

Harm Reduction in Canada: The Many Faces of Regression

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The authors dedicate this chapter to the memory of Jack Layton, friend and colleague, leader of Canada's New Democratic Party, who died in August of 2011 at age 61. In his eloquent letter to Canadians, released the day after he died, Jack called on us to join together to build on the work he left unfinished, and he left us a guide to how to do it: "My friends," he wrote, "love is better than anger. Hope is better than fear. Optimism is better than despair. So let us be loving, hopeful and optimistic. And we'll change the world."

Historical Background to Harm Reduction in Canada

Drug Policy

The legal framework of the current system of drug control in Canada was laid down in the early part of the 20th century. In 1908, all medicines, as well as tobacco and alcohol, were on the way to regulation and the Opium Act created drug prohibition, the basis of the current system. An increase in illicit drug use in the 1960's and 1970's was met by greatly increased criminalization and the associated individual and social costs. Rates of use climbed sharply through the 1960's and early 1970's, despite a large allocation of enforcement resources (Erickson, 1992). The strain on the courts, and the rising numbers of otherwise law-abiding youth being sentenced for drug offences (particularly cannabis possession) created pressures for the liberalization of Canada's drug laws. The Commission of Inquiry in the Non-Medical Use of Drugs (1972, generally referred to as the Le Dain Commission) was formed in 1969 to address this growing concern about drug use and appropriate responses.

The Le Dain Commission described and analyzed the social costs and individual consequences of the criminalization policy and represents an important step in the development of a policy of harm reduction in Canada. Following much consultation and study, the Le Dain Commission inquiry concluded that drug prohibition results in high costs but relatively little benefit. The majority of the commissioners recommended a gradual withdrawal from criminal sanctions against people who use illicit drugs, along with the development of less coercive and costly alternatives to replace the punitive application of criminal law. The Le Dain Commission served the role of most Royal Commissions: it delayed action on a controversial issue long enough for the public demand for action to subside. Interest in reform of drug policy gradually declined (Single, Erickson, & Skirrow, 1991). Attempts to reduce the consequences of criminalization met with limited success.

By the mid-1980s there was growing acknowledgment of the serious limitations of law enforcement and education in reducing the demand for drugs. In 1987 the Canadian federal government announced "Action on Drug Abuse", Canada's Drug Strategy. Canada's Drug Strategy (CDS) gave a means to address substance use with both supply and demand reduction strategies. The new drug strategy brought \$210 million in new funding in roughly equal amounts to enforcement, treatment and prevention programming and had the aim of reducing drug-related harm. It defined harm as "sickness, death, social misery, crime, violence and economic costs to all levels of government". Canada's Drug Strategy was funded for an initial five-year term ending in April 1992 and was renewed to 1997. The Canadian Centre on Substance Abuse was founded in 1990 as part of this strategy. In its Policy and research Unit, Diane Riley and Eric Single researched and documented alternatives to drug prohibition and promoted the principles and practice of harm reduction and other evidence-based approaches. This unit, often under criticism for its anti-prohibitionist stance, was shut down

in 1996 as part of the demise of the drug strategy (Oscapella & Riley, 1997). In Riley's approach, what came to be called pillars were tightly integrated threads, not distinct entities (Riley, 1993; Riley et al, 1999). The term "Drug Strategy" was reapplied to the remaining efforts in 1998, but it is a strategy without the weight, collaborators, or funding of the forerunners. With drug issues being brought under the general umbrella of "population health".

With the introduction of a new drug law in the 1990s, there was an opportunity to address some of the problems of past law and to benefit from what had been learned from the experience of other countries. The new law, the Controlled Drugs and Substances Act, however, is soundly prohibitionist; and rather than retreating from the drug war rhetoric of the past it expands the net of prohibition further still. The problems related to criminalizing people who use illicit drugs, the social and economic costs of this approach, and its failure to reduce drug availability have still not been addressed. As a result, the costs, both financial and human, of licit drug use remain unnecessarily high while the costs of criminalizing illicit drug use continue to rise, steadily, predictably and avoidably. The result: harms increased rather than reduced (Oscapella and Riley, 1997).

In 1994 the Canadian Foundation for Drug Policy (CFDP) was created and during the next several years this small NGO helped to bring about some drug reform, including the legalization of medical marijuana. In 1999 members of the CFDP wrote a review of drug policy in Canada for the Senate with a view to drug policy reform (Riley, 1998). In 2000 the Senate began an inquiry into the non-medical use of drugs and soon after the House of Commons began its own review of drug policy. The results of both reviews were disappointing, with the most significant being that the Senate called for legalization of cannabis, but there was little resulting change in policy or practice.

Harm Reduction Programmes

As in other countries, harm reduction in various forms has been practiced for centuries but not explicitly labelled as such. The first form of harm reduction as we define it today was practiced in the early 1980s in Toronto, Ontario, in the form of controlled drinking programs (Riley and O'Hare, 2000). In 1987, as concerns rose in the community about the spread of HIV through injection drug use, bleach programmes were started at Alexandra Park in Toronto; these developed into syringe exchange programmes in 1988 and were taken over by the City of Toronto in 1989 (Riley and McCrimmon, 1988). A grant application submitted by Jack Layton (now leader of the New Democratic Party), then Chair of the Toronto Board of Health, and Diane Riley to the Federal government received \$11 million in AIDS funding over three years, including funds for syringe exchange and other harm reduction initiatives. This helped to ensure low prevalence of HIV among IDU in that city (Riley, 1993, CPHA, 1994). Syringe exchange programmes were started in Montreal and Vancouver in 1989, and in other urban and rural communities across Canada in the following years (CPHA, 1994). A number of NGOs began to conduct workshops on harm reduction and to carry out advocacy throughout Canada and then internationally. In the late 1980s and early 1990s the number of methadone programmes in Canada increased significantly and became somewhat more liberal in nature.

As in many countries, the real impetus for harm reduction was the rise of HIV infection among injection drug users. In Canada, injection drug use is second only to homosexual/bisexual activity as a means of HIV transmission in men and second only to heterosexual acquisition in women. These individuals are concentrated, for the most part, in the metropolitan areas of larger cities, but there is injection drug use in most urban and rural areas of Canada. In 1997 a health emergency was declared as a result of the rapid increase of HIV infection in injection drug users in Vancouver's Downtown East Side. Prevalence levels had reached more than 20 percent and incidence rates more than ten percent. In 1998, prevalence rates were estimated at between 25 and 35 percent (Vancouver/Richmond Health Board, HIV Reports; BC Ministry of Health AIDS Surveillance Reports). These rates placed Vancouver in the unenviable position of having the highest levels of HIV infection

in injection drug users in the Western world. In addition, Vancouver has had the highest levels of overdose deaths in Canada, with more than 3,000 since 1991. The high levels of infection and other drug-related problems have been linked to the poverty and social dislocation of many of the residents of some of its neighbourhoods. This outbreak was one of the main forces behind Vancouver's move toward harm reduction policies and programs and sent a strong warning message to other cities in Canada, sadly, by no means always heeded (see below).

Traditionally, heroin has been the main drug administered by injection in Canada; Talwin (a depressant) and Ritalin (a stimulant) have also been popular as injectables at various times in different parts of the country, and are still very popular in some provinces. Over the last two decades, cocaine and methamphetamine have been used increasingly by injection drug users, either on their own or in combination with heroin (Riley, 2008). There is also increasing non-medical use of injectable steroids by athletes, dancers and the general male population throughout Canada. Cocaine, in the form of crack, is the most universally used drug in Canada - typically it is smoked, but it is also injected. Prescription opiates have grown in popularity and are readily available through dealers.

Rates of HIV among drug injectors in Canadian cities range from approximately 5% to more than 30%. Some regions of Canada report higher incidence rates, especially among Natives and in correctional institutions (see chapter by Jurgens in this volume) Aboriginal peoples are overrepresented in inner city injection drug use communities and among clientele using inner-city services such as needle exchange programs and counseling/referral sites. It is important to note that Hepatitis C is - a more important issue for most drug users in Canada than is HIV.

Recent Developments

The current status of harm reduction in Canada, at both the policy and programme level, is best described as "in regression". There are two types of regression; structural regression is the "natural" process of sanitizing that sets in when something radical is institutionalised or professionalised and becomes part of the mainstream, when it "comes of age". This is a slow, insidious type of regression. The second type of regression is deliberate and swifter than the first type, and it is often ideologically driven.

Ideologically driven regression has moved Canada's federal drug strategy away from harm reduction. As noted above, the National Drug Strategy of 1987, as well as its revisions in 1992 and 1998, acknowledged the existence of harm reduction. This was a somewhat brave move, even in this essentially prohibitionist and enforcement-oriented strategy, because of Canada's proximity to the United States, with its war on drugs. Good words were far more numerous than good actions, and the majority of funds dispersed under the drug strategies continued to be dedicated to enforcement. According to the Auditor General, in 1991 95% of federal expenditures related to illicit drugs were used for drug law enforcement, with little success to show for it. This percentage has been only slightly modified since then.

The impact of having a "balanced" drug strategy - even if it was in name only - was ambiguous. On the one hand, federal recognition of harm reduction as a viable public health measure gave license to supporters in the community as well as in the public service to engage in implementing harm reduction policies and practices, albeit unevenly, across Canada and also gave provinces and municipalities the impetus to incorporate harm reduction into their own drug strategies. Currently, four provinces and two territories explicitly advocate for or include harm reduction as a component of their strategies, as do nine cities and municipalities. One of those cities is Vancouver, whose "Framework for Action" initiated, in 2001, Canada's infatuation with the concept of "Four Pillars": harm reduction, prevention, treatment and enforcement.

On the other hand, the federal government's shameless lack of reasonable support for harm reduction and its

commitment to enforcement maintained Canada's affection for prohibition and set up harm reduction as a lightning rod for controversy. Harm reduction programs and services are always forced to prove their worth, even in the face of overwhelming evidence that indeed they do work, both on a scientific level and on the level of "what is right". Core program funding continued to be difficult to get, and little if anything was done to address underlying issues which support substance dependency: poverty, trauma, mental illness, stigma, lack of honest information about drugs and drug use, lack of compassion, inequity and disrespect. At the same time, harm reduction was expanding its focus well beyond HIV and HCV prevention, and took it upon itself addressing social justice and the right to health for people using illicit drugs, incorporating the best of health promotion.

In 2008, with the Liberals losing control of governing Canada to neo-conservatives, led by Stephen Harper, the duplicity and hypocrisy of surrounding harm reduction's place in Canada's drug strategy ended. The Liberal's dithering about harm reduction begat the withering that the current government is all too happy to accelerate (Riley and O'Connell, 2006, 2007). Among its earliest actions was the Prime Minister's announcement of its \$64-million-dollar National Anti-Drug Strategy.

The National Anti-Drug Strategy was developed through close collaboration between our government's ministers and senior bureaucrats from the Bush White House, and was stripped of all mention of not just harm reduction in general, but of needle exchange specifically. Harper also put an end to the prior government's plan to decriminalise possession of small quantities of marijuana and removed drug issues from the Ministry of Health, leaving them solely under the jurisdiction of the Ministry of Justice.

The government also promoted a stringent "law 'n' order" agenda about crime in general, and in particular, youth and drug crime - despite a drop in both the volume and severity of crime consistent over the past five years. The Anti-Drug's Strategy's views are simplistic: drugs are the principal cause of crime, and the best weapons against drugs are incarceration, longer prison sentences, property seizure, and just-say-no-to-drugs education, all of which have spotty records. Under the Anti-Drug Strategy, 70% of the funding is allocated to law enforcement, 4% to prevention; 17% to treatment, and 2% to harm reduction, even though it is not listed in it.

The Conservative's claimed that the Liberals had put Canada on the road to drug legalization and that they intended to stop this (in truth, legalisation was never the Liberal agenda). Saying that parents and police alike know that the last thing Canada needs is more drugs on our streets, they have declared that get-tough-on-crime-and-criminals policies are needed fix this; prison reform measures are particularly heinous. They have vowed to end house arrests, cut back on probation, and ensure mandatory minimum prison sentences and large fines for "serious" drug offenders, including marijuana growers and dealers of crystal meth and crack; to prevent the decriminalization of marijuana; to beef up law enforcement; and to seriously undermine the rights of incarcerated people. All these measures have been passed or are underway.

Despite evidence that this American-style approach has been such a disaster and that even the Americans are retreating from it, a significant proportion of the Canadian electorate is embracing it, largely without informed public debate. Yet this agenda benefits no one save those involved in the illegal trade and black market and the prison-industrial complex. Drugs are more available than ever, stronger and in greater variety, and people continue to be incarcerated, get longer sentences and - even worse - die of highly preventable diseases and conditions. Further, in Canada, the war on drugs has been conflated with its war on terrorism. Canada's supports anti-drug operations in Afghanistan to the tune of many millions, and our troops are heavily involved in this.

Harper's Conservatives blatantly attack harm reduction in their policies (e.g., tough-on-crime bills, continually

trying to shut down the safe injection site, Insite), and in their discourses (e.g., distributing pamphlets fraught with inflammatory anti-drug-user and anti-harm-reduction messages).

In the summer of 2007, staff from the Canadian Harm Reduction Network and the Canadian AIDS Society travelled from coast to coast to coast in Canada, researching the state of harm reduction in small-to-medium-sized cities. One result of this project was the report *Learning from Each Other: Enhancing Community-Based Harm Reduction Programs and Practices in Canada* (2008). It was found that, though programs were sometimes insufficient and spotty, a great deal of inventive and effective work was being done. There was hope, then, that things would get better for people using drugs - even though it was tempered by growing apprehension about the direction of the new federal government.

Three years on, the balance between hope and concern has shifted. There have been no major leaps forward in the provision of services for people who use drugs, and we do the best we can now to maintain what we have and not make waves. In some cases this may mean serving people inadequately or even degrading or undermining harm reduction. Science is vilified, caring is scorned, and mean-spiritedness is becoming institutionalised. When it comes to harm reduction, we are a nation in regression.

A brief overview of harm reduction across Canada

The Territories

The northernmost part of Canada comprises three Territories: Yukon and Northwest Territories and Nunavut. The land area is vast: nearly 4,000,000 square kilometres. The population is small: just over 100,000 people. In the Yukon Territory, the challenges for harm reduction are formidable and include lack of anonymity, sparse populations over large areas, and limited funding. While not unlike the situation throughout rural Canada, it is much more so, and people have come up with imaginative solutions tailored to local needs. In Whitehorse (the capital) services have a quality that is much stronger than in other parts of the country: broad community collaboration. Agencies, a service club, volunteers, the local college and community members work together to address the joint issues of drug use and poverty. Programs are embedded in the community itself, and no one agency takes heat for problems or prejudice. Whitehorse's harm reduction program is operated by a partnership of three community agencies and Yukon College. The outreach van program, receives financial backing from the Territorial Government, while some local restaurants provide food and coffee. These collaborations mean that harm reduction is a community initiative in which many have ownership.

The territorial government allows a safer crack kit distribution program to operate, but does not fund supplies, which are paid for by the local Rotary Club. A spanner in the works is SCAN - the Safer Community and Neighbourhoods program - which is territory-wide. SCAN programs have been sprouting up across Canada; they encourage citizens to contact their offices through "snitch lines" when they suspect that activities such as producing, selling or using illegal drugs, sex work, solvent use or the unlawful sale and consumption of alcohol are taking place in their neighbourhood. Complaints are kept anonymous and result in a boldly coloured lawn or door sign on the residence of the offending person, informing all that it is under surveillance. An investigation by the SCAN team of law enforcement personnel eventually takes place. "Remedies" such as closing down the residence, evicting the occupants and seizing their assets may be applied. Alternative housing and support and treatment for the occupants may be offered; but, in Whitehorse outreach workers state that most people who had been "marked" simply disappear and cannot be provided with services. Eviction in Whitehorse is cruel and callous. Winter temperatures there often exceed 40 degrees Celsius below zero.

British Columbia

The Province of British Columbia is seen by many as the leader in harm reduction in Canada. Though not necessarily an accurate assessment, it is the perception, largely because of Insite, Canada's best known safe

injection site. (This is one of two safe injection sites in Vancouver; the other is at the Dr. Peter Centre); VANDU, Canada's largest drug user group; the NAOMI trial (North American Opiate Maintenance Initiative), which successfully addressed recalcitrant opiate addictions with heroin or dilaudid; and the Portland Hotel Society, whose "Harm Reduction Housing" program has, since 1993, promoted, developed and maintained supportive, affordable lodging for adult individuals who are considered "hard to house" and at the highest risk of homelessness. Their principal residents are people with HIV/AIDS, substance misuse problems, forensic issues, mental illness and/or concurrent disorders.

In 2001, Donald MacPherson, Vancouver's Drug Policy Coordinator unveiled Canada's first urban drug strategy, Vancouver's "Framework for Action", a "four pillar" approach: harm reduction, prevention, treatment and enforcement. Recently, MacPherson resigned his post and he is not being replaced. Vancouver is a major public battle ground for the federal government's war on harm reduction. Their principal focus is Insite, started in 2003, after many years of planning by local and national activists. Despite its clear success in preventing overdoses and other personal and community harms, the federal government have repeatedly tried to shut it down (see, e.g., Kerr, T et al 2004, Wood, et al 2005). The RCMP, too, campaigns against Insite, contributing to public misinformation. Some workers have suggested that Vancouver's preoccupation with Insite is impeding the development of other, much-needed harm reduction services, especially in the suburbs and rural areas. Insite remains open, and other sites for safe injection and inhalation have been proposed in British Columbia and Quebec, but none has moved beyond the speculative stage.

The province is cutting prevention-focussed community support for people using drugs, including treatment. They have scrapped many contracts with community social service agencies which work with people suffering from both mental illness and addiction. In many parts of the province, outreach to people who use crack is woefully incomplete: Pyrex pipe stems are not supplied. There is considerable community activism, however, around decriminalisation of marijuana. BC has some of the most innovative harm reduction programmes for women in Canada, including Fir Square and Sheway for pregnant women and mothers.

Victoria, the capital of British Columbia, has an open drug scene second only to Vancouver's. Victoria has been without a fixed-site needle exchange since May 2008 because: residents and businesses object and politicians claim it "not ready" for a fixed site. Syringes are available in two public health offices, but users tend not to go there. There is some mobile exchange organised by the drug users themselves but mobile services are not allowed in certain sections of the city, including some where drug use is highest. Coquitlam is part of greater Vancouver; in an effort to make it more "family-friendly," the city will ban exotic dancing and methadone clinics. In another city, Abbotsford, the council has passed an anti-harm reduction bylaw.

The Prairies

Recently, the Province of Alberta centralised its health services. Consequences of this move include the loss of local autonomy and the Non-Prescription Needle Use Initiative, a very effective provincial drug and harm reduction networking scheme. Funds, programs and staff for programs practising harm reduction have been cut; coordinated services downgraded; regional needs and differences dismissed; and the province's annual harm reduction conference cancelled. Programs across the province are no longer able to come together routinely, and many opportunities for training or policy discussion have been curtailed. This has led to greater isolation, fewer mentorship opportunities, diminished opportunities to track trends across the province and less partnership work. A highly successful collaborative model has been replaced with one based on competition among communities for scarce funding. Even so, Edmonton has found a way to continue to support drug user organising and also maintain its innovative overdose-death-prevention program which provides peers with a supply of naloxone, which they can use to save the lives of people overdosing on opiates. It is the only program of its kind in Canada.

Within a political atmosphere that is hyper-responsive to public opinion, especially that driven by conservative family and social values it is difficult for policy makers to support harm reduction publicly, though many seem to favour it privately. The creation of fear is a common theme in Alberta. People pursuing harm reduction activities and applying for funding for programs report that almost universally report that they avoid words "harm reduction".

Saskatchewan's rates of HIV/AIDS are currently the highest in Canada - 20.3 per 100,000 as opposed to the national rate of 9.3, with 75% of those cases found in injection drug users. Its premier wants to halt unlimited needle distribution and mandate a limit of ten needles per visit in all its needle exchange programs, despite an earlier government-ordered review that found the existing system helps curb disease and reduce healthcare costs. He has, however, offered no new funding for these interventions. In Regina, Saskatchewan's capital city, the return rate of used needles is 94%, one of the highest in the world. Should the premier study what happened in Vancouver in the 1990s, he would see how foolish and ill-informed his idea is: It was tried there; and, before it was altered, Vancouver had attained the highest HIV rate of any major first-world city. Like Vancouver, Saskatchewan's injectable drug of choice is cocaine.

Ontario & Quebec

In Ontario there is ambivalence about harm reduction, but it continues to lead the way in Canada in the implementation of needle distribution and, in some areas, crack kits. That leadership is based on a 2006 publication, Ontario Needle Exchange Programs: Best Practice Recommendations. The application of these best practice guidelines is uneven, and some public health personnel still consider needle exchange as "enabling". More extensive scorn is directed toward crack kit distribution, including by a number of Medical Officers of Health. Although smaller towns and rural areas continue to be very seriously under-served, there is increased awareness about harm reduction's efficacy in medium-sized cities such as Sudbury, Thunder Bay, Kingston and Kitchener-Waterloo. Methadone is available across the province, though the provincial guidelines for methadone treatment draw strong criticism from clients because of their restrictiveness. There is little access for methadone treatment in locations away from cities and towns, and clinics still have to fight business and residents' associations over locations.

The province recently completed its ten-year mental health and addiction strategy. It was a struggle to ensure that the voice of the drug user was included at a volume even half that of the mental health client, and the strategy is to be accomplished without any new funding.

Even now, though most of those who provide services to people who use or at risk of using illicit drugs are aware of harm reduction, many don't understand what harm reduction really is and neglect even its most basic principle. Worse, many construe it solely as an intervention rather than a way of working, which means that both its health promotion and social justice planks may be ignored. This narrowness is not unique to Ontario

The city of Ottawa is conservative in its approach to harm reduction; the current police chief continues to lobby for 1-for-1 needle exchange. Five years ago, led by a mayor disinclined to respect evidence, Ottawa closed its highly successful safer crack kit program. The province's ministry of health subsequently stepped in and saved it by funding a community health centre to take it over. Ottawa does what it must and can do, but there is a sense that homeless people, most of whom do use illicit drugs, are no longer welcome there.

Toronto has long had a vibrant harm reduction community, initiated by a combination of community activists, front-line workers, people with current drug-use experience, academics and even some city politicians. The AIDS Network of Toronto (later the Harm Reduction Network), established in 1987, conducted education and provided syringe exchange, setting up Canada's first needle exchange in a community housing project in 1988. Toronto then led the way in Canada in setting up decentralised needle exchanges under the leadership of

Public Health. There are now approximately 30 needle exchange sites across the city, plus a mobile program. Canada's first drug users' group was established in Toronto in 1991, the FUN Group, and it is still operating. In 1994 the group produced Canada's first video on safer injecting, FIT, and marketed it internationally.

It is encouraging that Toronto has a comprehensive drug strategy and that harm reduction plays a central role in it. However, as in the now defunct federal government drug strategies, no real money has ever been allocated to realizing the strategy's potential, and harm reduction is left vulnerable. Toronto has engaged in a five-year effort to sort out whether or not it should set up safe drug-use rooms. Harm reduction has a high profile in the city, but it also has its opponents - neighbourhood and business organisations, police and opportunistic politicians being the most prominent; Toronto's Police Service have maintained a "War on Drugs" mentality.

Programs in urban Quebec have been daring and effective, largely because early on they adopted harm reduction as a core principal and made extensive use of indigenous knowledge. Harm reduction was accepted in a full range of institutional and community organizations, including the CACTUS needle exchange, one of Canada's first such programs. Lately, political support for harm reduction programs has been slipping and funding more difficult to obtain. Harm reduction has been subjected to baseless criticism from many provincial and municipal politicians and funding has been withdrawn from successful programs and services.

In the Quebec legislative assembly, the deputy leader of the opposition claimed that a cocaine harm reduction information card produced by a leading Montreal agency was promoting cocaine use. The opposition party has criticised needle exchange and the minister of health will not support the establishment of a safe injection site. The highly praised book, *Drogues: savoir plus, risquer moins*, with over 125,000 copies already in distribution, was pulled off the market: it was too friendly to harm reduction.

In Quebec City, the major harm reduction program, Point de repères, is fighting for its life, being pushed out of a high-drug-use neighbourhood to facilitate gentrification. For many years, this neighbourhood has been the home base for a large community of illicit drug users; Point de repères is being framed as the reason that these people are coming to the neighbourhood, rather than it being recognised that the agency is in the neighbourhood because the drug users are already there. Quebec City is again enforcing the law that anyone caught with drug paraphernalia (needles, pipes, etc.) will be fined.

Atlantic Provinces

In these eastern-most provinces (Nova Scotia; Prince Edward Island; New Brunswick; Newfoundland and Labrador), harm reduction services tend to be more constrained, and even in the cities they stay as conservative as the government, in order to maintain their funding. The focus of needle exchange programs continues to be mostly on the syringe itself, with access to other safer injecting supplies being limited, as are crack kits, even though the demand for them has increased, often surpassing that for needles as drug-use patterns have changed. The availability of methadone is far more restricted than in Ontario or Quebec. In the past few years, there has been some additional outreach into rural areas, but it is insufficient in coverage and scope of service provision. Satellite harm reduction sites remain scarce, the development of networks of drug users or dealers who can distribute harm reduction equipment has not really taken place, and a culture of clean needle and disposal access is not well supported. Many people see harm reduction as a do-gooders' activity that coddles people who use drugs and helps them to stay hooked, at the taxpayers' expense.

In Nova Scotia, there is no provincial leadership for harm reduction. The needle exchange in the capital, Halifax, in operation since 1992, still exists by grace of discretionary "grants", not permanent funding, and opportunities for sharing information and ideas, developing provincial or regional strategies or providing basic client support simply don't exist, unless it is through research projects. Program funding, as elsewhere, is often

tied to short-term pilot projects, a dismal practice, with no guarantee of continuity for the program or the staff; "Death by pilot" is a common joke. There is also the threat, here as elsewhere, that harm reduction services will be subsumed into a generic mental health & addiction basket, where addiction will play second fiddle to mental health and harm reduction will all but disappear. In this scenario, while it's impossible to fault people for becoming schizophrenic, it's easy to blame (and shame) them for becoming drug-dependent.

The increased presence of police around needle exchanges, as has been the case in Halifax, is ominous. The tensions caused by this and the limitations put on the number of crack pipes available elevate tension and are used to "justify" municipal sweeps of established street communities. One Chief of Police, in Moncton, New Brunswick, acknowledges the futility of the revolving door approach in which people move in and out of jail and get sicker; recognising the efficacy of nursing and social work interventions; he has become a proponent for harm reduction.

Through all of this, Maritimers remain pragmatic, and there is quiet support for harm reduction. There seem to be more people talking about harm reduction initiatives as a practical approach to addressing the problems arising from illicit drug use - as long as they are not situated in their neighbourhoods. There are also more researchers participating in and fostering community-based research with a focus on harm reduction. This is providing an opportunity to train community researchers and to reach new people with the messages about what "least harm" might mean. Because of government disdain for harm reduction some workers have become surreptitious and clandestine in providing services necessary for helping people stay alive until they are ready to make changes in their use of substances. This noble form of anarchism maintains the stigma endured by people who use drugs. At the same time it makes workers themselves vulnerable and causes burn-out; this is a worker issue throughout Canada.

At-Risk Groups

There are a number of groups in Canada who would benefit from additional harm reduction services. All of them have elevated rates of HIV. These include, but are not limited to, youth, women, Aboriginal/First Nations people, transgender and transsexual persons, and prisoners. Abstinence-only approaches are widespread, despite their demonstrated shortcomings.

Women, particularly those who work in the sex trade, need special programs; but few exist. The most effective are those few run by current or former sex-trade workers, most of which are in a constant struggle for funding, especially now that "family values" are once again in the ascendancy, and the rights of women are being subverted. Many women do not know how to inject drugs properly. This renders them dependent on their partners, who use this as a means of control and to disallow them from making essential life and safety choices; this situation could be rectified through safe drug use sites. Pregnant women and mothers also need programs which address their needs; there are far too few of these in Canada. Of those programs that do exist, some of the best programs are in Vancouver and Toronto; these programs, too, are at risk.

Transgendered people are the most severely marginalised and least well understood sexual minority; they don't fit in traditional agencies and are often mocked, stigmatised and dismissed because of who they are. They are also at very high risk of drug-related harm, including HIV/AIDS and Hepatitis C. There has been little if any change in their status within the communities they interact with, and they receive no recognition from most governments; agencies who work with them struggle for funding.

Prisoners are one of the highest risk groups for injection-related communicable diseases, especially HIV/AIDS and Hepatitis C. Yet, healthcare on the inside is far from the equivalent of that on the outside. Corrections Canada closed down a successful safer tattooing program in its prisons. It steadfastly refuses to consider making new needles available to prison inmates, despite constant pressure from community groups over the

past two decades and despite the fact that prison syringe programs have been successfully implemented elsewhere. It is not that Corrections Canada denies that inmates use drugs and that, as a consequence, some get infected with HIV or HCV while they are incarcerated; in fact, they admit in meetings (but not on paper) that such infection is known to occur in their institutions. It is likely that this situation will only change when legal action is taken (as occurred with methadone availability); a number of NGOs are working on a legal challenge (for more details on prisons in Canada and around the world, see chapter by Jurgens in this volume).

Most Aboriginal and First Nations communities continue to embrace and promote an abstinence-based approach to drug use issues, despite all evidence that its treatment and tools do not work for the majority of people who attempt them or on whom they are imposed. Canadian Aboriginals have very high rates of HIV and Hepatitis C, suicide and premature death, intense and unbearable poverty, and extreme levels of incarceration: the prison system is the new residential school. Homeless Aboriginal people in Canadian cities may receive the benefit of harm reduction programming. Most live in rural and remote parts of Canada, where the extent of harm, if there is any, is usually in the form of secondary needle exchange and little else. Some Aboriginal leaders recognise that harm reduction could fit into traditional thinking and practices, but most don't; there is much work to be done in this area.

Conclusion

Changes in the practice of social work over the past decades shed light on the structural regression taking place in harm reduction in Canada. Early social work was a magnet for progressive reformers with a strong commitment to social justice, actualised through social action. The ability to show independence of thinking and commitment to justice were the qualities that made the traditional social worker a "professional". By the 1950s, social work had virtually deserted idealistic intellectualism and in the process relinquished the utopian vision that guided early practitioners. It moved away from its vision of social justice, to a narrow preoccupation with methods and skills. Increasingly, social work strove to fit the client to the system rather than be concerned with the reduction of inequality and social injustice which had subverted the client's life in the first place. Incrementally and ineluctably, through professionalization social workers distanced themselves from the people they worked with. Social work became mainstream, increasingly routinised and standardised, with an emphasis on expert-driven, quantitative-research-based practice that stressed standardized, ritualistic, empirically-tested forms of treatment - "Best Practices" - and where research and theory drove practice across the board, top-down. By and large, social workers have earned a poor reputation with people on the street through losing their connection with the field's radical roots and buying into the new professionalism.

There is evidence that a similar process of regression is taking place in harm reduction, driven by "experts", once again the people in power, the gate-keepers who have committed themselves to maintaining their status at the expense of the other. Will harm reduction in Canada cease to be user-driven and become distanced and impersonal? The answer at the moment would be "yes".

In certain communities, harm reduction has already become part of "the system"; while not necessarily a bad thing, we must remain watchful. As it moves into mainstream organisations, academia and public policy, harm reduction is given a suit and a haircut, made presentable and told to behave. Acting within a temple of power, as part of the establishment, harm reduction can perpetuate the structure of domination by emphasizing the enforcement of social control and order and getting individuals to fit into society, rather than promoting social welfare, responding to societal changes and respecting people's human needs. In this paradigm, the most profoundly disenfranchised users of illicit drugs are further marginalised, stigmatised and neglected in the race to make them meet the providers' expectations of what a client is and how a client must behave in order to get help.

In a publication from the 1990s, Ontario's Centre for Addiction and Mental Health described harm reduction

as the best alternative to try "when efforts to treat, prevent or punish addiction problems have not succeeded". Second best - to punishment? The director of a street-based youth agency funded to run a harm reduction program refuses to allow needle exchange to be done by her staff because "it will give the wrong message". Another states that she doesn't allow needle exchange on site, because the clients know that she is opposed to their injecting drugs. Harm reduction for whom?

Methadone Maintenance Programs (MMT) - at least in Ontario - have become big business, with quasi-franchise operations located around the province. Though this has made MMT more accessible, programs have not been consistent in offering the supportive services or atmosphere which would make them effective. Many patients are very dissatisfied with the treatment they receive, refer to MMT as a "cash cow" for doctors who run the clinics, and see methadone itself as "liquid handcuffs", not just because of restrictive guidelines but also because, as they report, it is difficult to get the prescribers' support when they express the desire to taper off it.

In the area of research, the promotion of and reliance on pilot projects can be harmful to participants, especially when follow-up is not sufficiently thought out. In the above-mentioned NAOMI project, even those whose lives had been turned around by having been prescribed heroin were taken off it at the end of the project and referred to MMT programs. A criterion for acceptance in NAOMI was evidence of repeated failures with MMT. Clearly both harm reduction research ethics and MMT are areas for future study.

What may keep Canadian harm reduction honest and effective is the inclusion of people with the lived experience of drug use in all phases of policy development and programming, from design through delivery through evaluation and research. This occurs in varying degrees across Canada, and continues to give harm reduction its authenticity and edge.

Harm reduction's regression in Canada is part of a larger context of the federal government's demonisation of drugs and the people who use them. This is a well-funded propaganda campaign, which appeals to fear, prejudice and greed. As a result, we are experiencing a value shift which is deeply upsetting and does not augur well for harm reduction, the well-being of people who use illicit drugs or for any marginalised people. How do we account for the public embrace of current neo-conservative propaganda? Is it simply a case of unenlightened self-interest and a shortage of compassion? Is it a temporary aberration, or is it a radical change in Canadian temperament?

We do know this: those who work with people who use drugs, as both clients and allies, must double and re-double our efforts to ensure that the gains we had made are not forever lost; that harm reduction attains its rightful place among the ways we use to address drug issues, not as a stand-alone "pillar" but as what informs all substance-related programming and work. This means that we give full attention to the consequences of what we do, including the unintended ones. Access to harm reduction services is both a health right and a human right. And rights for oppressed people are an anathema to our current government which - for ideological reasons - ignores not merely rights but also science. The result: "regression to the mean" ... in both senses of the term.

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