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Beyond the Buzzword: A Concept Analysis of Harm Reduction

Dominique Denis-Lalonde, BN, RN

Candace Lind, RN, PhD

Andrew Estefan, RPN, PhD

Faculty of Nursing, University of Calgary, Calgary, Alberta, Canada

Background and Purpose: Harm reduction is a concept that is increasingly applied in health and social care, as well as law and policy development around the world. Despite being used in a variety of contexts for decades, there is no universal understanding of harm reduction, and this may interfere with its implementation in various settings. Using Rodgers' (1989) evolutionary approach to concept analysis, this article defines the key attributes of harm reduction, along with surrogate terms, relevant uses, antecedents, consequences, related concepts, a model case, and implications for practice. **Methods:** Following Rodgers' (1989) method, a literature sample from a variety of disciplines was selected using keywords. The review included 25 key publications of international origin, as well as several web-based resources, with a focus on illegal psychoactive drug use and healthcare outcomes. **Results:** Seven key attributes of harm reduction were identified: a focus on harms, the participation of people who use drugs, the promotion of human rights, a public health approach, value neutrality and nonjudgment, practicality and pragmatism, and innovation and adaptability. **Implications for Practice:** The harms associated with illegal drugs are a global health problem, and advocacy is needed to promote harm reduction policy at health provision, community, and government levels. Without a concerted understanding of harm reduction, the concept is at risk of being relegated to a buzzword that lacks meaning. This concept analysis provides health and social care providers with a point of reference for meaningful harm reduction initiatives and strategies within their practice.

Keywords: harm reduction; concept analysis; healthcare; illegal drug use; social care

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Harm reduction is a concept that is increasingly applied in healthcare and social services, as well as law and policy development around the world. The World Health Organization (WHO) recommended harm reduction as an alternative approach to drug control in 1973, over 40 years ago (Ball, 2007). The term made its official global debut in 1990 at the first harm reduction conference in Liverpool, United Kingdom (Erickson, 1995), but the concept's definition continued to confuse advocates and critics alike for years (Riley et al., 1999). Beirness, Notarandrea, Jesseman, and Perron (2008) noted that "strongly held opinions [. . .] have caused a rift between people who should be working together" (p. 524).

Despite its rapidly expanding use, there is no universal definition of harm reduction (Ball, 2007; Harm Reduction Coalition, 2018). Lack of clear definition of a concept can inhibit talking and understanding more about it, as well as limit its application in a variety of contexts (Rodgers, 1989). A methodical analysis of concept evolution and application is valuable as a way to promote collaboration and evidence-based approaches to practice. In this article, we present a concept analysis of harm reduction, using illegal drug use to frame the "harm" being addressed. Using Rodgers' (1989) evolutionary concept analysis method (Table 1), we explore the historical development of harm reduction, clarify key attributes of harm reduction practices, and determine implications for health and social care practice.

SURROGATE TERMS AND RELEVANT USES

In the literature, harm reduction is sometimes conflated and used interchangeably with "harm minimization," "use reduction," "risk reduction," "risk minimization," "risk management," "vulnerability reduction," and "reduction of harm" (Ball, 2007; Lenton & Single, 1998; Marlatt, 1996; Riley et al., 1999; Wodak & Saunders, 1995). As early adopters of harm reduction policies, the Australian government declared in 1985 that their national drug strategy included "harm minimization" but they did not define this new term (Wodak & Saunders, 1995). Ball (2007) observed that due to some underlying tensions regarding harm reduction, alternate terms may have been used when harm reduction was considered taboo. To further complicate matters, reduction of harm and harm reduction sound like similar phenomena, yet not all measures that reduce harm are considered to be harm reduction (Wodak & Saunders, 1995). In an attempt to reduce confusion between these terms, the

TABLE 1. The Rodgers (1989) Method of Concept Analysis

1.	Identify and name the concept of interest.
2.	Identify surrogate terms and relevant uses of the concept.
3.	Identify and select an appropriate realm (sample) for data collection.
4.	Identify the attributes of the concept.
5.	Identify the references, antecedents, and consequences of the concept, if possible.
6.	Identify concepts that are related to the concept of interest.
7.	Identify a model case of the concept.

Centre for Addiction and Mental Health (Centre for Addictions and Mental Health [CAMH], 2002) recommended exclusively adhering to the term "harm reduction" and avoiding other similar terms.

Harm reduction means many things: it is a philosophy, a movement, policies, frameworks, strategies, approaches, perspectives, interventions, programs, goals, and measures. Application of harm reduction strategies most often apply to illegal substance use, but it is also applied to alcohol, tobacco, and prescription drug use, as well as sexual practices, sex work, gambling, or other behaviors associated with risks. Some commonly cited examples of harm reduction in practice include the distribution of sterile injection supplies, supervised consumption services (SCSs), overdose training and naloxone kit distribution, methadone and other opioid replacement therapies, safer sex supply distribution, outreach and education approaches, law enforcement styles, alcohol and tobacco programs, and the development of drug and health policies.

In their 1995 editorial piece, Wodak and Saunders (1995) woefully stated that "harm reduction is that most unfortunate of beings—a term in search of a meaning" (p. 269). As a relatively new concept with many surrogate terms and uses, the concept has evolved in diverse ways over the last three decades, and the lack of an agreed upon framework has affected how the concept is applied in practice (Fry, Treloar, & Maher, 2005). Rodgers' (1989) approach acknowledges the existence of vast and dynamic interrelationships; it focuses on the behaviors and actions that are possible as a result of understanding a concept, rather than simply trying to reach an immutable definition of a concept.

Data Collection

Following Rodgers' (1989) method, a relevant literature sample was selected from computerized databases from a variety of disciplines, and a wide time range was applied to capture the concept's evolution. The following databases were searched: EBSCOhost, PubMed, CINAHL, ProQuest, ScienceDirect, and Google Scholar. Keywords used in this search included: *harm reduction, harm minimization, risk reduction, drug use, approach, strategy, drug policy, public health, HIV/AIDS, health policy, definitions, principles, and concept*. Disciplines represented included: addictions and substance use, drug policy, nursing, public health, mental health, law, and pharmacology. Twenty-five articles were located; those related to illegal psychoactive drug use and consequent public health outcomes were included, while articles that were focused on legal drugs, tobacco, or alcohol, medical treatments for addictions, or drug supply economics, were excluded. The articles originated from Canada, Australia, the United States, Switzerland, and Denmark, and included concept and discussion papers, policy documents and reviews, a qualitative study, an editorial, a systematic review, and a case study. Web-based information and resources as well as a book and journal articles already in the first author's possession were included to supplement the literature review. As there was no evidence of the use of the term

harm reduction prior to 1995, all publications reviewed were published between 1995 and 2018.

CONCEPT ATTRIBUTES

There is variation of the definition and application of the term harm reduction in the literature. Single (1995) offered one of the first definitions of harm reduction as, "a policy or programme directed towards decreasing adverse health, social and economic adverse consequences of drug use even though the user continues to use psychoactive drugs at the present time" (p. 289). A few years later, Lenton and Single (1998) elaborated by offering their definition:

> A policy, programme, or intervention should be called harm reduction if, and only if: (1) the primary goal is the reduction of drug-related harm rather than drug use *per se*, (2) where abstinence-oriented strategies are included, strategies are also included to reduce the harm for those who continue to use drugs; and (3) strategies are included which aim to demonstrate that, on the balance of probabilities, it is likely to result in a net reduction in drug-related harm. (p. 219)

Over a decade later in 2010, another definition—which is still in use today—was developed by Harm Reduction International (2018):

> "Harm Reduction" refers to policies, programs, and practices that aim primarily to reduce the adverse health, social, and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits people who use drugs, their families and the community. (Definition section, para. 1)

What is not reflected in these simplified definitions is the extensive and sometimes contradictory social, moral, and political commentary in the literature. On some level, any drug policy or program (including criminalization or abstinence-based programs) have the objective of reducing the harmful effects of drug use (Beirness et al., 2008; Riley et al., 1999), and so there is a need to explore the defining attributes specific to the concept of "harm reduction" beyond the goal of reducing harm. Thinking in this way helps health and social care providers identify practices that are aligned with a harm reduction approach, and provides somewhat of a framework for implementing them in different ways, in different places, and with different people.

Among the first to attempt to determine a comprehensive set of principles for harm reduction, Hawk et al. (2017) used qualitative data from interviews with patients and staff members in an HIV clinic in the United States. Their six principles for harm reduction included humanism, pragmatism, individualism, autonomy, incrementalism, and accountability without termination. The US-based Harm Reduction Coalition (2018) developed a set of eight principles considered to be central to harm reduction practice, whereas Harm Reduction International (2018)

defined seven principles. Using an evolutionary concept analysis approach, seven key attributes emerged from the literature, and are as follows.

A Focus on Harms

Echoing the preceding definitions, harm reduction focuses on the reduction of *harm* rather than the reduction of *use* (Lenton & Single, 1998). Although it is clear that abstinence-oriented programs aim to eliminate drug use, harm reduction includes programs that reduce harm but not necessarily use (Marlatt, 1996). On an individual level, harm reduction could mean a change in mode of drug administration (from injecting to smoking) or in pattern of use (Centre for Addictions and Mental Health [CAMH], 2002) to reduce harm. On a larger scale, it involves addressing health, social, and economic factors that negatively affect people who use drugs, communities, and society as a whole (CAMH, 2002). There was unanimous agreement in the literature that harm reduction puts the focus on reducing the harms of drug use rather than on eliminating or reducing the incidence or prevalence of drug use.

Participation of People Who Use Drugs

Another perspective in the literature is that people who use drugs are key stakeholders and participants in harm reduction program planning and delivery (Boyd, Carter, & MacPherson, 2016; Erickson, 1999; Marlatt, 1996). For example, the Vancouver Area Network of Drug Users (VANDU) was established in 1998 when people came together to create a drug user-run organization (Kerr et al., 2006). The philosophy of the group was user involvement and empowerment, and they strived to represent the concerns of drug users, placing a high value on peer support approaches. Smith (2012) suggested that the evolution of harm reduction reveals a tenuous relationship between people who use drugs and institutions and that it is "imperative to place users at the very center of harm reduction, re-situating people with lived experience as the driving force" (p. 216) rather than governments, or well-meaning organizations. Klein (2015) also discussed the empowerment of people who use drugs to help one another via peer-based support and street outreach, and suggested that harm reduction has counter-hegemonic potential, meaning that people who use drugs can bring about critical changes to institutions that marginalize them, such as the criminal justice system. The idea of direct user involvement is reflected in a phrase commonly used by drug-user groups around the world: *nothing about us without us* (Canadian HIV/AIDS Legal Network, 2008).

Promotion of Human Rights

Harm reduction upholds the human rights of self-determination and self-preservation for people who use drugs (Ciccarone, 2012). Harm reduction also promotes a person's right to be treated with dignity rather than as a criminal (Single, 1995), even though their drug use may be considered criminal behavior in some contexts. These humanistic values are primary characteristics of harm reduction

(Boyd et al., 2016; Riley et al., 1999). Additionally, the right to health is supported by international human rights organizations, and harm reduction services support this right (Boyd et al., 2016). Despite human rights being inconsistently addressed in the reviewed literature, the frequent mentions of dignity and respect point to the promotion of human rights for people who use drugs as a key attribute of harm reduction.

Public Health Approach

The deep roots of harm reduction in public health traditions focused on HIV/AIDS prevention and replacement treatment for opiate users was frequently discussed in the literature (Ball, 2007; Erickson, 1999; Klein, 2015). In 1995, harm reduction was considered to be an emerging public health approach (Erickson, 1995). Twenty years later, Klein (2015) asserted that harm reduction has been guided by and is closely tied to public health principles, while Smith (2012) examined how harm reduction, despite its anarchistic roots, has become institutionalized as public health policy. Harm reduction is closely tied to population health promotion in that it aims to prevent disease and promote health in communities and populations, and emphasizes the significant role of the social and economic determinants of health in the health outcomes of a population (Riley et al., 1999). Harm reduction is not designed to be a stand-alone solution for drug-related harms but rather should be part of a comprehensive continuum of health services that includes prevention, education, treatment, and follow-up (Beirness et al., 2008; Boyd et al., 2016). In Canada, most harm reduction services are consistent with a public health approach; they are low-threshold, delivered in the community, and utilize population-specific strategies in promoting health (Boyd et al., 2016).

Value Neutrality and Nonjudgment

The apparent value neutrality of harm reduction toward drug policy, law, morals, and long-term goals is heavily debated in the literature. Fry et al. (2005) identified that some harm reduction advocates avoid moral questions about drug use and people who use drugs as well as the role of the government or community in preventing or interfering with drug use. As a key characteristic of harm reduction, Klein (2015) proposed that value neutrality means both a commitment to nonjudgment, and the perspective that drug use is a morally neutral behavior. This dedication to nonjudgment regarding people who use drugs was discussed by several authors (Beirness et al., 2008; Boyd et al., 2016; Canadian Nurses Association [CNA], 2011) and Klein (2015) discussed "meeting the client where he or she is" (p. 465) as an instrumental practice. Historically, harm reduction had maintained a mostly neutral stance toward drug policy and the criminalization of drug use and people who use drugs (Single, 1995), and this may have been in part to avoid political tensions. Without explicitly denouncing the significance of value neutrality in harm reduction, Fry et al. (2005) proposed that value neutrality may actually impede

the social impacts of harm reduction on people who use drugs due to its core values and broader systemic goals remaining undefined. Despite being "perhaps the most contested element of harm reduction" (Smith, 2012, p. 214), nonjudgment and value neutrality continue to be widely presented as fundamental aspects of harm reduction.

Practical and Pragmatic

When VANDU established an unsanctioned needle distribution service in Vancouver's Downtown Eastside (DTES) in 2001, it was a practical and effective response to the HIV epidemic occurring among injection drug users in their neighborhood (Kerr et al., 2006). Harm reduction is known for "elevating pragmatism over prohibitionist ideology" (Klein, 2015, p. 449), and focusing on finding practical means to reach achievable goals (Ball, 2007). When a harm reduction strategy results in a net reduction of drug-related harms, it can be concluded to be an evidence-based, practical approach (Lenton & Single, 1998).

Riley et al. (1999) discussed harm reduction as a pragmatic approach that acknowledges drug use as a common facet of human existence. Recognizing that drug use has and will always exist, the CAMH (2002) advocated that the aim of harm reduction should be to reduce the immediate and tangible effects of substance use as well as the harms of criminalization. Supporting this stance, the CNA (2011) stated that harm reduction is evidence-based and cost effective, and should challenge policies that increase harm for people who use drugs and their communities. Described as a rational and pragmatic approach to addiction (Smith, 2012), harm reduction has a significant role to play in the development of pragmatic drug policy, innovative research, and the implementation of practical interventions (Fry et al., 2005).

Adaptive and Innovative

Early on, researchers identified that harm reduction strategies are always evolving to meet the immediate, pressing, and changing needs of people who use drugs (Erickson, 1995; Kerr et al., 2006). Erickson (1999) and Klein (2015) described harm reduction as a dynamic and flexible response to a problem. Harm reduction programs should have minimal requirements for client involvement (Boyd et al., 2016; Riley et al., 1999) and many accessible service entry points and intervention options (Ball, 2007; Lenton & Single, 1998). The CAMH (2002) depicted harm reduction as a holistic process requiring creativity and innovation to maximize options for people who use drugs in communities in which they live. Many of VANDU's initiatives were responses to the unprecedented needs of drug users in the DTES (Kerr et al., 2006). Illustrating this, Smith (2012) called for harm reduction to be "re-conceptualized as a living document, . . . where practice can adapt to accommodate changing community needs" (pp. 215–216). Since harm reduction is sometimes defined as a movement (Ciccarone, 2012), it is clear that it continues to develop and adapt in response to circumstance and needs, which is a key attribute of the concept itself.

CONCEPT ANTECEDENTS

Concept antecedents are events or phenomena that are often found to precede an occurrence of the concept or that lead to its development (Rodgers, 1989). Several antecedents for the concept of harm reduction were found. Harm reduction has European origins, dating back to physicians prescribing replacement treatments to opioid users in the 1920s (Marlatt, 1996), and public health efforts that aimed to benefit society but allowed for drug use to continue, such as methadone maintenance therapy (Erickson, 1999). There is also evidence of the concept being applied in public health approaches in the 1960–1980s, particularly relating to alcohol and tobacco use (CAMH, 2002; Klein, 2015). Smith (2012) suggested that in some instances, harm reduction is an anarchist practice as it often begins as an illegal, unsanctioned activity surrounded by criticism and controversy. The institutionalization of harm reduction as public health policy was first evident in the establishment of needle exchange programs in Europe in the 1980s (Smith, 2012).

The threat and rapid transmission of HIV/AIDS among people who injected drugs in the mid 1980–1990s was a catalyst for the development and implementation of harm reduction strategies as a public health response (Ball, 2007; Erickson, 1995; Riley et al., 1999). The sharing of used injection equipment and the marginalization of people who use drugs accelerated virus transmission (Erickson, 1999), which prompted the provision of sterile injection equipment to reduce the incidence of HIV infection (Riley et al., 1999). In the Vancouver DTES, the drug-user group VANDU emerged as a result of epidemics such as HIV and hepatitis C, as well as increasing overdose deaths (Kerr et al., 2006).

Of significant importance is the widespread stigma and beliefs of moral deviance associated with addiction and substance use (Fry et al., 2005; Kerr et al., 2006; Marlatt, 1996). In order for harm reduction to become fully supported, health and social care providers must recognize and accept that many people will use drugs despite all efforts to deter use (Erickson, 1995; Riley et al., 1999; Single, 1995). Marlatt (1996) suggested that many high-risk behaviors should be defined as "maladaptive coping responses rather than as indicators of physical illness or personal immorality" (p. 788). A harm reduction approach recognizes that substance abuse and addiction are complex and multifaceted issues with serious consequences that are nearly impossible to completely avoid (Beirness et al., 2008; Erickson, 1999), particularly with the widespread availability of both legal and illegal drugs. The complexity and inevitability of drug use and the stigma experienced by people who use drugs are critical antecedents to the development of harm reduction.

Having evolved from the "zero-tolerance" (CAMH, 2002; Single, 1995) and "suppression at any cost" (Erickson, 1995, p. 284) approaches to drug control, harm reduction deviates significantly from this drug policy style commonly referred to as the "war on drugs" (Lenton & Single, 1998; Smith, 2012). Several authors observed that these approaches to deter drug use have resulted in serious unintended harms to people who use drugs and their communities (Boyd et al., 2016; Riley et al., 1999). Fry et al. (2005) asserted that this politico-legal context created

a chasm between criminal justice and public health responses as the traditional zero-tolerance approach proved to be ineffective in addressing drug-related harms.

CONCEPT CONSEQUENCES

The implementation of harm reduction strategies have led to many positive outcomes. According to Boyd et al. (2016), "Harm reduction provides skills in self-care (and care for others), lowers personal risk, encourages access to treatment, supports reintegration, limits the spread of disease, improves environments and reduces public expenses. It also saves lives" (p. 103). Through harm reduction programs, people who use drugs become knowledgeable about how to avoid negative outcomes, and become equipped with the means to bring about change in their lives (Erickson, 1995; Riley et al., 1999). Harm reduction programs have been effective in connecting people with treatment and rehabilitation services (Beirness et al., 2008; Boyd et al., 2016; Erickson, 1995), and for some, a goal of abstinence may also be achieved through harm reduction (Riley et al., 1999).

Harm reduction has created common ground and supportive alliances between people who share the goal of reducing drug-related harms (Erickson, 1995; Lenton & Single, 1998) and has consequently stimulated significant program innovation (Riley et al., 1999). Harm reduction outreach, for example, has allowed front-line workers to make contact with at-risk individuals who may otherwise not receive services (Riley et al., 1999). Innovations in research and interventions have resulted in the reduction of drug-related mortality and morbidity (Fry et al., 2005) and have demonstrated effectiveness in supporting people who use drugs to stabilize their lives by creating a path to change that preserves dignity (Boyd et al., 2016; Riley et al., 1999).

Empirical studies have indicated harm reduction programs reduce the impact and transmission of HIV/AIDS and other infections (Ball, 2007; Boyd et al., 2016; Erickson, 1995; Riley et al., 1999). Australia and the United Kingdom have effectively reduced drug-related harms due to their quick implementation of harm reduction strategies (Lenton & Single, 1998). The evidence that needle distribution programs reduce the risk of HIV and hepatitis C transmission is also well-documented, as is the evidence that methadone maintenance programs reduce mortality and morbidity rates for opiate users (Riley et al., 1999). The implementation of SCSs have also demonstrated significant benefits to people who use drugs, including reduced frequency of overdose, safer injection techniques, and various benefits to the public as well (Potier, Laprévote, Dubois-Arber, Cottencin, & Rolland, 2014).

The literature focused primarily on the benefits that harm reduction has had at a personal and practice level. Looking forward, harm reduction might also help transform broader social views and policies as more health and social care providers, researchers, and people who use drugs are able to engage with policy makers (Jourdan, 2009; Smith, 2012). In this way, it might be possible for further

conversations that explore newly emerging ideas like *benefit enhancement* and *benefit maximization*. These emerging concepts "extends the principles of harm reduction towards recognizing the possibility for non-problematic use of substances" (Sage & Michelow, 2016, p. 6). These ideas allow for a view of substance use as potentially beneficial or therapeutic when used in an informed way and while using safer practices. Not only might this contribute to de-stigmatizing recreational drug use, it might also, over time, serve to normalize research into the use of illegal substances (such as psychedelic drugs) for prescribed therapeutic purposes.

RELATED CONCEPTS

Described as a rich but vague concept (Jourdan, 2009), harm reduction is closely associated with several other concepts. As harm reduction may mean many things to many people (Fry et al., 2005), it is appropriate to discuss related concepts within Rodgers' (1989) evolutionary approach to concept analysis. As extensively noted in the literature, harm reduction is sometimes believed to be synonymous with drug policy reform, drug legalization, or decriminalization (Beirness et al., 2008; CAMH, 2002; Riley et al., 1999; Single, 1995; Wodak & Saunders, 1995). Although harm reduction does not implicitly support a particular legal regime (Erickson, 1995), the legal provision of drugs may be considered harm reduction while the use of criminal law to deter drug use is not considered harm reduction (Single, 1995). Expanding on this, Lenton and Single (1998) declared that "a war on drugs is in fact a war on drug users—people are jailed, not the drugs they use" (p. 219). In this way, the incarceration of people who use drugs is not harm reduction (Wodak & Saunders, 1995).

In the literature, harm reduction is presented as both primary and secondary prevention. Drug education, for example, can take a harm reduction approach—by being fact-based and nonjudgmental—and would be considered primary prevention (Marlatt, 1996); while minimizing risks for those already using drugs would be considered secondary prevention (Beirness et al., 2008; Riley et al., 1999).

The application of harm reduction for youth is minimally discussed in the literature and has its own unique characteristics. Most harm reduction programs are directed at adults, whereas programs for youth tend to favor a use reduction and abstinence approach (Erickson, 1995; Reuter & Caulkins, 1995), potentially due to the limited evidence of the efficacy of harm reduction approaches in this population (Poulin, 2006). These programs do not reduce harmful consequences for people who continue to use drugs and therefore, use reduction and abstinence-based programs are not harm reduction (Lenton & Single, 1998; Single, 1995). However, Sage and Michelow (2016) asserted that understanding youth culture is critical to implementing harm reduction strategies that are meaningful for youth, such as drug-checking services. Given the "unique patterns of substance use [that] place youth at high risk of serious harm" (Poulin, 2006, p. 11), the Canadian Centre on Substance Abuse (2015) discussed the need for harm reduction strategies aimed

at young people and their particular recreational and social drug use at music festivals.

MODEL CASE

In Rodgers' (1989) concept analysis method, "a model case of a concept enhances the degree of clarification offered as a result of analysis by providing an everyday example that includes the attributes of the concept" (p. 334). This model case demonstrates how the previously defined harm reduction attributes might be enacted in a specific health and social care setting.

> Geoff is a 28-year-old construction worker with a recent history of injecting opioids. He has been intermittently homeless for several months since he lost his job and apartment following a hospital stay. Geoff has been accessing a busy, government sanctioned supervised consumption service (SCS) that recently opened following an unprecedented increase in opioid-related overdose deaths in his city. When he enters the building, he is greeted warmly by name, by the peer worker, who then asks him how his day is going and directs him to a vacant booth. As Geoff settles in and prepares his injection using the sterile equipment provided, a nurse approaches with a wheelchair, and since he often falls asleep after injecting, kindly offers it to him so he can be moved aside for monitoring; so the booth becomes available to the next client. Geoff is feeling irritable as he has not injected in many hours, and begrudgingly obliges. The nurse is not bothered by this, and noticing that he is quite shaky, offers to help Geoff prepare his equipment for self-injection. Geoff declines and mutters "I should have done this hours ago when my buddy offered his needle." The nurse gives him a gentle smile and says "I'm glad you came here instead" and packs him a small bag of sterile injection supplies that she offers to him "just in case." Geoff injects his dose and promptly dozes off. The nurse moves him to another location, watching him closely for signs of overdose. Twenty minutes later, Geoff awakens and prepares to leave. The nurse asks if she can take a quick look at his veins for infection, and as she does this, Geoff asks how long it takes to get started on opioid replacement therapy and if people are successful with it. The nurse answers his questions, and the peer worker offers to connect him to a local group of people with a history of drug use called "Grateful or Dead" that meet monthly to share stories, provide outreach, pick up discarded needles, and advocate for policy changes. Geoff says he will consider this, and as he is leaving, the nurse invites him to return.

In this case study, all seven key attributes of harm reduction are present. Both the peer worker and the nurse uphold human rights by offering this critical health service and treating Geoff with dignity throughout his visit. The SCS itself is a recognized public health approach to reducing frequency of overdose as well as transmission of bloodborne pathogens and has many other health, social, and economic benefits (Potier et al., 2014). Upon learning Geoff had considered sharing injection equipment, the nurse does not castigate him, but instead provides him with some supplies to take away, demonstrating both nonjudgment and pragmatism. The nurse's innovative use of a wheelchair for this particularly sleep-prone client is a practical way of ensuring access to the SCS for others. At no time does the

nurse attempt to prevent or dissuade Geoff from using drugs, instead she focuses on reducing the harms associated with his use, such as overdose and infection, and is adaptable to Geoff's needs during his visit. Lastly, the presence of a peer worker at the SCS and the promotion of the local group exemplifies the participation of people who use drugs in both harm reduction settings and in our communities. A thorough application of harm reduction principles is reflected in the behaviors of the health and social care providers. The care is sensitive, client-centered, and aims to reduce harm as Geoff continues to live, work, and experience health in the context of the broader socioeconomic and political determinants that shape his life.

IMPLICATIONS FOR PRACTICE

The harms associated with illegal drugs are a global health problem. Illegal drugs, the people who use them, and the harms associated with their use exist and will likely proliferate in societies that criminalize drug use and endorse prohibitionist drug policies. Health and social care providers are ideally positioned to advocate for policy change toward harm reduction approaches, so they can deliver care aligned with their client's needs. Advocacy is needed to promote harm reduction policy at health provision, community, and government levels.

There are many examples of grassroots harm reduction initiatives that can form the basis for thinking about policy and practice change in a variety of contexts. Harm reduction has gained significant support from academics, researchers, and government in some jurisdictions. Without a concerted, international understanding of harm reduction, the concept is at risk of being relegated to a fringe practice, or a buzzword that lacks meaning or potential. Having knowledge of these seven key attributes of harm reduction provides health and social care providers with important insights—a point of reference—for beginning to plan, implement, and evaluate meaningful harm reduction approaches within their practice settings.

CONCLUSION

As defined by this concept analysis, harm reduction is a broad concept with specific attributes that include: a focus on harms, the participation of people who use drugs, the promotion of human rights, a public health approach, value neutrality and nonjudgment, practicality and pragmatism, and innovation and adaptability. Harm reduction has several surrogate terms, uses, and related concepts that warrant additional investigation. Areas for further research could include Jourdan's (2009) suggestions to explore the dynamics of shifting attitudes toward harm reduction and the challenges associated with the use of harm reduction strategies in practice. As a more meticulously defined concept, harm reduction principles provide a framework to reduce risk-related harm; and given its widespread application, shows significant potential to improve health outcomes and save lives.

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Correspondence regarding this article should be directed to Dominique Denis-Lalonde, Faculty of Nursing, University of Calgary, 2500 University Drive NW, Calgary, AB Canada T2N 1N4. E-mail: ddenislalonde@ucalgary.ca