality.

Ground Rules for Exercises

- We participate in our own way.
- Risk taking and self-disclosure are encouraged and supported.
- All opinions are honoured.
- Confidentiality is maintained — what is said here, stays here.
- Respect myself and others.
- Diversity is valued.
- Agree to honour one another in word and action. Oppressive behaviour is not acceptable.
- We are encouraged to speak, owning our own words, e.g. I feel . . .
- We are responsible for our own learning.
- Have the courage to be imperfect.
- Build on the skills and abilities we already have.
- Recognize and validate our commitment to our work.
- *Learning is a process. Open yourself to the possibilities.*

It may be a challenge to make time to do these exercises, and to follow through on making some changes that you may decide are needed once you do them. Here are some tips to consider to help get the benefit of the exercises:

- Start by engaging co-workers in discussion. Try to get a group interested in doing the exercises together. Discuss the importance of doing this work.
- Use a team meeting or staff meeting time to do the exercises.
- Suggest collaborating with colleagues from similar organizations to do the exercises together. Perhaps your organization belongs to a coalition of agencies that could work together on this.
- Pair up with one other organization and commit together to a process of reflecting.

Exercise 1 Who Am I?[5]

Objective 1:

To explore and validate the origins of our attitudes, values and beliefs.

Purpose:

To provide participants with the opportunity to reflect upon the origins of our attitudes, values and beliefs and how they contribute to who we are.

Instructions

A) By yourself, take several minutes to think about the following questions. Write down your answers if you want.

1. Describe the people in your life and the significance of your relationships with them (e.g. partner, spouse, sister, brother, parent, child, co-worker, friend).
2. Describe the values by which you live your life — that are fundamental to the person you believe you are.
3. What are your likes and dislikes? (This can be fun or serious, e.g. "I like chocolate.", "I dislike drivers who don't use the turn signal.")

[5] Adapted from Addiction Research Foundation . *HIV Program In-House Staff Training Workshop.* January 1997.

4. Describe the significant events that have shaped your life and brought you to your work.

B) With a co-worker share what you identified about yourself in part A (only what you are comfortable with). Check into two areas: your emotional response (I felt . . .), and your cognitive response (I learned . . .). If you are doing this exercise by yourself, make a list of your reactions.

Talk about what you have learned, and how it is important to your work. This begins the process of integrating new learning and transferring skills and knowledge to your work environment.

Were there any surprises for you? What challenges have you now identified? How willing are you to share some personal information with colleagues? What are the barriers? How does this affect your working relationships?

If you experienced some discomfort, or learned something new, spend some time reflecting on their meaning, personally and professionally. Some things can take time to surface. You may want to ask someone you trust to listen and provide feedback to what you are thinking and feeling.

Discussion

As we understand our attitudes, values and beliefs, we are better able to challenge assumptions and look at new ways of dealing with complex issues. This is an opportunity for personal growth and development. Clients also have attitudes, values and beliefs that are integral to their lives. As we learn new skills and enhance our abilities, we serve our clients better.

Front line work is difficult. The basic values and beliefs that brought us to HIV/AIDS work are the same ones that apply to working with substance users. The overriding principle is to empower clients to deal with the challenges in their lives.

Exercises 2 and 3 are designed to check our attitudes, values and beliefs about substance use and HIV. Exercise 2 is adapted from a questionnaire for health care workers to measure the way they feel about caring for people who are HIV positive and use substances. [6]

[6] *AIDS and Substance Abuse: A training manual for health professionals.* San Francisco: The Addiction Health Project. 1987.

Exercise 2

So You're HIV Positive and You Use Substances

Objective 2:

To experience feelings and responses with clients who are HIV positive and use substances.

Purpose:

To measure your attitudes, values, and beliefs about people who are HIV positive and use substances.

Instructions

A) Working by yourself, consider each statement carefully, then write the number in the value column that corresponds to your feeling.

5 Strongly agree 4 Agree 3 Neither agree nor disagree 2 Disagree 1 Strongly disagree

Statement	Value
1. Once a person is infected with HIV, there is no point initiating treatment for substance use.	
2. Substance use is not prevalent in women.	
3. You can only help a person who uses substances if they ask for treatment.	
4. I find it difficult to be sympathetic to injection drug users who get AIDS.	
5. Substance users are less concerned about their health than others.	
6. People who use substances, as patients usually request pain medication whether they need it or not.	
7. Substance users need not be taken seriously when they complain of discomfort.	
8. Transfusion recipients and children are the innocent victims of HIV/AIDS.	
9. If illegal substances were made legal, violent crime would decrease.	

Statement	Value
10. I find it hard to be sympathetic to substance users who get HIV/AIDS.	
11. No more than 10% of hospital admissions result from substance use.	
12. Dealing with the behaviour related to alcohol and other substance use is beyond the scope of safer sex counselling.	
13. A health care worker should have the right to refuse care to a person with AIDS.	
14. The difference between substance use and misuse is the amount used.	
15. A health care worker should have the right to refuse care to a substance user.	
16. Use of alcohol is not as serious a problem as use of other substances.	
17. Cocaine is not as dangerous as the media makes it seem.	
18. A person who commits a crime while under the influence of alcohol or other substances should not be held responsible for it.	
19. Use of alcohol and other substances by a parent should be hidden from the children to protect them.	
20. The relationship between physical and sexual abuse and the use of alcohol and other substances is negligible.	
Total score:	

Your total score gives you an indication of how your attitudes, values, and beliefs impact on your comfort level in working with people who are living with HIV/AIDS and who use substances, according to the following chart.

Point Score	Ease in working with substance users
1–20	You are generally at ease in working with substance users with HIV.
21– 40	You are relatively at ease in working with substance users with HIV. You may benefit from reading more on the subject.

41–80	You have some discomfort in working with substance users with HIV. You may benefit from reading more on the subject.
81–100	You may have considerable fear or difficulty in working with substance users with HIV.

B) Discuss the results of part A with a partner or with the entire group, using the following questions as a guide.

1. Were you comfortable with the questions? If not, why not?
2. What did you learn about yourself? How do you feel about what you have learned?
3. Do you have any concerns about your workplace's attitudes, values and beliefs? If yes, how can they be improved?

Discussion

If you would like to improve your level of comfort in working with people who use substances and have HIV/AIDS, you may want to do some reading. Our comfort level always increases when we know more about a previously less familiar issue. Refer to the *Further Reading* section at the back of this manual for good resources. Also, the staff in your agency can all benefit by organizing an in-service training session with a local resource person. Your local drug and alcohol treatment facility or referral and assessment service may reciprocate your offer of training their staff about HIV/AIDS issues by training your staff on substance use issues.

Exercise 3

What About My Own Drinking or Using?

Objective 2:

To experience feelings and responses with clients who are HIV positive and use substances.

Purpose:

To examine your own practices around alcohol and substance use, and explore how these are related to your attitudes, values and beliefs.

Instructions

A) Working by yourself, answer these questions:

1. Do you drink and/or use drugs? If so, where, how much, how often, for what reasons? If not, why not?
2. What did you learn about substance use when you were growing up?
3. What are your attitudes now about alcohol and drugs?
4. What do you experience when you see a man under the influence of a substance? A woman under the influence of a substance? Is there a difference?
5. Do you have any unresolved conflict, anger, etc. from the effects of a significant other's drinking and/or drug use? (If so, this will interfere with your ability to provide effective service to your clients. What do you need to do?)
6. If you are in recovery, do you compare a client's substance use to your own past use? Do you feel safe working with active users? Can you keep perspective?
7. Do you look negatively on substance use in others even if you have used on occasion yourself?
8. How do you distinguish between social drinking, the use of alcohol in moderation, and heavy drinking? Do others have a different way of measuring?
9. Can you talk rationally with others about their use of alcohol and/or substances, especially when their patterns of drinking/using differ greatly from your own?

B) With a partner, or with the entire group, discuss your responses to part A. Respect each other's privacy and share only what you feel comfortable with. Use the following questions as a guide.

1. What have you learned about yourself regarding your attitudes, values and beliefs about substance use?
2. How did you feel responding to these questions?
3. How do you think your client might feel when you ask questions about their using patterns?
4. Have you identified any biases? If yes, what can you do about them?
5. What are you most uncomfortable with?
6. Are you aware of what you do not want to share and why?

Discussion

Learning is an on-going process. If you feel the need to further explore aspects of your personality, connect with the local mental health services, try therapy, join a support group, start a support group, or do some reading on the subjects that interest you.

Exercise 4 Case Studies

Objective 3:

To learn how to better manage and understand attitudes, values and beliefs when working with others.

Purpose:

To provide you with the opportunity to apply what you are learning and problem solve realistic situations.

Instructions

In groups of three, choose a case study to role play. The cases are real people but the descriptions are sketchy and incomplete. The client has come to see you at the ASO. One person plays the client, another plays the support service worker and the third is the observer. Take 10 minutes to act out the scene. Then provide feedback to the each other about the exercise, using the questions that follow as a guide. If you are unable to practice this exercise with others, you can still benefit from reading the case studies yourself, and reflecting on how you would respond.

Checklists are provided with each case study as a guide. They are not complete or comprehensive, but rather a way of asking you to check your assumptions, promote thought and discussion, and look at areas that might not be readily obvious. There are no simple right or wrong answers in these cases. There are some ethical dilemmas involved, just as there are in all the support work we do. Discuss the different choices you and your colleagues make in these cases.

1. Sally is a 19 year old IV drug user who is currently having a sexual relationship with an HIV positive male. Sally does not know his serostatus, but you know from case management work with your team. She is afraid of becoming HIV positive. Sally is pregnant.

   Checklist:

   ❑ What do you do with the information that her partner is HIV positive? Testing?

   ❑ Current substance using practices? Clean needles? Condoms?

   ❑ Is she receiving perinatal care?

   ❑ Other medical complications?

   ❑ What is her housing situation?

   ❑ How can you get Sally to talk about her fear?

   ❑ Are there other risk factors?

2. Fred is a 32 year old heterosexual IV drug user. He was diagnosed HIV positive three years ago. Since then he has spent most of his time in jail or in treatment facilities. Fred has become "institutionalized" and acts like he knows all the answers. His attitude is "Why bother?"

   Checklist:

   ❑ Is he still using?

   ❑ Substances of choice?

   ❑ Who is he hanging out with?

   ❑ How can you work with his attitude?

   ❑ Current unresolved legal problems?

   ❑ What does he want?

   ❑ What is important to him?

   ❑ What harm reduction strategies might you suggest?

3. Paul is a 34 year old gay male who left a long term relationship six months ago. At that time, neither of them were infected with HIV. Paul's behaviour has changed, his drinking has escalated and he has recently tested HIV positive. Paul is looking for support in a social context — a group of people who are HIV positive and who "just want to have fun."

   Checklist:

   ❑ What else about his behaviour has changed?

   ❑ How does he feel about his serostatus?

   ❑ What is his relationship with his previous partner?

   ❑ Has he told his previous partner his serostatus?

   ❑ Is he receiving any medical care?

   ❑ What lifestyle issues are coming up for Paul?

   ❑ What about a safer sex discussion — virus mutation etc.?

4. Tom is a 28 years old and bisexual. He drinks and uses cocaine. He supports himself as a sex trade worker and receives social assistance. Tom was diagnosed HIV positive 18 months ago and tells everyone his serostatus. He says he wants to "get clean and sober" but says he can't.

   Checklist:

   ❑ How can you explore the contradiction between what he says and what he does?

   ❑ How does he use cocaine?

   ❑ What safer sex practices does he use?

   ❑ Does he inform his clients of his serostatus?

   ❑ What motivational obstacles are there?

   ❑ What kind of support system does he have?

5. Carol is a 26 year old mother of two children. She was recently released from prison (for drug trafficking). While in jail she was tested and diagnosed HIV positive. Carol is reeling from this information. She cries, apologizes a lot, and writes poetry about "how wonderful life is." Carol arrives for her appointment appearing to be high.

Checklist:

- ❑ What is going on for Carol right now?
- ❑ How has she been feeling about the recent diagnosis?
- ❑ What is her support network?
- ❑ What are her questions, concerns?
- ❑ Can she tell you what she needs?
- ❑ How do her children fit into all of this?

6. Create your own client case study with issues relevant to your experience.

Case Study Questions

Discuss the following questions after each case study. Be aware of your responses cognitively and emotionally.

1. What kinds of things did you miss?
2. What assumptions did you make?
3. Are there gaps in service delivery? What can you do about it?
4. Have you the resources in your agency and community to address these issues?
5. How comfortable are you suggesting harm reduction strategies?
6. Are there any conflicts between your attitudes, values and beliefs and the clients'? What can you do about it?
7. What have you learned?

Developing New Guiding Principles

Reflect back on Exercise 1. What are the values by which you choose to live your life? honesty? integrity? acceptance? safety? courage? respect? being non-judgmental? what else? Name them. These principles are the characteristics of your significant relationships. You bring yourself to your work. It is essential to know yourself in order to be able to be open to other people, to acknowledge the differences, and to remove barriers.

Review the Ground Rules on page 11. These can be guiding principles for you and your colleagues to work with all the time. You can also apply them to your interactions with your clients. There is no difference. Imagine what your clients deal with almost daily — being treated as less than human, with few

rights respected. The way you treat your client has a huge impact on whether or not they connect with your agency.

By now, you probably have a good idea how some of your attitudes and values have been formed and how they affect your work and your life. If you are honest with yourself, you will be able to admit there might be room for improvement! How easy is it for you to let go of beliefs that are no longer serving you well? What will take their place? How can you integrate your new attitudes, values and beliefs into your life? It is one thing to promote healthier ways of being, it is quite another to live them.

Awareness, commitment to growth and change, practice and patience will help you alter your attitudes, values and beliefs. Bring the best you to your work. Strive to be open-minded, non-judgmental, tolerant, understanding, caring and honest. Respect people for who they are and where they are — they have a right to be there.

Exercise 5 Linking New Learning

This exercise gives you the opportunity to reflect on the new learning you have acquired in this chapter and how you can integrate it into your life. It is based on the Balance Theory of learning as described on page 8.

Purpose:

To integrate your new learning from this chapter into your work practices.

Instructions

After your group has completed exercises 1 to 4 and read the whole chapter, reflect on the process by answering the following questions. Take 15 to 20 minutes to answer questions 1 to 4 by yourself, then do question 5 with your group.

1. How will the conceptual skills and enhanced self-awareness you have gained in these exercises assist you in

a) your work? _____

_____

b) your life? _____

_____

2. List the ways in which you could introduce this new learning to

a) your home: _____

_____

b) significant others: _____

_____

c) your agency: _____

_____

3. If appropriate, develop one or two goals that could serve as a guide in assisting you to become more effective with your attitudes, values and beliefs in working with HIV positive clients who use substances.

_____

_____

_____

4. What part of this section has had the most meaning for you? Can you explain why?

_____

_____

_____

5. Discuss in a group the impact of this section for you and your plans for implementing this learning in your work. How will the new learning be integrated into the work of the organization?

_____

_____

_____

Review of Important Concepts

- Substance use and HIV/AIDS present unique challenges to support service workers in CBAOs.
- Our attitudes, values and beliefs affect the way we work.
- We have skills and abilities that we can build on.
- All clients deserve our respect.
- Staff, volunteers and board members can benefit from training and orientation about attitudes, values and beliefs regarding substance use and HIV/AIDS.
- Policies can be developed and implemented that reflect the values of the agency in serving diverse population groups of persons living with HIV/AIDS.
- Support mechanisms should be available for support service workers, e.g. peers, colleagues, training, leave, policies, supervision.

2.3 Relationships, Boundaries, and Ethics

Boundaries and Ethics — What Are They?

Boundary: Something that functions as a dividing or limiting line.

Ethics: Formal or professional rules of right and wrong; a system of conduct or behaviour.

Why are boundaries and ethics important when working with substance users? What role does power play with these two elements of your relationship with a client? How can culture impact on boundaries? This chapter will explore these questions.

Boundaries are the dividing line between you and someone else. Boundaries are an integral part of your relationship with another person. They allow you to know you have separate feelings, thoughts and realities from others. Boundaries give you a sense of balance, and your perception of how you differ from others.

Ethics are standards of behaviour. They are found in civil and criminal law, religious and spiritual principles, and professional codes. Ethics permit you to function in society, and usually there are consequences for straying from them. You probably follow several different codes of ethics at once. For example, you choose your own personal ethics to guide your behaviour, and you adhere to professional ethics that are determined by your employer, or your professional association. Your personal ethics may differ in some ways from those of the agency where you work. Many CBAOs have a mission statement as well as policies and procedures. Check them out at yours. Make sure you are aware of them. You could find yourself in conflict with your agency. How then would you deliver services and remain true to your self?

Different Kinds of Boundaries

There are many types of boundaries. Below are a few examples. Can you think of others?

Type of Boundary	Example	Comment
Physical	Your body Your space	Has anyone touched you in a way that you didn't want?
Emotional	Your feelings	Have you been told that what you feel is wrong or irrelevant?
Intellectual	Your thoughts Your beliefs	Have your views ever been ridiculed?
Spiritual	Your awareness of and connection to a life force, power, or religion.	How comfortable are you in discussing your spiritual beliefs?
Power/relational	One person is seen as having power over the other.	What occurs when a client is addressed as "sweetie" or another term of endearment?
Language	People speak different languages; someone uses words to offend.	What do you do to confront verbal abuse towards you?
Sexual	Your sexuality	What does it feel like to receive unwanted sexual advances?

Type of Boundary	Example	Comment
Cultural	Your cultural customs	When you are offered a gift (which according to the giver is a sign of thanks), but you cannot accept it, how do you feel?
Philosophical	Your theories on the nature of things	How are you affected when your beliefs are challenged?
Political	Your views on government and its responsibilities.	What happens when you discuss politics with someone who has very different views?

Personal, Professional, and Organizational Boundaries

Boundaries are necessary in our personal and professional lives. Professional boundaries include those between staff, board members, volunteers, peers, and students. We need to be able to distinguish between barriers (which are fear-based) and boundaries. Personal boundaries are found in our relationships with friends, family, and lovers. Organizational boundaries define what an agency can and cannot do, who it serves, and what restrictions are placed on it from within and without. Organizational boundaries are discussed later in the section on ethics. The following chart compares the characteristics of professional and personal boundaries.

Professional Boundaries	Personal Boundaries
Professional boundaries serve the client in two ways: staff with client, and staff with staff, to provide services to the client.	Personal boundaries are characterized by mutuality. We are able to negotiate our needs and wants.
In our professional role, we are responsible for making the needs of the client primary.	In our personal lives it is important that we both assert our needs and treat each other as equals.

Professional Boundaries	Personal Boundaries
We must remain aware of the power difference inherent in all helping roles.	Power differences in personal relationships make intimacy difficult.
Boundaries are fixed. We are always the helper. We work with and for the client.	Boundaries are variable. Sometimes we help, sometimes we receive help.
We are always accountable for maintaining boundaries. The client is not accountable to us to maintain boundaries.	Responsibility for boundaries is shared.
We need to maintain emotional detachment and objectivity. When this is not possible, we need to transfer the client to a colleague.	Emotional interaction is essential to these relationships. This includes expressions of our sexuality.
Self disclosure to a client is for the purpose of illustration. Self disclosure to a staff member is for support.	Self disclosure is essential to build intimacy in personal relationships.
We are legally and ethically obliged to maintain confidentiality. If we do not, we place the helping relationship in jeopardy. We put the client, our job, and the ASO at risk.	We have an ethical responsibility to treat others with respect, making mutual trust possible, thereby investing in a safe relationship, family, community. Failure to do so results in a breakdown of the relationship.

Exploring Boundaries

Here are some exercises to help you look at boundaries in your role at your ASO. They have the following goals and objectives.

Goals:

1) To assist you in understanding the importance of boundaries and ethics when working with people who are HIV positive and who use substances.

2) To develop guiding principles which support new ways of working with people.

Objectives:

1) To reflect on our boundaries and ethics.

2) To examine how our boundaries and ethics affect our clients.

3) To identify when our boundaries and ethics are clear or blurred.

Exercise 6 Boundaries Between You and a Client

Objective 1:

To reflect on our boundaries and ethics.

Objective 2:

To examine how our boundaries and ethics affect our clients.

Instructions

Working by yourself or with a group, answer the following questions:

1. In each of the following scenarios, what boundary issues are involved?
   a) A client asks you for money.
   b) You are attracted to your client.
   c) You and the client drink or use substances together.
   d) You disclose similar experiences to client.
   e) A client gives you a gift.
   f) A client asks for your home phone number or calls you at home.
   g) A client goes to other staff to get what she/he wants.
   h) A client socializes with the same group of people as you do.
   i) A client wants you to drive her/him somewhere.
2. Describe a boundary situation you have experienced or witnessed in your work. What was the effect on you, on the client, on the co-worker? What could have been done differently?

Discussion

Everyone is at risk when boundaries are unclear. Boundaries equip the worker and the agency with the necessary structure to serve the client. Many substance users have developed survival strategies that present challenges to your boundaries. For example, they may challenge your right to say "no" to a request for

your home phone number. People who have developed these strategies use them with many other people in their lives to get what they need.

By keeping your boundaries firm, you may fear that the client won't like you or trust you, but actually you are sending a very positive message. Your message is that you are consistent, reliable, and that you will be there for the client, on terms that are comfortable for you, over the long run. You may even show clients who are used to having people take advantage of them that they don't have to accept that behaviour, just like you don't!

Often we have different jobs or roles within the ASO and the boundaries can and do overlap. The following exercise looks at some of these roles.

Exercise 7 Your Role in Your CBAO/ASO

Objective 2:

To examine how our boundaries and ethics affect our clients.

Objective 3:

To identify when our boundaries and ethics are clear and when they are blurred.

Purpose:

To compare the different roles you and your co-workers may occupy in your CBAO, to understand the relationship of boundaries to real and perceived roles, and to recognize the boundaries associated with power and relationships in roles.

Instructions

Working by yourself or with a group, answer the following questions:

1. Which word best describes your role in your ASO?

   a) counsellor c) friend e) peer counsellor

   b) volunteer d) support service worker

2. Describe your role. What are your activities, your responsibilities, your goals?

_____

_____

_____

3. In your role, what boundaries do you strive to maintain between yourself and the client?

   a) What is always okay?

   b) What is never okay?

   c) What is sometimes okay?

Discussion

It is important to have a clear understanding of your role in providing support to clients. Is your job to give advice to the client on what they should do, or to give information and help them choose between options? Is your job to share your expert knowledge, or to develop a supportive relationship based on your shared culture or social environment? Knowing your role will help you maintain clear boundaries with the client on what you will and will not do for them, and help you provide better service. Below are some common descriptions of the roles found in many ASOs. How does your understanding of your role compare to these?

Counsellor: This is a structured role, bound by the rules of confidentiality. It does not extend beyond the professional relationship. It is not a mutual relationship (you can not ask the client to help you). It requires a high level of training, education, professional ethics and emotional well being. This role is focussed, objective and centred on the client.

Volunteer: This is a less structured role that is defined by several variables: your reasons for volunteering, the position and value of volunteers at the ASO, your availability for shift work, whether or not you feel part of the community. Are you a volunteer member of the board? If so, what does that mean for your involvement in the day-to-day operation of the ASO?

Friend: This is a mutual relationship in which needs are asserted and negotiated. Both persons have responsibilities. Boundaries are variable. There is trust here. How do you see your role as a friend functioning within the ASO? Are you friends with some of your co-workers? with clients?

Support Service Worker: This is a broad category that has many and varied interpretations in different agencies. Does your ASO clearly describe this role? Do you know what your responsibilities are? What are your expectations of the client? It is essential that you explain to the client what services your ASO offers.

Peer Counsellor: A peer relationship is one in which both people give and take and both share equal power within the relationship. This role works well in many situations, such as substance users (or former substance users) working with other substance users. You connect with the client easily because of your common experiences.

Boundaries are what define these roles — what is and is not appropriate for you to do in them. These definitions are different at different ASOs. If you are unclear on some aspects of your role, discuss your concerns with your colleagues, or your supervisor. There are many cultural and philosophical differences between ASOs. Be sure that you are a good match for where you work.

Emotional Boundaries in the Helping Relationship

As you work with a client to address their needs, you must create a safe environment for them to feel comfortable sharing private and sometimes painful emotions. Fear, shame, guilt, anger, and other emotions may be hard for them to share, and sometimes hard for you to listen to, evoking your own emotional responses. Sometimes either you or the client get confused in this relationship, and it's hard for each of you to know whose emotions are whose. Transference and countertransference are two such responses that can occur in helping relationships. It is important to be aware of these potential problems and know how to address them.

Transference: The process whereby the client interprets your behaviour according to what the client has learned to expect. The client imagines you have feelings that you don't really have. For example, a client sees your smile and your concern for him as a sign that you are sexually attracted to him. It is common for people who are receiving support to misinterpret the helpful, friendly behaviour of a support worker. This is normal. However, you are responsible for clarifying these misinterpretations and getting the helping relationship back on track.

Treat sexual feelings like all feelings: identify and label them. Discuss clearly with the client what your real feelings are. Set boundaries and limits. Intervene according to the situation. Never shame the client for misinterpreting you.

Countertransference: The process whereby your reaction to the client is based on unconscious or unresolved issues from your past. Your unfinished personal or professional business interferes with the functioning of the relationship. Your personal history with substances, including childhood memories and adult experiences may also emerge here for you. As another example, a client tells you that her boyfriend has been hitting her. You had a similar experience with an abusive partner that you still have confused feelings about. As she tells you her story you feel afraid, and you assume she must feel the same way.

To address countertransference:

- Figure out what your feelings mean. They are related to your own history, not the client's.
- Stop and think before you act on your feelings.

- Return to the process. Deal with what the client is saying. Ask them to clarify their feelings. Explain that your emotions have been triggered by something the client said, but that you will deal with that later. Focus on the client.
- Don't blame the client or aggravate their feelings of shame.
- Talk to your supervisor or your colleagues for support. You may want to address your own emotional issues with a therapist or other professional. Does your ASO have a policy regarding extended health benefits, counselling, leave?

Boundaries in the Work Environment

The area where you work can help support professional and organizational boundaries that will maintain safety, and create a comfortable place for both you and the client. Here are some tips for arranging your physical space.

- Remove articles that might trigger thoughts of using (those things that remind the client of using, e.g. cigarette papers, spoons, bottle caps, pop cans, alcohol swabs, needles, foil).
- When sitting with the client try to remove barriers like a desk or table from between you.
- Decorate your office to reduce any "institutional" or "authority" feeling.
- Keep all client files securely stored away.
- Offer hospitality — coffee, snack, meal.
- Have condoms, bleach kits and information on display and available for clients to help themselves.
- Post the code of conduct or house rules in prominent place.

Cultural Differences in the Helping Relationship

As HIV knows no cultural boundaries, neither does substance use. Your clients live in many social and cultural environments. Some of them will be similar to you in social and cultural characteristics, others will be quite different. You may feel an immediate "connection" with some clients based on your shared culture, or you may realize there is a lot you don't know about another client's culture — their attitudes, values, beliefs, history, etc. It is your responsibility to ensure you can work with all your clients effectively and respectfully.

Think of all the characteristics of culture: dress, self-adornment, values and beliefs about males and females, young people and older people, economic relationships, language, family structure, marriage customs, social environment, standards of behaviour, manners, thinking process, sexual orientation, forms of mood altering (including substances and alcohol), recreation and relaxation. [7]

[7] Most of the material in the section is adapted from: Addiction Research Foundation. *HIV Program In- House Training Manual.* January 1997; and Hall, Edward *The Silent Language and Beyond Cultures.*

From these traits emerges a cultural identity that gives all human interactions meaning: patterns of communication (verbal and non-verbal), action and inaction (not doing something can be very meaningful). Behaviour communicates. For example, for youth, music and dress communicate a lot about personal identity.

Our unfamiliarity with a client's cultural identity may result in disorientation. This confusion challenges us — our sense of self identity. Our identity is nurtured within the group(s) that we associate with and is reinforced by them. It is a symptom of human nature to gravitate toward like-minded people and work in areas that are congruent with our beliefs. When these cultural reinforcements are confronted by people from diverse backgrounds we can feel that our own cultural identity is threatened or denied.

Tips When Working with Cultural Diversity

- make no assumptions
- know yourself, be yourself
- accept people where they are and for who they are
- be present in the moment
- respect all cultures and differences
- be real
- be teachable

Ethics and Guiding Principles for Helping Relationships

Your behaviour sets the stage for the development of the helping relationship. You help the client by establishing a clearly bounded, cooperative relationship. Usually the client is looking for something that they are unable to sort out on their own. The client hopes that you (and the ASO) can provide it. You bring your ethics, knowledge, skills, techniques, attitudes and values to your work. A power differential is inevitable. Your responsibility is to help the client, to facilitate a process. The client has no obligation or responsibility for your emotional well-being nor does the client owe you anything. You have no ulterior motives. You are an objective listener.

Change does not occur except in relationship. According to Carl Rogers, the qualities "necessary and sufficient" for this client-centred relationship are:

- Respect the client as an individual.
- Be non-judgmental.
- Be concrete. Focus the client's attention on specific behaviours, as they occur.
- Challenge the client. Present the client with their own behaviour pointing out discrepancies. This requires being genuine and honest.

Difficulties can arise when the client uses substances. Their perceptions and abilities are altered. The client's freedom of choice is affected. You need to be very clear about the difference between accepting the person and accepting behaviour that crosses your boundaries.

For example, a client comes to see you at the ASO and wants some bus tickets for appointments. But the ASO has recently changed its policy and no longer gives out bus tickets. When you inform the client about this change, the client becomes angry and starts yelling at you. You say to the client that you understand their frustration but you will not accept the yelling, that you are willing to work with the client to look at other ways to get to those appointments but not if the yelling continues. By responding in this way, you are respecting the client, being non-judgmental and concrete. The client is accepted and the behaviour is addressed.

Ethical Guidelines for the Helping Relationship

The following are some guidelines that help promote a healthy helping relationship. Which of these principles do you follow already in your work? Which would you like to improve on?

1) Be clear and direct in your communication. Make sure that what you have said is what the client has heard. Ask the client to re-phrase what you have said.

2) Inform the client of your role and what kind of services and support you can offer, and what you cannot do.

3) Listen actively to the spoken word and observe the unspoken body language.

4) Understand and maintain the laws of confidentiality and informed consent.

5) Set fair and enforceable limits with your clients.

6) Power differences obligate you to maintain certain boundaries.

7) Supervision, debriefing, or peer support is essential to normalize feelings and thoughts, and to maintain your emotional well-being.

8) Accept that you will have different emotional responses to different clients. Strive for consistent standards of behaviour.

9) Repair boundaries that have been overstepped. You may want to get peer or supervision support for this.

10) Deal with any inappropriate expectations you may have of your clients (e.g., you want them to stop their substance use or be grateful to you). Get supervisory or peer support.

11) Physical contact is a boundary issue. *Always* ask the client before touching and explain your motive — to provide support. Touching can be misinterpreted as a sexual advance, or it may evoke fear. Be cautious.

12) When working with a dying client, boundaries can and do shift as the relationship changes. For example, more therapeutic touching may be appropriate — check with the client and check your own motivations and reactions.

Exercise 8 Linking New Learning

The following exercise gives you the opportunity to reflect on the new learning you have acquired in this chapter and how you can integrate it into your life. It is based on the Balance Theory of learning as described on page 8.

Purpose:

To integrate your new learning from this chapter into your work practices.

Instructions

After your group has completed exercises 6 and 7 and read the whole chapter, reflect on the process by answering the following questions. Take 15 to 20 minutes to answer questions 1 to 4 by yourself, then do question 5 with your group.

1. How will the conceptual skills and enhanced self-awareness you have gained in these exercises assist you in

a) your work?

b) your life?

2. List the ways in which you could introduce this new learning to

a) your home:

b) significant others:

c) your agency:

3. If appropriate, develop one or two goals that could serve as a guide in assisting you to become more effective with applying boundaries and ethics in working with HIV positive clients who use substances.

4. What part of this section has had the most meaning for you? Can you explain why?

5. Discuss in a group the impact of this section for you and your plans for implementing this learning in your work. How will the new learning be integrated into the work of the organization?

Review of Important Concepts

- Healthy boundaries and ethics protect the client, yourself and the organization. They create an atmosphere in which a helping relationship can grow, where trust can be developed.
- Build on the boundaries and ethics you already use.
- The roles you have within the organization provide some guidelines around boundaries and ethics.
- Policies and procedures are required to create safety for the client, yourself and the organization.
- Staff, volunteers, and board members need to receive training and orientation about boundaries and ethics regarding substance use and HIV/AIDS.
- Sometimes our personal and professional lives overlap. Seek support/feedback from people you trust.
- If you feel unsupported within the agency, reach out and network with others who work in similar situations (helps to stem feelings of isolation); develop and practice self care strategies.
- Ethics or standards of behaviour permit you to live and work as a caregiver in our society.

2.4 Listening Skills

> *The capacity to give one's attention to a sufferer is a very rare and difficult thing. It is almost a miracle; it is a miracle. — Simone Weil*

One of the greatest gifts anyone can give another person is to truly listen. Unfortunately, too often we do not consider listening to be a skill. We tend to equate hearing with listening, believing that because hearing is a natural function (unless you are hearing impaired), listening must be effortless as well. In fact, listening is an active skill which requires effort and practice.

Active Listening involves listening to the total message (both the content and the feelings) the client is sending. Then, mirror (reflect) back to the client the feelings that are coming across through the message. This develops a climate in which you can be non-judgmental and accepting of the client. The essential characteristic of active listening is that the listener (you) tries to grasp both the *facts* and the *feelings* in what you hear. Here are some examples of good listening and poor listening practices. [8]

You Are Listening to Me When . . .

- you come into my world and let me be me;
- you try to understand me even when I may not make much sense;
- you grasp my point of view even when it goes against your beliefs;
- you realize that the hour I took from you is gone;
- you didn't tell me that funny story you were bursting to tell me;
- you allowed me the dignity of making my own decisions even though you may not have agreed;
- you did not take my problem away from me but trusted me to deal with it in my own way;
- you gave me enough room to discover for myself why I felt upset/sad/angry/happy, and enough time to think for myself what is best;

[8] Adapted from: AIDS Committee of Ottawa's volunteer training program.

- you held back your desire to give me good advice;
- you did not offer me "pat answers," jargon expressions or religious comfort;
- you accepted my gift of gratitude by telling me it was good to know you had helped.

You Are NOT Listening to Me When . . .

- you say you understand before you know me well enough;
- you have an answer for my problem before I have finished telling you what it is;
- you cut me off before I finish speaking;
- you finish my sentence for me;
- you find me boring and don't tell me;
- you feel critical of my grammar, word usage or accent;
- you are speaking to someone else in the room;
- you are dying to tell me something, or want to correct me;
- you are disturbed by loaded words or abusive language;
- you are trying to sort out all the details and are not aware of the feelings behind the words;
- you sense that my problem is embarrassing/distasteful/uncomfortable and you want to avoid it;
- you get excited and stimulated by what I am saying and want to jump right in before I invite your response;
- you need to be successful;
- you tell me about your experience which makes mine seem unimportant;
- you refuse my thanks by saying you really haven't done anything;
- you do not care about me, and you cannot care about me until you know something about me.

Listening is a skill and not a passive process because it is we who make the sense of what we hear. We do this not only from any meaning attached to the sounds of the words themselves, but on our observations of non-verbal behaviour and our subjective impressions and feelings.

Exercise 9 Listening Skills

List at least seven statements beginning with *"When I listen I . . . "* choosing from the list below.

_____

_____

_____

_____

_____

_____

_____

"When I listen I . . ."

- am relaxed physically and mentally
- check how I feel about what I'm hearing
- observe the client
- stay alert
- show active interest
- allow the client time and space
- check that what you have heard and understood is what has been said
- avoid interrupting
- respond
- encourage the client
- paraphrase and affirm
- ask for clarification
- maintain good eye contact (when culturally appropriate)

We avoid truly listening to what clients are saying if we are uncomfortable with ideas which are in conflict with our beliefs. We avoid listening to block out or deny disturbing feelings and events. Try not to ask "why" questions; they tend to sound critical and ask for reasons or explanation. The more we listen, the more information there is to work with.

Active Listening Skills

Listening is a two-way process. Once you have perceived what the client is telling you through verbal and non-verbal behaviour, you respond in a way that shows you understand.

Some active listening techniques you can use are:

Empathy: You can convey empathy in what you say and do, e.g. "I can see that you are finding this painful to talk about." You are reflecting an understanding of what has been said.

Use words that are non-judgmental: For example, "How good is the coke on the street these days?" You are showing non-judgmental interest.

Paraphrase: For example, the client says, "Someone stole my welfare cheque and those bastards won't give me any money." You respond, "Your cheque is gone and you need money." You restate the facts and not the feelings.

Ask questions that encourage the client to respond: E.g. "Tell me what it's like when you get hassled?" You are listening and focussing on the specific situation and asking the client to talk more about it.

Summarizing: Summarizing is a technique which can condense large amounts of information into its key points. It helps you tie together the essential components of the conversation with the client. There are three characteristics of effective summarizing: (1) it is short; (2) it is to the point; (3) it does not add any new information, meaning or interpretation to the message.

Exercise 10 Linking New Learning

The following exercise gives you the opportunity to reflect on the new learning you have acquired in this chapter and how you can integrate it into your life. It is based on the Balance Theory of learning as described on page 8.

Purpose:

To integrate your new learning about listening skills into your work practices.

Instructions

After your group has completed exercise 9 and read the entire chapter, reflect on the whole process by answering the following questions. Take 15 to 20 minutes to answer questions 1 to 4 by yourself, then do question 5 with your group.

1. How will the conceptual skills and enhanced self-awareness you have gained in these exercises assist you in

a) your work?

b) your life?

2. List the ways in which you could introduce this new learning to

a) your home:

b) significant others:

c) your agency:

3. If appropriate, develop one or two goals that could serve as a guide in assisting you to become a more effective listener in working with HIV positive clients who use substances.

4. What part of this section has had the most meaning for you? Can you explain why?

5. Discuss in a group the impact of this section for you and your plans for implementing this learning in your work. How will the new learning be integrated into the work of the organization?

_____

_____

_____

Review of Important Concepts

- Listening is essential to developing a trusting and effective relationship with the client.
- Workers may have more knowledge and skills in certain areas, but clients also have skills that workers don't have. Workers can teach and learn, and clients can do the same.

2.5 Self Care

So how do you sit with a shattered soul? Gently, with gracious and deep respect. Patiently, for time stands still for the shattered, and the momentum of healing will be slow at first. With tender strength that comes from an openness to your own deepest wounding, and to your own deepest healing. Firmly, never wavering in the utmost conviction that evil is powerful, but there is a good that is more powerful still. Stay connected to that Goodness with all your being, however it manifests itself in you. Acquaint yourself with the shadows that lie deep within you. And then, open yourself, all that is you, to the Light. Give freely, take in abundantly. Find safety, your refuge, and go there as you need. Hear what you can, and be honest about the rest: be honest at all cost. Words won't always come; sometimes there are no words in the face of such tragic evil. But in your willingness to be with them, they will hear that for which there are no words.

When you can, in your own time, turn and face that deep chasm within. Let go. Grieve, rage, shed tears. Find those you trust and let them be with you. Know laughter, the healing power of humour. Trust yourself. Trust the process. Embrace the world, this world that holds you safely now. Grasp the small tender mercies of the moment. Let you be loved. Let you love. The shattered soul will heal. [9]

Dealing with substance use and HIV/AIDS is chronically stressful. Stress is a necessary part of life: it adds flavour, challenge and opportunity to our existence. The human parade that passes through the doors of your ASO stretches the abilities of even the most gifted workers. You are working with people who are traumatized by substance use and HIV/AIDS, the wounded and the damaged, the survivors. The stigma and fear both workers and clients can feel is unique.

How we react to these stressors is distinctive and personal to each of us. What may be relaxing to one person may be stressful to another. Also the effects of substance use and HIV/AIDS stress ebb and flow as experiences, situations and skills change.

Self care involves health promoting activities that express the individual's desire for well-being. This includes physical, emotional, psychological, sexual, social and spiritual health. The practice of self care is not just to meet the per-

[9] Steele, Kathy. "Pilgrimage"in *Journal of Personal Exploration and Psychotherapy.* Vol. 15, No. 6, 1987.

sonal needs of the support worker, but also to ensure that unmet personal needs do not result in violating or abandoning a client. Self care is about how we become aware of the stressors in our personal and professional lives. Our internal strengths and resources need to be nurtured, replenished and protected, so we can continue to do the work that inspires us.

The following exercises will help you identify your sources of stress, and coping strategies that can benefit you, the organization, and the client.

Exercise 11 Sources of Stress in HIV/AIDS and Substance Use Work

Purpose:

To increase your awareness of the sources of stress for you in your work.

Instructions

Take a look at the lists of sources of stress that you may encounter in your work. Identify and check off the degree of stress (0 to 4) of two or three items that are relevant to you.

0 no stress 1 slight stress 2 moderate stress 3 extreme stress 4 unbearable stress

RELATIONSHIP FACTORS	0	1	2	3	4
So many dying	❑	❑	❑	❑	❑
Young people dying	❑	❑	❑	❑	❑
Not having a cure	❑	❑	❑	❑	❑
Knowing my own HIV status	❑	❑	❑	❑	❑
Not knowing my own HIV status	❑	❑	❑	❑	❑
My own risk factors for HIV	❑	❑	❑	❑	❑
Fear of my own death	❑	❑	❑	❑	❑
Guilt/inadequacy	❑	❑	❑	❑	❑
Substance users with HIV/AIDS	❑	❑	❑	❑	❑
My own substance use	❑	❑	❑	❑	❑
My experience with substance users in my personal life	❑	❑	❑	❑	❑
Women with HIV/AIDS	❑	❑	❑	❑	❑

Infants/children with HIV/AIDS	❑	❑	❑	❑	❑
Co-workers with HIV/AIDS	❑	❑	❑	❑	❑
Friends with HIV/AIDS	❑	❑	❑	❑	❑
Unpredictable behaviour/symptoms	❑	❑	❑	❑	❑
Discussion of suicide	❑	❑	❑	❑	❑
Not knowing what to say	❑	❑	❑	❑	❑
No one to talk to	❑	❑	❑	❑	❑
Other (please name) _____	❑	❑	❑	❑	❑

EXTERNAL FACTORS	0	1	2	3	4
Demanding clients	❑	❑	❑	❑	❑
Lack of resources	❑	❑	❑	❑	❑
Long hours	❑	❑	❑	❑	❑
Lack of training	❑	❑	❑	❑	❑
Poor team communication	❑	❑	❑	❑	❑
Low team morale	❑	❑	❑	❑	❑
Lack of policies	❑	❑	❑	❑	❑
Agency "politics"	❑	❑	❑	❑	❑
Legal/ethical issues	❑	❑	❑	❑	❑
Lack of public support	❑	❑	❑	❑	❑
Demanding supervisors	❑	❑	❑	❑	❑
Insufficient staff	❑	❑	❑	❑	❑
Lack of supervision/debriefing	❑	❑	❑	❑	❑
What's happening at home?	❑	❑	❑	❑	❑
Personal finances strained?	❑	❑	❑	❑	❑
Other (please name) _____	❑	❑	❑	❑	❑

Discussion

Sources of stress vary from person to person. Substance use and HIV/AIDS related stress can be used in a positive way that prevents it from becoming distress. To do this you need to become aware of your own sources and reactions to stressful events.

1. What items best described your stress?
2. Are there other sources of substance use and HIV/AIDS related stress that you think should be listed? If so, what are they?
3. People seldom discuss the positive effects of substance use and HIV/AIDS related stress. What are some of the positive effects of this stress (such as motivating you to engage in advocacy)? How do these fit in with your experience?

Ways of Coping With Stress

These are just a few ways people cope, positively and negatively, with stress.[10] Which coping strategies do you use now? Adapt this list to make it your own.

Yes	No	PHYSICAL
❑	❑	Physical exercise
❑	❑	Eat a balanced diet
❑	❑	Listen to your body
❑	❑	Take a warm bath
❑	❑	Have sex
❑	❑	Strive for self-improvement
❑	❑	Take stretch breaks
❑	❑	Develop headache/backache/nervous stomach
❑	❑	Others (please list) _____
❑	❑	_____
		MENTAL
❑	❑	Express your emotions
❑	❑	Set clear goals
❑	❑	Worry
❑	❑	Study, read

[10] Adapted from: Canadian Hospital Association. *Caring for HIV/AIDS Care Givers: A Stress Management Program.* 1992.

Yes	No	
❑	❑	Scream, rage
❑	❑	Practice relaxation techniques
❑	❑	Laugh
❑	❑	Feel confident and optimistic
❑	❑	Work/Play in balance
❑	❑	Pretend nothing is wrong
❑	❑	Use alcohol or substances to change your mood
❑	❑	Others (please list) _____
❑	❑	_____
		RELATIONAL
❑	❑	Seek help and support
❑	❑	Share with family or a friend
❑	❑	Nourish an intimate relationship
❑	❑	Say "no" to people intruding on your free time
❑	❑	Change focus or activity
❑	❑	Visit/play/dance/party with friends or family
❑	❑	Stick up for yourself
❑	❑	Demand your own way, be stubborn
❑	❑	Get even, be sarcastic
❑	❑	Others (please list) _____
❑	❑	_____
		SPIRITUAL
❑	❑	Pray or meditate
❑	❑	Participate in a spiritual activity with others
❑	❑	Accept limitations
❑	❑	Explore the meaning of life
❑	❑	Take up a cause
❑	❑	Forgive

Yes	No	
❑	❑	Have a non-judgmental attitude
❑	❑	Others (please list) _____
❑	❑	_____
		RESPITE
❑	❑	Take a break from work
❑	❑	Reward yourself for your work
❑	❑	Make your home a comfortable place to be
❑	❑	Have a hobby, outside interest
❑	❑	Take vacations from work
❑	❑	Procrastinate
❑	❑	Avoid conflict situations
❑	❑	Others (please list) _____
		_____

Reflect on your responses to Exercise 11. In which areas (physical, mental, relational, spiritual, respite) are your coping responses effective in decreasing stress? In which areas could your coping responses be more effective? What specific activities would you like to do to change you coping behaviours?

Professional and Organizational Self Care Strategies

There are also professional and organizational ways to enhance self care. Review the checklists below to determine what options would best decrease your stress.

Professional Checklist

❑ reduce your isolation

❑ know your patterns

❑ create variety in your work (individual, group, administrative, training, etc.)

❑ identify your triggers (what gets you going)

❑ set boundaries and limits

❑ continue your education

❑ have an emergency plan for coping

- ❑ do ongoing evaluation of your professional growth
- ❑ have fun with a peer
- ❑ attend staff retreats
- ❑ find a mentor
- ❑ have peer supervision
- ❑ work in teams

Organizational Checklist

- ❑ Are there opportunities for continuing education and training?
- ❑ Does your work environment value you as a person, even in disagreement?
- ❑ Are you rewarded for new ideas and creativity?
- ❑ Does your agency encourage leadership?
- ❑ What team enhancing strategies are encouraged?
- ❑ What is the physical state of your work area?
- ❑ Are there occasions to acknowledge and celebrate the victories?
- ❑ What policies and procedures does your agency follow to provide support to staff, volunteers and board members?

Are there gaps professionally? organizationally? What can you do about them? Bring your concerns to staff or team meetings. What is working well? Build on those strengths.

Critical Incident Stress

A **critical incident** is a crisis that is beyond the scope of the normal experiences we encounter in our work. For example, a client's sudden death of a drug overdose may be a critical incident for you, if you are not expecting it to happen, and you're not prepared for it. By contrast, the death of a client from AIDS, while it is a difficult event to deal with, is probably not a critical incident for you because it is a normal part of your work.

A critical incident is defined as any event that is outside the normal range of your experience, and that has the power to cause extreme cognitive, emotional or physical distress. Policies and procedures need to be in place at the agency to support those involved. Critical Incident Stress debriefing is recommended as a method of addressing the trauma experienced by staff following a critical incident.

Critical incident stress describes the normal and predictable emotional, physical, cognitive and psychological reactions of an individual subjected to an abnormal traumatic event.[11] The following are some signs and symptoms during and/or immediately following a critical incident that are indicators of critical incident stress:

Physical	Cognitive/Thinking	Emotional
nausea	confusion	fear, anxiety
crying	inability to concentrate	denial
muscular weakness, tremors	difficulty in decision making and integrating information	anger, rage
chest pain/tachycardia	memory loss	emotional numbness
hypertension	communication difficulties	self doubt
dizziness, hyperventilation	images of past events and/or future outcomes	grief
heightening of the senses	intrusive thoughts	sorrow
incontinence	disorientation	

The intensity of the critical incident stress depends on:

- the degree of personal loss
- duration of the incident
- the perception of the event
- the amount of terror/horror experienced
- child or children involved
- media intrusion
- the individual's coping skills and adaptive behaviour
- available support systems

Coping with Critical Incident Stress

There are usually at least two people involved in a critical incident — the client and the staff person. For example, it may be a critical incident for the support worker if a client attempts suicide, or if a client physically assaults the worker.

[11] Mitchell, Jeffrey. *International Critical Incident Stress Foundation.* 1992.

Both of these events are extremely rare, and may lead to critical incident stress in the worker. In situations like these, both the worker and the client have post crisis reactions that require therapeutic responses.

When approaching the client during this phase consider the following:

- The client should not be left alone immediately following the incident.
- Be alert to: the client's confusion or depression about what has happened; the client's fear of retaliation by staff; the need to find a way for the client to make amends, if appropriate.
- Once the client has sufficiently settled, determine how the client understands what has happened.
- Give information in a calm, non-judgmental manner, e.g. "You lost control of your behaviour and punched a hole in the wall."
- Explain the extent of any injuries or damage in the same manner.
- If the involved staff member is not available, explain this absence.
- Reassure the client that staff will continue to work with her/him, if agreeable to both parties.
- Clearly explain to the client the immediate plan (and any possible changes).
- Deal with your own feelings about the incident.

Critical Incident Stress Debriefing

When a staff person's usual coping abilities are overwhelmed by a critical incident, consider using the following debriefing process as a guide through the reframing of the experience. This process uses a response team made up of people who will help the affected person or people affected by the critical incident.

Introduction: The introduction includes an explanation of who the response team members are, what they know about the situation and how it happened that they were asked to deal with these circumstances.

Facts: The fact phase encourages participants to describe exactly what happened to develop a cognitive context within which their responses can be understood.

Thoughts: After their view of the facts has been established, the support team listens as the staff person discusses their thoughts about the facts that have just been presented and their understanding of how they have been affected (separation of thought and feelings is critical in re-establishing a sense of control).

Emotional reaction: Then, on an emotional level, staff openly talks about their specific emotional reactions to the previously more intellectualized events. The reaction phase is often the most difficult and powerful component of the debriefing.

Symptoms: Reactions often have provoked or will provoke symptoms such as bodily changes, emotional deviations and an inability to function normally on the job. The staff are encouraged to freely discuss these symptoms with the support team.

Teaching: A period of teaching follows which promotes a return to a thinking level and re-organization of individual norms of functioning.

Re-entry: A re-entry stage includes sensitizing supervisors and arranging for individual and/or group follow-up.

Supporting One Another

Debriefing

Debriefing is a necessary and useful strategy to assist workers in dealing with the challenges of substance use and HIV/AIDS in clients. This is a process that is ongoing and is a regular part of case management, staff or team meetings and supervision. The formal setting of these meeting safeguards the clients' confidentiality. For the worker: it helps normalize and ground your experience; it helps you be in touch with what is going on with you; it is cathartic work; and it helps you to leave what is distressing at work.

Steps of Debriefing

1) Clarify the purpose

It is the responsibility of the worker who wants to be de-briefed to say, "I need to talk about something. Do you have time now?" This is the time to listen.

2) Create an atmosphere of respect

Provide focussed support, affirm your co-worker's experience in non-judgmental and non-shaming ways.

3) Problem solving and learning piece

Is there something concrete to do? This is the time for constructive feedback — that is, information that helps you create another step in the process.

Feedback

Feedback is an important element in debriefing, group discussion, counselling and supervision. To be effective, feedback must be specific, clearly expressed and correctly understood. The following are suggested guidelines for constructive feedback:

- Use "I" statements in describing your reaction. Describe your own reactions clearly, but don't evaluate the other person's behaviour.
- Comment on the specific situation, generalizing about behaviour is too vague and not helpful.
- Make sure the comment serves a need for you and the receiver. Be careful not to vent just your own needs.
- Give feedback only when it can effect change. It isn't helpful or fair to give feedback on a behaviour over which a person has no control.
- Make sure the feedback is wanted.
- Try to give feedback immediately following a situation.
- Check to see that the receiver heard your intended message. Did they hear what you thought you said?
- Avoid "why" questions. Check to see if your question masks an opinion, then state the opinion.

Exercise 12 Linking New Learning

The following exercise gives you the opportunity to reflect on the new learning you have acquired in this chapter and how you can integrate it into your life. It is based on the Balance Theory of learning as described on page 8.

Purpose:

To integrate your new learning about self care into your work practices.

Instructions

After you have completed this chapter, reflect on the whole process by answering the following questions. Take 15 to 20 minutes to answer questions 1 to 4 by yourself, then do question 5 with your group.

1. How will the conceptual skills and enhanced self-awareness you have gained in these exercises assist you in

a) your work?

b) your life?

2. List the ways in which you could introduce this new learning to

a) your home:

b) significant others:

c) your agency:

3. If appropriate, develop one or two goals that could serve as a guide in assisting you to become more effective at self care.

4. What part of this section has had the most meaning for you? Can you explain why?

5. Discuss in a group the impact of this section for you and your plans for implementing this learning in your work. How will the new learning be integrated into the work of the organization?

_____

_____

_____

Review of Important Concepts

- Working with substance users with HIV/AIDS can have a profound effect on you.
- It is okay to be: angry, over-whelmed, sad, frustrated, fed-up, tired etc. Be aware and open to feedback, and take action to change.
- It can be difficult keeping your personal/professional/volunteer life separate.
- Know yourself, your strengths and abilities.
- Debriefing, peer support, supervision are important elements of professional self care.
- Are there built-in organizational supports for workers, such as policies and procedures, team building training, staff retreats, special leave. Does the benefits package cover regular and alternative therapies?
- Self care is *how* you survive and thrive. Find the ways that improve the quality of your life and *just do it.* As you advocate for your clients, so must you advocate for health in your workplace — it is your responsibility and your right.

2.6 Harm Reduction

> *It will be impossible to get any extensive user-based harm reduction going unless it comes out of what already exists out there on the street. What already exists is based on genuine, normal, day-to-day issues of use, which is where most people are. Users are already using harm reduction, but we don't necessarily want to know about it because it involves drug sales and getting high or beating a methadone program, instead of hygiene or political campaigning. Users are already doing what they can with what they have to reduce drug-related harm in their lives, based on their very real needs in a hostile environment. We need to make sure they can talk about how they are using, and not just how they ought to be using, in order to help people make this transition. Their voice has been there all along, naming the problems, naming the harms. Are we truly willing to listen?* [12]

The philosophy of harm reduction as applied to substance use is controversial for many people. The reality is that with substance users, abstinence works for some but the majority do not choose this path. How can those who choose to use substances be helped? The practical strategies suggested by harm reduction practice are worthwhile and effective options.

Support service workers in CBAOs are often frustrated when dealing with the substance using person living with HIV/AIDS. The dedicated staff, volunteers and board members that so effectively launched the education, prevention and services for the first wave of the HIV/AIDS epidemic are at risk of burn out with the second wave. Fortunately, the basic skills are already in place. For example, we are already accustomed to delivering harm reduction messages about safer sex. We take a non-judgmental approach to sexual behaviours, advocating the use of condoms as a harm reduction method.

The harm reduction philosophy provides a framework to relieve the frustration of working with clients who take risks with their health through substance use. Harm reduction advocates no judgement, meets the client "where they're at," and supplies the tools for the client to make their own choices. The spectrum that encompasses harm reduction ranges from not using this substance, this way, right now — to include abstinence. The operating principle of harm reduction is *any positive change.*

Adopting a harm reduction model allows CBAOs to increase their ability to provide services to substance users who are HIV positive, and allows clients

[12] Grove, Donald. "Real Harm Reduction: Underground Survival Strategies" in *Harm Reduction Communication.* No. 2, Spring 1996.

to feel less isolated. Harm reduction prioritizes the health of substance users who continue to use (meeting the user "where they're at") and offers a variety of options for decreasing the associated harms. Harm reduction is a value based, client centred, respectful, realistic and non-moralistic perspective.

Harm Reduction Philosophies

Harm reduction has been applied differently by different organizations over time. Sometimes the laws limit what can be done. For example, needle exchanges are permitted in some provinces in Canada, but not in some other countries. Agencies have to determine their approach from a number of choices and debates going on in the evolving field of harm reduction services for substance users and people living with HIV/AIDS. This section will give you a better idea of what harm reduction means in the area substance use, starting with a look at how it started in England.

A Brief Harm Reduction History

The following quote illustrates how harm reduction was first applied by one of the leading proponents: the Merseyside drug treatment facility in Liverpool, England.

In the UK, harm reduction can be traced back to the old "British System," which emerged as a result of recommendations of the Rollerston Committee of the 1920s. This group of leading British physicians concluded that in certain cases maintenance on drugs may be necessary to help drug users lead useful lives. To this day, injectable opiates are prescribed on a take-home basis in Merseyside, a centre for harm reduction policy serving the area around the port city of Liverpool. The Merseyside model developed in response to an epidemic spread of drug use, particularly heroin, in the early 1980s. The Merseyside clinics, pharmacists and police force worked together to establish a unique model of harm reduction, a comprehensive approach involving prescription drugs, syringe exchange and helping rather than punishing drug users.

In the early 1980s, Amsterdam adopted a psychological approach to drug use which included acceptance of the fact that, since some users will continue to use drugs, medical and social care must be provided to the user to ensure the health and safety of the user as well as of community. The city's first needle exchange program in 1984 was operated by the "Junky Union", a recognized organization of injection drug users. Taking a pragmatic and non-moralistic attitude toward drug use, the city developed a variety of harm reduction programs . . .

A number of countries and organizations have now adopted harm reduction as both policy and practice. The British Advisory Council on the Misuse of Drugs (ACMD) concluded that the spread of HIV is a greater danger to individual and public health than drug misuse. The World Health Organization (WHO) has expressed a similar opinion, stating that attempts to reduce drug use must not com-

promise measures against the spread of AIDS. In 1987, the Canadian government adopted harm reduction as the framework for Canada's National Drug Strategy (CDS). It defined harm as "sickness, death, social misery, crime, violence and economic costs to all levels of government." [13]

The Mersey model is a multi-disciplinary approach providing treatment, care, control and education. It involves the cooperation of health providers, police, drug treatment centres, prevention workers and other services whose clients use substances. The guiding principle behind this strategy is to provide and maintain user friendly services (low entry barriers, informal atmosphere, client-appropriate hours of service, located in the community and relevant to the lives of the clients) which attract them to contact the agency and empowers them to change their behaviour. Underlying the harm reduction model is a philosophy which offers the same rights and privileges of life to substance users as non-substance users.

Harm Reduction: An Illustration

Here is how one of the originators of harm reduction at Merseyside illustrates the meaning of the approach.

Harm reduction is perhaps best described in an anecdote related by one of its founders and key proponents, Pat O'Hare of the Merseyside drug programme. At a Toronto public forum in which he took part along with Alex Wodak and others, Pat told the story about his young daughter playing on a swing. As young children are wont, his daughter leaned back until her head was almost touching the ground as she swung higher and higher. This exaggerated the sensation of speed and sense of fun for her. Unfortunately, it was also dangerous. Her head was within an inch of the ground at the bottom of her arc. The swing also tended to drift sideways as it got higher and her head came alarmingly close to the hard metal supporting poles. From past experience, Pat knew that if he told her to stop doing that, she would likely do it again once he was out of sight. So instead he explained his concern. He made it clear he would rather she not do it at all, but if she must, he showed her how to hold her head in, not letting it sway or droop too low. This still gave her the sensation of speed and letting go, but it was much less dangerous, as her head was no longer as close to the ground or to the supporting poles.

That, in a nutshell, is harm reduction. Harm reduction developed in response to the prevailing conceptualizing of illicit drug use, specifically the zero tolerance approach to deter use. Harm reduction focuses on reducing the consequences of drug use rather than eliminating drug use. It seeks to adopt practical rather than idealized goals. Thus, focus is placed on safer drug use patterns rather than the immediate deterrence of use per se. Harm reduction programmes have often faced resistance from those who are understandably concerned that they may condone or facilitate drug use and thus increase drug problems. [14]

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[13] Riley, Diane, *The Harm Reduction Model.* Harm Reduction Network Printing. 1996

[14] Single, Eric "Defining harm reduction" in *Drug and Alcohol Review.* 1995.

As this example illustrates, harm reduction is not specific to substance users and HIV/AIDS. The underlying theory and principles are applicable to any social welfare or public health issue, particularly those that largely affect marginalized individuals and communities. Wherever field outreach is done, it involves dealing with not solely behaviours, but with whole people and communities with complex needs. The acceptance, holistic and supportive approach inherent in harm reduction serves to create the relationships and an environment in which users feel safe enough to make the changes that decrease their own harm and that done to those they love and their communities.

The Basic Tenets Of Harm Reduction

According to the American Harm Reduction Coalition, these are some of the basic tenets of harm reduction.[15]

Harm reduction:

- Recognizes the intrinsic value and dignity of all human beings.
- Seeks to maximize social and health assistance, disease prevention and education while minimizing repressive and punitive measures.
- Recognizes the right for comprehensive, non-judgmental medical and social services for the fulfilment of basic needs of all individuals and communities, including users, their loved ones and the communities affected by drug use.
- Emphasizes the necessity for a comprehensive approach to drug use that addresses the isolation, survival needs and drug use of the user.
- Does not judge licit and illicit drug use as good or bad, rather it looks at people's relationship to drugs, and emphasizes the reduction of drug-related harm while encouraging safer drug use.
- Recognizes the competency of users to make choices and changes in their lives.
- Provides options in a non-judgmental, non-coercive way.
- Demands that the individuals and communities affected by drug use be involved in the creation and implementation of harm reduction interventions.
- Recognizes the diversity of users and drug use, and the necessity for outreach and services that reflect every user's needs.
- Expects accessible, non-judgmental drug treatment upon demand.
- Supports legal syringe exchange and accessible sterile drug using and safer sex equipment.

[15] American Harm Reduction Coalition. *Basic Tenets of Harm Reduction.* San Francisco: Author. October 1993.

- Challenges current drug policy and its consequences, such as misrepresentations of drug users and misinformation about drug use.

A Reality Check

The following is from an article by Donald Grove.[16]

Drug use continues in a very day-to-day manner. People dodge and conceal, but they don't stop copping. Prices go up and purity goes down, and yet people continue to use. If adversity were a deterrent to drug use, surely there would not be the massive numbers of users that exist today. The normality of drug use should not be used to deny the devastation it can cause, but it should help us realize that the apocalyptic consequences of drug use are in fact an accumulation of ultimately mundane matters made worse by harmful social policy . . . Although the user's voice is the only voice capable of identifying the full extent of the damage created by current drug policy, it is also the voice given the least attention or credibility . . . The only way to hear the user's voice is to allow users to name the issues . . . My experience working with daily cocaine and heroin users has taught me that there are three major day-to-day priorities for this population: quality of drugs, availability of drugs, and money for drugs . . . The quality and availability of a drug can determine whether a user is sick or well, and can even have life-and-death consequences . . . by far the biggest problem for users is the expense of their drugs. Despite their primacy in the lives of users, these issues are addressed only minimally, if at all, by harm reduction programs that focus on HIV prevention. The user's experience should form the basis for all harm reduction . . .

When not being subjected to the threat of imprisonment or the loss of their home or family, users turn out to be just like everyone else, and they love to talk about their lives and the things which matter to them, many don't see their drug use as a component of their identity. Some are excited by their use, and others want to stop. But there is unanimous agreement among users about the importance of getting good drugs and avoiding law enforcement. Both of these priorities are viewed by the public as pathological behaviours brought on by drug use rather than common sense — something which drug users are not supposed to have . . . think about it: can someone use what I offer them? Do I give users room to tell me if they can't? What are their priorities? . . .

Drug users are already organized on a lot of levels. The shooting gallery is one common form of user-based organization that promotes harm reduction. Many people think of this as part of the horrible underworld of drug use, but gallery owners provide a valuable service by giving a user a place to inject which isn't in an alley or doorway, and where they don't have to hurry. This is harm reduction, even if it was done exclusively by users without talking to any "experts."

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[16] Grove, Donald. "Real Harm Reduction: Underground Survival Strategies" in *Harm Reduction Communication.* No. 2, Spring 1996.

Harm Reduction Approaches in Substance Use and HIV/AIDS Support

Below are a number of concrete examples of harm reduction approaches in action. Programs that are based on harm reduction have some or all of the following goals. What do you think are the goals of the programs shown below?

Some Goals of Harm Reduction Programs

- save lives
- safer substance use
- reduces substance use
- getting off substances
- improves emotional state
- improves health
- better living situation
- more stable income
- better social relationships
- reduces social isolation
- increases normalization
- reduces risky behaviour
- better functioning family units
- reduces violence and aggression
- increases ability to love and be loved
- higher self-esteem
- reduces stigma
- creates opportunities for self efficacy

Examples of Harm Reduction Programs

HIV-Related Interventions

- needle exchange/distribution;
- bleach kits;
- promotion of safer sex practices, including condom distribution;
- HIV pre-test and post-test education, counselling and referrals;
- HIV-related medical care referrals, traditional and alternative;
- psychosocial care and case management;

Substance Use Treatment Options

- use of harm reduction strategies to attain abstinence, for those who desire it; goal of abstinence must be freely chosen by user; moderation goals accepted;
- user treated with dignity and respect;
- The Prochaska-DiClemente "Stages of Changing Behaviour" model (see pages 66–68);
- Motivational interviewing;[17]

[17] Miller, William, and Rollack, Stephen. *Preparing People to Change Addictive Behaviour.* New York: Guilford Press. 1991.

- acupuncture;
- tapering substance intake;
- medicate withdrawal symptoms during detox;
- user sets time-frame for change (client focussed);

Substance Use Interventions

(for those who want to continue using substances)

- teach safer substance use (e.g., proper injection techniques);
- methadone maintenance for heroin users;
- abscess management, vein care;
- information about substance combinations and interactions;
- suggesting changes in method of use (e.g. from injecting to smoking);
- substitution of less harmful substances (overdose prevention);
- encourage less harmful substance use (e.g., more control over when, how often, where, how and with whom one uses; keeping medical appointments; respecting the rules of agencies regarding substance use on the premises);
- modifying substance use (e.g., controlling dosage, cutting down);
- make related behaviour safer (e.g., using condoms in sex trade work, decrease violence potential);

Community Interventions

- education, organization and support in communities affected by substance use;
- advocacy for changes to laws regarding substance paraphernalia, possession, sentencing, etc.;
- promotion of rehabilitation and vocational training in prisons;
- coalitions with law enforcement agencies, health care providers, AIDS service organizations, substance use treatment centres, prevention and education workers;
- lobbying local, provincial and federal politicians to support the national strategies on AIDS and on substances;
- user friendly services which attract people to contact them: low entry barriers, informal atmosphere, client-appropriate hours of service, agencies located in the community which are relevant to the lives of the clients;
- applying consumer pressure to large, rich corporations to fund research, experimental treatments;
- talking about what you know, and what you don't know about substances, alcohol and HIV/AIDS — normalize and humanize these issues;
- volunteer at a community-based agency — get involved.

The Prochaska-DiClementi "Stages of Changing Behaviour" Model

One of the approaches listed above to providing harm reduction substance use treatment is the "Stages of Changing Behaviour" model developed by Prochaska and DiClementi.[18] This model is used by substance use treatment counsellors, but can also be useful to support workers in other settings such as ASOs who have clients who use substances. It can help you understand your client and support them to make some change that will benefit their health. For example, the Gay Men's Health Crisis (GMHC) in New York trains their support workers to use this model, because it provides them with a new way of helping their clients. As Richard Elovich of the GMHC said, "If the only tool you have is a hammer, everyone starts to look like a nail." The following section explains the model in more detail, and how you can use it.

Supporting Self-Directed Change

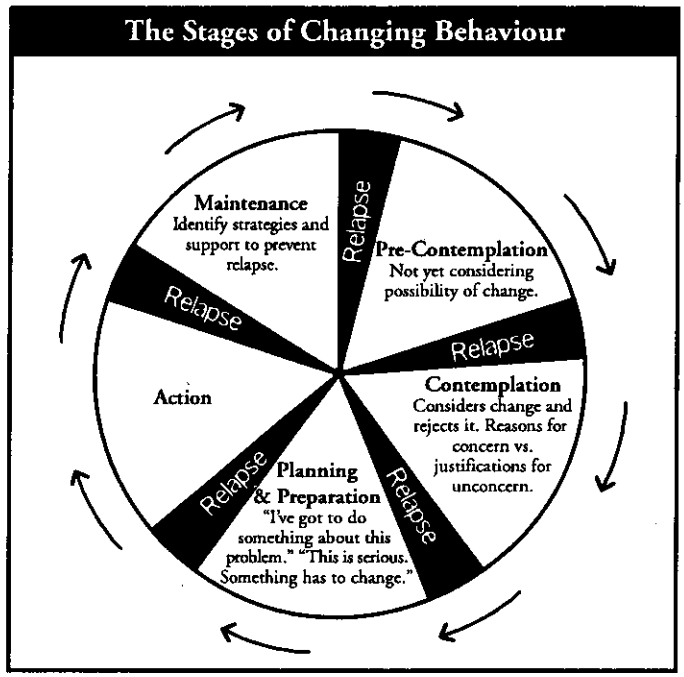
Harm reduction is a method of HIV/AIDS prevention and support. Substance use education needs to be integrated into our work in a way that meets each individual's self-identified purposes and needs. Harm reduction supports a continuum of change which replaces the all-or-nothing approach, and acknowledges that small incremental steps are still progress and necessary to longer term change.

Think about something in your life you are contemplating changing — flossing your teeth, going on a diet, stop smoking, regularly exercising? How does the thought translate into action? What obstacles do you have to overcome to accomplish this goal? How much time does it take for this change to take place?

Understanding how people change is outlined in Prochaska and DiClemente's "Stages of Changing Behaviour" model which recognizes the complexity of the human decision making process.

[18] Gay Men's Health Crisis. *Harm Reduction and Steps Toward Change: The Role of Counseling: Working with Ambivalence and Building Motivation for Change.* New York: Author. 1994.

The Stages of Changing Behaviour



The model defines five stages of change:

Pre-Contemplation The client is not considering change, but has some ambivalence about the issue.

Contemplation The client is thinking about change. Ambivalence is high and the possibility of change is unfocused.

Planning and preparation The client is talking about actual strategies of change. The balance has shifted toward change. The ambivalence is about taking action, identifying realistic alternatives and removing obstacles.

Action The client works through the conflict between belief and action, and change begins.

Maintenance Earlier ambivalence, particularly concerning the costs of making change, is re-identified in order to maintain change. Change continues and becomes normalized.

This model is seen as a wheel rather than a linear path because most people making change cycle through stages repeatedly before building the motivation and skills for effective action and maintenance. Ambivalence is normal to the decision making process. It is about thinking and feeling, about movement, about conflict between belief and action. A person may stay in the same stage for a length of time, or move back and forth between stages. It is not necessarily a linear progression. Relapse (moving back to an earlier stage) is possible at

any time. The support worker has to be ready to work with the person at whatever stage they are at.

Harm reduction applications fit each stage. The goal and objective in the earliest stages of intervention is to encourage the person to return to your agency. What can you do to help the person stay engaged? Hold them for the possibilities, for growth, for farther than they can see? The "Stages of Changing Behaviour" model has a great deal of relevance for harm reduction interventions. According to Edith Springer:

The model explains why abstinence oriented treatment models fail more often than succeed. People don't leap from a state of ignorance about their problems and no motivation to change directly into action to change. Missing is the procedure by which individuals recognize that they have a problem and consider how to address that problem. These missing stages translate into the disease model's pejorative description of the state of "denial". Often the literature speaks of the "merry-go-round of denial" and the recommended intervention of "breaking denial" through "confrontation." This process of confronting drug users and insisting that their drug use is problematic and that they must stop using is the beginning of a conflict based relationship which drug treatment encourages and requires. A majority of people who receive such intervention run as fast and as far as they can from this uncomfortable and anti-therapeutic situation . . . interventions must be individualized . . . treating everyone the same is "naive." [19]

Your Role as a Support Service Worker in Each Stage of Change

Here are some ways you can use the model to understand where your client is at in the change process, and how you can support them.

Pre-Contemplation

Client Harm reduction assumes that this is where the client is — that the client has no intention of changing behaviour in the foreseeable future. The client is unaware of the problem(s) even if others see it.

You Give information and feedback, suggest choices, but do not insist on them or push the client into them.

Contemplation

Client The client says, "I think I have a problem with my drug use, but I'm not sure if I can, or want to, change it." Many people who cannot see themselves substance-free in this stage, can see themselves making small changes in their substance use which will reduce harm and make them healthier.

[19] New Jersey AIDS Education and Training Center. *Taking Drug Users Seriously: Harm Reduction, Participants Manual.* UMDNJ-Center for Continuing Education. Newark, NJ: Author.

You Present intermediate choices, such as cutting down rather than stopping, or changing the route of administration (e.g. from injecting to smoking), or looking at dangerous combinations and less harmful alternatives.

Planning and Preparation

Client The client works through some of the change choices they have chosen. In terms of harm reduction, this person has entered a recovery process. The talking indicates movement toward change.

You Support and guide the appropriate and effective choices the client makes (e.g. tapering off, using a less harmful substance, practising vein maintenance). Maintain a realistic basis for change.

Action

Client The client takes small steps over time and builds upon them to modify their behaviour. There is a great deal of back and forth and some gains are consolidated for a time, then lost, then re-consolidated. The client uses you as an external monitor of their activity.

You Help the client increase their sense of self-efficacy (the client's perception that they are capable of carrying through with this action). Help them focus on their successes. Help them take credit for what they accomplish.

Maintenance

Client The client works to maintain the small changes that were made and avoid returning to the old ways of using. Uses newly developing skills that replace the substances as a coping mechanism.

You Help the client identify and use these strategies, supporting the progress.

Relapse

Relapse is a word that is familiar to substance use treatment and 12 Step programs. Another word that is used is *slip*. Both words mean returning to using drugs or alcohol after a period of non-using or using less. This can and does occur in any and all stages of change. The client's struggle to achieve their goals is difficult, workers need to provide support that is not shame-based.

Checklist of Supportive Strategies

- ❑ Build change based on the client's strengths.
- ❑ Invest in the process, not the outcome.
- ❑ Engage your client's ambivalence.
- ❑ Don't get too attached to the outcome.
- ❑ Challenge your own ambivalence.

❑ Show people they have some control e.g., "I used less", "I waited two hours."

Your contact with the client provides an opportunity for you to engage the client "where they're at." What is the presenting problem, the immediate need (a shower, a meal, a change of clothes, money)? By meeting that need you are doing something relevant in the client's life. You are making a connection that can provide the client the opportunity to build on their strengths and courage. Change takes place over time, at the client's pace and in small steps.

Here are some examples of questions that meet the client "where they're at":

- What brought you here?
- How can I make this comfortable for you, so you feel like you might want to return?
- Is there a time of day that is better? Tell them it matters that they came.
- What works for you?
- How does it (the drug of choice) make you feel? e.g.. strong? connected? uninhibited? sexy? What is the opposite feeling? This leads you to what feeling they are medicating.
- Walk me through . . .
- Help me understand . . .
- What do you get out of _____? This leads the substance user to talk about the cost — not just money.

Strategies

- Acknowledge their expertise about their own lives.
- Using first names helps set up a comfort zone.
- You have certain knowledge, skills and abilities to teach. What do you need to learn?
- Are you comfortable asking your client to demonstrate how they use? Can you show how to clean works? put on a condom?
- Do you have your own agenda for the client? Tell the client you are not there to judge them.
- When clients drop in without appointments, is there some way you can connect briefly; condoms, needles, coffee, etc.?

Working with human beings is complex. People are in different stages and at different times. Many factors can de-rail the process. Your efforts are "works in progress."

Another strategy you can use is to ask the client to name the harms and benefits of a particular behaviour. It helps the client see for themselves what is happening. Look at the short term and the long term.

Substance Use Behaviour

	Benefits	Harms
Short Term		
Long Term		

Harm Reduction Practice Tips

- Be non-judgmental and self-aware.
- Be patient with yourself and the client.
- Be realistic in your expectations.
- Listen well — actively and empathetically.
- Remember you are witnessing their important events and struggles. You will be affected.
- Regular participation in the harm reduction process can reduce "magical thinking" or dissociative behaviours associated with substance use.
- Create an opportunity for the client to think of themselves as part of a community.
- Interventions that imply pathology or require the wearing of labels are not useful.
- Keep asking what's working and why? What doesn't and why not? Who is being reached? Who is not?
- Experience tells us that a higher level of participation by the client (over time) often means more sustained change.
- Be objective, reflective, a mirror. Resist evaluating or projecting.
- Ask yourself: what do you want to achieve? what do you want to prevent?
- Ask the client: what do you want to achieve? what do you want to prevent?
- Empowerment adds to peoples skills and abilities.

Let's Talk — Words and Language

Language can seem like a maze. Harm reduction theory and practice brings new words, and HIV/AIDS has a whole lexicon of its own. Substance use treatment has evolved over time, changing the language it uses along the way: "chemical dependency", "substance abuse", "drug or alcohol addiction." To impose a particular vocabulary denies the cultural differences inherent in the experience of each group. You can acknowledge your language preferences as well as honour the client's choices. There is room for both. What may be offensive, condescending, judgmental and inappropriate to you may be none of that to the client. Your awareness of oppression and injustice can find its voice when the relationship with the client develops.

Listen to what the client is saying, in their own frame of reference. If you do not understand the language, ask the client for clarification. There are slang and "street" terms which vary from place to place. Many street-involved people are familiar with drug and alcohol treatment jargon and their conversations contain these references.

The language of the drug and alcohol treatment community may also be a source of difficulty for you, as the vocabulary of HIV/AIDS may be a challenge for them. You are not expected or asked to be substance use counsellors, but you can become familiar with the terms they use. To familiarize yourself with treatment terminology, ask your local detox/assessment and referral service or treatment facility to do an in-service training at your agency. In return, offer to do the same for their agency.

There is also the self-help movement, represented by A.A. (Alcoholics Anonymous), N.A. (Narcotics Anonymous) and C.A. (Cocaine Anonymous). These groups are also called 12 Step programs. They have various types of meetings: open (anyone may attend) and closed (only those who claim membership may attend). These programs are abstinence-based and have their own literature and key phrases. 12 Step programs are located in most communities and offer public information to other community-based agencies. They're in the phone book.

Exercise 13 Linking New Learning

The following exercise gives you the opportunity to reflect on the new learning you have acquired in this chapter and how you can integrate it into your life. It is based on the Balance Theory of learning as described on page 8.

Purpose:

To integrate your new learning about this chapter into your work practices.

Instructions

After you have completed this chapter, reflect on the whole process by answering the following questions. Take 15 to 20 minutes to answer questions 1 to 4 by yourself, then do question 5 with your group.

1. How will the conceptual skills and enhanced self-awareness you have gained in these exercises assist you in

a) your work?

b) your life?

2. List the ways in which you could introduce this new learning to

a) your home:

b) significant others:

c) your agency:

3. If appropriate, develop one or two goals that could serve as a guide in assisting you to apply principles of harm reduction in your work with substance using clients.

4. What part of this section has had the most meaning for you? Can you explain why?

5. Discuss in a group the impact of this section for you and your plans for implementing this learning in your work. How will the new learning be integrated into the work of the organization?

_____

_____

_____

Review of Important Concepts

- Harm reduction is a client-centred, holistic approach that organizes appropriate and co-operative interventions around the provision of food, clothing, housing and primary health and social services which address the clients survival needs.
- Work with the client "where they're at."
- Work co-operatively with the client to set their own priorities and time lines
- Help the client develop self-efficacy (the belief that they are capable and can change).
- Develop and integrate harm reduction philosophy into policies and procedures around substance use and HIV/AIDS for the agency.
- Provide training and education on harm reduction practices to staff, volunteers, board members, peers and students.

2.7 Policies and Procedures

Most community-based AIDS organizations have a mission statement, philosophy or set of guiding principles to assist them in focussing on the agency's purpose, goals and provision of services. Having clearly defined and communicated policies and procedures is a proactive response to preventing problems. CBAOs show leadership and initiative when policies and procedures are developed and consistently applied to people and situations.

Substance using people living with HIV/AIDS offer CBAOs challenges and opportunities. The development of policies and procedures around substance use are essential. They provide clarity, guidance, leadership, consistent treatment of people and situations, safety for everyone and set standards of behaviour.

Components of comprehensive policy include: a general statement reflecting the purpose of the policy; applicability to all affected groups; procedures (what to do if . . .); and personnel policies related to the issue e.g. leave and other benefits, hiring practices, job sharing/back-up.

The Policy Development Process

All the affected participants need to be involved in the formation of policies and procedures — staff, volunteers, peers, members of the board of directors, students and people living with HIV/AIDS who use substances.[20] When all interested and affected parties are committed to policy development and implementation, agencies avoid management by crisis. A calm, rational discussion process promotes team building. In developing new policies, it can help to research effective policies that are already in place at other agencies. (The AIDS Committee of Toronto [ACT] is in the process of writing comprehensive policies and procedures. Phone (416) 340-8484 ext 237, to be published in April 1998).

When a consensus has been reached, a draft version of the policies and procedures should be circulated to all the representative groups for discussion. Conditions change, local or regional concerns may vary and direction shifts.

Policies and procedures are then finalized and are posted in plain sight for easy reference. They also need to be an integral part of all staff, volunteer, peer, and board member training and orientation. The goal is for policies and procedures to be available, useful, consistent and provide support and safety to service users and service providers. Policies should be reviewed annually and revisions made.

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[20] Adapted from unpublished material by Elisse Zack of the Canadian AIDS Society's HIV/TB Project; and Young, Jim. *Making Space For PHAs: A Manual for Setting Up and Operating a Drop-in Centre for Persons Living with HIV/AIDS.* Ottawa: AIDS Committee of Ottawa. 1997.

Characteristics of Policies

Strong Policies	Weak Policies
• all who are affected by the policies need to be involved in their development	• affected parties not involved in development
• can be easily implemented	• are too rigid
• allow people to act	• are too bureaucratic
• are based on correct and current information	• are too difficult to follow/ implement
• are consistent with the organization's mandate, activities, philosophy, budget/resources	• are not clear
• are useful	• are based on incorrect or out-of-date information
• are clearly written	• are unrealistic
• are realistic	• are inconsistent with organization's mandate, activities, philosophy, budget/resources
• states who is responsible for ensuring policy is followed	• no one clearly responsible for implementation
• are flexible	• not part of training and orientation for staff, peers, board members, students
• are reviewed and amendable	• people (including clients)don't know about them and have no access to them
• are part of training and orientation for staff, peers, board members, students	• are not useful
• are posted and available for people (including clients) to read	

Policies Regarding Substance Use and HIV/AIDS

The population using CBAOs is changing. People living with HIV/AIDS and substance use issues may test your patience and tolerance. Clients may not feel comfortable accessing services at a CBAO. It is essential to have comprehensive policies and procedures to protect the client, worker and organization. Below are some suggested areas that your agency's policies should address in order to facilitate service to this client group.

Confidentiality and Privacy

Clients have the right and expectation of confidentiality and privacy. If there are exceptions to this policy they must be stated up front to the client. Exceptions include: the information that the client divulges may be discussed in case management with other staff (who also are bound by strictures to keep confidentiality), disclosures about child abuse, and threats of harm to self or another person. Privacy concerns for service providers cover mentioning who you saw or spoke to and where that occurred. Assurances of confidentiality extend to written as well as verbal communication and information.

Attitudes, Values and Beliefs

The mission statement of the agency, organization or group often defines attitudes, values and beliefs. This philosophy needs to be incorporated into all policies and procedures and represents the core concepts on which the CBAO builds its infrastructure. All staff, peers, board members and volunteers benefit from orientation and training on attitudes, values and beliefs. Knowing the organization's principles allows you to be open to others, to acknowledge differences, to work to remove barriers to service, to be lesbian, gay, bisexual, transgendered and heterosexual positive, and to honour cultural diversity. Your agency may want to develop specific policies to address: racism, homophobia or heterosexism, misogyny, and use of inclusive language.

Boundaries and Ethics

Boundaries and ethics are two important characteristics that define relationships. Boundaries provide limits to physical and emotional space. Ethics set the more formal standards of behaviour within the work environment and also in your own life. The necessity for clarity cannot be understated, as everyone (client, worker and agency) is at risk when boundaries are blurred. Ethics permit you to live and work in society, they are the conventions of behaviour that are followed. e.g. treating the clients with respect; being clear and direct in your communication with clients and co-workers.

Code of Conduct

These "house rules" spell out what is appropriate and inappropriate behaviour. A code of conduct provides safety and consistency for everyone as well as a process to follow when situations arise. Subject areas to cover are: the use of alcohol and/or drugs on the premises (including drug dealing, collecting drug debts, sex for money etc.); weapons; abusive language and behaviour; discrimination; smoking; illegal activities; general expectations of consideration and respect for others.

Self Care

Self care strategies are essential when working with HIV/AIDS and substance use. The skills and abilities you have can become eroded by chronic stress. Nurturing yourself requires that you pay attention to signs and symptoms that could indicate burnout. Agencies need to recognize and support the workers in policy, procedure and practice.

Harm Reduction

Harm reduction is a philosophy that is controversial but offers the opportunity to reach more people "where they're at." It promotes openness and honesty, advocates no judgement and provides the client with tools so that better informed choices can be made. The operating principle of harm reduction is *any positive change.* When ASOs adopt this outlook they enhance the worker's position and empower the clients.

Harassment/Sexual Harassment

These two areas require a section of their own. Specific behaviours are described (these may vary from agency to agency) but need to include: threats, intimidation, unwanted physical contact, jokes, pornography, gestures, sexually oriented references, innuendo, come-ons, comments. Harassment/sexual harassment can be between staff and client and staff and staff.

Suspension/Banning

This section describes the behaviour that the agency has deemed as unacceptable and the corresponding consequences including warnings to suspension/banning (measured in time, days/weeks/months). The policy also details who makes these decisions, who is responsible for their enforcement, how the client is to be informed, what recourse the client has, notification to the client of the availability of alternate services and the process for review and revision.

Conflict of Interest

Policy here is for the protection of the service user by guarding against intentional and unintentional "taking advantage" of clients. Conflict of interest is defined as any behaviour that could be construed as affecting the objectivity and judgement of staff, volunteers, and board members. Potential areas of concern include: material gain, outside employment, receipt of gifts, bequests, or donations (including time). For example: a client helping support worker paint the worker's apartment; a volunteer getting drugs from client.

Safety, Security and Non-Violent Crisis Intervention

These issues must be acknowledged and confronted to maintain a safe space for clients and staff. Substance use and HIV/AIDS when combined with poverty, marginalization, fear, anger and stigmatization can produce strong emotions. Policies and procedures in this area may address: staffing (at least two people on each shift); providing a secure place to keep valuables; equipping staff with panic buttons; procedure for police liaison; training all staff on non-violent crisis intervention and fire safety; and a requirement to record all incidents.

Child Protection

With a substance using, HIV positive clientele, your agency may be challenged with the implementation of child protection laws: what constitutes abuse, neglect, danger to the child, the timing of a signaling to the child protection agency, working with the parent versus contacting right away. It may be helpful for your organization to develop some guidelines for workers.

Child Care Provision for Clients

Does your organization have child care services for clients on site or an arrangement for provision of child care, so that clients who have a child or children can access your services?

Complaints By Service Users

Clients need to know that there are options available to them if they have a complaint about a service provider. The policy will cover the procedure for making a complaint (oral and/or written), the right of the client to involve other services (police, medical, legal etc.), who arbitrates, when and how complaints are mediated, and notification of the results of the process. Fair and equitable complaint policies protect and empower clients.

Referral to Other Services

Building relationships with other community services helps to create an atmosphere that promotes case management, advocacy, working cooperatively and supportively. These services can include drug and alcohol treatment, medical, housing, legal, child care, nutrition, dental, etc. Referrals that are mutually agreed upon reduce barriers to client services.

Medical and Psychiatric Emergency Procedures

Staff and volunteers should immediately contact the emergency department of a hospital for any medical emergency. In the event of a crisis situation or an intoxicated client, decisions about transporting the client to an appropriate service (detox, hospital, shelter) need to be made. For insurance reasons, staff and volunteers are not advised to personally deliver clients to their destination. These emergency situations can happen to anyone at anytime for any reason. Clear and prompt responses are required.

Supervision

Supervision describes the process through which a staff member reviews, discusses their cases or other work issues with either peers or a supervisor. The time is structured and regularly scheduled (bi-weekly is the suggested frequency). The purpose is to provide constructive feedback and support to the staff. A policy that makes supervision meetings mandatory can help CBAOs to commit to preserving and protecting workers, regardless of fluctuating demands on times and resources. This ensures that knowledgeable and skilled staff are sustained and the risk of staff burnout is reduced.

Policy Implementation

Once policies are developed, they must be implemented by educating all affected persons. Education involves making people aware that the policy exists and how to put it into practice. This could involve bringing in an outside trainer or buddying with other service providing agencies to share training costs.

Below is a generic education template that sets out a schedule for training.[21]

Education Template

Learners	Policy	Trainer	When	How
Staff				
Volunteers				
Board members				
Clients				

[21] Adapted from unpublished material by Elisse Zack, HIV/TB Project, Canadian AIDS Society.

Exercise 14 Linking New Learning

The following exercise gives you the opportunity to reflect on the new learning you have acquired in this chapter and how you can integrate it into your life. It is based on the Balance Theory of learning as described on page 8.

Purpose:

To integrate your new learning about this chapter into your work practices.

Instructions

After you have completed this chapter, reflect on the whole process by answering the following questions. Take 15 to 20 minutes to answer questions 1 to 4 by yourself, then do question 5 with your group.

1. How will the conceptual skills and enhanced self-awareness you have gained in these exercises assist you in

a) your work? _____

_____

b) your life? _____

_____

2. List the ways in which you could introduce this new learning to

a) your home: _____

_____

b) significant others: _____

_____

c) your agency: _____

_____

3. If appropriate, develop one or two goals that could serve as a guide in assisting you to improve the effectiveness of the policies and procedures in your agency relevant to your work with substance using HIV positive clients.

4. What part of this section has had the most meaning for you? Can you explain why?

5. Discuss in a group the impact of this section for you and your plans for implementing this learning in your work. How will the new learning be integrated into the work of the organization?

3.0

Resources

3.1 Substance Use 101

This chapter contains basic background information about substances, their effects, how they are used, and treatment options that can help you work with substance using clients. We all bring different areas of expertise to our work supporting people living with HIV/AIDS. You may be familiar with a lot of this material already. To others, there will be some new and useful information here. This chapter provides you with a quickly accessible resource of some information that will be useful to you.

What is a Substance?

A substance is something that is usually used for its mood-altering or psychoactive properties. Substances include alcohol, street drugs, some prescription drugs, and other things like gasoline and aerosol sprays. Aside from the desired effects, a substance often poses the possibility of harm to the user such as medical complications, behavioural changes, difficulties with social relationships, and legal problems.

The Physiological Effects of Substance Use

Substances affect the user's body through the central nervous system (CNS), the main highway of the brain and the spinal cord. It functions by receiving stimuli (input), processing the information (process), and carrying out decisions based on the information received (output). Any or all of these systems can be affected by psychoactive substances. The degree of interference varies depending on the substance, the amount used, left over or residual substances stored in the body, tolerance, how long the person has been using, pattern of use, etc. Substances affect all three stages of the central nervous system's activities: input, processing, and output. Some of the specific body functions affected are listed below.

Brain Input:

- visual — what is seen
- auditory — what is heard
- olfactory — sense of smell
- gustatory — sense of taste
- touch, pressure, pain, sense of temperature

Process:

- learning
- memory
- abstract thought
- judgement
- concentration
- mood
- level of alertness

Output:

- Voluntary outputs include motor functions (muscles involved in speech, movement, coordination), and cognitive functions (behaviour, memory).
- Unconscious(involuntary) outputs include cardiovascular, gastrointestinal, and urogenital responses.

Who Uses Substances and Why?

There are many reasons why people use substances. The reasons include, but are not limited to: poverty, racism, boredom, sexism, classism, peer pressure, homelessness, curiosity, to obtain social acceptance, to test limits, to produce pleasurable feelings, to lower inhibitions, a survival strategy in response to sexual abuse and violence, and marginalization.

Substance users are not a homogeneous group. They vary according to culture, gender, sexual orientation, socio-economic status, etc. There is no single stereotype of the typical substance user. Also, people who use substances differ in their preferred substance, their frequency of use, and their patterns of use.

There are three basic elements in substance use: the substance, the person who uses it and the social and cultural context in which the use occurs. These three components are interdependent and inseparable.

Common Substances, Their Effects, and Harm Reduction Strategies

The following chart provides a quick reference on frequently used substances and related behaviours.[22] Harm reduction strategies specific to each substance are also listed.

[22] The Addiction Research Foundation is the source of this information.

ALCOHOL

(booze, brew, hooch, grog)

First stimulates, then depresses

Methods of Use

Swallow; sometimes inject.

Short-term Effects

Effects vary with size, sex, metabolism, stomach contents; initial relaxation; loss of inhibitions; feeling of warmth; skin flushed; impaired coordination.

With Larger Doses and Longer Use

Slower reflexes and thinking; risk-taking and bad judgement; blackouts; slurred speech; staggering gait; effects magnified by other depressants; increase likelihood of accidents; sleepiness; unconsciousness; overdose may be fatal.

Long-term Effects

Possible gastritis, pancreatitis, liver cirrhosis, cancers of the gastrointestinal tract, heart disease, brain and nerve damage; suppression of sex hormones; loss of appetite; vitamin depletion; risk of damage to the fetus; psychological and physical dependence.

Withdrawal Symptoms

Insomnia; headache; appetite loss; nausea: sweating; tremors; convulsions; hallucinations; and sometimes death.

Harm Reduction Strategies

Drink instead of injecting; use clean needles.

AMPHETAMINES

(speed, ice, glass, crystal, crank, bennies, uppers)

Stimulates CNS (central nervous system)

Methods of Use

Oral, smoked; injected

Short-term Effects

Enhanced mood; increased energy; talkativeness; alertness; restlessness; reduced appetite; rise in heart rate and blood pressure; dilated pupils.

With Larger Doses and Longer Usage

Excitability; sense of power; aggression; delusions and hallucinations; violence; high blood pressure, dry mouth, fever, sweating.

Long-term Effects

Malnutrition; emaciation; susceptibility to infections; kidney damage; lung problems; strokes; other tissue damage; hyper excitability in infants born to users; tolerance; and psychological dependence.

Withdrawal Symptoms

Long, troubled sleep; ravenous hunger; depression; sometimes suicidal.

Harm Reduction Strategies

Do not share fits/works; use a new syringe for each injection; smoke instead of injecting.

BARBITURATES

(downers, barbs, blue heavens yellow jackets, red devils)

Sedative and CNS depressant

Methods of Use

Oral; sometimes injected.

Short-term Effects

Small dose produces mild "high"; dizziness; lethargy; drowsiness; impaired short-term memory; nausea; abdominal pain; with large dose effects similar to alcohol; mood swings; risk-taking; bad judgement; lower blood pressure, heart rate, breathing.

With Larger Doses and Longer Use

Unpredictable, extreme behaviour; severely impaired thinking, coordination; distorted perceptions; sleep or unconsciousness; extremely dangerous when combined with other depressants; possible death from overdose

Long-term Effects

Impaired memory; thinking; hostility; depression; mood swings; impotence; menstrual irregularities; chronic fatigue; possible birth defects and behavioural abnormalities in infants born to users; rapid tolerance and dependence.

Withdrawal Symptoms

Temporary sleep disturbances; trembling; anxiety; weakness; seizures; delirium; visual hallucinations; high temperature; possible death from cardiovascular collapse, or cerebral haemorrhage.

Harm Reduction Strategies

Do not share fits/works; use a new syringe for each injection.

CANNABIS

(marijuana, pot, grass, hashish, hash oil, weed)

Hallucinogen

Methods of Use

Smoked in joints, pipe or eaten.

Short-term Effects

A "high" or happy feeling; faster pulse rate, reddened eyes; quietness; sleepiness.

With Larger Doses and Longer Use

Distorts time; sharpens or distorts senses; impairs short-term memory, thinking, ability to perform complex tasks; combining with alcohol increases effects on thinking, behaviour, muscle control; hallucinations with very large doses.

Long-term Effects

Loss of energy; ambition; risk of bronchitis, lung cancer, reduced sex hormones, impaired judgement, decrease in immunity; retards fetal growth; psychological dependence and moderate tolerance.

Withdrawal Symptoms

Possible insomnia; irritability; appetite loss; anxiety.

Harm Reduction Strategies

Smoke less often; smoke marijuana instead of hashish.

COCAINE

(crack, coke, C, blow, flake, snow)

Stimulant

Methods of Use

Sniffed; injected; freebase is smoked.

Short-term Effects

Quick "high"; talkativeness; energy; mental alertness; loss of appetite; no need for sleep; increased self-confidence; aggression; contemplativeness; anxiety; rise in heart rate, blood pressure; risk of sudden heart failure.

With Larger Doses and Longer Use

Stronger, more frequent "highs" followed by agitation, depression; erratic, violent behaviour; paranoid psychosis; crawling sensation under skin; tremors; vertigo; blurred vision; muscle spasms; nausea; cold sweat; shallow breathing; risk of convulsion, coma, death.

Long-term Effects

Weight loss; restlessness; mood swings; paranoia delusions; hallucinations; depression; impotence; risk of obstetrical complications; psychological dependence.

Withdrawal Symptoms

Extended but restless sleep; hunger upon wakening; possible depression.

Harm Reduction Strategies

Do not share syringes, cookers, water filters; use a new syringe for each injection; smoke, snort instead of injecting.

LSD and OTHER HALLUCINOGENS

Derived synthetically from mushroom (psilocybin), from cactus (mescaline), from morning glory seeds, nutmeg, jimson weed. Other examples include LSD ("acid") and PCP ("angel dust", "hog").

Hallucinogen

Methods of Use

Oral; sniffed; or injected.

Short-term Effects

Rapid pulse; dilated pupils; arousal; raised temperature; distortions of perception; exhilaration, or anxiety, panic; sense of power; violent behaviour; occasionally convulsions.

With Larger Doses and Longer Use

Anxiety; panic; paranoid delusions; occasional psychosis; injury or accidents due to delusions; increased risk of fetal abnormalities; tolerance develops rapidly, disappears quickly; with PCP, high fever, muscle spasm, erratic behaviour, psychosis.

Long-term Effects

May include muscle tenseness; "flashbacks" — brief, spontaneous recurrence of prior hallucinations; panic; profound depression; no physical dependence.

Withdrawal Symptoms

Possible flashbacks; anxiety.

Harm Reduction Strategies

Do not share fits/works; use a new syringe for each injection.

PAINKILLERS — NARCOTIC ANALGESICS

(derived synthetically from Asian poppy; opium, codeine, morphine, heroin)

Stimulates then depresses brain

Methods of Use

Oral; smoked; or injected.

Short-term Effects

Surge of pleasure, then muting of hunger, pain; taken orally, effects are slower with no initial pleasure surge; restlessness; nausea; vomiting; body warmth; limb heaviness; mouth dryness; oblivion to surroundings.

With Larger Doses and Longer Use

Constant drowsiness; tiny pupils; skin cold, moist, bluish; progressively slower breathing; overdose from a street "hit" can result in death from suppressed breathing; dangerous combined with alcohol.

Long-term Effects

Weight loss; reduction in sex hormones; heart, liver and brain damage from unsterile injection; difficult pregnancy and childbirth; rapid tolerance, physical and psychological dependence.

Withdrawal Symptoms

Anxiety; diarrhea; abdominal cramps; yawning; goose bumps; runny nose; craving for the drug.

Harm Reduction Strategies

Do not share syringes, cookers, water filters; use a new syringe for each injection; smoke instead of injecting.

SOLVENTS and AEROSOLS

(glue, gas, sniff)

Methods of Use

Fumes inhaled often by holding solvent-soaked bag or cloth over face (risk of suffocating). Aerosols sometimes sprayed into mouth (risk of throat spasms, death by choking).

Short-term Effects

Exhilaration; lightheadedness; confusion; slurred speech; dizziness; distorted perception; seeing and hearing things; poor muscular control; nausea; drooling; sneezing; slow reflexes; sensitivity to light; feelings of power and recklessness.

With Larger Doses and Longer Use

Drowsiness; unconsciousness; hallucinations; severe disorientation; antisocial behaviour; risk of sudden heart failure.

Long-term Effects

Pallor; thirst; nose, eye and mouth sores; mental confusion; hostility; depression; fatigue; weight loss; possible irreversible damage to kidney, liver and brain; other drugs compound damage; physical and psychological dependence.

Withdrawal Symptoms

Anxiety; restlessness; irritability; upset stomach; chills; headaches; hallucinations; delirium.

Harm Reduction Strategies

Use less often; change drug of choice.

STEROIDS

(juice, white stuff, roids)

Methods of Use

Orally; injected.

Short-term Effects

Aggressiveness ("roid rage", "killer instinct"); depression; mood swings; paranoia; higher sex drive; euphoria; high blood pressure; rapid heartbeat; water retention; abdominal pain; loss of flexibility; recurring injuries; headaches; nosebleeds, difficulty sleeping.

With Larger Doses and Longer Use

May or may not increase muscle strength and performance; some claim greater ability to train intensively and resist pain; confidence; enthusiasm. In females: facial and body hair; male-pattern baldness; deepened voice; acne; menstrual difficulties; infertility. In males: smaller testicles; infertility; enlarged breasts; acne.

Long-term Effects

Irreversible stunting of growth in children and adolescents; heart attack; stroke; liver damage; masculinization of users' female babies; physical and psychological dependence.

Withdrawal Symptoms

Severe depression; anxiety; sweating; tremors; diarrhea.

Harm Reduction Strategies

Do not share needles; use a new syringe for each injection; take orally.

Emerging Trends in Designer Drugs

Below are some substances that have begun to be used in Canada in recent years.

Ecstasy

Ecstasy is a substance that has some hallucinogenic and stimulant properties. Its effects begin within one hour and can last four to six hours. Ecstasy can produce a mild intoxication, a strong sense of pleasure and feelings of euphoria. There is often an increased sense of sociability or closeness to others. The user feels full of energy and confidence. Ecstasy users can also experience increased sweating, increased blood pressure and heart rate, nausea, grinding of the teeth and jaw pain, anxiety or panic attacks, blurred vision and vomiting. These negative effects can last for days or weeks.

Higher doses of Ecstasy can intensify the negative effects and produce a distortion in perception, thinking or memory. It can also produce psychosis, paranoia, hallucinations and long lasting bouts of anxiety or depression. Other symptoms include weight loss, confusion, irritability and exhaustion. Reactions can be severe and unpredictable. Long term use can result in jaundice and liver damage. There have been several deaths associated with Ecstasy use. Deaths have occurred from kidney and cardiovascular failure.

Some of the names Ecstasy goes by are: *E, XTC, Adam, Euphoria, XMDM,* and *Love Doves.* Ecstasy is usually sold in tablet or gelatin capsule and taken in doses of 50 to 200 mg. It may also be sold in powder form, or the tablets may be crushed and then snorted. The substance comes in different shapes, sizes and colours depending on who is making it. The cost of the substance varies, but $10 a tablet is common. Ecstasy is popular with some young people involved in the rave scene.

Herbal Ecstacy

Herbal ecstacy has gained popularity recently as a "safer" alternative to ecstasy. Herbal Ecstacy contains caffeine and the herb Ma Huang which contains ephedrine. Ephedrine is a CNS stimulant that some athletes use to enhance performance. Potential adverse effects associated with the use of ephedrine include headache, dizziness, insomnia, irritability, hypertension and stroke.

Ritalin

Ritalin (methylphenidate) is a prescription drug used in treating Attention Deficit Hyperactivity Disorder (ADHD). This syndrome usually emerges in early childhood and consists of excessive restlessness, impulsiveness, and difficulty in sustaining attention. The disorder is three times more common in boys

than in girls. In many cases the problems seem reduced once the child reaches puberty. However, as many as one third of the children continue to have hyperactivity problems into adulthood. Amphetamines and Ritalin produce beneficial results for those with ADHD.

There are anecdotal reports of Ritalin being sold to people who do not have ADHD. In this circumstance, Ritalin acts as a stimulant and the effects include: increased alertness, excitement, euphoria, increased pulse rate and blood pressure, insomnia, and loss of appetite. An overdose can produce increased body temperature, hallucinations, convulsions and possible death. Withdrawal is characterized by severely depressed mood, prolonged sleep, irritability and disorientation. Ritalin capsules can be ground up and snorted or injected.

Talwin

Talwin (pentazocine) is an prescription drug that acts as a painkiller that is effective with moderate pain. A common side effect of Talwin is hallucinatory episodes, which most people find unpleasant or alarming. Users have discovered that if Talwin is crushed and mixed with a common antihistamine (pyribenzamine) and injected together, the combination produces a unique and better buzz. This process is commonly known as *T's and Blues.* The manufacturer tried to intervene by adding naloxone to counteract the effect, but these efforts met with little success.

Another phenomenon of more recent development is injecting a mix of Talwin and Ritalin (called *T's and R's*). Anecdotal reporting suggests that these two drugs are being used in a harm reduction framework as alternatives to more powerful stimulants and opiates.

Rohypnol (The "Date Rape Drug")

Rohypnol (flunitrazepam) is a prescription medication used in over 60 countries as an anaesthetic or for short-term treatment of insomnia, but is not legally used in Canada or the U.S.[23] It can create a psychological and physical dependency. Toward the late 1980s, Rohypnol appeared on the U.S. black market. It is now also available in Canada. Effects of ingesting 0.5 to 2.0 mg of the drug include drowsiness, sleep, visual impairment, lack of muscular coordination, confusion, nausea, and memory loss. Effects can last 8 to 12 hours, and memory loss lasts up to 24 hours.

Rohypnol is used for two very different purposes. Some people use it to facilitate a sexual assault — by dissolving the odourless, colourless drug in a person's drink (in a bar or at a party for example), the target becomes drowsy and unable to resist. Later, the person who has been assaulted may have very little memory of the event. The other use is as a voluntarily ingested substance

[23] The information on Rohypnol and GHB is adapted from: Gaudet, Micheline, forensic toxicologist, unpublished fact sheets prepared for the Government of Quebec in 1996 and 1997.

that is gaining in popularity among young people. Common names of Rohypnol are: *mind eraser, date rape drug, forget-pill, Mexican Valium, R-2,* and *roopies.*

Gamma Hydroxy Butyric Acid (GHB)

Like Rohypnol, GHB is also used in sexual assaults. Some people use it voluntarily. This drug can be made at home using instructions which are available on the Internet. Effects of GHB include memory loss and sleepiness at low dosages. Higher dosages can cause unconsciousness, coma, vomiting, hallucinations, convulsions, and hypothermia. The effects vary tremendously in the same individuals and from one individual to another. The reaction to a low oral dose varies with age (adolescents are more susceptible to depressive effects than adults) and the combined use of other CNS depressants.

An analytical method for detecting and determining levels of GHB in blood and urine is being developed. GHB is unnoticeable under standard analytical methods used in forensic toxicology. For victims of sexual assault, the time available to detect and confirm the presence of this drug is limited. Urine sampling is vital as soon as possible after a sexual assault.

Drug Interactions

Substances are sometimes used in combination (more than one at the same time), or used at the same time as prescribed medications. Some substance users take specific combinations of substances to help manage their symptoms of withdrawal. Some substances have an extended or second life—that is they are stored in body tissue and released at a later date (as in LSD flashbacks). See the chart *Detection Period for Various Substances* below.

Combined substances can produce opposing effects, for example mixing a substance that stimulates with one that sedates. Some combinations enhance each other's effects. Substances can reduce or negate the actions of prescribed medications. Other combinations can even produce psychotic breaks or induce schizophrenia.

[24] Allan and Hanbury. *Athletic Drug Reference.* Durham, NC. 1994 (p. 19). Inaba, Daryl S., and Cohen, William E. *Uppers, Downers, All Arounders.* Ashland, Oregon: Cinemed. 1989. (p. 206).

Detection Period for Various Substances

Substances stay in the user's body for varying lengths of time. The following chart summarizes the length of time a substance may be detected in the person's body.[24]

Substance	Detection Period
Alcohol	1/2 to 1 day
Amphetamines and derivatives	1 to 7 days
Barbiturates; amobarbital, pentobarbital, secobarbital	2 to 4 days
phenobarbital	up to 30 days
Benzodiazepines	up to 30 days
Cocaine	
occasional use	6 to 12 hours
repeated use	up to 48 hours
Marijuana	
casual use up to 4 joints per week	5 to 7 days
daily use	10 to 15 days
chronic, heavy use	1 to 2 months
Opiates and opiate-like substances	
dilaudid, heroin, morphine	2 to 4 days
darvon	6 to 48 hours
methadone	2 to 3 days
Phencyclidine (PCP)	
casual use	2 to 7 days
chronic, heavy use	several months
Quaaludes	2 to 4 days
Anabolic steroids	
fat-soluble injectables	6 to 8 months
water-soluble oral types	3 to 6 weeks
Over-the-counter cold medications containing ephedrine derivatives as decongestants	2 to 3 days

Methods of Using Substances

There are many ways to take substances. The choice of which method to use depends on many variables. In some environments prestige is associated with a particular method of use. Other factors include how strong an effect the user wants, how fast, how long-lasting, etc. Each method has advantages and disadvantages and some are dictated by economic necessity. Many have different levels of health risks involved, for example, the risks of HIV and other diseases associated with injection methods.

Oral Administration (by mouth)

Method: by swallowing or consuming as in eating or drinking.

Advantages: slow absorption time; possibility of rejecting poisons and overdoses.

Disadvantages: slow absorption time; no immediate effect.

Examples: medications in pill form, marijuana baked in food, amphetamine and methamphetamine, barbiturates, LSD (swallowed or licked off paper), PCP, opium, methadone, codeine, caffeine, alcohol.

Injection (by hypodermic syringe)

Intravenous Injection

Method: by needle positioned into a vein.

Advantages: very fast absorption time; immediate effects.

Disadvantages: cannot be undone; risks of allergic reactions.

Examples: PCP, methamphetamine, heroin, methadone, morphine.

Intramuscular Injection

Method: by needle positioned into a large muscle.

Advantages: quicker to administer than an intravenous injection.

Disadvantages: somewhat slower absorption time than an intravenous injection; risk of piercing a vein by accident.

Examples: many inoculations.

Subcutaneous Injection

Method: by needle positioned underneath the skin.

Advantages: easiest administration of all injection techniques.

Disadvantages: slower absorption time than an intramuscular injection; risk of skin irritation and deterioration.

Examples: heroin and other narcotics.

Inhalation (by breathing)

Smoking

Method: by burning drug and breathing smoke-borne particles into the lungs.

Advantages: very fast absorption time.

Disadvantages: effect limited to time during which drug is being inhaled; risk of emphysema, asthma, and lung cancer from inhaling tars and hydrocarbons in the smoke; lung and throat irritation over chronic use.

Examples: nicotine (from tobacco), marijuana, hashish, methamphetamines, ICE, freebase cocaine, crack cocaine, PCP, heroin, and opium.

Vaporous Inhalation

Method: by breathing in vapours from drug.

Advantages: very fast absorption time.

Disadvantages: effect is limited to time during which drug is being inhaled; lung and throat irritation over chronic use.

Examples: surgical and dental anaesthetics, paint thinners, gasoline, cleaning fluid.

Absorption (through skin membranes)

Method: by positioning drug against skin, inserting it against rectal membrane, snorting it against mucous membranes of the nose, or placing it under the tongue or against the cheek so it diffuses across into bloodstream.

Advantages: quick absorption time.

Disadvantages: irritation of skin or membranes.

Examples: cocaine, amphetamine, methamphetamine, nicotine, snuff tobacco, coca leaves.

The Links Between Substance Use and HIV/AIDS

These are some of the issues that impact on people living with HIV/AIDS who also use substances.[25]

Sharing needles, cookers, water filters

Sharing these tools of drug injection is a risky activity for the transmission of HIV.

Use of mood altering substances prior to sexual activity

May lead to unprotected sexual behaviour.

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[25] Adapted from: New Jersey AIDS Education and Training Center. *Taking Drug Users Seriously: Harm Reduction, Participants Manual.*UMDNJ-Center for Continuing Education: Newark, NJ. 1994.

Unprotected sex (including sex trade work)

Any sexual activity that lets blood, semen, vaginal secretions or breast milk get inside someone's body or under their skin is a risky activity for the transmission of HIV. Sex trade work (where sex is exchanged for money, food, shelter, alcohol or drugs) can involve pressure from customers to refrain from condom use.

Substances that damage the immune system and affect viral load tests

Alcohol, cocaine, amphetamines, amyl nitrates and butyl nitrates ("locker room" and "rush") damage the immune system, making people more susceptible to HIV infection if exposed. Their use can also cause increases in viral load.

Holes in the skin caused by needle use

Injection drug users are at increased risk for infections of various types through punctures in their skin (the skin is the immune system's first line of defence).

Perinatal transmission

The legal status of a substance may be a barrier to prenatal care. The effectiveness of AZT (to reduce the risk of perinatal transmission) in substance users is not known.

Pain management

Doctors are sometimes reluctant to prescribe pain relieving medication to known substance users, because many of these medications are addictive.

Drug interactions

The interactions between pharmaceutical medications and street substances can cause problems, or reduce the effectiveness of HIV/AIDS treatments.

Compliance

Medical professionals often hesitate to prescribe retro-viral medication to substance users who they feel may not succeed in following the strict regime required. Access to clinical trials may also be hindered.

Multiple diagnosis

Other medical complications including bacterial infections, hepatitis, tuberculosis, and mental health problems are sometimes present with substance users who are HIV positive.

Access to complementary treatments

Barriers to accessing complementary treatments are a problem.

Legal status of a substance

The use of illegal substances may pose a barrier to treatment (due to organizational policies not to serve substance users, fear of judgement, fear of loss of custody of children).

Links Between Substance Use and Policy in CBAOs

A substance user's social conduct can sometimes be disruptive. Some examples: bragging, loudness, swearing, threats, intimidation, stealing.

Does your agency have a policy regarding intoxicated clients at the agency? This has a direct bearing on your ability to deliver services. Is there a plan to cope with staff who feel at risk at work? If the agency does not have a policy, the implications can be serious for both clients (no boundaries) and staff (no safety). People under the influence can be, and need to be, held accountable for their behaviour.

Health Effects of Substances on People Living with HIV/AIDS

Not a lot is known about the interactions between substances and HIV/AIDS medications. The following chart "Making Links Between Substance Use and AIDS" provides a synopsis of current knowledge.[26] (Please note it does not take into account the positive effects an individual may experience/derive from substance use.) For up-to-date information on substance interactions with HIV/AIDS treatments contact CATIE. They are listed under "National Resources" later in this book.

Another area that concerns many health care professionals is the effects of substance use on the ability of some people to follow complex courses of treatment (compliance). Some physicians are reluctant to work with substance using HIV/AIDS clients because they believe that the substance user cannot be depended upon to take their medications when required. We can work with our clients to protect their access to treatments and help them follow the treatments that are available.

Substance	Direct Effects	Indirect Effects	AIDS-Related Effects (Negative)
Alcohol	Liver and heart damage; stomach, intestinal and oesophageal damage; anaemia; nerve and brain damage; powerful physical addiction.	Lowered inhibitions; depression; impaired perception and motor coordination; increased anxiety; diminished sensitivity to pain (allows physical harm to go unnoticed); conducive to high risk sexual activity.	Lowers effectiveness of antibiotic and antiviral drugs; immuno-suppression; increased incidence and duration of infection; may encourage growth of oral candida (thrush); complication in treatment of brain disorders; lowers viral load test count.

[26] Adapted from Delaney, Martin, Goldblum, Peter, and Brewer, Joseph. *Strategies for Survival: A Gay Men's Health Manual For The Age of AIDS.* 1987.

Substance	Direct Effects	Indirect Effects	AIDS-Related Effects (Negative)
Cocaine (including freebase and crack)	Heart and lung damage; stroke; cardiovascular irregularities; possible physical addiction	Distortion of judgement, values, and senses; dangerous delusions of grandeur and strength; intense anxiety, paranoia; financial strain; leads to poor judgement about high risk sexual activity	Likely immuno-suppression; increased stress; if smoked, complicates treatment of pneumonia.
Downers (tranquillizers, sedatives, hypnotics, sleeping pills)	Suppression of autonomic systems, such as breathing and heartbeat (in overdose); potential for lethal overdose; possible powerful physical addiction.	Passivity, suggestibility; distortion of judgement, values, and senses; lowered sensitivity to pain; conducive to high-risk sexual activity; potential for psychological addiction.	Unknown; very likely immuno-suppression.
Synthetic (MDA, Ecstasy, designer drugs)	Effects vary greatly by drug and by batch; possible liver damage; possible neural and heart damage (MDA); amphetamine-like damage; high risk of unknown, impure chemicals.	Severe alterations in perception and judgement; very conducive to high-risk sexual activity; extreme suggestibility; similar to psychedelics and amphetamines.	Possible immuno-suppression (not consistently agreed upon by researchers).
Marijuana	Potential for lung damage with regular use.	Impaired judgement; inducement of high-risk sexual activity; potential for psychological addiction.	Unknown.

Substance	Direct Effects	Indirect Effects	AIDS-Related Effects (Negative)
Opiates (heroin, morphine, codeine, other pharmaceuticals)	Suppression of autonomic systems, such as breathing and heartbeat (in overdose); interference with digestive processes; high potential for severe physical addiction.	Extreme passivity, suggestibility; distortion of judgement, values, and senses; lowered sensitivity to pain; severe financial strain; very conducive to high-risk sexual activity.	Statistical link to Kaposi's sarcoma (KS an AIDS-related cancer); suspected immuno-suppression.
Poppers (amyl nitrate, butyl nitrate)	Possible heart damage; fibrillation (compulsive, erratic heart rhythms); possible stroke and resulting brain damage.	Conducive to high-risk sexual activity; distortion of judgement and senses.	Unknown.
Psychedelic (LSD, mushrooms, etc.)	Usually caused by impurities, such as strychnine; few direct effects due to low quality of chemical; early reports of chromosome damage unverified.	Severe alterations in perception and judgement: possible psychosis, mental instability; conducive to high-risk sexual activity; extreme suggestibility.	Likely immuno-suppression; potential unknown for risk and drug interactions; complication in treatment of brain disorders.
Speed (crystal, amphetamines; most commonly injected)	Liver and heart damage; neuropathy (nerve damage); possible brain damage; weight loss; nutritional and vitamin depletion; adrenal depletion (uses up the body's energy reserves).	Distorted judgement, values and senses; delusions of strength; anxiety, paranoia, rebound depression; financial strain; powerful psychological addiction; conducive to high-risk sexual activity.	Immuno-suppression; potential for unknown and risky drug interactions; complications in treatment of brain disorders.
Tobacco (cigarettes)	Several forms of lung disease, including lung cancer, cancers of the mouth; heart disease; arteriosclerosis; increased spread of skin cancers; extreme physical addiction.	Harm to others from second-hand smoke; accidental fires; social rudeness; property damage.	Immuno-suppression; complications in treatment of lung diseases; increased frequency and severity of lung disease.

Substance Use Treatment Options

There is a broad range of substance use treatment approaches. Some of the programs that may be available in your community are described below.[27] By familiarizing yourself with the programs available to your clients, you can provide them with some basic information and options, if they are considering stopping their use. All options but one are abstinence based; their goal is to help the client stop using altogether. Harm reduction is the exception.

Assessment and Referral Agencies
Clients are assessed by an addiction worker, referral to treatment programs are made based on client needs, wants, housing, finances, etc. Some assessment and referral centres offer individual counselling and group treatment programs.

Short-term Residential
Clients are housed at a program up to 42 days. All treatment is in-house or community agencies are accessed. Clients live together, attend treatment together, have individual counsellors in-house, etc. This treatment option is good for those clients that do not have stable housing, community support, or are unable to abstain from substance use outside of a protected environment.

Long-term residential
Similar to short-term, however the program is 90 days or longer. Clients appropriate for this program are those for whom short-term is not long enough and for those who require assistance re-entering the community after completion of treatment.

Outpatient program
Clients attend individual counselling and/or group counselling on an outpatient basis. Clients attending this type of program usually have a stable support network, employment, family responsibilities and are able to abstain from substance use outside of a protected environment.

Recovery Homes
This is a house for transition from a treatment program into the community. This program offers support, groups, counselling, etc. However, clients are responsible for seeking employment, going to work/school. Programming is not as structured and clients can remain in this transition for up to one year.

[27] Addiction Research Foundation of Ontario, HIV Program.

Self-help Groups

Services that are supportive in nature. These groups are facilitated by group members themselves. Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, Women for Sobriety, Adult Children of Alcoholics, HIV positive Alcoholics Anonymous are all examples of 12 step self-help groups and are based on the same philosophy of working through the 12 steps and helping each other maintain abstinence. While not considered actual treatment, these groups provide a world-wide permanent support system for those in recovery from chemical dependency. There are corresponding groups for family and friends of addicts and alcoholics that also follow the same philosophy.

Methadone Programs

This program is for opiate (heroin) users that are unable to abstain from use. Methadone is a synthetic opiate given to users in a controlled monitored environment. Individual counselling on all life aspects is a condition of methadone treatment. In some facilities, methadone is offered to taper clients from heroin withdrawal. This service is appropriate for those clients that want to abstain from the use of opiates.

Detoxification Programs

Most facilities are non-medical based. Detox is for clients to withdraw from a substance in a supervised safe place. Staff is trained to assist clients as they experience withdrawal and also to refer clients for medical assistance if withdrawal is severe and requires medical attention.

Physicians

Most doctors do not provide counselling for substance use, however they may be aware of community services and can access them on the client's behalf.

Spiritual/Religious Healing

These are substance-free programs which focus on healing the spiritual part of the substance user. Some of them use traditional treatment methods alongside prayer and reflection to achieve their goals.

Harm Reduction

This non-judgmental model views substance use as a continuum of using behaviours. The theory recognizes that substance use involves bio-psycho-social harms. Harm reduction strategies aim to reduce the harmful consequences of substance use, e.g. needle exchange/distribution programs; encouraging not sharing fits/works; bleach kits for cleaning syringes; teaching safe injection techniques; suggesting alternate ways of taking substances; discussing substance substitution; condom, lube and dental dam distribution.

Alternative Therapies

Some examples of alternative therapies are:

Acupuncture
Acupuncture helps to detoxify people. Acupuncture increases the production of endorphins, the natural opiates in the brain, giving a feeling of well-being and reducing discomfort.

Nutrition/Vitamins
Vitamin therapy and special nutritional diets are used to fight the toxicity of substances and improve general health.

Stress Reduction
This involves a wide variety of techniques involving relaxation, visualization, meditation, aerobic exercise and mental exercises to reduce stress, improve general health and mental attitude.

Antabuse
Antabuse is a prescribed medication that can be taken daily by alcoholics. An individual who drinks while taking Antabuse gets very ill. This is an aversion behaviour modification technique.

Naltrexone
Naltrexone is a prescription medication that occupies the opiate receptor sites in the brain so the person may use opiates but won't feel them. It is a behaviour modification technique used with opiate addicts in recovery to prevent relapse.

Antidepressants
Withdrawal from cocaine often involves clinical depression. Antidepressants are used during detoxification and its aftermath.

Clonidine
Clonidine is a substance used for heart problems. It has been found to reduce or eliminate withdrawal symptoms in many people. It has been used in hospitals when detoxifying people from opiates, including methadone.

3.2 Glossary

The glossary contains terms related to substance use.[28]

Amphetamine a synthetic central nervous system stimulant with cocaine-like effects.

Antidepressant a substance used to elevate mood and relieve certain types of mental depression.

Antianxiety drug a substance commonly referred to as a minor tranquilizer, that acts somewhat like a sedative-hypnotic and is useful in treating anxiety and neurotic conditions.

Bang slang for injecting.

Barbiturate a sedative-hypnotic substance from the depressant group; derived from barbituric acid and used in medical practice to calm nervous individuals and induce sleep.

Benzodiazepine an antianxiety drug, such as Librium or Valium, used in medical practice to treat anxiety and various neurotic conditions.

Blackout alcohol induced amnesia or memory loss without loss of consciousness.

Bong slang name for a pot pipe.

Booting a procedure whereby IV heroin users inject the needle into their veins, withdraw some blood, mix it with the heroin and then completes the injection.

Cannabis marijuana or any preparation derived from the hemp plant

Chasing the Dragon the most common way to smoke heroin is to place it on a small sheet of tin foil, melt the heroin by heating it over a flame, and inhaling the smoke as it comes off the melting substances.

Chipping the taking of heroin on an occasional basis.

Cocaine a powerful central nervous system stimulant, derived from the coca leaf, commonly sold as water-soluble hydrochloride salt for sniffing or injecting.

Codeine a natural occurring narcotic widely used in medical practice, particularly as pain killer, which is closely related to morphine but is less potent.

Convulsion a condition produced by the blockage of inhibitory transmission in the brain, marked by an involuntary, sudden attack of muscle contractions.

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[28] Carroll, Charles R., *Drugs in Modern Society.* Ball State University, Brown & Benchmark. 1993.; and Fishbein, Diana H., Pease, Susan E. *The Dynamics of Drug Abuse.* Allyn and Bacon. 1996.

Cookers spoons and bottle caps used to mix up the powder with water and in some cases heated to melt the substances. After drawing up the liquid, some substances will be left behind in the cooker.

Coping the process of adjusting or accommodating to the demands of stress and daily living without being overwhelmed so that one's personal and social effectiveness is maintained.

Crack cocaine a smokeable, intensified form of cocaine now considered one of the most addictive substances ever known.

Crashing a disturbing period of mental depression occurring when a person stops taking a central nervous system stimulant after a period of chronic use.

Craving an overwhelming desire to use a substance, usually to increase positive feelings and then to decrease negative experience of the withdrawal syndrome.

Cut ingredients added to a substance to increase its bulk.

Dependency the development of psychological and/or physical need for a substance to maintain an individual's sense of well-being and avoid withdrawal symptoms.

Depressant a substance that slows down body functions; a sedative that depresses the central nervous system, relaxes, tranquillizes, or produces sleep.

Designer drugs slang for substances derived from fentanyl-type opiates with both stimulant and hallucinogenic properties.

Detoxification the process of alcohol/substance withdrawal in which the body is allowed to rid itself of the toxic effects of the alcohol/substance in the bloodstream.

Doing a wash is taking water into the used needle and adding it back into the cooker, getting the last of the substances. Blood from the needle is now in the cooker.

Downers a slang term for barbiturates.

DTs — delerium tremens a severe form of alcohol withdrawal, characterized by hallucinations, mental disorientation, agitation with continuous motor activity, involuntary body tremors and convulsions.

Ecstasy a popular name for a designer substance, MDMA, that has psychedelic qualities and provides a euphoric "rush" of cocaine-like, mind-expanding effects without scary visual distortions.

Eight-ball slang for 8 grams of cocaine.

Filters cigarette filters, cotton swabs, Q-tips used to filter out any particals, solid chunks or impurities. Adding water from a used needle to the filter during a wash can leave blood in the filter.

Fits slang for syringes

Flagging drawing blood into the syringe

Flash a short, intense generalized sensation of total well-being experienced soon after intravenous injection of cocaine or methamphetamine; the so-called "rush" reaction.

Flashback an undesirable recurrence of the substance's effects with no recent substance consumption to explain changes in consciousness and experience of illusions and hallucinations.

Freebasing the chemical process of changing common white cocaine powder into a purer, more potent, smokeable form of cocaine "base," which the user then smokes in a glass water pipe that is heated by a butane lighter.

Hallucination groundless false perception having no real external cause, which may occur in any field of sensation; auditory, visual, olfactory or tactile.

Hallucinogen a substance that induces or produces hallucinations in a substance user.

Hangover the temporary, acute physical and psychological distress following excessive consumption of alcohol.

Hashish a cannabis preparation more potent than marijuana, and derived from the resinous secretions of the cannabis plant's female flowers.

Hash oil a dark, viscous liquid produced by repeated extraction of cannabis plant materials with a THC concentration greater than that of hashish.

Heroin a synthetic narcotic, one of the more powerful dependency-producing drugs, made by treating morphine with acetic anhydride.

Hot Knives knives that are used to smoke hash. The knives are heated on the stove or with a blow torch and small pieces of hash are picked up on one knife and pressed against the other, cooking it and the smoke is inhaled. A paper or glass tube will protect the lips from burning against the hot knives.

Ice a highly addictive crystallized form of methamphetamine that produces a euphoric high that lasts for several hours; ingested in pill form, snorted, or injected IV.

Inhalant a chemical that evaporates easily and whose vapours, when breathed in, produce mind-altering effects.

Injection the introduction of a substance into the bloodstream without having to be absorbed through the digestive tract.

Intoxication a temporary state of mental chaos and behavioral dysfunction resulting from the presence of a neurotoxin, such as ethyl alcohol, in the central nervous system.

Jonesing slang for craving.

Lysergic acid diethylamide (LSD) one of the most powerful synthetic psychedelics derived from the ergot fungus.

Mainlining a substance administration method in which a drug is injected directly into a vein; intravenous injection.

Marijuana any part of the cannabis plant or its extract, used for its hallucinogenic and mind- altering properties. The active constituents are primarily tetrahydrocannabinols (THC).

Mescaline a hallucinogenic substance found in the peyote cactus.

Methadone a synthetic narcotic that produces many of the same effects of heroin and morphine but whose duration lasts up to 24 hours, thus making the substance useful as a harm reduction strategy.

Methamphetamine a synthetic amphetamine substance, know as "meth" or "speed," commonly abused by intravenous injection for the rapid, intense euphoria of the "rush" or "flash" effect.

Morphine a naturally occurring narcotic substance, derived from opium and used medically as a sedative and for pain relief.

MPTP an extremely nerve-damaging designer drug that attacks that part of the brain that regulates movement, resulting in permanent symptoms of Parkinson's disease. Use of this "designer heroin" causes arthritis-like symptoms at first, such as stiffness, tremors, body seizures, difficulty in speaking, and eventually results in a stiffening body paralysis.

Narcotic a drug that has both sleep-inducing and pain-relieving action; an opioid or opiate.

Opioid a narcotic so named because it is derived from the opium poppy plant or made synthetically to have the same actions of morphine, a major ingredient of opium.

Opium a naturally occurring narcotic derived from the opium poppy, and considered as the "mother drug" or main source of non-synthetic narcotics.

Overdose "OD" undesirable physical and mental experiences ranging from tremors and agitation, hostility, panic to death.

Paraquat a herbicide or plant killer that has been used to reduce the growth of cannabis plants; a marijuana contaminant associated with both temporary and permanent damage to specific body organs — the heart, kidneys, central nervous system, liver, skeletal muscles and spleen.

Peyote the fleshy green cactus tips or mescal buttons of the peyote cactus which, upon chewing, swallowing, or smoking, will cause stomach disorders, nausea, vomiting, and a variety of LSD-like effects. Can be used in a native ceremony.

Phencyclidine (PCP) a unique psychoactive drug having psychedelic, stimulant, depressant, hallucinogenic, psychotomimetic, analgesic, and anaesthetic properties, used legally today only in veterinary medical practice, because of its unpleasant side effects in humans.

Pipes the smaller bowled pipe is used mostly for smoking hash and the larger bowl is used for smoking the leaves and flowers of the marijuana plant.

Poke slang for injecting.

Pop Cans pop cans with a dent in the side and small holes pushed into it, making a screen. Cigarette ash is placed on the screen and the rock of crack on top of that. The crack melts as it is heated and the smoke is drawn through the cans' opening.

Psilocybin a psychedelic substance derived originally from so-called sacred or magic mushrooms, having effects similar to but less intense than LSD.

Psychedelics substances that can affect one's perception, awareness, and emotions, which sometimes cause hallucinations and illusions.

Rock slang for crack.

Roid rage slang for the tendency of some anabolic steroid users to become unusually aggressive and display sudden bursts of explosive violence.

Rush a short-lived jolt and tingling sensation of intense well-being or euphoria experienced soon after injecting directly into a vein.

Sedative a substance that has a calming effect, relaxes muscles, and relieves feelings of tension, anxiety, and irritability.

Sedative-hypnotic a substance that induces sleep and has a calming effect.

Side effect a substance effect other than the intended or anticipated one.

Shooting gallery a place where substance users can go to inject substances. Needles and/or other paraphernalia may be available.

Skin-popping slang for injecting substances under the skin with a hypodermic needle.

Snorting a method of substance taking in which a substance, such as cocaine, is inhaled or sniffed, with the finely chopped cocaine powder being absorbed through the mucous membrane lining the nose.

Speed methamphetamine.

Speedball a mixture of cocaine and heroin that is injected into the veins; a combination of any central nervous system stimulant and depressant.

Speed runs prolonged periods of heavy stimulant use in which an amphetamine solution is injected as often as every hour.

Stacking jargon for using more than one anabolic steroid at a time to equal several times the therapeutic dose of steroids and enhance their effects.

Step on a process whereby substances such as baking soda, talc, lactose, and/or quinine are added to a drug to increase its bulk and reduce its purity.

Stimulant a chemical substance that tends to speed up central nervous system function, resulting in alertness and excitability.

THC the most active and principle psychoactive ingredient in marijuana.

Tolerance the need to increase the dosage of a substance to produce the same effect — the user becomes increasingly insensitive to the substance's effects.

Tourniquets or Ties belts, dry condoms, string or rubber tourniquet used to tie off the arm in order to help get the veins to stand out. This makes it easier for users to hit themselves.

Trafficking unauthorized manufacture, distribution, or possession with intent to distribute any controlled substance.

Trip a variety of mind-altering effects induced by a psychedelic substance and subjectively interpreted.

Valium a frequently prescribed brand name of diazepam that functions as an antianxiety drug or minor tranquilizer.

Water Bottles and Syringes pipes that are made from equipment supplied by needle exchange programs. The needle is broken off of a syringe to make a tube and melted through the side of a water bottle. The top of the bottle is covered with tin foil with small holes for a screen. The pipe is smoked the same way as the pop can.

Water Pipe considered the most healthy way to smoke pot (and tobacco), the water acts as a filler removing more of the toxins than a cigarette filter, giving the smoker THC rich smoke.

Withdrawal occurs when a user discontinues drug administration and may include several symptoms of pain and dysphoria, including vomiting, nausea, diarrhea, headache, depression, irritability, anxiety, cramps, elevation of heart rate and blood pressure, and convulsions.

Works slang for the equipment used to inject substances (syringe, needle, plunger, cooker, cotton, water glass).

Notes

There are many terms (including slang) that vary by community and region. Add your own definitions of terms that you come across in your work.

3.3 Further Reading

The following are recommended sources of more in-depth information on substance use, issues related to specific populations that you may serve, and other topics covered in this manual.

Substance Use

AIDS and Substance Use: A Training Manual for Health Professionals. San Francisco: The Addiction Health Project. 1987.

HIV, AIDS, and Injection Drug Use: A National Action Plan. Ottawa: Canadian Centre on Substance Abuse and Canadian Public Health Association. 1997.

McCoy, Clyde B., and Inciardi, James A. *Sex, Drugs, and the Continuing Spread of AIDS.* Los Angeles: Roxbury Publishing. 1995.

McKeganey, Neil, and Barnard, Marina. *AIDS, Drugs and Sexual Risk: Lives in the Balance.* Glasgow: Open University Press. 1992.

Miller, William, and Rollack, Stephen. *Preparing People to Change Addictive Behaviour.* New York: Guilford Press. 1991.

Quackenbush, Marcia, Benson, J.D., and Rinaldi, Joanna. *Risk and Recovery: AIDS, HIV and Alcohol, A Handbook for Providers.* New York: Guilford Press. 1992.

Shernoff, Michael (Ed.). *Counselling Chemically Dependent People with HIV Illness.* New York: Harrington Park Press. 1991.

Sorensen, James L., et al. *Preventing AIDS in Drug Users and Their Partners.* New York: Guilford Press. 1991.

Substance Use & HIV: *A Comprehensive and Pedagogical Guide for the Care of Persons Living with Addiction,* CANAC (available January 1998)

Aboriginal People

Atlantic First Nations AIDS Task Force. *Healing Our Nations: Resource manual.* Halifax: Author. 1995.

Candian AIDS Society. *Building Bridges: Responding to HIV/AIDS in Ethnocultural and Aboriginal Communities.* Ottawa: Author. 1996.

Canadian Public Health Association. *Responding to Diversity: A Manual for Working on HIV/AIDS Issues with Racially and Ethnically Diverse Communities.* Ottawa: Author. 1993.

DuBois, M.J., Brassard, P. and Smeja, C. "Survey of Montreal's Aboriginal Population's Knowledge, Attitudes and Behaviour Regarding HIV/AIDS," in *Canadian Journal of Public Health,* Vol. 87, No.1, 1996.

Four Winds Development Project. *The Sacred Tree.* Edmonton: Author. 1993.

McLeod, Albert. *Aboriginal Communities and HIV/AIDS: A Joint Project with the Canadian AIDS Society and the Canadian Aboriginal AIDS Network: Final Report.* Ottawa: Canadian AIDS Society. 1997.

Minor, Kit. *Issumatuq: Learning from the Traditional Healing Wisdom of the Canadian Inuit.* Halifax: Fernwood Publishing. 1992.

Myers, T. et al, *Ontario First Nations AIDS and Healthy Lifestyle Survey.* 1993.

Ontario Aboriginal AIDS Strategy. Toronto. 1996.

Children and Youth

Canadian AIDS Society. *Make Noise!: Empowering Youth to Confront HIV/AIDS.* Ottawa. Author. 1996.

Canadian AIDS Society. *Sharing the Energy: A National Workshop on Street-Involved People and HIV/AIDS: Workshop Report.* Ottawa: Author. 1995.

The Teresa Group and the Hospital for Sick Children. *Our Children and HIV: A Guide for Families.* Toronto: Authors. 1996. Phone the Teresa Group at (416) 596-7703.

Hard Hits: Injection Drug Use and the Experience of Youth, Video recording (23 minutes) Santa Cruz Needle Exchange, 1994. Phone: (408) 429-9489

Ethics

Overall, Christine and Zion, William P. (Eds.). *Perspectives on AIDS: Ethical and Social Issues.* Toronto: Oxford University Press. 1991.

Harm Reduction

American Harm Reduction Coalition. *Basic Tenets of Harm Reduction.* San Francisco: Author. 1993.

Barnett, Jacqueline, and Robertson, Scott. *Harm Reduction for Injection Drug Users.* Victoria: British Columbia Ministry of Health. 1995. (A 23 page handbook for health care providers).

Care, Treatment, and Support for Injection Drug Users Living with HIV/AIDS: A Consultation Report. Ottawa: Health Canada. 1997.

Edith Springer on Harm Reduction. Video recording (25 minutes). New York: Gay Men's Health Crisis. 1995. Phone: (212) 337-3343.

Erickson, Patricia G., Riley, Diane M., Cheung, Yuet W., and O'Hare, Patrick A. (Eds.). *Harm Reduction: A New Direction for Drug Policies and Programs.* Toronto: University of Toronto Press. 1997.

Fit. Video recording (25 minutes). Toronto: Parkdale Community Health Centre. 1994. Phone: (416) 537-2455.

Gay Men's Health Crisis. *Harm Reduction and Steps Toward Change: The Role of Counselling: Working with Ambivalence and Building Motivation for Change.* New York: Author. 1994.

Grove, Donald. "Real Harm Reduction: Underground Survival Strategies," in *Harm Reduction Communication.* No. 2, Spring 1996.

The HIV Positive Client: A Guide for Addictions Treatment Professionals. Toronto: Addiction Research Foundation. 1993.

New Jersey AIDS Education Training Center. *Taking Drug Users Seriously: Harm Reduction, Participants Manual.* Newark, New Jersey: UMDNJ Center for Continuing Education, Division of AIDS Education.

"The Point Project Summary of Final Results," in *AIDS Update Quarterly Report.* Vancouver: British Columbia Centre for Disease Control. 1996. This report presents a study of risk factors for HIV infection among Vancouver's substance using community.

Riley, Diane. *The Harm Reduction Model.* Harm Reduction Network Printing. 1996.

Single, Eric. "Defining Harm Reduction," in *Drug and Alcohol Review.* 1995.

Harm Reduction World Wide Web Sites

Push Harm Reduction: http://www.cts.com/crash/habtsmrt/hrmtitle.html

North American Syringe Exchange Network (NASEN): http://www.nasen.org

Safe Works AIDS Project: http://www.safeworks.org

International Harm Reduction Association: http://www.drugtext.nl/ihra

Observatoire français des drogues et des toxicomanies: http://www.dgldt.fr

People with Disabilities

Understanding a Need: Alcohol and Other Drug Abuse Prevention for People with Disabilities. (brochure, 10 pp.). Washington: VSA Educational Services. 1992.

Policies and Procedures

Young, Jim. *Making Space for PHAs: A Manual for Setting up and Operating a Drop-in Centre for Persons Living with HIV/AIDS.* Ottawa: AIDS Committee of Ottawa. 1997.

Prisoners

Canadian AIDS Society and Canadian HIV/AIDS Legal Network Joint Project on Legal and Ethical Issues. *HIV/AIDS in Prisons: Final Report.* Ottawa: Authors. 1996.

Self Care

A Stress management Program for HIV/AIDS Caregivers. Ottawa: Canadian Hospital Association. 1992.

LeBoutillier, Megan. *"No" is a Complete Sentence: Learning the Sacredness of Personal Boundaries.* New York: Ballantine Books. 1995.

McCann, I.L. and Pearlman, L. "Vicarious Traumatization: A Framework for Understanding the Psychological Effects of Working with Victims." *Journal of Traumatic Stress.* Vol. 3, No. 1, 1990. pp. 131–149.

Pearlman, L. & Saokvitne, K.W. *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors.* New York: W.W. Norton & Company. 1995.

Women

Addiction Research Foundation, Toronto, produces selected bibliographies that are good sources of information on specific topics. Titles include: *Drug Use and Pregnancy; Violence and Women; Sexual Abuse and Alcohol/Drug Abuse; Gender and Substance Abuse; Women and Substance Abuse.* (See Regional Resources at the end of this manual for contact information.)

Canadian AIDS Society National Women and HIV Project. *Positively Sexual Women: A Resource for Women Living with HIV and AIDS.* Ottawa: Author. 1997.

Canadian AIDS Society National Women and HIV Project. *Women and HIV Projects and Committees Inventory.* Ottawa: Canadian AIDS Society. 1997.

Lek, Barbara W. "Alcohol and Other Drug Abuse Among Women," in *Alcohol Health and Research World,* Vol. 18, No. 3, 1994. pp. 212–219.

Nelson-Zlupko, Lani, Kauffmann, Eda, Morrison-Dore, Martha. "Gender Differences in Drug Addiction and Treatment: Implications for Social Work Intervention with Substance-Abusing Women," in *Social Work.* Vol. 40, No. 1, Jan. 1995. pp. 1045–54.

Rudd, Andrea, and Taylor, Darien (Eds.). *Positive Women: Voices of Women Living with AIDS.* Toronto: Second Story Press. 1992.

Wilke, Dina. "Women and Alcoholism: How a Male-as-Norm Bias Affects Research, Assessment and Treatment," in *Health and Social Work,* Vol. 19, No. 1, Feb. 1994. pp. 29–35.

Wilsnack, Sharon C. "Research on Lesbians and Alcohol: Gaps and Implications," in *Alcohol Health and Research World,* Vol 18, No. 2, 1994. pp. 202–205.

Women's Choices, Women's Voices: Healthy Drug-Free Ways of Coping. Video recording (28 minutes). Toronto: Addiction Research Foundation. 1996.

3.4 Who Do You Call? National, Regional and Local Resources

National Resources

Canadian AIDS Society (CAS)
Phone: (613) 230-3580
Fax: (613) 563-4998
E-mail: casinfo@cdnaids.ca
Web: www.cdnaids.ca

Canadian Aboriginal AIDS Network (CAAN)
Phone: (613) 567-1817
Fax: (613) 567-4652

Canadian Centre on Substance Abuse (CCSA)
Phone: 1-800-214-4788 or (613) 235-4048, ext. 221
Fax: (613) 235-8101
E-mail: pubs@ccsa.ca

Canadian Public Health Association (CPHA)
Phone: (613) 725-3769
Fax: (613) 725-9826

Community AIDS Treatment Information Exchange (CATIE)
Phone: 1-800-263-1638
Fax: (416) 928-2185
E-mail: info@catie.ca
Web: www.catie.ca

National AIDS Clearinghouse (NACL)
Phone: (613) 725-3434
Fax: (613) 725-1205

Prisoners with HIV/AIDS Support Action Network (PASAN)
Phone: (416) 920-9567 (collect calls from prisoners in Canada are accepted)
Fax: (416) 920-4314

Regional Resources — AIDS

The following list provides provincial entry points for AIDS information.

British Columbia AIDS Hotline: 1-800-661-4337

Alberta AIDS Hotline: 1-800-772-2437

Saskatchewan AIDS Hotline: 1-800-667-6876

Manitoba AIDS Hotline: 1-800-782-2437

Ontario AIDS Hotline: 1-800-668-2437 (English), 1-800-267-7432 (French)

Quebec AIDS Hotline: 1-800-463-5656

New Brunswick AIDS Hotline: 1-800-561-4009

Nova Scotia AIDS Hotline: 1-800-566-2437

Prince Edward Island AIDS Hotline: 1-800-314-2437

Newfoundland and Labrador AIDS Hotline: 1-800-563-1575

Yukon Territory AIDS Hotline: 1-800-661-0507

Northwest Territories AIDS Hotline: 1-800-661-0844 (Western Arctic)
1-800-265-3333 (Eastern Arctic)

Regional Resources — Substance Use

The following list provides provincial entry points for substance use treatment information:

British Columbia ADP, Alcohol and Drug Programs
Prevention and Health Promotion Branch, Ministry of Health
Phone: (604) 952-1019 or 1-800-663-1441
Fax: (604) 952-1570

Alberta Alberta Alcohol and Drug Abuse Commission (AADAC)
Phone: (403) 427-2837
Fax: (403) 423-1419

Saskatchewan Saskatchewan Health, Programs Branch
Phone: (306) 787-6092
Fax: (306) 787-7095

Manitoba Addictions Foundation of Manitoba (AFM)
Phone: (204) 944-6226
Fax: (204) 786-7768

Ontario Addiction Research Foundation (ARF)
Phone: (416) 595-6048 / 1-800-565-8603
Fax: (416) 595-9997
E-mail: isd@arf.org
Web: http://www.arf.org

Quebec Ministère de la santé et des services sociaux
Phone: (418) 643-9887 / 1-800-265-2626
Fax: (418) 646-1880

New Brunswick Department of Health and Community Services
Phone: (506) 453-3092
Fax: (506) 453-2726

Nova Scotia Drug Dependency Services
Phone: (902) 424-7220
Fax: (902) 424-0550

Prince Edward Island Health and Community Services Agency
Phone: (902) 368-6718
Fax: (902) 368-6136

Newfoundland Drug Dependency Services
Phone: (709) 729-0623
Fax: (709) 729-5824

Yukon Territory Alcohol and Drug Services, Treatment
Phone: (403) 667-5777
Fax: (403) 668-4818

Northwest Territories Department of Health and Social Services
Phone: (403) 973-7047
Fax: (403) 873-7706

Local Resources

Complete these resources for your community.

Regional Public Health Unit

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Local Drug and Alcohol Treatment Programs

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Local Assessment and Referral Service

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Local Detox Program

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Local Needle Exchange

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Local Self-Help Groups (Alcoholics Anonymous, etc.)

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Local Street Population Services (drop-in centres, shelters, etc.)

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Local Youth Services (drop-in centres, shelters, etc.)

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Local Women's Services (drop-in centres, shelters, etc.)

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Local Aboriginal Services (drop-in centres, shelters, etc.)

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Local Ethnocultural Services (drop-in centres, shelters, etc.)

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Local Gay, Lesbian, Bisexual, Transgendered Organization

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Other Local Resources

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Address: _____

Phone: _____

Contact person: _____

Notes: _____

Address: _____

Phone: _____

Contact person: _____

Notes: _____