Relapse, Acceptance, Recovery:
Applying Queer Theory to Harm Reduction Treatment and Addiction

This report aims to deconstruct normative understandings of, and responses to relapse; in doing so, an alternative understanding of relapse can be identified. Two articles will be reviewed in this paper: "Integrating Harm Reduction Therapy and Traditional Substance Abuse Treatment" by G. Alan Marlatt et. al, and "Toward a Feminist History of the Drug-Using Woman—and Her Recovery" by Trisha Travis. The first article explains Hard Reduction Therapy (HRT) through 8 principles, contrasting it with traditional treatment, and then assess how the two could be integrated. This construction of relapse could potentially address The Acre's dilemma of providing HRT to relapsing individuals without exposing others to drugs via Safe Injection Sites (SIS).

Before HRT can be applied to The Acres, it is important to understand what HRT is and how it works. Unlike traditional substance abuse treatment, HRT approaches addiction and treatment with the objective to "reduce or minimize the harm associated with ongoing or active drug use". This client-minded approach is driven by the idea "that drug users know best what their needs are;" as such, HRT proactively employs low-threshold policies to better reach more drug users. (Marlatt et. al 14, 16). While these low thresholds do not require abstinence at first, abstinence is a critical part of HRT: "abstinence is the endpoint on the continuum of harm reduction approaches, and while not insisted upon for treatment entry, many people eventually choose abstinence after initially seeking a moderation goal" (Marlatt et. al 20). To this end, HRT treats addiction and treatment as a continuum, with the starting point being unrestricted drug use, and the end point being abstinence; the goal is to meet the client where they're at and to help them work their way down the continuum (Marlatt et. al 17). This continuum model also applies to relapse too; unlike traditional models of relapse, which understand relapse as an all-or-nothing event, a continuum model of relapse makes distinctions between individual lapses and a full-blown relapse. Lapses are considered "a slight error typically due to forgetfulness or inattention," while relapses are "to slip or fall back into a former worse state" (Merriam in Marlatt, 19). By making this distinction, the client is given a space to make mistakes and arms them with the mental tools to prevent lapses from growing into full blown relapse:

> It is a relapse prevention model (Marlatt & Gordon 1985) that suggests the probability that a lapse will turn into a full-blown relapse depends in part on the individual 's emotional and cognitive reactions to the slip and his or her ability to use coping skills to escape the situation and limit continued use. While it may be the natural course for many unchecked lapses to eventuate in relapse, a relapse prevention therapy (RPT) approach demonstrates that lapses can be contained and damage control exercized before they reach a full-blown relapse. Along with other cognitive and behavioral interventions, the RPT model helps both clients and practitioners make an important distinction between a lapse or slip and a relapse, allowing for a more hopeful, tolerant, and compassionate way to handle the problem of relapse in substance abuse treatment. (Marlatt et. al 19)

Ultimately, both lapse and relapse are viewed as temporary setbacks that are expected to occur during a normal and healthy recovery process.

With this understanding in mind, the Acres could better provide to clients by thinking about where it's mission exists along this continuum. If on-site SIS endanger the abstinence of recovered/still-recovering addicts, then Relapse Prevention Therapy could be a powerful tool to help relapsing individuals resolve their relapse without having to be removed from their communities; further research must be done to assess if this is a viable option.

The second article, "Toward a Feminist History of the Drug-Using Woman—and Her Recovery," analyzes the history of substance abuse and treatment, and how that history impacts treatment today. It starts by articulating how Victorian gender models and politics have be fundamental in disadvantaging and excluding marginalized people from accessing treatment. As Travis surmises:

> Substance abuse as such, despite professions to the contrary by the biomedical establishment, remains a poorly understood and largely unstable concept, inextricably intertwined with the politics of respectability…the US has practically no feminist theory of substance abuse, much less a feminist theory and practice of treatment/recovery. (212).

This connection begins in the late 19th century with the rise of urbanization and capitalism; alcohol and substance consumption rose in response to the social upheaval at the time. As a social problem, gender roles shaped the social conventions around drug use (Travis 213). The rise of Alcoholics Anonymous (AA) popularized a disease-based model of alcoholism, dispelling the idea of addiction as a moral failing; however, this model privileged men at the cost of marginalized people: "by claiming white men from the respectable classes as their primary constituency, the modern alcoholism movement tacitly distanced itself from nonwhite, nonrespectable drugs users" (Travis 216, McClellan in Travis 218). This distancing impacted the development of narcotics treatment, which "grew out of AA, but they abandoned the disease concept and its associated respectability politics —while retaining its gender bias" (Travis 219). With the advent of the War on Drugs in the 1970s, women's substance abused was made invisible by the flawed data that policy makers used (Travis 223). In response to this, Second Wave Feminists developed trauma theory through their work with female drug users: "substance use should be recognized as a means of coping with trauma and that trauma should be recognized as a potential complicating factor in treatment" (Travis 224); yet, when studying how this theory is applied to women's residential programs, scholars take note of the aggressive tactics used to rehabilitate women:

> [Some women's residential programs] require an aggressive intervention the staff calls "getting gut-level." This entails recognizing through confrontational therapy (individual and group) that not merely their own habits of mind, but also their communities, romantic partnerships, and families are toxic sites of wounding— and then disavowing them as such…"the trauma framework" used at WTS plays "a key part of the program's construction of women as addicted to punishment (McKim in Travis 229).

While this treatment is grim, McKim theorizes that the destructive nature of this therapy is due to the fact that residential programs are unable to change normative society directly; reshaping women to fit normative gender roles might seem to be the only option available (Travis 230). Treatment for drug use continues to be entangled in respectability politics; paradoxically, it is as if for an individual to end their substance abuse, they must become a socially respectable person that is worth saving.

The Acres will be influenced by the same social forces that have shaped drug policy so far. As an affordable housing community by and for recovering individuals, The Acres (especially residents of the community) also has the opportunity to displace the respectability politics that hamstring meaningful recovery. HRT centres the client's needs, so conforming to normative social roles would not be prerequisite to treatment. To go a step beyond, the Acres could become a community that continues to provide opportunities for clients even post-recovery; job opportunities and other on-site ventures could integrate and enable individuals to support themselves while remaining in a space that does not impose the same normative social roles that harmed them in the first place. It is imperative that The Acres considers not just where it is positioned physically, but where it exists within a living history, a history that will continue to shape substance abuse treatment and the people who undergo it.

The (Re)-Envisioning of the Relapse

This section of our project focuses on how we can facilitate any members of The Acres who may have experienced a relapse in their sobriety, left The Acres, and then returned back to continue working with The Acres. I will examine what framework we can apply to support these individuals in their return to The Acres, their community, while also considering the sobriety and safety of our other members.

Substance use is an ongoing global issue, with Canada, like many other countries, currently experiencing an opioid crisis. There has been a rapid increase in hospitalisations due to substance use in recent years. In the province of Alberta, as displayed in the graph below, 1,144 deaths in 2020 have been linked to opioid overdose, out of a total of 6,214 nationwide (Statista, 2021). At The Acres we are in direct contact with individuals who may have experienced heavy substance use and are now aiming to stop or significantly reduce their usage. This journey is not easy, nor straightforward. Therefore we must ask ourselves, what can we do to support our fellow members at The Acres?

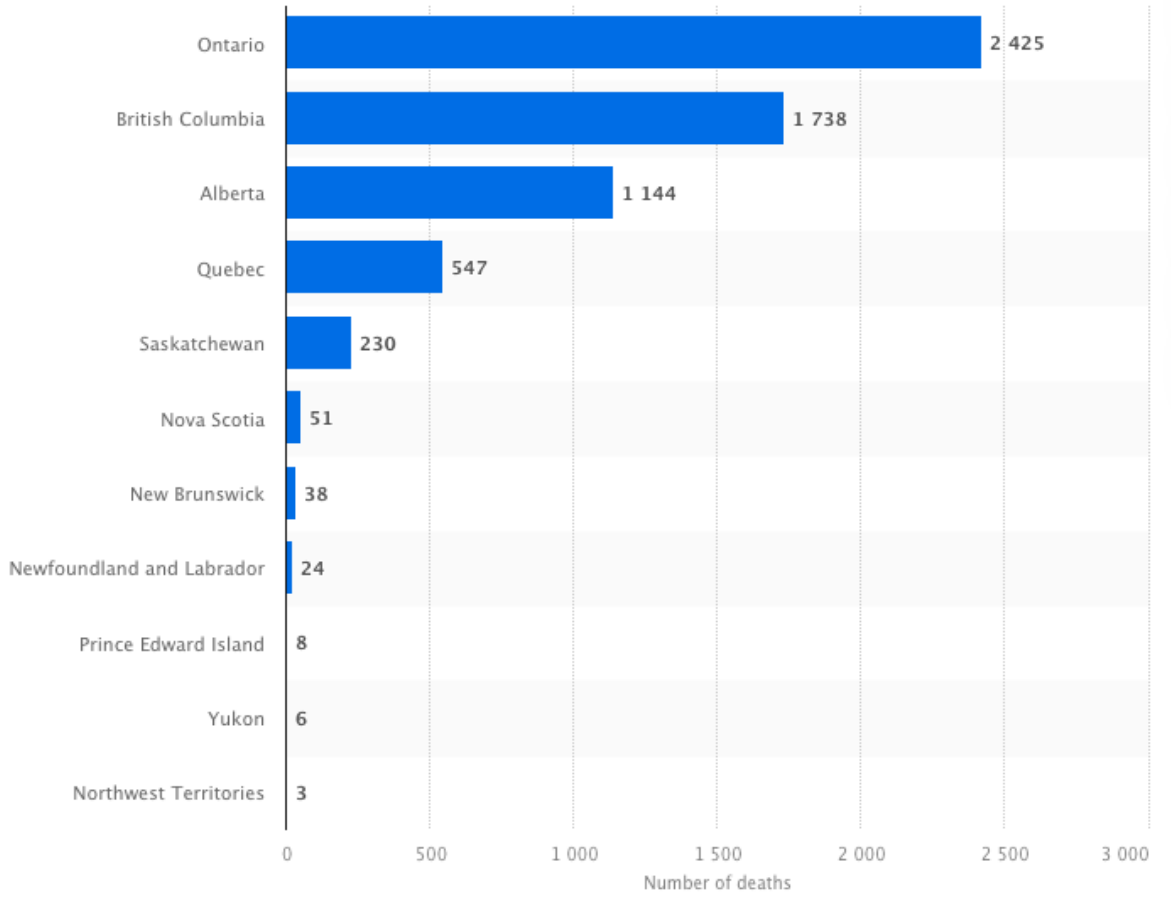

Figure 1: 'Number of Opioid Overdose Deaths in Canada in 2020, by Province'
Source: Statista, 2021

A sense of shame, guilt and failure are some of the most commonly cited feelings associated with relapse (Osten and Switzer, 2013). This can in part arise from worries of letting oneself or ones loved ones down during a journey from substance use to recovery. A relapse is often seen as a sign of a person's inability to recover from substance use. However, if we tell a person in recovery they are a failure this may lead the individual to feel as though they cannot recover, and then question why they should even continue trying. This line of thought can be very destructive to a person's confidence in their recovery, perhaps leading to further relapses in the future (Osten and Switzer, 2013). Additionally, it can be argued that these feelings may also stem from societal pressure to succeed, where substance use itself and any associated relapses are deemed "failings". Should a relapse be seen as a failure? What could it mean for members at The Acres who have experienced a relapse if we re-envisioned our understanding of this?

At this point introducing queer theory could be very helpful. In his book 'The Queer Art of Failure' Jack Halberstam (2011) turns our interpretation of failure on its head by describing

failure as something productive, essentially "queering" our understanding of what it means to fail. In our society, a life without substance use is viewed as the "norm" and being successful is something we are taught to desire. When we talk about success it is meant in the traditional sense, by working full time, increasing economic growth and an economy's gross domestic product. However, when a person does not achieve this they are labelled "unproductive", having "failed" and looked down upon by others. Halberstam (2011) takes this idea of failure and examines it under the lens of low theory, which can be used to undermine heteronormative definitions of success we are taught from birth by our family, peers and society at large. Halberstam (2011) argues that failure to live up to these societal standards which support our system of capitalism may not and should not be such a terrible thing.

'Failing, losing, forgetting, unmaking, undoing, unbecoming, not knowing may in fact offer more creative, more cooperative, more surprising ways of being in the world' (Halberstam, 2011: 2).

Is it possible to be productive and successful outside the realm of capitalist greed? I would argue that firstly a person's value should never be defined by their productivity or apparent successfulness. Furthermore, using low theory, it is clear to me that our community at The Acres is a perfect example of how an individual can be just as productive and successful in their own alternative ways. Our members come from many walks of life which can all be deemed "failings" in the conventional sense, but if it were not for these "failings" The Acres may very well not exist today. At The Acres our members and staff have built a community we can rely on, where we encourage and support each other, work with and nourish the land, and share our vision with our neighbours to help our wider community continue to grow and flourish. How can this be seen as a failure, just because it is not lining the pockets of CEO's? By reframing failure we have the ability to set ourselves free and relapse into the right perspective, approaching the situation as a learning opportunity to further improve our coping skills for possible future relapses.

The reconstruction of our interpretation of relapse is a vital foundation of this approach, but what other steps should we at The Acres take when a member experiences a relapse? After some research I would argue that a mixture of harm reduction therapy (HRT) and relapse prevention therapy (RPT) should be implemented at The Acres. Harm reduction is an umbrella term used to describe interventions aimed at reducing the problematic effects of

various destructive behaviours (Logan and Marlatt, 2010). This can range to a multitude of behavioural disorders, but is most commonly used in tackling the effects of substance use. HRT is different to many other recovery programmes as abstinence from substance use is not a requirement, instead it supports any step in the direction of recovery no matter how small it may seem. During HRT those recovering from substance use who may have relapsed are assisted in setting reasonable goals, practicing refusal skills, identifying alternative behaviours and discussing a relapse prevention plan (Logan and Marlatt, 2010). Non-judgemental directive techniques are at the core of HRT. In many psychological studies motivational interviewing has proved effective. Motivational interviewing involves providing a non-judgemental and trustworthy space where an individual can explore their reasons for change. This allows you to build a sense of rapport with the individual and support the growth of their sense of self-efficacy, allowing them to take the necessary steps to recovery themselves (Osten and Switzer, 2013).

One of the main criticisms of HRT is its view that abstinence should not be a requirement. This difference in the definition of therapeutic progress has been labelled as enabling or excusing poor choices. This begs the question, what should we consider a poor choice? I would argue that this understanding echoes our heteronormative and capitalist fuelled definition of what it means to live a successful life, and that this needs reformation. An interesting example used in the study by Logan and Marlatt (2010) could help to visualise the argument. In their example a recovering substance user presents after 1 month of HRT treatment and reports drinking an average of 5 alcoholic drinks per night. An abstinence-based recovery programme would see this as a “failure”, possibly even turning the individual away from their treatment programme as they did not deliver on their agreement to complete abstinence. Although this approach has its benefits, it may in certain cases fuel an individual’s “failure” narrative. Moreover, studies suggest that when an individual in recovery experiences a relapse after a period of abstinence they have a tendency to continue to engage in problematic behaviour and give up on themselves (Melemis, 2015). This is known as the abstinence violation effect and I would argue it is another reason why a HRT approach may be more effective at The Acres.

Under a HRT approach the individuals progress would first be assessed. If an individual had previously been a heavy substance user and now experiences the odd lapse or relapse this would not signify a failure, but rather an opportunity to learn. HRT does not mean that we

ignore the negative consequences associated with an individuals decision to continue problematic behaviours, or celebrate instances of lapse or relapse (Logan and Marlatt, 2010). Rather, we acknowledge that no situation on the journey of recovery is black or white. We should not take recovery in all or nothing terms. For some people abstinence is something they want to strive for and that should be encouraged, but we should acknowledge that no journey is the same. A HRT approach means we do not withhold any services when an individual cannot or will not meet certain goals that have been set out.

'*Harm reduction therapy means we meet the client where they are and help them along for as far as they will let us'* (Osten and Switzer, 2013).

Many studies suggest that when any individual attempts to change a problematic behaviour, an initial setback known as a lapse, often followed by a complete relapse into the previous behaviour pattern, is highly probable (Witkiewitz and Marlatt, 2004). If those in recovery are likely to experience a relapse, then why do we label this as a "failure"? A relapse is not something we cannot merely avoid. It is important to acknowledge and accept this possibility, and put personally tailored strategies in place which detail how to cope effectively in the case of a relapse. This approach is known as relapse prevention therapy (RPT) and can be used in addition to HRT to support our members at The Acres who may have experienced a relapse to improve their coping skills and prevent future instances.

The first step in RPT is the assessment of any potentially high-risk situations for a recovering individual. Through motivational interviewing expectations of the perceived positive effects of substance use can be challenged and the individuals sense of self-efficacy to make more informed decisions in difficult situations can be promoted (Osten and Switzer, 2013). In 1985 Marlatt established a cognitive-behavioural model of relapse which highlighted increases in stress levels as triggering high-risk situations. Marlatt's model featured below displayed how a slight reduction in coping efficacy greatly increases the likelihood of a person using an ineffective coping response, increasing the probability of a relapse (Witkiewitz and Marlatt, 2004). However, this earlier model was criticised for placing relapse factors in a hierarchal order, with certain aspects given more gravity than others.

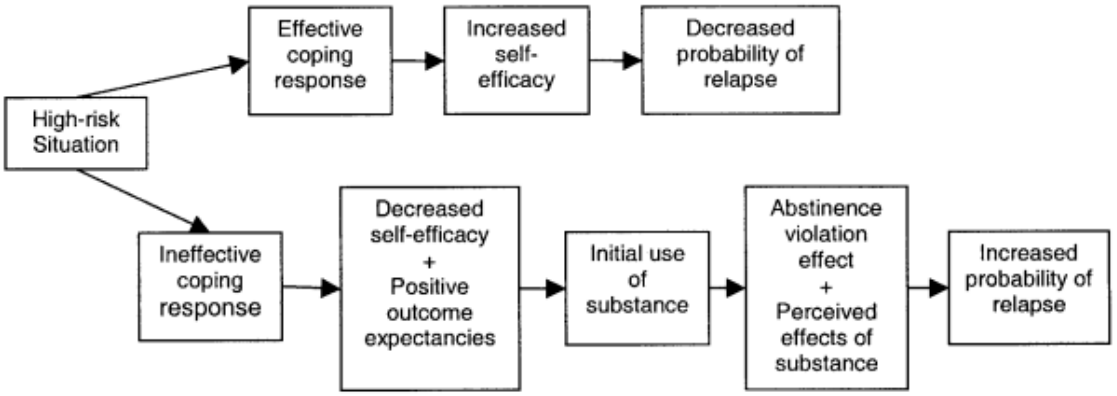

Figure 2: Cognitive-Behavioural Model of Relapse
Source: Witkiewitz and Marlatt, 2004, pp. 225.

This led Marlatt and Witkiewitz (2004) to develop the dynamic model of relapse which focuses on the interrelationships between dispositions, contexts and experiences, reconceptualising relapse as a multidimensional and multicausal system. In the model, a person's distal risks, such as family history and social support, are defined as their predisposed vulnerability to experience a lapse in their recovery. Proximal risks, such as self-efficacy and motivation, are added factors which then help to realise the probability of a lapse. These risks are situated within tonic processes and phasic responses. Tonic processes signify an individual's chronic vulnerabilities which can build up and lead to a relapse, whereas phasic responses are an individual's situational experiences which have the possibility to change their substance use behaviour. Witkiewitz and Marlatt (2004) outline several studies which have demonstrated this model as self-efficacy (a tonic process) has been found to predict lapses, while the daily variation in self-efficacy (a phasic response) can predict an individual's progression from a lapse to a relapse. Therefore it is clear that a lapse or relapse is far more complex than we may think as the dynamic interaction between these various factors can direct an individual into a high-risk situation. Any seemingly unimportant changes in the life of an individual in recovery has the possibility of igniting a multitude of triggers and their consequences. It is imperative that we at The Acres recognise the complexity of this issue when constructing our relapse prevention strategies.

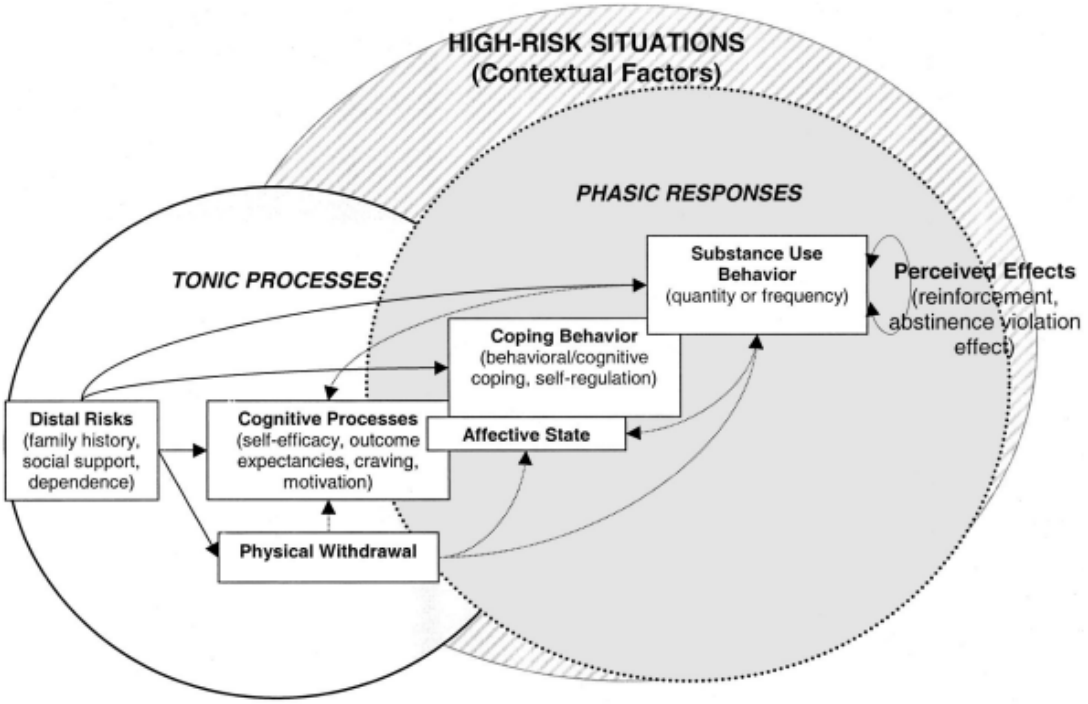

Figure 3: Dynamic Model of Relapse
Source: Witkiewitz and Marlatt, 2004, pp. 230.

A further consideration for RPT mentioned in many studies is that the experience of deprivation may compel a recovering substance user to try to fill the void the best way they know how, their substance (Melemis, 2015). The following acronym spells out the five most common emotions associated with deprivation which we should keep a close eye on as they may ignite a lapse/relapse:

B – Boredom
H - Hunger
A - Anger
L - Loneliness
T - Tiredness

This acronym signifies a cluster of emotions which a person in recovery may mistake as an urge to use their substance. When hungry and sleep deprived a person's judgement and sense of impulse control may be impaired, increasing the likelihood that they will fail to respond effectively to an external trigger (Melemis, 2015). Boredom, anger and loneliness then are common triggers for anxiety for any sober person, a feeling that can be magnified for substance users, with boredom being a deprivation of engagement, anger of understanding

and loneliness of engagement and often love (Melemis, 2015). For a substance user their substance is often used as a tool to combat those feelings of deprivation. However, it is not only negative feelings which can trigger relapse. Any feeling in an extremity can lead to a relapse. For instance, extreme happiness could trigger a recovering person to want to experience even greater levels of pleasure such as when they used a substance (Osten and Switzer, 2013). Learning how to work through these feelings in healthy ways with fun sober activities is a crucial step needed in a person's recovery. We need to work with our members at The Acres to determine their threshold tolerance, which can be monitored and adjusted in accordance with recovery progress and different life stressors. This is why it is crucial that we build trust with our members at The Acres so that they may feel comfortable to openly and honestly discuss their feelings with us. When they confide in us that they are feeling an urge to use a substance we need to implore them to reflect on whether they are actually feeling this urge, or are they misinterpreting their need for something else.

But what are the benefits of RPT and has it been found to work? Studies suggest there is the existence of a lapse-relapse learning curve in RPT (Witkiewitz and Marlatt, 2004). In the findings there was a higher chance of a lapse immediately following treatment, but developments in coping skills developed in RPT then decrease the probability of a relapse over time. RPT seems to provide continued improvement over a longer period of time, whereas other treatments may only be effective during a shorter time period (Witkiewitz and Marlatt, 2004). Ultimately RPT requires hard work, but the benefits are long-lasting.

One final point I would like to stress is the importance of keeping close ties with our wider community, its facilities and services in our approach to support our members at The Acres who may be in substance use recovery. For example, successful opioid substitution therapies have been developed for those who are recovering from heroin, oxycodone, oxycontin and morphine use. Studies suggest such therapies have reduced illicit opioid use, HIV risk behaviours, criminal activity and opioid related deaths (Logan and Marlatt, 2010). Although Canada is currently experiencing an opioid crisis and opioid use should not be encouraged, these therapies have been found to provide a less harmful substitution which can be used under medical supervision to ween an individual off more harmful drugs. These therapies remain controversial however, and are currently under strict governmental regulation, which limits our availability.

Needle and syringe exchange programmes have been developed to reduce the spread of blood-borne diseases among injective drug users. In terms of effectiveness, a review of 45 studies from 1989 to 2002 concluded that these programmes are effective, safe and cost effective, with no evidence of any harmful effects (Logan and Marlatt, 2010). More recently safe injecting facilities have been introduced where an individual can bring their own drugs and are then provided with clean equipment, medical supervision and a safe way of disposing of their drug paraphernalia. Similarly, over 25 studies have been published highlighting the success of these facilities. The reports have documented significant reductions in needle sharing and reuse, overdoses, injecting/discarding needles in public spaces, fatalities due to overdose and interestingly an increase in enrolment levels in detoxification programmes and other therapies (Logan and Marlatt, 2010). Although controversial, research suggests reduced harms to both individuals and communities. As previously mentioned, a lapse which may lead to a relapse is highly probable for recovering substance users. Therefore I would argue that these services should be highlighted with our members at The Acres to prepare them in the event of a relapse, ensuring they are aware of harm reduced methods of substance use. Ultimately substance use is inevitable for some people and we need to take a humanitarian approach to this issue.

In conclusion of this section I would like to stress the importance of reconstructing our understanding of the relapse. By framing a relapse as a "failure" we only add to the likelihood of future relapses. The implementation of a HRT and RPT approach would allow us to assess the situation of individual members and set goals without withholding our support if these goals are not met. It is integral that we promote open and non-judgemental conversation in order to identify triggers, develop coping mechanisms and re-envision the relapse as an opportunity for further learning. By keeping close ties with our local services in Edmonton we could recommend members if they experience a major relapse in their recovery. This way they can get the help they need which we may not be qualified to give, without compromising the sobriety and possibly the safety of other members and staff.

As previously mentioned however, loneliness and isolation can trigger relapse or be damaging for an individual's mental health. Therefore I would argue that it is vital that we do not to make any members at The Acres who have experienced a relapse feel excluded from their community. Perhaps we can continue to have group check ins and meetings where members who are undergoing treatment or actively using drugs are invited, but only under

the mutual agreement that active substance use is prohibited on site. This way all members can remain involved in the community while the sobriety of others is respected. Before any meeting however, it is vital that all members are first assessed. We would need to discuss with each member whether they feel comfortable or stable enough in their recovery to engage with members who may have resumed substance use. People who use substances, places where substances can be purchased or used, as well as substance paraphernalia and substances themselves are all listed as common triggers in inciting a relapse. Due to this it would be impossible to house active substance users and those in recovery simultaneously at The Acres, which Leonie will develop on further in the following section. We should always bear in mind that no two stories are the same. In sum, relapse should be normalised as a common aspect of recovery and if a member at The Acres has a relapse and leaves, but then chooses to come back and agrees to stop actively using on site we should welcome them back without any reservations, even if they are not prepared to completely cut out their substance use in general.

Raising the question: Can we accommodate active drug users at The Acres?

In the previous sections we have examined normative understandings of relapse and explored possibilities of providing harm reductive support to those who have relapsed and wish to recover. In this section, I elaborate on whether we can provide support to individuals who actively use substances at The Acres and wish to continue doing so. I am student volunteer from Germany working remotely to support Lady Flower Gardens and The Acres project. I first got in contact with Kelly from Lady Flower Gardens through a cooperation of my German University with the University of Alberta. When she told me about their plans for The Acres, the idea resonated deeply with me. In recent years I have learnt to appreciate the power of grassroots organisations. Too often, we look for a quick and easy fix for a problem. The issue with this approach is that it does not tackle the root cause of the problem, it only treats the symptoms. The word “root“ derives from the Latin word “radix“ which is why the English word “radical“ means to tackle a problem at its root. This is exactly what grassroot organisations do. A grassroot organisation needs creative minds and passionate people that are committed to the cause of tackling the root cause of the problem. With substance use, there are plenty of causes that can cause people to start using substances or to relapse, for instance temptation by mates, seeking pleasure, well off living, mental stress, irritation,

demoralisation, family conflicts, unemployment, feeling distrusted by the family, lack of care or love from the family, and discrimination (Wang and Wang 2007).

The aim of this project is to minimise those triggers by providing a safe, non-judgmental environment for substance users. Edmonton, like many places in this globalised world, is a diverse city with people who have made very different life experiences for various reasons. It can be challenging to feel connected or to reach out to people with a different background when the Western world has made us internalise the naturalisation and essentialisation of the colour of our skin, our sexual orientation, our bodies or our socio-economic background. I feel that for this reason, it makes a lot of sense that The Acres is working with the concept of "Mutual Aid" by Dean Spade (2020), which makes a suitable framework for the project. In the concept of Mutual Aid, people from one community support one another no matter their backgrounds. Spade (2020:33) proposes that communities should support the most marginalised "through collective action rather than waiting for saviours". He offers three tools that can be used to transform a community into a supportive network, which was elaborated on page 11 in the governance section of The Acres report. Using the concept of Mutual Aid, the Edmonton community at The Acres could grow and learn how to share one space in peace and with respect for each other, but also learn to value our differences and understand what it means to love and support one another despite and maybe even because of our differences. At The Acres, this can be made possible through the connecting link that is the land that is shared and cultivated by all residents who then come together as a community.

Experiences made by Edmonton residents can include having been to prison or to a psych ward. There are also people who are drug users. Some of them stopped using, some of them want to stop using and some of them want to continue using. As difficult as it can be watching a friend or a family member using because there can be harmful consequences for themselves and sometimes others, it is their body, their life and therefore their decision which is a lesson that we all need to learn. As mentioned earlier, The Acres tries to tackle the root causes of the problems and the problem is not the substance user or the substance itself, but the way that society looks at this issue and the way we choose to deal with it. What I mean by this becomes clear when we look at the three main features that constitute the philosophy behind harm reduction as outlined by Bierness (2008): *Pragmatism* means that we recognise that substance use is inevitable in a society. Therefore, it is necessary that we make a joint effort to minimise potential harms. We need to establish *Humane Values* in this community

where the individual choice is considered and people who decide to keep using substances are not being judged. The dignity of those who use is respected. Thus, we need to *Focus On Harms*: An individual's substance use is a secondary concern to the potential harms that may result in that use. The concept of harm reduction is not new. We use harm reduction measures every day, not only in the context of substance use. Harm reduction also means using a helmet when cycling or a seatbelt when driving. It is a practice that we use to minimise risk (Bierness 2008). To summarise, substance use is inevitable in a society, and addictive behaviour is more common than we think. But the consequences of the use differ and therefore different harm reduction measures must be taken.

As a conclusion, we need to start a conversation about what we can do as a community to support not only those who have stopped using drugs, or those who have relapsed after going through recovery, but also those who made the choice to keep using drugs. It goes without saying that the same type of harm reduction cannot be used for everybody. Where recovered individuals can benefit from care and support from their family and society, employment assistance and changing their living environment, an individual that is actively using substances would have different needs. We might even go as far as saying that their needs interfere and are not easily reconciled. Changing a recovering user's living environment for example usually involves taking them away from people who are using substances, as one of the main causes for relapse is temptation by their mates (Wang and Wang 2007). As we could not find any studies of communities where active substance users have been living together with abstinent users, it is challenging to think about how this could be made possible. While brainstorming with my peers we had the idea to create areas where drugs can be used, but not in the communal spaces. The aim is to keep them as part of the community, so another idea was to have regular meetings where people check in with one another in order to keep the communication open. To create a structure to these meetings, a peer support programme could be established within The Acres, where non-substance users are trained to check in with substance users. This way, those who are in potential danger of relapsing themselves might not come into interaction with active users while they are not sober. Of course, community events would need to be attended sober, so no one is exposed to any potential risks.

The issue with this, we discussed, is that those who are actively using substances can still put other community members into danger or trigger abstinent users to relapse when they

interact. Schiffer et. al (2011) conducted a study showing that substance use disorders in men can cause structural brain alterations that are associated with violent behaviour. While still aiming to fight stigmatisation of substance users, we do have to face the fact that substance use does change a person's behaviour and they might engage in activities that they would not engage in when they are sober. This can potentially harm another person, especially those who made the choice to recover. While we must respect the choice they made and trust in their ability to judge what is the most effective for them to reduce harm, we also need to consider the needs of those individuals that come to interact with them. Where one individual's life choice is putting other peoples' lives at risk, it seems that the individual needs to be removed from this community, for we cannot risk an entire community's safety for the well-being of one person. It does not seem right to pull away the support from this person as they are just as deserving of love and support as everyone else and the question raised in this section is - as it seems - a moral dilemma. But how can this dilemma be resolved?

I might not be able to give an easy answer, or any clear answer, to this question today. However, we should not shy away from dealing with questions that are difficult to answer, as those type of questions are sometimes the ones that need to be discussed most. Sometimes, we need to be able to withstand the urge of finding a quick answer and endure the feeling of not knowing what to do. In this case, a decision needs to be made and since there seems to be no research to show that including active substance users in a project like this can work without putting others at risk, it seems to be the solution for now not to include them into this community for the safety of the community. As this decision is based on preliminary discussions and is only as informed as it can be at this point in time, I want to emphasise that further research is needed on policies for communities with active and inactive substance users. Ultimately, we still need to keep in mind that not including a person who is using substances can have serious consequences for them. We shall not forget about them. This paper is not offering a solution, but it is an exploration of where to go, and raising awareness of this issue that needs a solution. Luckily, this growing grassroots community has plenty of creative minds that are working towards finding a solution for this problem. Tremendous things can be achieved when we unite.

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