We want to thank PEP-AH for inviting us at HM|HC to host and contribute to the first installment in a three-part webinar series this spring. On a personal note, I've been grateful for the opportunity to have been part of various conversations in the past with PEP-AH personnel. I also had the privilege and pleasure of participating in a PEP-AH western symposium in Calgary in 2018 and at a national event in Sherbrooke Quebec in 2019.

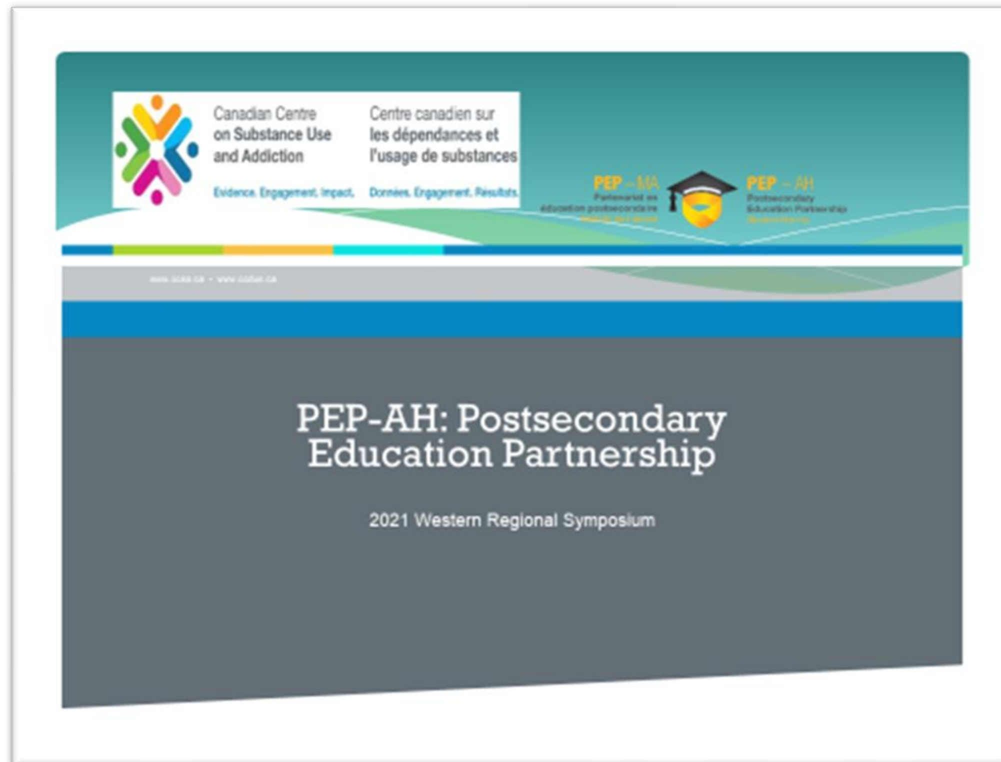
The title for today's session has been identified in the promos and is on the slide before you: (). But before we get into it, an acknowledgement and some brief introduction to our sponsors, PEP-AH.

Territorial Acknowledgment

I'm presenting today from the traditional, ancestral and unceded territories of the Semiahmoo, Katzie, Kwikwetlem, Kwantlen, Qayqayt and Tsawwassen First Nations, on which lands I am privileged to learn, work and play.

Pronunciation Guide of BC First Nations

Katzie – KUT-zee
Kwikwetlem – Kway-quit-lum
Qayqayt – Kee-kite



PEP-AH is short for Postsecondary Education Partnership-Alcohol Harms. It's been in active operation since 2015 and you can check it out at much more length on its website (https://pepah.ca/home/).

PEP-AH has some national staff support from the Canadian Centre on Substance Use and Addiction.

About PEP-AH

- PEP-AH is a strong partnership of postsecondary institutions from across Canada.
- It is a network of campuses committed to:
  - understanding the student drinking culture,
  - working to develop best practices to reduce harms from alcohol, and
  - sharing these practices to help promote student health and safety across the country.

PEP-AH is represented in nearly every province in our country, including BC.

You see three major PEP-AH commitments, and HM|HC likewise encourages efforts to understand campus drinking cultures, consider the most promising ways to reduce harms, and do that collaboratively.

About PEP-AH

MISSION

- Reduce alcohol-related harm on Canadian campuses
- For all students to live up to their fullest potential, and free from harm caused by alcohol.

OBJECTIVES

- Evidence-informed decision making;
- Sharing of best practices;
- Regular evaluation of efforts.

Here are PEP-AH's clear mission statements, which -- by envisioning students living up to their potential -- go beyond harm reduction.

As well, there are three featured objectives in PEP-AH's endeavor that can be readily appreciated.

Next Wed., and two weeks after that on May 12, will come the second and third webinars in this PEP-AH series hosted respectively by HCS and HCA, and we would welcome your presence at those webinars too with their particular foci for reflection and action: (), ().

Our focus today while perhaps not so obviously concrete and particular, is, I would suggest, more foundational and a fitting starter to the series: again, **alcohol harm reduction within campus community health promotion**.

Harm reduction *within* health promotion?

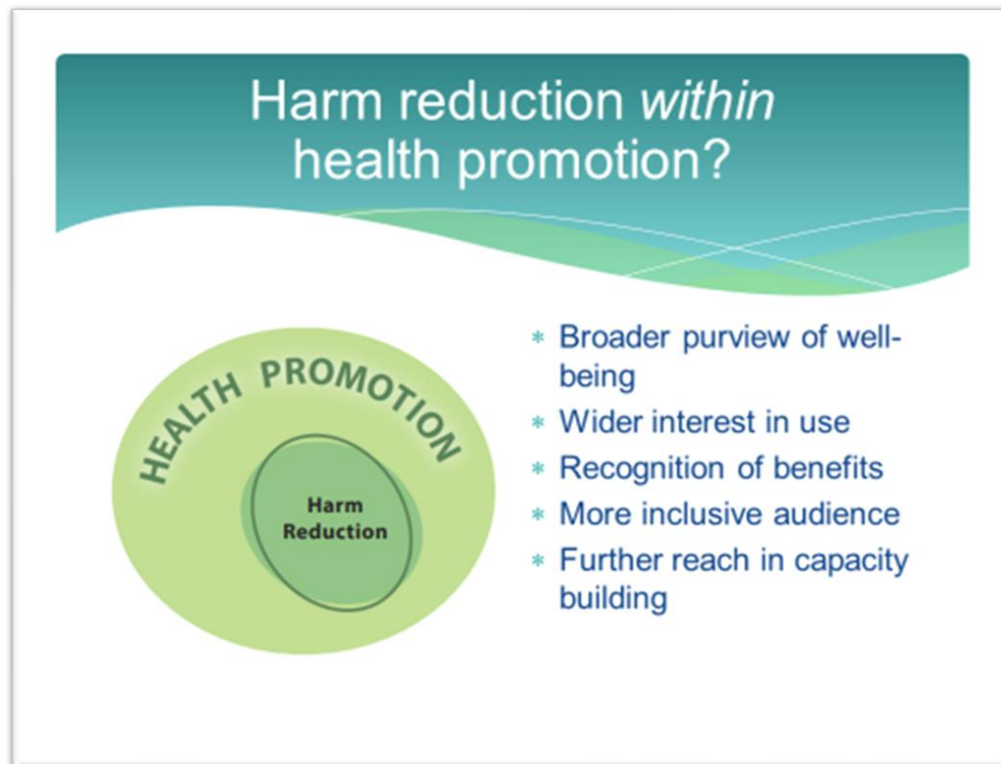
Different? What features distinguish health promotion and differentiate it from harm reduction?

What do they have in common?

Why harm reduction *within* health promotion?

We’re not seeking here to applaud one at the expense of the other, or to set them at odds as conflicting rivals instead of close relatives. But are there differences that we should attend to and reflect on and work with (when we’re responding to substance use including alcohol)? Hence these questions for you to listen to and talk with each other about in breakout rooms.

You can keep these questions in front of you by opening the link in the chat box right now and opening a second window on your screen to see the questions once you’re in a group. We’re only giving you **8** minutes in the breakout room, just barely enough to start listening to and talking with each other about these questions (without an assigned facilitator), so be brief with your intros and comments to each other. Click on accept/join when you get your invitation, and we’ll bring you back. Go to it!



Our own take on the relationship between health promotion and harm reduction is summarily offered in the new HM|HC resource we are formally introducing in connection with this webinar: *Harm reduction: a guide for campus communities*. Re health promotion, we draw on the 1986 Ottawa Charter, the 2015 Okanagan Charter, David Buchanan (2000 …), Joubert & Raeburn (1998), etc. [A more encompassing, conditioning construct of health promotion than in the PEP-AH Framework]

Aspects of difference:

Health promotion has a broader (salutogenic) purview of holistic, integrated well-being than harm reduction's (pathogenically framed) focus on avoiding injury and illness; health promotion seeks well-being at both a personal and a collective level

Health promotion is interested in a whole complex range of phenomena (features, factors, drivers/prompters) related to use as a social practice, while harm reduction is concentrated on particularly risky patterns of behaviour and their contexts.

Health promotion acknowledges and appreciates positive outcomes/benefits from use, while harm reduction is primarily concerned with minimizing negative consequences, detriments/damage.

Health promotion addresses a more inclusive audience (communities and their members), while harm reduction especially targets those who use and care providers.

Health promotion aims at participation, increased capacity to variously manage, control and improve health, while harm reduction seeks protection, uptake of specific strategies, ways and means; hp less predetermined than hr, more affirmative than a protectionist orientation

Harm reduction *within* health promotion?

* Empathic
* Egalitarian, equity-driven
* Affirming autonomy, agency and dignity
* Consultative, collaborative

In-common values: both more empathic, identifying, egalitarian, equity-driven, more about affirming autonomy, agency and dignity, more consultative, dialogic, collaborative than the tendency of strict use prevention to be predetermined, authoritarian, unidirectional, prescriptive, to impose measures

(Re harm reduction we draw on, e.g., Harm Reduction International's definition and description; Riley et al., 1999)

HM|HC's attempt

Changing the Culture of Substance Use (CCSU)

* Project funded by BC Ministry of Health, 2012-2017
* To build sustained capacity BC-wide to address use in the campus context (alcohol a major focus)
* A variety of cultural endeavors relating to substance use
* Ongoing community of practice
* Much more on CCSU at healthycampuses.ca under Projects

Our HM|HC attempt to promote healthier relationships with alcohol and other drugs has been especially through the CCSU initiative.

There are different cultures of substance use in the campus context, including around alcohol; hp change objectives might vary among these cultures.

Isn't culture something rather abstract, nebulous, ethereal, fuzzy, elusive? Why try to relate to that instead of something more tangible, concrete, practical, focused (like reducing harm, where arguably the rubber meets the road)?

Why make such an attempt?

Philosophical-educational-cultural considerations	Location of meaning for human experience in interconnected embodiment
	Awareness of finitude, fallibility, need to listen, learn, be open to possibility
	Recognition of elitist self-interest in social control, need for public conversation not to privilege technical expertise

(A confluence of considerations has proven compelling for us)

Phenomenological insight: attempt to understand the meaning of human lives by observing/describing/reflecting/inquiring more immediately on experience as being in the world, in intermingled, interdependent relationship and interaction with our surroundings, not least the social;

Identity one of interconnectedness, interpenetration (versus Cartesian dualism, strict body-mind, subject-object dichotomy, detachment)

Merleau-Ponty, Heidegger; van Manen

Hermeneutical perspective: quest to understand, acknowledging that we are finite, fallible, need to listen, learn, broaden horizon, be open to possibility

Gadamer

Critical theory tenet: recognition of self-interest in social control; need for reflexivity, diversity, inclusion, social justice, equity

Deliberative democracy contention: public conversation, communal collaboration that does not privilege technical expertise [doesn’t ignore either, but not to be regarded as definitive/determinative, solely decisive, necessarily superior and sufficient …]

Habermas, Taylor

Why make such an attempt?

Philosophical-educational-cultural considerations	Classical humanist education encourages critical reflection, seeks to develop character, equips people to be citizens who contribute to public well-being
	Cultural attentiveness is alert to the reality that influence can flow in both directions – culture affecting people and people shaping cultures
	A humanist approach rejects primacy for positivist instrumental reasoning and respects practical reasoning about appropriate means to valued ends

(A confluence of considerations has proven compelling for us)

CHE: encouraging critical reflection, developing character, equipping people to be citizens positively contributing to collective public well-being

e.g., Ernest L. Boyer; Jonathon Porritt (to prepare them not just for the world of work but for the work of the world)

Culture: everything in our surroundings that has been socially transmitted, a context of collective understanding that readily affects/colors our ways of thinking, speaking, believing and behaving, influences what we do, why and how we do it, does so in ways we are often not conscious of: e.g., R. Eckersley, E. Schein, G. Kuh, many others' metaphors; shared meaning & values

Influence goes in the other direction: individuals, groups can shape (and reshape) cultures; can manipulate or collaborate

Buchanan, D.: humanistic approach to health p/ed rejects sufficiency of positivism (causal accounts, employment of predictive/instrumental/technical/procedural reason, focusing on effective means, control), respects practical (moral/ethical) reasoning about appropriate means for valued ends by autonomous agents; cf. Bell, K. (2017). *Health and other unassailable values*.

[Shove et al., Blue et al., Supski et al.: Social practices (collective activity with meanings, materials, competences) vs. atomistic focus on individual behaviours

Cf. natural drinking groups (Lange, Devos-Comby, Dumas). Note typical student response to Experiential Expectancy Challenges (they want to have alcohol nonetheless). Appropriate response not to alter conditions unilaterally but to explore motivations, possibilities?)]

Culture change *à la* health promotion?

What aspects or layers make up a culture (including campus drinking cultures of concern)?

What would characterize a health promotion approach and process to changing a culture?

What strata of a culture do we need to take into account? What implications do such layers have for efforts to change a culture?

We're not asking yet about specific action components, particular strategies or even areas for intervention (as the PEP-AH Framework can help with) but about the traits and facets that would compose and condition a culture change process conducive to harm reduction (among other positive outcomes). These questions, then, for your next breakout. [Time allocation: **8** min.]

How to change culture *via* health promotion?

By being:

- respectful and inquisitive in exploring this aspect of community life
- attentive to and intentional about social practices and discourse
- constructively critical about different values and ideals
- reflective about a variety of basic assumptions and beliefs

Respectful and genuinely inquisitive …: twofold prerequisite

Thinking in terms of dimensions or strata of a culture, is it a matter of digging down from the more readily perceptible, tangible surface features through to the most deeply deposited elements, expressions that are most difficult to expose and identify?

Observing practices and perceiving that there is meaning and purpose involved that can be recognized and not just overlooked, ignored

Discourse: predominant discourse reflects, reinforces attitudes, outlooks, and can afford to be inspected for its prejudices, biases (cf. alcoholic, binge drinker), no discourse is entirely objective, impartial, non-impactful; language shifts signal, invite change

Values and ideals: less apparent (though not the most deeply embedded), but need to be articulated, examined, not just inferred; worthy objects of exploration (versus empirical focus on hard data, facts), broader-based priorities about meaning & morality that affect second-order reflection on personal/individual desires, wishes/wants

Intentional: rather than that's the way it's been done, what's expected; consider reasons, benefits, adjustments, alternatives

Reflective …: deepest, most substantive scrutiny in regard to notions about human nature, behaviour, connections involves asking probing, penetrating questions of ourselves and others, exposing conceptual underpinnings, tacit acceptances, less and more conscious persuasions

How to change culture *via* health promotion?

By being:

- collectively engaged in exploring this aspect (and others) of community life
- appreciative of diverse experience and perspective
- collaborative in choosing and pursuing goals and means
- dialogic

Collectively engaged …: versus just focusing on some as a target audience, in deficit, recipients, passive objects of intervention, acted on; it's about building relationships, partnering, inviting, eliciting, learning together

Appreciative …: Not necessarily more in agreement with, or in approval of; but recognition, receptivity instead of presumption, ignorance, indifference, dismissal; body of evidence of a different sort to be taken into account

Collaborative: versus imposition, control; cf. MI partnering toward outcomes desirable to the other

Dialogic? Why? (Next slide)

Dialogic?

What makes dialogue an apt means of health promotion (including harm reduction)?

What concerns come to the fore in ensuring that dialogue happens?

Two more questions for you to take up in breakouts. [Time allocation: **10** min.]

Dialogue: particular manner of communicating, two-way conversations where people really listen to each other (reflects a way of being with, relating to others)

identifying divides, building bridges, seeking to put ourselves as much as possible in others' shoes

Egalitarian, among fellow human beings as peer partners

Unanimity not likely, but consensus enough to proceed collectively with continued sensitivity to diversity, minorities

Create the container: inviting/welcoming context conducive to openness, safe exchange

Helps: cisur.ca > publications & resources > dialogue resources (around understanding and facilitating dialogue)

Gadamer (1960>2004) *Truth & Method*, cf. Buber (1970) *I & Thou*; D. Bohm (1996), W. Isaacs (2001), D. Yankelovich (1999), M. McKee (2003) Excavating our frames of mind

Broad community-level (health promoting) harm reduction

Need not focus on or even mention substances at all but can impact use; e.g.,

* Initiatives that supply the social glue
* Efforts that help people to navigate and cope
* Offerings that provide elevated experience

Thinking of the campus community in particular; among other intended benefits broadly directed strategies to improve overall well-being can have (like a natural by-product as it were) a positive effect on substance use patterns and outcomes, since that use is not a separate domain detached from other areas of life but is instead influenced by them)

Broad campus well-being thrusts that bear on harm reduction

What does and could our campus do to

* **build relationships,**
* **make the system more user-friendly,**
* **make the post-secondary experience more meaningful and rewarding?**

Another query for you to take up in breakouts. [Time allocation: **8** min.]

Interrelated aspects across various levels

These three aspects are at play together in health promotion guided harm reduction strategies

- that function at the broad campus community level
- that aim at campus members' substance use in general
- that address concerns around use of particular substances such as alcohol

We see and outline in our guide three aspects to collective harm reduction efforts that reflect health promotion themes: nc, pl & as. Integral, intertwined, bound up with each other: when one aspect is being pursued in a health promotion manner, the other facets are involved, part and parcel.

Without having named them, we can realize in retrospect that they are operating in broad campus efforts to supply the social glue, help people navigate the system and make experience more enriching.

They also should give direction to strategies that explicitly address campus members' substance use, whether in general or in particular such as use of alcohol.

Harm reduction around general campus substance use

How could a health promotion perspective improve our

* **policy processes and positions,**
* **standing services and supports,**
* **event-oriented protective provisions?**

[Time allocation: **8** min.]

Core questions on our response to concerns around alcohol

How well do (and how better could) our campus efforts to reduce harm from alcohol use

- foster and strengthen connection, belonging?
- enhance ability, skills to manage & improve health?
- relate to contexts of use in relevant, constructive ways?

Our harm reduction guide lists some alcohol-specific strategies and the PEP-AH Framework lays some out as well. Here are some questions to take with you as worth posing in relation to all sorts of actions you might consider and pursue.

Appropriate markers?

How do we look for progress in and impacts from efforts in these aspects

- community cohesion across diversity?
- increased capacity for and mutual support in responsible use?
- safer, satisfying situations?

Toward a community marked by transparency and accountability, shared purpose, inclusivity, connectedness, engaged participation, justice and equity, mutual respect and caring

Often gradual, perhaps incremental, progressive attainment of enhanced literacy (generated knowledge, skills), ongoing quest, increased ownership

Extended support (lay, non-professional, friends, fellow members, networks)

Enlarged involvement in upholding standards: casual, informal, routine collective, aspirational self-regulation versus formal, constrained, confrontational enforcement; willing adherence versus constrained compliance

Reduced experience of harms (frequency and severity) and reliance on professional services

A range of measures apt for the outcomes
Not so much about individual behavioural change (NCHA, CCWS) in volume & frequency of use
If measures are strictly quantitative, they will be inadequate (breadth, but not depth); abstinence, indulgence both respected, considerate

Collective capacity, growth in competence, sense of and activity as a community; not unanimity, uniformity, but inclusion, identification, integration

E.g., interviews, experience forms confirming shifts in thinking, orientation, attitude/stance, practice; responsive evaluation
Stories (cf. Most Significant Change)
Transformation of collective conversation, public discourse, feature events

The aspiration?

"In the end, the field of public health needs to engage the public directly in building consensus on what we owe each other in creating a society in which all citizens feel supported in living decent lives characterized by dignity, integrity, and mutual responsibility."

David R. Buchanan

Buchanan (2008). Autonomy, paternalism, and justice: Ethical priorities in public health. *American Journal of Public Health*, 98(1), 15-21, p. 20.

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