



**BC Centre for Disease Control**  
An agency of the Provincial Health Services Authority

655 West 12th Avenue  
Vancouver, BC V5Z 4R4  
Tel 604.707.2400  
Fax 604.707.2441

[www.bccdc.ca](http://www.bccdc.ca)

# BC Overdose Prevention Services Guide

2017

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## 1.0 ACKNOWLEDGMENTS

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### **The Guidelines Committee is comprised of the following individuals:**

Cheryl Prescott, Senior Practice Leader, Clinical Prevention Services, BCCDC

Meaghan Thumath, Senior Practice Leader, PHSA HIV Program, BCCDC

Monica Durigon, Nurse Educator, Clinical Prevention Services, BCCDC

Dr. Marcus Lem, Senior Medical Advisor, Addiction and Overdose Prevention Policy, BCCDC

Dr. Jane Buxton, Epidemiologist and Harm Reduction Lead, BCCDC

Dr. Mark Tyndall, Executive Medical Director, BCCDC

The Guidelines Committee would like to gratefully acknowledge the following groups and individuals:

### **Contributors:**

Danielle Cousineau, (Interim) Clinical Practice Leader, Primary Care, Vancouver Coastal Health

Sally Kupp, Clinical Educator, Community Health, Prevention, Vancouver Coastal Health

Sara Kathryn Young, Harm Reduction Coordinator, Mental Health & Substance Use, Vancouver Coastal Health

Lindsay Bendickson, Practice Initiatives Lead, Professional Practice, Vancouver Coastal Health

Barb Lawrie, Vice President, Professional Practice and Chief Clinical Information Officer, Vancouver Coastal Health

Shannon Riley, Project Manager Illicit Drug Overdose Response, Prevention, Vancouver Coastal Health

Tim Gauthier, Clinical Coordinator, Insite and Onsite, Vancouver Coastal Health

Miranda Compton, Regional Director, Prevention, Vancouver Coastal Health

Coco Culbertson, Senior Manager of Programs, PHS Community Services Society

Russ Maynard, Research and Policy Manager, PHS Community Services Society

Dr. Christy Sutherland, Medical Director, PHS Community Services Society

Dr. William Dick, Vice President Medical Programs, B.C. Emergency Health Services

Dr. Bernie Pauly, Associate Professor, School of Nursing, University of Victoria

Jordan Westfall, President, Canadian Association of People Who Use Drugs

Jack Phillips, Society of Living Illicit Drug Users

Daniel Benson Maple Overdose Prevention Site

Sue Oullette Maple Overdose Prevention Site

Lana Fox, Mobile Response Team Coordinator, Provincial Health Services Authority

**Reviewers:**

BC Supervised Consumptions Services and Drug Checking Task Group:

Sophie Bannar-Martin, Manager STOP HIV, Blood Borne Diseases & Harm Reduction, Vancouver Island Health Authority

Carl Swanson, Manager, Communicable Disease Control, Vancouver Island Health Authority

Kathleen Perkin, Manager, Harm Reduction Policy, BC Ministry of Health

Dr. Shannon McDonald, Deputy Chief Medical Officer, First Nations Health Authority

Tonia Enger, Executive Director of Law Enforcement, BC Ministry of Public Safety and Solicitor General

Dr. Mark Lysyshyn, Medical Health Officer, Vancouver Coastal Health

Dave Attfeld, Superintendent of Operations, Surrey, Royal Canadian Mounted Police

Dr. Andrew Gray, Medical Health Officer, Northern Health Authority

Christopher Buchner, Director of Clinical Operations, Population and Public Health, Fraser Health Authority

Corrie Campbell, Director, Legislative Initiatives and Police Accountability, BC Ministry of Public Safety and Solicitor General

Dr. Thomas Kerr, Associate Director of the BC Centre on Substance Use (BCCSU) and Director of Research

Shannon Tucker, Manager, Office of Crime Reduction and Gang Outreach, BC Ministry of Public Safety and Solicitor General

Corinne Dolman, Practice Lead, Interior Health Authority

Rae Samson, Manager Mental health and Substance Use, Interior Health Authority

Dr. Silvina Mema, Medical Health Office, Interior Health Authority

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Eric Boechler, Clandestine Lab Enforcement and Response Team, E Division, Royal Canadian Mounted Police

Conor King, Staff Sgt., Victoria Police Department

## 2.0 INTRODUCTION

### 2.1 Overview of OPS Protocol and Resources

This guideline is intended for service providers and Public Health practitioners offering overdose prevention services (OPS) in the community. OPS were initiated by the BC Minister of Health in Dec. 2016 due to increasing mortality from illicit drug overdoses. While this document provides guidance for the majority of circumstances service providers and practitioners may encounter, knowledge and practice are always evolving and you are encouraged to connect regularly with your local Harm Reduction Program leads and Medical Health Officers. Although there may be overlap between OPS and Supervised Injection/Consumption Services (SIS/SCS), a separate provincial guideline has been produced and should be referred to by SIS/SCS sites approved by Health Canada.

The guidance in this document primarily concerns and references injection drug use, however the authors recognize that clients may prefer to use drugs in other ways. Consequently, the guideline may also be applied to clients who ingest their drugs orally (i.e. swallow) or nasally (i.e. snort).

The guideline does not cover opioid smoking. Although law enforcement follows trends in the chemical composition of illicit drugs and their cutting agents, very little is known about what chemical by-products are produced when these drugs are burned, or their effects on health. Also, unlike injecting, swallowing or snorting, smoking illicit drugs will release these unknown chemicals into the air. For this reason drug smoking should only be permitted outside, and not within the enclosed space of an OPS. In non-emergency situations where clients are smoking drugs inside, they should be told to open the windows and staff should allow the room to clear of smoke before entering.

OPS provide designated spaces for the purpose of monitoring people who use drugs for signs of an overdose. This permits rapid intervention if an overdose occurs to prevent brain injury and death. For an overview of OPS protocols and service recommendations, see Appendix A: Overdose Prevention & Response Protocol Recommendations for Service Providers (Vancouver Coastal Health and Fraser Health, 2016). For guidelines and resources for OPS within supportive housing and homeless shelters, see Appendix B: Guidelines and Resources for Supportive Housing Providers, Homeless Shelter Providers and Regional Health Authorities on Overdose Prevention and Response.

## **2.2 Key Elements in Overdose Prevention**

Key elements in preventing deaths from overdose are:

- (1) educating and encouraging people not to use drugs alone;
- (2) ensuring that individuals monitoring people who use drugs are willing and able to provide or call for assistance;
- (3) ensuring that naloxone and other life-saving first aid are available quickly in the event of an overdose.

Key elements in preventing deaths from overdose may be achieved by:

- providing education to residents and clients about overdose risk and how to reduce it;
- encouraging people residing in shelters and housing to ask staff or peers to periodically check in on them;
- providing residents with a designated space within the shelter or housing facility where they can be monitored while using drugs
- providing harm reduction and first aid supplies, including naloxone, in designated spaces and anywhere else there may need to be access to them;
- training staff, and possibly interested peers (persons with past or present experience with injection drug use) and/or volunteers, to monitor a designated space and respond to an overdose;
- arranging for visits by health care providers to provide supplies, advice, and support to staff and residents.
- providing referrals to health and social supports, including addiction treatment and primary care.

### **3.0 PURPOSE**

This document outlines principles, protocols, training and related supplies to enable teams of peers, lay staff and health care workers to provide a space designated for overdose (OD) prevention. Such a designated space may be integrated into an already existing social service or health care setting or may be in a newly established location.

## 4.0 BACKGROUND

### 4.1 Epidemiology

British Columbia is in the midst of a drug overdose crisis due to illicit opioids. According to the BC Coroners Service, there were more than 930 apparent illicit drug overdose deaths in BC from Jan. 1 to Dec. 31, 2016. This compares to 518 in 2015, an increase of 79.2%. In December 2016, there were 142 illicit drug overdose deaths: the highest monthly mortality number in provincial history and more than double the average monthly number since 2015 (59).

89.9% of illicit drug overdoses in 2016 occurred inside (61.3% private residences, 28.7% other inside locations), 9.2% occurred outside in vehicles, sidewalks, streets, parks, etc., and 0.9% had an unknown injury location (BC Coroners Service – Illicit Drug Overdose Deaths in BC, January 1, 2007 - December 31, 2016).

### 4.2 Legislation and Regulation

On April 14, 2016, the BC Provincial Health Officer declared a Public Health emergency under the *Public Health Act* in response to increasing overdoses and overdose deaths.

Health Canada revised the Federal Prescription Drug List on March 22, 2016 to make naloxone more accessible to Canadians in support of efforts to address the growing number of opioid overdoses. In September 2016, the College of Pharmacists of British Columbia changed the scheduling of emergency use naloxone from Schedule II to unscheduled to increase accessibility. Consequently, naloxone can be made available for sale/purchase anywhere. Consequently, the *Health Professions General Regulation* under the *Health Professions Act* was amended to enable any person in a community or acute care setting to administer naloxone and first aid to another person if they suspect that person is suffering from an opioid overdose.

On December 8, 2016 Overdose Prevention Services (OPS) opened as part of the provincial response to the opioid overdose (OD) emergency as ordered by the BC Minister of Health. The Health Minister of British Columbia enacted the ministerial order under the *Health Emergency Services Act* and *Health Authorities Act* to support the development of overdose prevention services. The minister has the authority to take such measures in the face of a public health emergency. The order was enacted on the advice of provincial health officer and will last for the duration of the Public Health emergency. The order gives BC Emergency Health Services and regional health authorities the ability to provide overdose prevention services as necessary on an emergency basis. It is the responsibility of each individual health authority to assess the need in their region and provide such emergency services in a manner consistent with federal legislation.

### 4.3 Health and Social Issues

Injection drug use may be associated with an array of severe health and social harms for people who inject drugs (PWID), as well as their families and their communities. This guideline supports low barrier service for PWID who often have experienced significant trauma, pain, stigma and discrimination due to drug use and other structural conditions. Many also struggle with mental health issues and may use drugs to self-medicate. Stigmatizing and/or criminalizing PWID contributes to the crisis by pushing people into more isolated situations where they are less likely to seek assistance and work to remain invisible during injection and/or receive help.

High rates of overdose, disease, and death in PWID, and the accompanying costs are critical and concerning indicators of drug-related harms in society. Providing services to help deal with the underlying traumas and challenges facing PWID is an important part of the provincial response.

## 5.0 GOALS, OBJECTIVES AND PRINCIPLES

### 5.1 Goals and Objectives

Aside from drug overdose, harms associated with injection drug use may include skin abscesses, transmission of HIV and hepatitis C, blood-borne infections (BBI), excess morbidity and mortality for PWID, stigmatization of PWID and exacerbated mental health issues.

**Goal.** The primary goal of OPS is to provide a space for people to use previously obtained drugs, with sterile equipment (in the case of injection drug use), in a setting where trained staff or volunteers are present and able to respond to overdoses as needed.

**Objectives.** The following objectives support OPS in attaining the overall goal of reducing harms associated with injection drug use:

- Provide space for PWID under the supervision of trained staff or volunteers trained to intervene in overdose
- Increase appropriate use of health and social services by PWID
- Reduce health, social, legal, and incarceration costs associated with drug use
- Create opportunities to work with PWID to build trusting relationships and facilitate stabilizing their lives
- Enhancing/supporting peer networks and the peer workforce as part of community capacity building

### 5.2 Principles

#### 5.2.1 Harm Reduction

Harm reduction is based on a strong commitment to public health and human rights with a primary aim of reducing the adverse health, social and economic consequences of using illegal drugs. OPS aim to reduce harms associated with injection drug use and promote health for PWID through:

- Reducing the number of overdose deaths
- Provision of Harm Reduction supplies to reduce transmission of blood-borne infections, endocarditis, and sepsis
- Increased access to low barrier services for PWID
- Increased referral pathways to local services
- Increased opportunity for peer support networks and peer participation

#### 5.2.2 Improved Population Health

OPS improves overall population health through increased community capacity to adequately respond to the current overdose crisis in BC and through providing a point of access to harm reduction services, primary care and/or referral to treatment based services for PWID.

#### 5.2.3 Integrated Services

OPS are uniquely positioned as a low barrier point of entry into health and or social services for PWID.

## **6.0 CORE SERVICES**

Overdose prevention services (OPS) are generally seen as an intensive intervention along the continuum of harm reduction services for extremely marginalized populations. OPS should be low barrier, person-centered and offer a trauma-informed, culturally safe and supportive environment. Abstinence may or may not be a goal for participants accessing the service. Aside from overdose prevention, OPS can also provide referral pathways for participants who wish to access services related to opioid use and/or other health or related social issues.

Core services of OPS Include:

- Provision of a designated monitored space for injection drug use
- Intervention for drug overdoses
- Harm reduction teaching, training and referral services
- Provision of Harm Reduction supplies (e.g. sterile needles, filters, cookers, condoms, etc.)

## 7.0 SERVICE PROVIDERS

### 7.1 Guiding Principles for Service Providers

OPS models will vary across BC depending on the environment and context. An institutionalized, 'one size fits all' approach is not appropriate for participant-centered, trauma-informed and culturally responsive services, and a tailored approach may be required which enables a wide variety of people who are vulnerable to overdoses and other harms of injection drug use to access services.

In some regions, service providers have found that minimizing signage and rules typically found within established supervised injection sites has improved access to overdose prevention for those most highly marginalized by injection drug use. Providers have found that by allowing people who use drugs to contribute to rules and culture, they experience fewer incidents of aggressive behavior and better staff-client relationships than in more formal health care settings.

#### 7.1.1 Relationship Building

Relationship building is an ongoing process. The act of monitoring drug consumption and responding to overdoses involves service providers in an intimate aspect of the client's life. The following qualities in staff and volunteers can significantly contribute to building trust with clients:

- Sensitivity and a working knowledge and understanding of the client population and local community
- Capacity to accept and respect the population
- Self-awareness, an open mind and the ability and willingness to reflect on one's own triggers, boundaries
- An ability to accept that all people make progress in their own way and at their own time
- A capacity for empathy
- An ability to 'back-off' and disengage should an intervention not be successful or welcomed
- A willingness to work as a team, and try different approaches when current ones are not working
- A sense of humor
- Good personal support networks and habits of self-care

#### 7.1.2 Professionalism

Service providers, whether staff or volunteers, should conduct themselves in a professional and respectful manner as they represent OPS within the community at large. Discrimination or harassment of any form should not be tolerated. Regulated services providers should adhere to their regulatory professional and practice standards.

Established codes of conduct for services providers offer a framework for professional work behavior. Conflict between service providers should be initially addressed by the parties involved in a respectful/professional manner. If an agreed upon solution cannot be met, support and advice should be sought from their management representative.

### 7.1.3 Confidentiality

Service providers, including volunteers and peers, should receive basic training in confidentiality and sign a confidentiality agreement (See Appendix C: *Service Provider Confidentiality Agreement Template*). The following are fundamental aspects of maintaining confidentiality when providing OPS:

- All participant information obtained by while working at the OPS is confidential.
- Because many OPS are often set up as a “one room” model, there may not be a separate area to have sensitive discussions. Take extra precaution to maintain participant confidentiality.
- Any information discussed on site, in staff meetings, during debriefing or in communication systems must remain confidential.

### 7.1.4 Responsibility/Accountability

Services providers act as role models and may be peers, volunteers and/or health professionals. Service providers and employers are responsible for ensuring appropriate training and/or professional designation of staff, or volunteers, in relation to the duties they may be carrying out (e.g. proper training for rescue breathing supported by bag/valve masks and oxygen, if available, vs. general rescue breathing with face masks). See Appendix D: Key Responsibilities for OPS Service Providers.

## 7.2 Documentation/Data Collection

Documentation is a crucial component for all OPS in BC in order to: 1) evaluate the impact and effectiveness of these programs; and 2) to meet regulatory standards for documentation and professional accountability. See Appendix E: *Required Documentation and OPS Intake Templates*:

- User Agreement/Release Form (1<sup>st</sup> visit only)
- OPS: Release of Responsibility Waiver (1<sup>st</sup> visit only)
- Visit and Overdose Log
- Youth Registration and Assessment (completed with every new intake)
- Overdose Prevention Sites Core Data Elements for Overdose Incident

## 7.3 Support for OPS Service Providers

Provision of OPS requires particular attention to the mental health and wellness of staff. Attendance to repeated overdoses, sometimes several during the same shift, can be traumatic. OPS provided by workers with experiential knowledge of drug use (peers) may face additional stresses given they are often working within their own community, often witnessing high overdose and mortality rates among their friends and family. See Appendix F: Support for Peers Providing Overdose Prevention and Response Services

## 8.0 SERVICE DELIVERY

The recommended service provider to participant ratio is 1:2. The maximum number of participants in the OPS at one time is determined by the number of tables for injection and service providers onsite. Staffing should take into consideration allowances for service providers' time to debrief and take breaks during their shift if required or when indicated. Ideally participants should also be monitored post injection in a nearby location.

For an overview of the recommended training, protocols, prevention and follow up for OPS, See Appendix A: *Overdose Prevention & Response Protocol Recommendations for Service Providers* ([VCH] & [FHA], 2016).

### Local Law Enforcement

Criminalization of drug use is inconsistent with the goals of OPS since OPS focuses on drug use as a health issue. The key is to ensure that people feel safe to access OPS and are not targeted or subjected to increased criminalization by police or security because of using services. This will create distrust and potentially increase mortality by driving people to use in hidden spaces and alone. Public order outside of OPS sites can be maintained without use of police or increased security measures such as paid security. Staff, particularly peer staff, can be employed to provide support to those leaving and entering the site. As well, service users often can be consulted and provide advice on strategies that will assist with management of the site that is both safe and acceptable to users, service providers and neighbors. See appendix Q for additional information.

## 8.1 Participant Profile

In order to maintain low-barrier service provision, personal information including contact information is not required for access to OPS. OPS participants may choose or be given a unique identifier and confidentiality will be maintained at all times. For youth who are assessed at significant risk, the *Child, Family and Community Services Act* supersedes participant confidentiality (see Appendix J: Participants with Special Circumstances).

### 8.1.1 Participant Codes of Conduct

Statements of participant rights, responsibilities and codes of conduct should be clearly outlined and posted so they are visible to everyone accessing the site (See Appendix G: *Participant Rights and Codes of Conduct*).

### 8.1.2 Management of Specific Behaviors

- Aggressive behavior can result from agitation, frustration, or anxiety related to the physical and mental side effects of illicit drug use, and/or experiences of homelessness, poverty, criminalization, and marginalization.
- An appropriate service provider response requires a caring, respectful manner and the provision of a quiet space when possible to lower levels of anxiety and prevent behavior escalation.
- Participant perception of judgemental behavior or strict rule enforcement may incite aggressive behavior.
- Service providers who have lived experience (Peers), the availability of food, drink and a warm dry place to relax post injection offers extra comfort which can minimize the potential for aggression.
- Participant rights, responsibilities and codes of conduct should be made available/visible to everyone accessing the site (See Appendix G: *Participant Rights and Codes of Conduct* [INSITE, 2016]).

For further recommendations see Appendix H *Management of Specific Participant Behaviors*)

### 8.1.3 Eligibility for OPS Access

To ensure the safety of everyone in the OPS, service providers must retain the authority to refuse entry and request ineligible participants to leave. It is recommended that staff consult with management before initiating a longer-term participant ban. Any use of bans should be appropriate to the behavior and employed beginning with least restrictive means. Service providers should be particularly sensitive that bans which restrict use of OPS should be avoided to prevent deaths. For example, use of substances in other agency locations such as washrooms should not result in ban from agency but rather redirecting people to appropriate sites for use. A goal of the OPS should always be to protect access for highly marginalized people, many of whom may exhibit challenging behaviors due to mental illness, pain or intoxication (See Appendix I: *Prohibition from Accessing OPS*).

**Eligible: The following criteria indicate participants as *eligible* to access OPS when they are:**

- Willing to sign the User Agreements and Waiver Release (site specific)
- Willing to adhere to the OPS Code of Conduct
- Not exhibiting overly aggressive behavior
- Not previously prohibited from entering the site
- Aged at least 16 years or over, or a mature minor capable of providing informed consent to their own health care as per the *Infants Act*
- Not using injection drugs for the first time and between the ages of 16-19 years

**Ineligible: The following criteria indicate participants as *ineligible* to access OPS when they are:**

- Immature minor incapable of consenting to their own health care (*Infants Act*)
- Under the age of 19 and no previous history of injection drug use (IDU). Overdose prevention services are generally seen as an intensive intervention along the continuum of harm reduction services for extremely marginalized populations. Youth who do not have a history of IDU should access resources that can more appropriately address their level of need.

Participants assessed as *ineligible* to use the OPS will be asked respectfully to leave the OPS.

Reasons for Service Refusal to Eligible Participants.

People may be politely denied admittance even when eligible if:

- They have no intention of using drugs on the premises
- The site is full

## 8.2 Prohibition from OPS

Prohibition occurs when participants are declined access to the service for an identified amount of time and should occur as a last resort. Service providers should be aware that prohibition from OPS should be avoided to prevent deaths. Participants who are initially assessed as eligible to use the service are subsequently refused access for various reasons (usually related to consistent refusal to follow established codes of conduct).

The decision to prohibit a participant from accessing OPS lies with the site supervisor and is often specific and temporary. (See Appendix I: *Prohibition from Accessing OPS*).

### **8.3 OPS Access for Participants with Special Circumstances**

The following individuals are considered as requiring specific considerations when seeking access to OPS.

- Youth
- Overly intoxicated
- First time using injection drugs
- Pregnant
- Non-Self Injectors

See Appendix J: Participants with Special Circumstances: Access to OPS.

## 8.4 Injection Services

### 8.4.1 Key Concepts

This section outlines key concepts to minimize the risk of needle stick injury and educate participants to safely prepare and then self-inject.

1. **Participants should self-inject where possible.**
2. **Service providers are not permitted to perform the venipuncture or administer the drug to the participant.**
3. **Unsafe injection of illegal substances is associated with:**
  - a. Blood-borne infections such as HIV and hepatitis C
  - b. Injection related infections
  - c. Death due to overdose
4. **Risk of potential harms can be reduced through:**
  - a. Health teaching and care by trained staff
  - b. Application of harm reduction philosophy and core principles of health promotion
  - c. Promoting participant empowerment/independence, especially in their injection practice
5. **Safe disposal of sharps including sharps containers is critical because:**
  - a. The main cause of HIV infection in occupational settings is via percutaneous (e.g. needle-stick) injury resulting in exposure to infected blood.
  - b. Research suggests that HIV infection is rare after a needle-stick injury, however infection of hepatitis B & C is much more easily transmitted through a needle.
  - c. Whether the risk of infection after a needle-stick injury is common or uncommon, this is understandably an issue of considerable concern for OPS service providers.
  - d. Use procedures laid out in this section to minimize chances of an accident related to needle-stick injury.

### 8.4.2 Physical Space

The space for monitoring drug consumption may vary depending on the size of the population being served and the resources of the organization. The following are recommended space attributes and equipment:

- The space should be warm and well-lit so that clients can easily inject
- Ventilation for OPS sites should meet the Canadian standard for air changes, which is dependent on occupancy. In most cases, one window or open door is sufficient for ventilation purposes. Please see Appendix K for further details on the standard.
- Mirrors may be strategically placed to facilitate monitoring and self-injection; or the site should provide portable mirrors for clients on request
- sharps disposals should be easily accessible for each client
- Table and chairs should have non-permeable, non-flammable surfaces, which can be easily cleaned with hospital grade cleaning supplies.
- Chairs may be positioned facing a wall so that the client has some privacy but is still accessible and able to be periodically monitored.
- There should be adequate space for staff or volunteers to perform naloxone administration and artificial respiration if necessary.
- The area should have a clear and open pathway to the entrance/exit should medical transport by emergency health services be required.

### 8.4.3 Equipment

Provide disposable trays for participants to collect equipment prior to proceeding to an injection booth. The following equipment should be available:

- Tourniquet
- Syringe 1cc or 0.5cc, sometimes called “rigs”. Choice in sizes varies and is a matter of personal preference.
- Sterile water for cooking
- Sterile cookers and filters (such as cotton) to filter the substance and reduce the amounts of harmful contaminants
- Alcohol swabs
- Gauze
- Band-Aids
- Ascorbic Acid (for breaking down crack cocaine)
- Sharps containers
- Cleaning supplies
- Fire extinguisher

Disposal systems for both bio hazardous waste and sharps should be easily accessible. Encourage participants to dispose of their own equipment.

#### 8.4.4 Safer Injection

The following practices significantly reduce the risk of needle stick injury to staff, participants or visitors to the OPS.

- Participant knowledge through education re: safe handling of injection equipment.
- Participants dispose of needles in appropriate containers.
- Staff clearly advises participants about the kind of containers they can and should use that are safe.
- When a service provider is supporting participants in injection procedures, the sharps container used should be provided by the OPS.
- Participants who use sharps outside of the OPS environment are instructed to put sharps in a heavy plastic or metal container with a secure lid.

OPS staff trained in safer injection techniques may offer education/guidance for participants. These activities are undertaken with extreme caution and carried out by trained staff. (See Appendix L: *Activities that Require Extreme Caution: Supporting Safer Injection*).

##### 8.4.4.1 Pre-Injection Assessment

Before the participant accesses the injection area:

- assess for participant safety
- assess the participant's ability to follow simple directions
- consider the participant's current state of mind
- assess whether the participant is currently prone to sudden or erratic movements
- request that the participant safely dispose of all used needles (reduce risk of needle stick injury)
- request that the participant places the rig to be used on the table
- offer the participant hand sanitizer or the option to wash their hands
- Consider the location of sharps container in relation to where the staff will be standing or sitting. Make sure staff is not in the path between participant and sharps container

Participants with history of injection drug-use may not require booth assistance and often serve as a valuable resource for safer injection practices.

\*If there is concern regarding safety based on the above assessment staff can inform supervisor and may choose to not engage in booth assistance, especially for activities listed in Appendix L: *Activities that Require Extreme Caution: Supporting Safer Injection*.

#### 8.4.4.2 Authorized Activities

Authorized Activities - Booth assistance by *trained* staff **if requested**:

- Verbally explain all steps in safer injection process (Harm Reduction Education).
- Palpate participant's arm for veins – land marking is an important part of vein care.
- Identify potential injection sites, including physically guiding participant's hand to the appropriate injection area.
- Encourage hand washing as a measure to prevent infection.
- Swab injection site with alcohol swab to reduce infection from unclean injection practices.
- Tie off participant's arm.
- Physically demonstrate all steps in safer injection process using separate set of clean equipment and own body (mock injection only).

Participants with substantive history of injection drug-use may not require booth assistance often serve as a valuable resource for safer injection practices.

#### 8.4.4.3 Jugular Self Injection (Jugging)

Jugular veins pose high risk of medical complications. If a participant insists on using this site to inject support the participant with the harm reduction education outlined in the protocol. (See Appendix M: *Injection into the Jugular Vein [Jugging]*).

## 8.5 Disposal of Injection Equipment

- After injecting, each participant disposes of their used injection supplies in the sharps container, which is readily accessible at each injecting station. Participants are asked to not bend or break off needles before disposal.
- OPS staff will supervise the disposal process.
- If needle pick-up is required – use tongs if available; if using hands wear industrial gloves (black rubber)
- The disposal containers should be puncture resistant plastic and not filled to more than three-quarter capacity.
- When three quarters full, the sharps disposal container should be sealed.
- The filled containers should be removed and placed in a large cardboard bin provided by a hazardous waste company (where available)
- All full sharps containers should be stored in a locked, non-service area.
- Needle disposal/pick-up should be arranged by the site supervisor
- Agencies are responsible for hazardous waste pick up: consult with the regional health authority.

## 8.6 Needle Distribution

Service providers should encourage all participants to stay and inject at the OPS; however, if participants intend to inject elsewhere, needle distribution should be provided. Needle distribution services include:

- Distribution of all supplies (e.g. cookers, sterile water) including syringes
- Education on safe disposal of injection equipment
- Extending access to whoever needs them, regardless of the person's age, substance-using status or choice of substance used. (see Appendix J: *Participants with Special Circumstances; Access to OPS* [re: Youth])
- Individuals should receive enough supplies (injection equipment) to enable a clean needle for each injection.

## 8.7 Secondary Health Problems Associated with Injection Drug Use

For information on common secondary health problems associated with injection drug use See Appendix N: *Secondary Health Problems Associated with Injection Drug Use*.

### 8.7.1 Referral for Substance Use Treatment Including Opioid Agonist Therapy

- Long term opioid agonist therapy including methadone, buprenorphine and other alternatives, are an evidence based overdose prevention strategy for people with opioid use disorder.
- OPS staff should familiarize themselves with local addiction treatment services and be able to refer clients to primary care and treatment supports as requested.

## 9.0 OVERDOSE

This section outlines information for recognition and response to drug overdose for both stimulants and opioids. All OPS staff should be trained to respond to an overdose.

### 9.1 Opioids: Background and stages of Intoxication

#### Background Information

Opioid drug class includes:

- Substances directly derived from the opium poppy (such as opium, morphine, and codeine),
- The semi-synthetic opioids (such as heroin), and
- The purely synthetic opioids (such as methadone and fentanyl).

Opioids affect central nervous system receptors. The pharmacological effects include sedation, respiratory depression and analgesia as well as intoxication and withdrawal. The time to peak blood concentration and half-life depends on the specific opioid in question and will affect the length of time to intoxication.

Commonly used opioids:

- Codeine
- Heroin
- Morphine
- Demerol
- Amileridine (Leritine)
- Methadone
- Hydromorphone (Dilaudid)
- Fentanyl
- Opium
- Pentayocine (Talwin)
- Percocet (Percodan)

Opioid intoxication symptoms:

- Depressed level of consciousness (LOC)
- Constricted pupils
- Decreased respiration,
- Gurgling, snoring
- Body is limp
- No response to noise or knuckles being rubbed firmly on the sternum
- Skin looks pale or blue, and feels cold
- Slow or no pulse
- Person cannot stay awake
- Pinpoint pupils
- Cannot talk or walk

Opioid withdrawal symptoms:

- Anxiety, irritability
- Dilated pupils
- Sweating
- Nausea/vomiting

**Stages of Opioid intoxication:**

| Stage  | Services Provider Response  |
|--|---|
| <b>One: Drowsy</b>   | <ul style="list-style-type: none"> <li>• Monitor Closely</li> </ul>   |
| <b>Two: Nodding</b> (intermittently falling asleep)                          | <ul style="list-style-type: none"> <li>• Remain calm, monitor – paying attention to respiratory rate/minute</li> <li>• May verbally check in with the participant – being mindful not to disrupt their experience</li> </ul>  |
| <b>Three: Nodding</b> with respiratory rate less than ten breaths per minute | <ul style="list-style-type: none"> <li>• Remain calm, attempt to wake participant</li> <li>• Gently shake and talk to participant</li> <li>• Get participant to open eyes</li> <li>• Get participant to talk</li> <li>• If responsive, assist to walk around</li> <li>• If available, may require oxygen</li> </ul> |
| <b>Four: Unresponsive</b>  | <b>Initiate Opioid Overdose Protocol</b>  |

### 9.1.1 Opioid Overdose Protocol (BCCDC, 2016)

Note: If oxygen or bag valve masks are available in your facility see Appendix O: *Protocol for providing Oxygen Therapy and Use of Bag Valve Masks*.

#### 1 Identify

- Before approaching MAKE SURE AREA IS SAFE- clear away any needles and put on gloves
- UNRESPONSIVE (doesn't respond to verbal stimulation [shouting their name] or pain. Tell them what you are going to do: nudge/touch them, then do sternal rub/pinch ear lobe/finger webbing)
- SLOW BREATHING (less than 1 breath every 5 seconds), may be snoring/gurgling
- Skin (may be pale or blue, especially lips and nail beds; may be cool or sweaty)
- Eyes (pinpoint (i.e. very small) pupils)

#### 2 Take Charge

DELEGATE the following Tasks (examples below, some can be done by 1 person, some may not be needed):

- (1) Phone 911
- (2) Rescue breathing
- (3) Meet emergency responders and direct them to the OD
- (4) Get overdose response supplies
- (5) Give naloxone
- (6) Crowd control

#### 3 Call 911

PHONE 911

- Say it is a medical emergency (not responsive not breathing) make sure ambulance is dispatched
- Give the address to the dispatchers
- Send someone to meet emergency responders at main entrance or street and direct them to the site of the overdose

#### 4 Rescue Breathing

- Clear mouth/airway & tilt head back
- You can use a breathing mask as a barrier
- PINCH NOSE and give 2 breaths
- Continue to give 1 BREATH EVERY 5 SECONDS (even after giving naloxone, until the person regains consciousness or paramedics arrive)

#### 5 Give Naloxone: If the person has not regained consciousness with rescue breathing.

- Swirl the ampoule, then snap the top off the ampoule (away from your body)
- Draw up all the naloxone in the ampoule (1 mL) into the VanishPoint syringe
- Inject entire dose at 90° STRAIGHT INTO A MUSCLE (THIGH, upper arm, butt) - can inject through clothes

#### 6 Evaluate

- WAIT 3-5 MINUTES to see if the person regains consciousness
- Don't forget to CONTINUE RESCUE BREATHING 1 breath every 5 seconds until the person is breathing on their own
- Give 40-50 breaths before deciding to give an additional dose of naloxone

#### 7 More Naloxone

- If there is no response after 3-5 minutes, GIVE A 2<sup>ND</sup> DOSE OF NALOXONE (as described above)
- WAIT 3-5 MINUTES - about 40 breaths (CONTINUE TO GIVE RESCUE BREATHS)
- Continue to give naloxone as described above every 3-5 minutes (while rescue breathing) until the person responds OR paramedics arrive

## **8 Document and Debrief**

- Tell paramedics about all emergency care provided (including # naloxone injections given)
- Fill out your organization's Critical Incident form and any other required paperwork
- Talk to your coworkers and/or site coordinator and/or site manager and/or access support through your employer (BCCDC, 2016)

### **9.1.2 Rescue breathing**

The greatest harm from opioid overdose is brain damage due to lack of oxygen. Rescue breathing is a critical component of an opioid overdose response.

In a witnessed overdose, it is very likely that the client's heart is still beating. Prioritizing giving breaths: the person is lacking oxygen due to depressed activity of the central nervous system. Breaths should be given every 3-5 seconds while preparing to administer naloxone AND approximately 30-40 breaths should be given between each injection of naloxone.

### 9.1.3 Oxygen Therapy and Bag Valve Masks (BVM)

Some OPS programs may have access to oxygen tanks or BVM supplies. For sites that do wish to provide oxygen the following guidance is offered. See Appendix O: *Protocol for providing Oxygen Therapy and Use of Bag Valve Masks*.

#### Background

- There is minimal published literature on oxygen use by laypeople in the outpatient setting and no known published studies on its utility in opioid overdoses in the community.
- Expert opinion, as outlined in the 2016 *Canadian Consensus Guidelines on First Aid and CPR*, allows for oxygen (O<sub>2</sub>) administration by trained first responders.
- There is expert agreement that provision of O<sub>2</sub> by lay people within the OPS context is appropriate. Some OPS have portable tanks of oxygen available for use in an emergency.
- Oxygen should only be used on people who are unconscious and whose oxygen saturation is less than 90%. This is to prevent the potential harm that oxygen can cause when given to someone who has an underlying respiratory illness.
- A person who is unconscious and showing a depressed respiration rate would benefit more from BVM with or without additional O<sub>2</sub> (e.g. room air) if used by someone trained and competent in its use.
- Sites that plan to have O<sub>2</sub> should also procure oxygen saturation machines and BVM. Staff must have received training on the safe use of the equipment as well as safe storage and maintenance of oxygen tanks and ensure supplies are maintained.

#### Definitions

- Oxygen therapy is the administration of oxygen as a medical intervention, which can be for a variety of purposes in both chronic and acute patient care. Oxygen is essential for cell metabolism, and in turn, tissue oxygenation is essential for all normal physiological functions.
- Bag Valve Masks (BVM) is an airway apparatus used to cover the patient's nose and mouth and begin ventilating the lungs mechanically by squeezing a reservoir of oxygen or air.
- Oxygen saturation refers to the extent to which hemoglobin is saturated with oxygen. Hemoglobin is an element in the blood that binds with oxygen to carry it through the bloodstream to the organs, tissues and cells of the body. Normal oxygen saturation is usually between 96% and 98%.
- Pulse oximeter: a device, usually attached to the earlobe or fingertip that measures the oxygen saturation of arterial blood by sensing and recording capillary pulsations.

#### 9.1.4 Naloxone

Naloxone is a safe and *highly effective* antidote to opioid overdose. Naloxone is an opioid antagonist and has a much higher affinity (attraction) for the same receptors in the brain as heroin and other opioids.

Naloxone displaces and prevents opioids from working at receptor sites in the brain. It has no effect on non-opioid drugs and no potential for abuse. If there are two first-responders, one can administer naloxone while the other manages airway, breathing, and circulation.

Once naloxone is administered, responders continue to perform airway, breathing, and circulation interventions. Naloxone has a short half-life: 15 to 30 minutes. This is much shorter than most opioids, so it is important to monitor a person after an overdose for 30 minutes or more. This is best done at the hospital.

## 9.2 Stimulants: Background and Stages of Intoxication

### Background Information

Stimulants can cause increased heart rate, blood pressure, and body temperature. A stimulant overdose can cause cardiac or respiratory arrest as well as seizure. Patients may report chest pain, shortness of breath, disorientation, or panic. These symptoms require medical attention, and the person should be supported to attend hospital via ambulance.

#### Commonly used stimulants include:

- Cocaine
- Crack cocaine
- Amphetamines
- Ritalin
- Adderall

#### Stimulant overdoses symptoms may include:

- agitation, shaking
- chest pain
- high level of anxiety
- seizure

### 9.2.1 Stimulant Overdose Protocol

Stimulant overdose has a variety of presentations and can be precipitated by lack of sleep. The person should be monitored, kept safe and encouraged to attend hospital.

A stimulant overdose can lead to seizure, heart attack, or stroke as a result of elevated body temperature, heart rate, blood pressure, as well as dehydration.

Additional steps in the event of a stimulant overdose:

- Apply cool cloth to back of person's neck or to forehead
- Limit stimulation by moving the person to a quiet location with low light
- Encourage person to take slow, deep breathes
- If person becomes unconscious or has chest pain call 911.
- Perform assessment/intervention to maintain airway, breathing, and circulation (PHS, 2016)

If the person is having a seizure:

- Don't restrict their movement
- Don't put anything in their mouth
- Protect their head (place a pillow underneath their head)
- Place the person in the recovery position.
- Call 911

## 10.0 OPERATIONAL PROTOCOLS

### 10.1 Cleaning the facility and Disposal of Equipment

To guard against infection and contamination, the OPS sites should be kept as clean and tidy as possible at all times. Keeping the site tidy also shows respect for the participants. When service providers' clean booths, take out garbage or tidy up the OPS space - the main focus is to AVOID NEEDLE STICK INJURIES through:

- Paying close attention – do not get distracted when cleaning debris off the booth or floor
- Never using hands to take garbage off a booth – use a small dustpan and brush.
- Ensure good lighting in the workspace

See Appendix P: *Cleaning Checklist Template for OPS Space* as an example template for cleaning recommendations at OPS.

Cleaning Booths/Floors – Reminders:

- Don't get distracted
- Never use hands to remove garbage from an injection booth or the floor
- Wear thick black rubber gloves whenever cleaning
- Use a dustpan and small brush to remove debris from the booth.
- Use a dustpan and large broom to remove debris from the floor
- Encourage participants to clean debris off their own booths
- Wearing thick black rubber gloves, wipe down booths/mirrors with industrial disinfectant wipes such as CaviWipes.

Refer to Section 7.0: *Service Delivery*

- *Safer Injection*
- *Disposal of Injection Equipment*
- *Equipment Disposal*

## 10.2 OPS Flow

### 10.2.1 Admission into OPS/Reception

- Reception staff greet each participant
- Reception staff assesses each participant for eligibility to access the service (See Section 7.0 *Service Delivery: Eligibility to Access OPS*)
- Participants sign the following forms (See Appendix E – *Required Documentation and OPS Intake Templates*):
  - Adults:
    - *User Agreement, Release and Consent Form: Overdose Prevention Services (OPS)* – (Signed on the 1<sup>st</sup> visit only).
    - *Overdose Prevention Services (OPS): Release of Responsibility Waiver* – (Signed on the 1<sup>st</sup> visit only).
  - Youth:
    - *Youth Registration and Assessment* - (To be completed for each visit by Senior Staff Member)
- All participants are registered in the *Overdose Prevention Services (OPS): Visit and Overdose Log* (Appendix E) before each visit.
- Participants will only need to provide their established identifier for subsequent visits.

### **10.2.2 Leaving the OPS to Provide Overdose Assistance (site specific).**

OPS Staff may, on occasion, see a person outside the facility who requires immediate assistance.

#### **Guidelines:**

- Depending on agency/regional health authority protocols, service providers may or may not be required staff to leave the facility to provide care.
- For some OPS, there may be an associated chill out area located outside or adjacent to the OPS area. If overdose occurs in this area, staff may be required to respond.
- Staff may respond to an overdose outside of the designated OPS space to provide care only if the safety of participants and other staff inside the OPS is ensured.
- The primary responsibility is to provide service within the OPS and to ensure the safety of participants and staff on-site.

Staff may choose to leave the facility to provide care when:

- The situation is life threatening and cannot wait until Emergency Health Services or police arrive.
- The situation does not present a risk to staff safety or health.
- Emergency services (911) have been called.
- A second person accompanies them or can observe them from inside the OPS.
- It is the individual staff member's decision to leave the facility to provide service/support.

### **10.2.3 Washroom Monitoring (Site Specific)**

Staff may be required to access the washroom in case of emergency, even if locked from the inside. Monitoring participant washroom use and initiating an appropriate response to any occurrence should be part of OPS protocol.

It may be beneficial to alert participants that staff will “check in” if the washroom is occupied for longer than usual. Indoor overdoses often occur in facility washrooms.

### **10.3 Death Protocol (site specific)**

- As with all medical emergencies, contact Emergency Health Services ambulance (911) to request immediate assistance.
- Secure the immediate area around the individual, providing privacy and prohibiting access to area by other participants.
- Place all the individual's belongings in a plastic bag with their name on it and secure them in an office or space separate from the OPS space.
- Call the supervisor immediately and/or the regional health authority or agency Administrator on call.
- Check in with team members to see if they need to debrief the incident.

## 11.0 OCCUPATIONAL HEALTH AND SAFETY (OCHS)

### 11.1 OPS Space Requirements

For OPS space requirements please refer to the following sections:

- Appendix K: *Physical Space and Ventilation Requirements*
- Section 7.0: Service Delivery:
  - *Physical Space*
  - *Equipment*

### 11.2 Equipment

The following equipment is recommended for cleaning purposes:

- Industrial black gloves
- Cavi-Wipes (Industrial cleaning product for wiping down booths– wear gloves)
- Dust pan and brooms:
  - Large for floors
  - Small for removing debris from tables
- Sharps Containers
  - Sharps containers should be located as close as practical to the work area.
  - Different sharps containers are required for different purposes and worksites.
  - Replace containers when they are 75% full.
  - Sharps container should be maintained upright throughout use.

### 11.3 Personal Protective Equipment (PPE)

- The risk of unintended fentanyl exposures to staff treating overdose victims is extremely low. Fentanyl citrate and fentanyl HCl crystals in powders intended for street use are too large to become airborne or easily inhaled.
- In BC, there have been no reported cases of secondary exposures of fentanyl to first responders, health care workers or private citizens administering naloxone, despite thousands of overdose reversals in the field and in health care facilities.
- No additional Personal Protective Equipment is required when attending patients with drug exposures unless there is a risk of respiratory and/or bodily fluid exposure.
- Routine practices such as gloves and additional precautions should continue to be used when there is a risk of respiratory and/or bodily fluid exposure. The additional practices and/or elevated levels of PPE used in other professions are not required at this time.

## **11.4 Equipment Disposal and Transportation of Sharps**

### Equipment Disposal

Service providers must be familiar with safety and handling guidelines: post these guidelines in disposal areas and janitorial closets.

### Transportation of Sharps

- Internal transportation of sharps containers should be kept to a minimum (examine at local worksite).
- When transporting sharps in vehicles, ideally sharps containers should be placed inside a secondary form of containment with a secure lid and always be transported in the trunks of vehicles.
- Lay sharps container on its side if tipping over is a concern.

### How to Handle Garbage Safely

- Consider removing garbage just outside of the OPS regularly to avoid sharps being disposed here.
- Physical handling of garbage in the OPS should be kept to a minimum.
- Use waterproof garbage bags.
- Be Alert! If possible look for sharps protruding from garbage bag, and listen for broken glass when moving the bag.
- Don't compress garbage or reach into garbage containers with your hands or feet.
- Don't use bare hands when handling garbage. Wear puncture resistant and liquid resistant gloves or use other tools designed for picking up garbage.
- Don't let garbage get too full. Leave enough free space at the top of the bag, so the top of the bag is easily handled.
- Change bags often to prevent over-filling. This allows for a lighter, less full back and makes it easier to hold away from the body when transporting.
- Hold the garbage bag by the top of the bag, away from the body – never hold the bag against the body.
- Do not place one hand under the bag to support it.
- Use tongs to pick up sharps.
- If tongs are not available, use a gloved hand to carefully pick up the needle. Dispose of gloves and WASH HANDS after needle contact.
- Hold needle tip away from the body.
- Put needle/s in a puncture resistant can or jar.

## **11.5 Needle Stick Injuries/Exposure to Blood and Body Fluids (Insite, 2016)**

In the event of a needle stick injury:

- Cleanse the area/puncture site thoroughly with warm water and soap, or a suitable antiseptic soap such as Hibitane or Salvodil.
- In the event of an eye splash, flush the eye with tap water for 10-15 minutes.
- Report to the supervisor immediately.
- Go directly to the local emergency department to be assessed for risk of exposure to blood-borne infection as soon as possible: preferably within two hours of the incident.
- If the source/person of the blood or body fluid is known, request (or parent/guardian) their consent to have blood testing as well. They can go to emergency as well – preferably at the same time.
- Request or designate the site supervisor to complete Worker's Compensation Board form -Employers Report of Injury or Industrial Disease (WorkSafe BC).

## **11.6 Unknown Substance Left Behind**

For any controlled or unknown substances left on site:

- Immediately bring to the attention of the site supervisor
- The site supervisor will place the substance in an envelope, which is then sealed, dated and initialed by the supervisor.
- The envelope should be placed in a locked safe in the staff-only area.
- The envelope will be logged into a record-keeping book, by supervisor.
- Contact the local police department
- A member of the local police department will log out the envelope

## 12.0 REFERENCES/RESOURCES

Toward the Heart [Internet]. Vancouver: BC Centre for Disease Control; <http://towardtheheart.com/>

Strike C, Hopkins S, Watson TM, Gohil H, Leece P, Young S, et al. Best Practice Recommendations for Canadian Harm Reduction Programs that Provide Service to People Who Use Drugs and are at Risk for HIV, HCV, and Other Harms: Part 1. Toronto, ON: Working Group on Best Practice for Harm Reduction Programs in Canada; 2013. [http://www.catie.ca/sites/default/files/BestPracticeRecommendations\\_HarmReductionProgramsCanada\\_Part1\\_August\\_15\\_2013.pdf](http://www.catie.ca/sites/default/files/BestPracticeRecommendations_HarmReductionProgramsCanada_Part1_August_15_2013.pdf)

BC Ministry of Health, BC Gov News Branch, Mental Health and Addictions. FACTSHEET: Actions to prevent overdoses in B.C [Internet]. Ottawa, ON; 2017 [cited 2017 May]. <https://news.gov.bc.ca/factsheets/actions-to-prevent-overdoses-in-bc>

Canadian Red Cross. 2016 Canadian Consensus Guidelines on First Aid and CPR [Internet]. 2016 [cited 2017 May]. [http://www.redcross.ca/crc/documents/Canadian-Consensus-Guidelines-document-Feb-2016\\_EN\\_Final.pdf](http://www.redcross.ca/crc/documents/Canadian-Consensus-Guidelines-document-Feb-2016_EN_Final.pdf)

Vancouver Coastal Health and Fraser Health Authority. Overdose Prevention & Response Protocol Recommendations for Service Providers: Version 4 [Internet]. Vancouver, BC; 2017 [cited 2017 June]. [http://www.fraserhealth.ca/media/Overdose\\_Prevention\\_Response\\_Protocol\\_Recommendations\\_Service\\_Providers.pdf](http://www.fraserhealth.ca/media/Overdose_Prevention_Response_Protocol_Recommendations_Service_Providers.pdf)

BC Ministry of Health, BC Coroners Service Branch. B.C.'s Public Health Emergency Progress Update on B.C.'s Response to the Opioid Overdose Crisis [Internet]. BC: Joint Task Force on Overdose Prevention and Response; 2017 [cited 2017 May]. <http://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/overdose-response-progress-update-jan2017.pdf>

BC Ministry of Justice, BC Laws Branch. Child, Family and Community Services Act [Internet]. CA: Queen's Printer; 2017 [cited 2017 June]. [http://www.bclaws.ca/Recon/document/ID/freeside/00\\_96046\\_01](http://www.bclaws.ca/Recon/document/ID/freeside/00_96046_01)

BC Ministry of Health, Mental Health and Substance Use Branch. Trauma Informed Practice Guide. CA; 2013 [cited 2017 June] [http://bccewh.bc.ca/wp-content/uploads/2012/05/2013\\_TIP-Guide.pdf](http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf)

Infants Act Backgrounder: [www.bclaws.ca/civix/document/id/complete/statreg/96223\\_01](http://www.bclaws.ca/civix/document/id/complete/statreg/96223_01).

## 13.0 APPENDICES

### Appendix A: Overdose Prevention & Response Protocol Recommendations for Service Providers (VCH & FHA, 2016)

#### OVERDOSE PREVENTION & RESPONSE PROTOCOL RECOMMENDATIONS FOR SERVICE PROVIDERS



##### PURPOSE

Provide guidance for service providers to develop overdose (OD) prevention and response policies and protocols.

##### OD PREVENTION & RESPONSE: FIRST AID & HARM REDUCTION TRAINING

Does your staff have:

- OD prevention and response training? Provincial training resources and a [Training Manual](#) can be found at [TowardTheHeart.com](#). Contact your local health authority for training support.
- First Aid Training that includes responding to overdoses? This is essential for unregulated care providers working where overdose risk is high.
- Harm Reduction Training? Knowledge of harm reduction practices is fundamental for staff who work with people who use substances. Harm reduction addresses: safer use of drugs and alcohol; appropriate use of harm reduction equipment; access to health care; personal and cultural safety practices; and mechanisms for dealing with critical incidents. Contact your local health authority for training opportunities. Access the online [Harm Reduction Training](#) from the Course Catalogue Registration System (CCRS).

##### SUBSTANCE USE PROTOCOL

Does your agency:

- Have a substance use protocol (examples found [here](#))? Policies that force drug use off site (or to be hidden) increase risk of undetected ODs, and greatly diminish your staff's ability to intervene effectively.
- Have punitive sanctions or a Residential Tenancy Agreement that states that "any drug-related criminal activity" is a reason for end of tenancy? This will likely inhibit communication about drug use and overdoses.
- Have a substance use protocol known by all clients? Share it with clients in casual conversations or posters.

##### OVERDOSE PREVENTION

Does your agency:

- Recommend that all staff who have contact with clients receive the training referenced above?
- Have a protocol addressing both onsite and offsite ODs?
- Track staff training? Does training happen yearly?
- Have an agency staff trainer (or an external resource)? This will help with timely new staff and client trainings.
- Have OD response drills at regular intervals at each facility in your agency?
- Identify quiet corners where clients and their guests might use substances and be at risk for OD? e.g. bathrooms, stairwells and develop a system for regularly checking these spaces.
- Have a public bathroom? If so, does this space have its own protocol to prevent ODs that includes:
  - Regular safety checks?
  - Secured, tamper resistant sharps containers?
  - Locks that can be opened from the outside?
  - Posted bathroom protocol for clients to see?
- Have regular site assessments? This will ensure a review of all OD prevention and response measures.

Does your agency have signage that includes:

- List of staff who are trained in OD response (particularly if not all staff are trained)?
- List of clients who are trained in OD response (voluntary)?

\*All underlined text is connected to a hyperlink

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- [SAVE ME](#) signs? Cue people on OD response steps (including those with low literacy).
- [Door signs](#) for clients who have naloxone and are trained in opioid OD interventions (voluntary)?
- A naloxone sign at the front desk? To inform clients and guests that staff are trained to respond with naloxone.

**Does your agency have client-focused OD prevention such as:**

- How to determine which clients are at risk of OD?** OD risk should be assessed at intake and on an ongoing basis. Clients can be at higher OD risk at different times. A resource for this is: [Housing Opioid OD Risk Assessment Tool](#).
- Developing care plans in collaboration with clients during known times of OD risk.** Can include but not limited to:
  - How to facilitate supporting clients to use alone more safely in their rooms:
    - Encourage clients to inform staff when using substances (with OD potential) in their room to facilitate a follow-up room check (may be via: in-person, phone call, intercom, baby monitor).
    - Timing for room checks should be based on route of administration, time of use, and ease of use.
  - Support client to be trained in opioid OD prevention and response.
  - Discuss with client when to call 911.
- Addressing stigma in your agency?** Is stigma about substance use preventing clients from accessing services?
  - Vertical stigma – staff to peer.
  - Lateral stigma – peer to peer.
  - Self-stigma – self-judgment.
- OD prevention as a standing item on all client advisory groups and staff meetings?** This will ensure continued evaluation, input and feedback from both groups.

## OVERDOSE RESPONSE

**Does your agency:**

- Allow trained staff to administer naloxone to clients in the event of an overdose?** Is there a protocol describing this intervention? Is staff trained yearly? Does your agency have naloxone onsite?
- Have a shift change checklist that:**
  - Details overdose responses that occurred on that shift.
  - Requires a communication log review.
  - Establishes roles and responsibilities of each person on shift in case of an OD (including volunteers/students).
  - Identifies clients with new or increased OD risk.
  - Include inventory checks of naloxone kit and emergency supplies.
- Have a means of emergency communication?** e.g. cell phones, walkie-talkies, panic buttons.
- Provide clients with access to phone, 24/7?**
- Have a system to ensure staff is always reachable?** e.g. posted phone number and/or staff location.

## POST OVERDOSE INCIDENT FOLLOW-UP

**Does your agency:**

- Debrief with staff and clients following an OD?**
- Have post-OD intervention duties?** e.g. restocking supplies, reporting: critical incident form, naloxone usage log, naloxone administration, OD response information form?
- Make alert posters to notify clients?** After how many ODs? Is a template used? When are posters removed?
- Alert extended community after OD incidents?** After how many ODs? Who is information shared with (managers, health authority, other non-profit organizations)?
- Have a [guide to promote staff resiliency and prevent distress](#) after an OD reversal?**

## CLIENT INVOLVEMENT

**Does your agency:**

- Encourage clients to get training including acquiring their own naloxone kit?**
- Have accessible venues to solicit client feedback?** A variety of options can be used together such as: monthly client peer meetings, annual anonymous surveys, a suggestion/complaint box.
- Have paid client peer trainers?** Peer trainers are an asset to both client and staff trainings.

\*All underlined text is connected to a hyperlink

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## Appendix B: Guidelines and Resources for Supportive Housing Providers, Homeless Shelter Providers and Regional Health Authorities on Overdose Prevention and Response

### Guidelines and Resources for Supportive Housing Providers, Homeless Shelter Providers and Regional Health Authorities on Overdose Prevention and Response

February 15, 2017

#### Purpose

The purposes of these guidelines are to provide management and staff of supportive housing and homeless shelters with best practice advice and resources on prevention, recognition and response to overdoses.

#### Background

Overdoses are unpredictable, can happen in any setting, and a quick response can prevent significant disability or death. People who use drugs may reside in any setting, and due to the illegality of drug possession their drug use may not be apparent to staff and tenants/clients at supportive housing and homeless shelters. As such, staff and management may need to take steps to prevent, recognize and be prepared to respond to overdoses should they occur.

Key elements in preventing deaths from overdose are (1) educating and encouraging people not to use drugs alone, (2) utilizing the actions below to reduce the stigma that encourages isolation and (3) ensuring that naloxone and other life-saving first aid is available quickly in the event of an overdose. These goals may be achieved by:

- providing education to tenants/clients about overdose risk and how to reduce it;
- ensuring that tenants/residents will not be evicted for disclosing drug use;
- allocating space within the shelter or housing facility where those who use drugs may do so in the company of others;
- provision of harm reduction and first aid supplies, including naloxone kits and sharps disposal containers, in allocated spaces and anywhere else there may need to be access to them;
- training of staff, and interested tenants/clients, peers and/or volunteers, to monitor allocated spaces and respond to an overdose;
- managing access to the space so that tenants/clients use is not impeded by guests, but also ensuring that guests do not use drugs unsupervised such as in bathrooms and stairwells.
- discouraging drug use alone; and for tenants/clients who choose to use alone, encouraging them to work with staff to establish a plan for room checking to reduce risk based on when a tenant/client is likely to be using drugs;
- arranging for visits by health authority community health nurses, or by community paramedics, to provide advice, advise on supplies, and provide support to staff and tenants/clients.

## Guidelines

Given the diversity of supportive housing and homeless shelters in BC the following may or may not apply to specific circumstances, and should be adapted accordingly.

1. Develop an overdose prevention, recognition and response protocol for your organization. This may include information on:
  - a. First aid and harm reduction training
  - b. A substance use protocol
  - c. Overdose prevention, recognition and response
  - d. Post overdose incident follow-up
  - e. Tenant/client involvement
  - f. Incident debriefing and psychosocial support for staff
  - g. Evaluation, with tenants/clients, of the effectiveness of the protocol.

Details on what should be considered under these headings may be found in the *Overdose Prevention & Response Protocol Recommendations for Service Providers* by Fraser Health and Vancouver Coastal Health (Resource # 1).

For non-profit community organizations which serve a population in a facility at risk of overdose, the BC Centre for Disease Control (BCCDC) may be able to provide supplies at no cost containing naloxone and other emergency overdose response supplies through the BC Facility Overdose Response Box Program (<http://towardtheheart.com/naloxone/forb/>). An expectation of this program is that information about overdose responses will be provided to BCCDC.

In addition information on planning tools i.e. sample protocols, policies and check sheets are available to any organization at <http://towardtheheart.com/naloxone/forb/program-modules>.

For more information about the Take Home Naloxone Program, which provides overdose prevention and response training, as well as naloxone kits to eligible individuals, visit <http://towardtheheart.com/naloxone/>.

2. Involve staff, volunteers, and tenants/clients in developing an overdose plan. People with lived experience can provide a rich perspective on what may and may not work in your facility. To learn more about how to involve people who use drugs in developing a plan see resource #2.
3. Determine who is at risk of overdose and level of risk (see resource #3)
4. Develop step-by-step instructions on how to recognize and respond to overdoses, including the importance of call 911 for all overdoses (see resource #4).
5. Review and practice your overdose response protocol regularly.

6. Ensure that facility policies are not a barrier for people who are prescribed opioid-assisted treatment medications such as buprenorphine/naloxone (e.g. Suboxone) or methadone to treat their opioid use disorder, as these medications are internationally recognized as a best practice in treating opioid use disorder.
7. Anticipate the psychological impacts of overdose events and the need for providing or referring staff and tenants/clients to psychosocial support services (see resource #6).

### Resources

1. *Overdose Prevention & Response Protocol Recommendations For Service Providers*  
([http://www.fraserhealth.ca/media/Overdose Prevention Response Protocol Recommendations Service Providers.pdf](http://www.fraserhealth.ca/media/Overdose_Prevention_Response_Protocol_Recommendations_Service_Providers.pdf))



Overdose Prevention  
Checklist V3.pdf

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2. *How to Involve People Who Use Drugs*  
([http://towardtheheart.com/assets/resources/how-to-involve-people-who-use-drugs-20140227posted\\_7.pdf](http://towardtheheart.com/assets/resources/how-to-involve-people-who-use-drugs-20140227posted_7.pdf))



how-to-involve-people-who-use-drugs.pdf

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3. *How to determine who is at risk of overdose, and the level of risk*  
(<http://www.drugsandhousing.co.uk/hoorat4colour.pdf>)



hoorat4colour.pdf

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4. *How to recognize and respond to overdoses*

<http://www.fraserhealth.ca/health-info/health-topics/harm-reduction/overdose-prevention-and-response/recognizing-an-overdose/>

<http://www.fraserhealth.ca/health-info/health-topics/harm-reduction/overdose-prevention-and-response/responding-to-overdose/>



RECOGNIZING AN  
OVERDOSE.pdf



RESPONDING TO AN  
OVERDOSE.pdf

5. See additional resources compiled by Fraser Health at:

<http://www.fraserhealth.ca/health-info/health-topics/harm-reduction/overdose-prevention-and-response/overdose-planning-organization/overdose-planning-for-your-organization>

or contact the Portland Hotel Society for their “Harm Reduction and Overdose Management Policy and Procedures” (604 683 0073) .

6. *Incident debriefing and psycho-social support resources*

- Take Home Naloxone: A Guide to Promote Staff Resiliency & Prevent Distress After an Overdose Reversal

[http://towardtheheart.com/assets/naloxone/naloxone-staff-resiliency-final\\_185.pdf](http://towardtheheart.com/assets/naloxone/naloxone-staff-resiliency-final_185.pdf)



Naloxone-staff-resilie  
ncy-BCCDC Dec 23 20:

- Healthcare Resiliency During Prolonged Response by Health Emergency Management BC



HEMBC Staff  
Resiliency.pdf

- In addition see resources available from the Public Health Agency of Canada at <http://www.phac-aspc.gc.ca/publicat/oes-bsu-02/index-eng.php> and listed below:  
[Taking Care of Ourselves, Our Families and Our Communities](#)

[Helping Children Cope](#)

[Helping Teens Cope](#)

[Self-Care for Caregivers](#)

- Additional information may be found in “*Opioid Overdose in Supportive Housing, How to Keep People Safe.*” by Shannon Riley RN, BSN, MPP, Project Manager, Illicit Drug Overdose Response, Prevention, Vancouver Coastal Health Authority  
(<http://summit.sfu.ca/item/16417>)

[Appendix – Ministerial Order with respect to Overdose Prevention Services](#)



## Appendix C: Service Provider Confidentiality Agreement Template

### CONFIDENTIALITY UNDERTAKING FOR OVERDOSE PREVENTION SERVICES SERVICE PROVIDERS

In consideration of my contract placement at \_(indicate regional health authority [RHA]/agency)\_; I acknowledge and agree to the following:

1. I will adhere to the Information Privacy and Confidentiality Policy and related policies and subsequent amendments, concerning the collection, use and disclosure of information obtained in the course of my service with *(indicate RHA/agency)*;
2. I understand that all personal information concerning staff and the people who receive services (including medical records) is confidential and may not be communicated to anyone in any manner, except as authorized by *(indicate RHA/agency)* or applicable policies;
3. I understand and acknowledge that all information regarding the affairs of *(indicate RHA/agency)*, including corporate, financial and administrative records is confidential and may not be communicated or released to anyone in any manner except as authorized by *(indicate RHA/agency)* or applicable policies;
4. I will not copy, alter, interfere with, destroy or remove any confidential information or records except as authorized by *(indicate RHA/agency)* and in accordance with established policies; and
5. I understand that compliance with confidentiality is a condition of my placement with *(indicate RHA/agency)* and that failure to comply may result in immediate termination of my placement, in addition to legal action by *(indicate RHA/agency)* and others.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Dated (mm/dd/yr) \_\_\_\_\_

## Appendix D: Key Responsibilities for OPS Service Providers

- Check the overdose response and harm reduction supplies inventory.
- Review overdoses from last shift – ensure proper paperwork has been submitted
- Initiate communication with OPS participants
- Role model respectful behavior
- Be responsive to participants requesting further information/ support (e.g. social, mental health or addiction services)
- Provide overdose response and life support
- Offer education on safer injection techniques
- Control the flow and numbers of participants into and out of each area in accordance with established staff to participant ratios
- Ensure the safety of resting participants; checking in for a response at least every 20 minutes, more often if they are at risk
- Monitor participant activity - enforce the OPS Code of Conduct as necessary.
- Apply guidelines for verbal de-escalation and consequences for aggressive behavior, as outlined in the Occupational Health and Safety Section of this manual
- Build a sense of ownership/shared responsibility among participants of the OPS
- Debrief work-related issues at the end of each shift *and* following any critical incident
- Work collaboratively with other team members and help to orient new staff and participants
- Maintain documentation and data collection as required
- Address concerns regarding breaches of the OPS policy/protocols to the responsible person in charge or alternate.
- Maintain a structured, healthy and clean worksite
- Dispose of used equipment in accordance with established protocols
- Clean OPS tables after each use in accordance with established protocols
- Regularly monitor the area outside of the site.
- Refer all media inquiries or public presentation opportunities to the supervisor or RHA/agency Communications Department
- Do not use drugs or alcohol during, or directly prior to providing service at an OPS

## Appendix E: Required Documentation and OPS Intake Templates

### Form 1: *User Agreement, Release and Consent Form: Overdose Prevention Services (OPS) – (Signed on the 1<sup>st</sup> visit only).*

Prior to using the OPS, I agree to the following:

- I have injected drugs in the past, am in this facility for the purpose of using injection drugs, and I intend to inject them regardless of any risks to my health.
- I will follow the direction of OPS staff and Codes of Conduct.
- I will remain in possession of my own drugs for injection at all times.
- I authorize OPS staff to provide emergency medical services if necessary.
- I am aware of the harmful effects of drug use and accept full responsibility for all risks to myself, including my death, and on behalf of myself and my heirs, hereby release the Overdose Prevention Site, (*Indicate Regional Health Authority/Agency*) and their employees, partners and agents from any and all liability for any loss, injury or damage I may suffer as a result of my use of this facility.

I understand the above and am able to give consent.

Name: \_\_\_\_\_ (must include first & last initials)

Date of Birth: \_\_\_\_\_ (D/M/Y)

Completed by: \_\_\_\_\_

Date: \_\_\_\_\_ (D/M/Y)

Handle or Identifier:  
(Name, nickname, or #,)

Revised February 4<sup>th</sup>, 2017

**Form 2: Overdose Prevention Services (OPS): Release of Responsibility Waiver – (Signed on the 1<sup>st</sup> visit only).**

Purpose: To waive responsibility of OD Prevention Services staff and volunteers upon a participant leaving the site against medical advice (AMA).

Participant Name/Handle: \_\_\_\_\_

I \_\_\_\_\_ have had the risks of leaving the OD prevention service AMA explained to me and I release all staff from all responsibility if my safety/life is compromised because of leaving this facility AMA. I am solely responsible for my own life/safety once I leave the OD Prevention Site.

Participant Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Staff Witness: \_\_\_\_\_ Date/Time: \_\_\_\_\_

OR

Participant left OD Prevention Service AMA, with knowledge of the risks involved, but without signing waiver.

Staff signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Witness: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Revised February 4<sup>th</sup> 2017

**Form 3: Overdose Prevention Services (OPS): Visit and Overdose Log**

Please fill out one row in the table for **each visit** and use a new sheet at the start of each day.

| Identifier/Handle<br>(if given) | Time of visit<br>(include time of day<br>and circle am or pm) | Did the person<br>overdose?<br>(Yes/No)                  | If the client overdosed, answer these questions as well:                                  |   |
|---------------------------------|---|--|---|---|
|                                 |   |  | Was naloxone given?   | Was the person taken by ambulance<br>to an emergency department?                          |
| 1.                              | am / pm   | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown |
| 2.                              | am / pm   | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown |
| 3.                              | am / pm   | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown |
| 4.                              | am / pm   | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown |
| 5.                              | am / pm   | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown |
| 6.                              | am / pm   | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown |
| 7.                              | am / pm   | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown |
| 8.                              | am / pm   | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown |
| 9.                              | am / pm   | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown |
| 10.                             | am / pm   | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown |
| 11.                             | am / pm   | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown |
| 12.                             | am / pm   | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown |
| 13.                             | am / pm   | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown |
| 14.                             | am / pm   | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown |
| 15.                             | am / pm   | <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown |

Form 4: Youth Registration and Assessment - (To be completed for each visit by Senior Staff Member)

Background

Youth represent the highest risk group for contracting HCV and HIV through IVDU. Research indicates that they engage in high-risk behaviours to a greater extent than adults with established intravenous drug use. Youth who do not have a history of IVDU should access addiction resources that can more appropriately address their level of need and prevent initiation to IVDU. Prompt referrals to addiction treatment programs is an evidence-based strategy at preventing initiation to IVDU.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Handle: \_\_\_\_\_

DOB: \_\_\_\_\_

Verified with ID?  Y  N

ID Type: \_\_\_\_\_

If <16 yrs. was old, MCFD Notified?  Y  N

Reasons for wanting to access OPS:

Drug History: Substances, routes, duration, frequency

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Injection sites visualized?  Y  N  N/A Congruence between history and presentation?  Y  N

Notes: \_\_\_\_\_

Understanding of risks related to IVDU:

- OD  Tolerance  Addiction  Infectious Disease  Emboli
- Vasc/Nerv Damage  Injecting Unknown Substances  Scarring/tracks  Access to HR Supplies

Notes: \_\_\_\_\_

Does youth present with need for immediate OPS access?  Y  N **OPS Access Granted?**  Y  N

Notes:

**Are there any adult contacts identified by the youth:**  Y  N

If yes, please complete the following:

Contact's Name: Relationship to youth:  
Phone/Cell#

**Harm Reduction Education**

*OD Prevention Not Using Alone Hand Washing ETOH Swab VC/location*  
*Flagging Disease Prevention Drug preparation Equipment Alt routes of ingestion*  
*Take Home Naloxone (if opiate use in drug hx)*

Notes: \_\_\_\_\_

**Referrals Provided?**  Y  N *If yes – where and was transport offered?;*

\_\_\_\_\_

**Form 5: Overdose Prevention Sites Core Data Elements for Overdose Incident (Complete for every OD incident)**

Contact: [margot.kuo@bccdc.ca](mailto:margot.kuo@bccdc.ca)

Last Revised: January 3<sup>rd</sup>, 2017

**Background:** On Dec. 8<sup>th</sup>, BC enacted a ministerial order to create overdose prevention sites. To support the decision making of the BC Health System Steering Committee on Overdose Response some basic metrics on the sites at a provincial level are needed.

**Objectives of Surveillance:** 1) To capture overdose events that may not otherwise be captured by existing surveillance 2) To monitor overdose events related to Overdose Prevention Sites.

**Focus of Data Collection:** Overdose Prevention Sites in BC operate on different models in a variety of settings. The focus is to provide no barrier venues for persons who use drugs to be in a safer environment with a person with naloxone available nearby in case of overdose. In keeping with this, data collection must not pose barriers while collecting minimum core elements from all sites with a focus on information that is readily available to any person, with or without medical training responding to an event.

This core data tool was developed collaboratively with Northern, Island, Vancouver Coastal, Fraser, BCCDC, and Interior Health Epidemiologists. Implementation will depend on settings and models.

**CORE DATA ELEMENTS**

**Person**

| Core Data Element (as it would ideally appear on a data collection tool)   | Definition and Other Information  |
|--|---|
| <b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Unknown       | The gender of the person experiencing the overdose. Data collection tools to include at minimum male, female, unknown.                  |
| <b>Age Group:</b> <input type="checkbox"/> under 19 <input type="checkbox"/> 19-39 <input type="checkbox"/> 40 or older <input type="checkbox"/> Unknown | The estimated age group of the person experiencing the overdose. Broad age categories are used to allow estimation by first responders. |

**Place**

|  |  |
|--|--|
| <b>Overdose Prevention Site or Response Group Name/Code:</b>                               | Name or Code of the Overdose Site (e.g. Powell St. Getaway). A list of overdose prevention sites by name and code with an address and Response Groups/Names with an affiliated site or area is required to interpret this field. |
| <b>Overdose Occurred:</b> <input type="checkbox"/> Inside <input type="checkbox"/> Outside | Indoors or Outdoors as best describes where the person experiencing the overdose was seen to overdose or was found.  |

| <b>Time</b>   |   |
|---|---|
| <b>Date: DD/MM/YYYY</b>   | The date of the overdose event  |
| <b>Time of Overdose:</b> _____:_____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.<br><b>HH      MM</b>   | The time that most closely approximates when the person showed observable signs of overdose or was found unresponsive.  |
| <b>Event/Intervention</b>   |   |
| <b>Was 911 Called:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  | Whether or not 911 was phoned.  |
| <b>Was Naloxone Given:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  | Whether or not Naloxone was given (any form but injectable is assumed for most settings)  |
| <b>How many injections of Naloxone were given:</b><br><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> more than 5 | The number of naloxone injections given as a part of this overdose response. The underlying assumption is that the 0.4 mg vials are standard in community kits and Overdose Prevention Sites. Only count injections prior to a paramedic taking over. |
| <b>Was rescue breathing performed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No   | Whether or not breaths were given or observed to be given by <u>anyone</u> as a part of the overdose response.  |
| <b>What was the outcome?</b><br><input type="checkbox"/> Client Left <input type="checkbox"/> Client Transported to the ED <input type="checkbox"/> Client Died   | The outcome of the event as best described by one of the three options. May also include unknown but this has been excluded from example format to encourage a usable answer.   |
| <b>Additional Summary Statistics Required Weekly:</b>   |   |
| 1. Estimated number of visits/interactions per site per week  |   |
| 2. Estimated number of ODs per site per week (should equal report numbers)  |   |

## Appendix F: Support for Peers Providing Overdose Prevention and Response Services

The experience of witnessing and/or responding to an overdose is often stressful and overwhelming. The impact on health care providers responding in emergency situations is well recognized and acknowledged in the health care system; with resources such as critical incident debriefing and counseling available through employers. As part of the overdose response, it is important to have resources available for all of those providing overdose prevention and response services. Experiences such as these, if unresolved, may interfere with performing one's daily life and work commitments, and trigger further trauma, grief and loss.

Unlike most health care professionals, Peers (a person who has both lived experience with drug use (either past or present), and uses that lived experience to inform their professional work) may be in a position where they lack the institutional support systems for immediate and ongoing emotional/mental health and well-being, thus often left to cope with the psychological impact of overdoses on their own.

A critical step in mitigating some of these impacts lies in the support and provision of regular and standardized services for Peers. These initiatives can be implemented at three levels: Peer-to-Peer, organization/agency for Peer, and community initiatives. They should all provide relevant, appropriate, and timely Peer supports.

### Peer-to-Peer

Peers themselves are best positioned to empathize and intimately understand the lived experiences of other Peers. Peer-to-Peer support cultivates a setting whereby Peers can both look to other individuals who may have lived similar experiences for support, whilst other Peers can share their knowledge and expertise.

One potential Peer-to-Peer initiative whereby this may occur includes the formation of a Peer support team specifically oriented to people with lived experience, who are working as Peer workers at Overdose Prevention Sites.

This team could:

- work with Peers to develop active Peer support practices within teams through training and education;
- offer support and debriefing to all Peer workers at Overdose Prevention Sites;
- nurture self-care and self-assessment among Peer workers; and,
- triage to other services if needed and available.

Peers can encourage self-care for themselves and each other by:

- being patient and understanding with themselves;
- taking time to relax and take breaks (ex. go for a 15-minute walk during a lunch or coffee break. Do something enjoyable);
- taking timeout from media reports (including social media) and breaks from thinking and talking about overdose events;
- taking breaks from work and/or limiting the number of hours worked in a day or week;
- negotiating or asking to do other types of work or trading off with work;
- ensuring a good night's sleep;
- taking time to practice self-care and reflection;
- encouraging communicating or stating needs with others they trust;
- normalizing expectations – talking about what does stress, anxiety, being overwhelmed look and feel like
- recognizing that the work you do is saving lives.

Know and respect your limits. Commit to regularly scheduled time off. If you feel exhausted and need extra time-take it. If, at any time, you feel overwhelmed and unable to cope, consider who is a safe person for you to talk with and debrief. Identify someone you trust and feel safe talking to, it could be: another Peer worker, harm reduction worker, or community worker for example.

## Organization/Agency for Peer

Organizations can enhance Peer staff resiliency by creating a supportive work environment and promoting self-care as a regular and worthwhile practice.

Actions to achieve this may include:

- openly acknowledge and value Peers and Peer work that is saving lives daily. Respect, and acknowledge the expertise and work being done by Peers in unusually stressful situations;
- Peers have important experiential knowledge about how best to provide services. Recognize and utilize that expertise in the development and operation of services;
- designate time and resources for Peer-to-Peer support including education and training for Peers to support each other;
- provide relief on short notice and on an as-needed basis to Peer workers;
- ensure that Peer workers have scheduled breaks and are encouraged to take them;
- prioritize and allow Peer staff to debrief following critical incidents - if they feel it would be helpful. If they prefer not to debrief, give staff a few moments (or whatever time they need) to recover from the adrenaline rush of reversing an overdose – they may need to take a walk, buy a coffee or make a phone call to a friend or family member;
- normalize the need to debrief and encourage taking time for oneself to manage stress, grief, loss and vicarious trauma;
- provide opportunities for regular debriefing with and among Peer workers including discussing how overdoses were managed ("what went well and what could be improved");
- provide a safe physical space where people can gather to discuss their experiences or seek respite;
- allow and encourage individuals to communicate when they feel stressed or overwhelmed. Further support this by encouraging and demonstrating non-judgemental responses or behaviour.
- obtain or secure support from community or leisure centres for streamlined access to passes.

In addition, the following resources outline suggestions as to how better to include Peers at a decision-making table or engagement process:

- [Peer Engagement Principles and Best Practices](#);
- [Peerology](#).

[A Guide to Promote Staff Resiliency & Prevent Distress after and Overdose Reversal](#) further outlines management strategies to address the risk factors that may lead to staff distress.

### Community Initiatives for Peer Support Services

Community initiatives that bring people together to give them the power or opportunity to act may include:

- information meetings about overdose events going on in your neighbourhood;
- memorials, candlelight vigils;
- regular acknowledgement of those who have died. For example, practice a moment of silence to recognize lives that have been lost next time you have a group gathering (ex. VANDU includes this practice at their meetings);
- Grief and Loss Support Groups - look for one in your neighbourhood, or consider starting one through existing Agencies.

Finally, a Provincial initiative (approved by the Ministry of Health and under the auspices of the Provincial Health Authority), not noted above, involves a current project that is underway for the rapid development and implementation of a Mobile Response Team (MRT). The MRT is a provisional team created in response to the recognition of the psychosocial impact that the opioid overdose public health emergency has on frontline workers.

The purpose of the MRT is to offer psychosocial supports to staff and volunteers of community-based organizations working within the opioid overdose public health emergency. This includes individuals who have been impacted by the effects of critical incidents such as multiple overdoses and/or deaths.

The activities and services the MRT are to provide include to:

- provide education and crisis response services;
- mobilize to designated sites across the province as a health resource for front line workers;
- provide psychoeducational materials;
- introduce Peer support tools to individuals and groups;
- assess and respond to province-wide critical incidents.

Team members will be deployed to areas experiencing high rates of overdoses and overdose deaths (i.e. the Lower Mainland, Surrey, and Downtown Eastside) before expanding to Vancouver Island, the Interior, and Northern BC.

More information can be obtained from: [mrt@phsa.ca](mailto:mrt@phsa.ca)

## Appendix G: Participant Rights/Responsibilities and Code of Conduct (Insite, 2016)

### Rights and Responsibilities of Overdose Prevention Site Participants

The rights and responsibilities offered below are not exhaustive. Ideally, OPS rights and responsibilities are developed to reflect the local context and in collaborative with PWID.

#### Rights

- To feel safe, respected and treated with dignity.
- To be in a place of respite.
- To be unharmed physically, emotionally, or psychologically by staff.
- To be in a clean environment.
- To receive appropriate support and attention.
- To access services even while under the influence of drugs or alcohol.
- To have a voice in the operations and functioning of the site, in conflict resolution processes and in regards to complaints or concerns.

#### Responsibilities

- To respect others while on site.
- To help create and maintain a safe place.
- To not cause physical harm to other participants or staff.
- To use the site for self-administration only; no “doctoring.”
- To not deal, exchange, share or pass drugs to anyone else on-site.
- To not use alcohol, smoke or ingest drugs other than by injection while on-site.
- To reduce harm by not sharing rigs or equipment, disposing of used supplies in the sharps container, and not walking around with uncapped rigs.
- To not display weapons or money on-site.
- To not bring outside conflicts into the site.
- To not engage in solicitation of any kind on site.
- To respect the property and privacy of others in the site.
- To follow the reasonable directions of OPS staff.
- To bring concerns or complaints to the attention of RPICs.

## Appendix H: Responding to Specific Participant Behaviors

### A) Responding to Observable Behaviors

#### Anxiety

Anxiety is an observable change in behavior and can increase through stimulant use. Mild anxiety can be beneficial for motivation and heightened awareness for problem solving. Moderate to severe anxiety can cripple the ability to perceive, think and conceptualize and the ability to cope with a situation.

**Table 1: Responding to Behaviors that Indicate Anxiety**

| Behaviours  | Service Provider Response  | Interventions  |
|---|--|--|
| <ul style="list-style-type: none"> <li>• Eye contact: loss of eye contact/avoidance, blank stare, rolling eyes, excessive blinking, eyebrow movement, smiling, frowning.</li> <li>• Verbal contact: talkative, quiet, laughing, crying, joking, talking faster.</li> <li>• Physical Signs e.g.:               <ul style="list-style-type: none"> <li>○ rocking, restless, pacing,</li> <li>○ sitting very still,</li> <li>○ a need for more personal space,</li> <li>○ holding their breath.</li> <li>○ wringing hands, drumming fingers, opening and closing hands.</li> </ul> </li> <li>• Other signs:               <ul style="list-style-type: none"> <li>○ asking lots of information seeking questions in an attempt to regain a sense of control (and a general dissatisfaction with answers to these questions)</li> <li>○ very poor short term memory</li> <li>○ procrastination.</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>• A caring, respectful response to anxiety behaviour generally provides adequate support to lower the anxiety level and prevent escalation to anger and other aggressive behaviours <b>in 95% of the population.</b></li> </ul> | <ul style="list-style-type: none"> <li>• Be respectful of the participant's belongings/ personal space (do not touch the participant without their permission).</li> <li>• Actively listen to gain understanding from their point of view and what may be driving the behaviour.</li> <li>• Answer questions to give the participant back a sense of control and reassurance.</li> <li>• If you cannot answer their question, find out the answer, direct them to who may be able to answer their question, or explain there may not be an answer (do not ignore the question or need).</li> <li>• Focus on what you <b>can</b> do for the participant not what you <b>cannot</b> do (e.g. "How can I help?").</li> <li>• Assist the participant to verbalize feelings in their own words, avoid using leading questions.</li> <li>• Re-direct participant's energy into safe activities.</li> </ul> |

## **B) Responding to Aggressive Behavior**

Depending on the stage of escalation, not all behavior perceived as aggressive requires participant eviction from the site. There are several techniques that can effectively dissipate aggression and restore a calmer environment. Service providers should understand how to assess for potential aggression and experiences or circumstances that can increase the likelihood of aggressive behaviors. It is important for service providers to present a consistent approach to participants. The key to the successful use of behavior modification techniques is a consistent approach by all staff.

Assessment for Potential Aggression:

- Assess the participant's potential for aggression on admission considering the indicators outlined below.
- Self-awareness; e.g. understand personal thoughts/attitudes, and actions towards people who are aggressive or have potential to become aggressive.
- Assess the environment for overall activity, e.g. a highly active, crowded or loud environment may stimulate or exacerbate behaviour.

Experiences/Circumstances that may contribute to a greater likelihood of participant demonstration of aggression:

- Previous history of aggression (this is the #1 predictor of aggressive behaviour)
- Chemical dependency (either in an intoxication or withdrawal state)
- Psychological factors, poor mental health
- Poor problem solving skills
- Inability to cope with stress on a day to day basis
- Cognitive impairment, lack of inhibition, labile moods
- Psychosis/Delirium/dementia
- Suicide intent, plan, thoughts or history
- Poor physical health
- Hypoxia
- Electrolyte imbalance
- Head injury
- Sensory impairment
- Sepsis
- Loss/grief (e.g. loss of central love interest, family member, housing, income, health)
- Feelings of powerlessness, anger, fear and failure
- Socio-economic indicators (e.g. poverty, low-income households)
- High residential mobility
- Education/IQ (low)
- Demographic indicators (e.g. aggression is more likely within the age range of 20-24 years and in males)

### **Verbal Aggression**

Verbal aggression can range from challenging (lowest form of verbal aggression) to threatening (highest form of verbal aggression). Lower stages of verbal aggression can often be managed through specific techniques and approaches. Threatening in the form of verbal aggression is intolerable and requires the participant to be directed to leave the OPS.

**Table 2: Responding to Lower Stages of Verbal Aggression**

| Stages of Verbal Aggression  | Service Provider Response  | Intervention  |
|--|--|---|
| <p><b>Stage One: Challenging Behaviors</b></p> <ul style="list-style-type: none"> <li>• Relentless questions, with no satisfaction - do not care what the answer is</li> <li>• Garden variety questions, which are questions that have nothing to do with the issue at hand but used as a distraction</li> <li>• Rhetorical questions - a form of distraction</li> <li>• Demanding/instant gratification</li> <li>• No respect for rules or regulations - challenge and test staff.</li> </ul> | <ul style="list-style-type: none"> <li>• If this line of questioning continues, it could become very personal and the service provider's credibility, skill or knowledge.</li> <li>• Acknowledge that the person has escalated from the information seeking questions of anxiety to the challenging questioning of the first level of verbal aggression</li> </ul> | <ul style="list-style-type: none"> <li>• Remain calm.</li> <li>• Do not argue; focus on a common goal.</li> <li>• Redirect them back to the issue at hand.</li> <li>• Ask them a question to distract them (e.g. "Can I ask you something?").</li> <li>• Give a positive directive to assist them in getting their needs met.</li> <li>• Give the individual reasonable choices or consequences - positive first, and a specified time to decide.</li> <li>• Use time and space.</li> </ul> |
| <p><b>Stage Two: Refusing Behaviors</b></p> <ul style="list-style-type: none"> <li>• Disagreeable</li> <li>• Refusing</li> <li>• Silence</li> <li>• Walk away</li> <li>• Verbally (calm or aggressive manner)</li> <li>• Distracting behaviours (refusal in disguise)</li> <li>• Repeated complaints, requests and demands</li> <li>• Blaming others</li> <li>• Exaggerated response of annoyance</li> </ul>   | <ul style="list-style-type: none"> <li>• Remember people in most situations have the right to refuse care. Our role is to give them a clear understanding of the choices they have and the consequences of the choices they make.</li> </ul>   | <ul style="list-style-type: none"> <li>• Remain calm.</li> <li>• Verify that they are refusing.</li> <li>• Verify the reason for the refusal.</li> <li>• Give a positive directive.</li> <li>• Give the individual reasonable choices or consequences- positive first, and a specified time to decide.</li> </ul>   |
| <p><b>Stage Three: Loud Behaviors</b></p> <ul style="list-style-type: none"> <li>• Button pushing</li> <li>• Yelling, shouting</li> </ul>  | <ul style="list-style-type: none"> <li>• At this level of verbal aggression, loud behaviours are driven by emotions and not rational thought. The participant may be feeling powerless and frightened, and escalate their behaviour in an attempt to create a sense of control for him or herself.</li> </ul>  | <ul style="list-style-type: none"> <li>• <b>FIRST PRIORITY: SAFETY FOR STAFF AND PARTICIPANT.</b></li> <li>• Remain calm - isolate the person if safe to do so, and either move them or clear the area of on-lookers</li> <li>• Give a directive to the participant that puts your safety first (e.g. "Please leave the building").</li> <li>• Provide time and space and assess the need for additional staff to be present, or call police.</li> </ul>                                    |
| <p><b>Stage four: Threatening Behaviors</b></p>  | <ul style="list-style-type: none"> <li>• <b>See Table 3: Physical/Verbal Aggression, Behavior that Challenges OPS Rules: Intolerable Behaviors Requiring Direction for Participant to Leave the OPS</b></li> </ul>   | <ul style="list-style-type: none"> <li>• <b>See Table 3: Physical/Verbal Aggression, Behavior that Challenges OPS Rules: Intolerable Behaviors Requiring Direction for Participant to Leave the OPS</b></li> </ul>  |

**Table 3: Physical/Verbal Aggression and/or Behavior that Challenges OPS Rules Requiring Direction for Participants to Leave the OPS\***

| Behavior  | Service Provider Response  | Interventions   |
|---|--|---|
| <p><b>Verbal aggression (stage four)</b></p> <ul style="list-style-type: none"> <li>Verbal threats are intolerable behaviour and will be managed as intolerable behaviour.</li> </ul> <p><b>Physical aggression</b></p> <ul style="list-style-type: none"> <li>Sexual touching.</li> <li>Physical touching with the intent to harm a person</li> <li>Throwing objects with the intent to harm a person or damage the facility.</li> <li>Punching or slapping a staff member or another participant.</li> <li>Kicking with the intent to harm a person or damage the facility.</li> <li>Spitting that is directed at a staff member or another participant.</li> <li>Fighting in the facility.</li> <li>Defacing the facility.</li> <li>Damaging equipment Setting fire to the facility.</li> <li>Walking around with an uncapped needle.</li> </ul> <p><b>Challenge of Facility Rules</b></p> <ul style="list-style-type: none"> <li>Refusing to stop drinking alcohol in the facility.</li> <li>Stealing.</li> <li>Refusing to stop any behaviour that facility staff have requested the participant to stop.</li> </ul> | <ul style="list-style-type: none"> <li>Staff Safety always comes first</li> <li>Consider past history with the participant, and whether or not a specific service provider has rapport with them.</li> <li>Be aware of your own limitations and the volatility of the situation.</li> <li>When asking the participant to leave the facility, assess the need for more staff to be present and/or whether it is necessary to contact the police.</li> <li>If the situation is volatile, remove yourself from until appropriate support arrives</li> <li>Be familiar with the course of action you need to take -know what you can and cannot do ahead of time</li> <li>Prepare for the unexpected:</li> <li>Be aware at all times re: who is available to assist you?</li> <li>Request the participant to return to the OPS for follow-up with the supervisor to negotiate when they may be able to return?</li> <li>Know your exits</li> </ul> | <p><b>For all Behaviours:</b></p> <p>In a calm, clear, matter-of-fact manner</p> <ul style="list-style-type: none"> <li>State the reason for asking the participant to leave</li> <li>Direct the participant to leave the facility.</li> <li>State when the participant may return</li> </ul> <p><b>1. Intervention: Physical Aggression/Assault:</b></p> <ul style="list-style-type: none"> <li>Quickly assess the situation <ul style="list-style-type: none"> <li>Call 911</li> <li>Assess if weapons present</li> <li>Clear exits for staff</li> <li>Remove bystanders from the area</li> </ul> </li> <li>Immediately have two staff members attend the incident while waiting for police: <ul style="list-style-type: none"> <li>One to give direction to the person being assaulted re: protecting themselves/removing themselves from the attacker. The victim should have only one voice to concentrate on, so as not to cause further confusion.</li> <li>A second staff member directs the participant to stop the attack and leave the facility. Attempts to distract the attacker (e.g. flicking the lights on and off or throwing ice water on the attacker) can offer the victim a window of opportunity to escape.</li> </ul> </li> <li>Clear bystanders from the area.</li> <li>Remove any potential weapons from the area.</li> </ul> <p><b>2. Staff Experience of Physical Assault:</b></p> <ul style="list-style-type: none"> <li>Call for help.</li> <li>Trigger an emergency call if available.</li> <li>Protect the vulnerable areas of the body (e.g. face, neck,</li> <li>Move to an area occupied by other staff</li> <li>Ensure that help is on the way.</li> </ul> |

\*The above behaviors have been identified as intolerable to the OPS. When a staff member asks a participant to leave and restricts access to the service, all staff must respect that staff member's decision in order to enforce limits behaviors.

## Evacuation

Should the building need to be evacuated because of violence in a room, staff will ensure that all people not involved in the incident vacate the building. Staff not taking charge of evacuating their areas should attend the incident and provide any assistance they can without putting their safety at risk. The closest staff member not directly involved with the incident will call 911. Advise the dispatcher that there may be sharps and bio-hazardous material in the site. When evacuating the building, staff will close and lock all doors if possible.

Evacuation of staff and participants from the OPS could be necessary in the following situations:

- Fire
- Violent/potentially violent incident which staff cannot contain
- Earthquake
- Bio-chemical hazard

In the above situations, safety of staff and participants is the primary concern. Should an exit be blocked for any reason (e.g. fire, violence or threat of violence, etc.) the staff person in charge of their area is responsible for leading everyone in their area to the next closest safe exit. The site supervisor checks that 911 has been called, coordinates the evacuation and ensures that all staff and participants have left the building.

## Appendix I: Prohibition from Accessing OPS

Participants can be prohibited from using the site for the day by any staff, due to:

- Uttering threats of violence or carrying out violence against anyone on the premises.
- Attempting to deal, purchase or share drugs on the premises.
- Periods of prohibition of more than one day will be set by the RPIC if they determine that the circumstances are severe enough to warrant it.

The following are recommended time frames for prohibition according to the circumstance:

1. Prohibited from using the site for the rest of the shift/day when a participant's behavior that is extremely difficult to control or there is refusal to follow staff direction
2. Prohibited from using the site for up to 24 hours. Access is reinstated only after speaking with the site supervisor. 24-hour prohibition is appropriate for circumstances where the participant has threatened violence directed toward a service provide or other participants, and/or a participant is dealing drugs on site
3. Prohibited from using the site for a period over 24 hours. Access is reinstated once consensus is reached with all services providers, including a supervisor and a manager. This may be reasonable for participants demonstrating:
  - Repeated or serious threats or violence
  - More than one prohibition has already been requested by service providers

### Readmission after Being Prohibited from Using the Site

Barred participants must meet with the site supervisor/manager. They will be readmitted after assurances are made that the behavior will not continue.

### The Steps for Service Provider/Participant Safety if Prohibition is Assigned to a Participant

1. The first step is to avoid triggering conflict (e.g. communicate openly, respectfully and calmly; do not demonstrate aggression or become demanding).
2. The second step is de-escalating the conflict. This includes backing up co-workers by appropriately intervening in conflict in ways that do not make the participants more defensive and by giving the parties to a conflict an easy way out.
3. The final step, when a situation cannot be de-escalated, is to call the police. In any situation involving violence, when staff or participants feel unsafe, the police should be called.

### Documentation of Prohibition from Using the Site

- Service providers must communicate with supervisors as soon as a prohibition occurs.
- The supervisor is responsible for making the decision to place a person on further prohibition after a review of the documented events.
- The prohibition list will be kept current at the sign-in. Reason for refusal will be clearly documented.

## Appendix J: Participants with Special Circumstances: Access to OPS

For sites entirely operated by peers or unregulated health care providers it is recommended to develop a link with your local health authority for clinical support and supervision from a regulated health care provider such as an RN, NP, paramedic or MD. Staff should have access to a regulated health care provider or primary care team to discuss challenging ethical issues and to provide additional support to link clients to local support services and health care.

### A) First Time Injection Drug Use

It is unlikely that a participant would present to the OPS as a first-time user. People who may be transitioning into injection drug use present an opportunity to offer appropriate harm reduction information, while at the same, an opportunity to deter them from initiating a potentially high risk behavior.

In most circumstances these participants are alienated, vulnerable youth who may be at a crossroads between increasingly high-risk behaviors and an opportunity to transition away from a street-entrenched lifestyle

#### Protocol

Access is granted to the OPS after staff member assessment.

Potential first-time PWID may be deterred from transitioning to injection drug use.

Participants who present with first-time injection drug use may have already made the decision to begin injection drug use; therefore, would not be denied the benefits of OPS harm reduction services.

A concerted attempt to refer the individual to a supervised injection site, if available, should be made.

In the event that first-time participants are determined to begin injecting drugs in the OPS, they will be granted access and then encouraged to have their next injection at a supervised injection site (if available) where they can access nursing support.

### B) Pregnancy

Denying access to pregnant women is unlikely to result in their abstinence from drug injection.

#### Background

There are inherent risks to both the mother and fetus associated with the lifestyle of injection drug use, however, pregnant PWID are both shamed by their use and traumatized by the harm that they may be causing to their fetus, making them less likely to access health care services.

#### Protocol

Pregnant participants may be amenable to interventions to reduce harm and access medical treatment and social services if low-threshold services are provided.

Engaging pregnant participants in the OPS activities to make it possible to assist them in moving towards safer drug-using behaviors, treatment and prenatal care services.

### C) Youth

#### Background

Youth represent the highest risk group for contracting hepatitis C and HIV through injection drug use.

Research has shown that younger PWID engage in high-risk behaviours to a greater extent than established PWID, including sharing needles and other drug equipment, engaging in sex trade work and using condoms inconsistently, increasing their vulnerability to blood-borne disease.

There is real potential to reduce the harm associated with ongoing injection drug use in this group, given the rapid acquisition of hepatitis C and HIV infection following initiation into use of intravenous drugs and their increased risk of drug overdose due to their relative inexperience with injection drugs.

The Infants Act explains the legal position of children under 19 years of age and states that children may consent to care on their own as long as the health care provider is sure that the treatment is in the child's best interest, and that the child understands the details of the treatment, including risks and benefits. It is up to the health care provider to assess and ensure the child's understanding of the treatment. For more information on the Infants Act, visit [www.bclaws.ca/civix/document/id/complete/statreg/96223\\_01](http://www.bclaws.ca/civix/document/id/complete/statreg/96223_01).

A child under the age of 19 is called a "minor". "Mature minor consent" refers to consent to health care given by a child who is assessed by a health care provider as having the necessary understanding to give consent. A child who is assessed by a health care provider as being capable to give consent is called a "mature minor". A child who is a mature minor may make their own health care decisions independent of their parents' or guardians' wishes. In B.C., there is no set age when a child is considered capable to give consent.

A health care provider can accept consent from the child and provide the treatment without getting consent from the parent or guardian if the health care provider is sure that the child understands: the need for the treatment; what the treatment involves; and the benefits and risks of having the treatment.

Protocol: OPS Assessment Procedure for Youth Between 16 and 19 years

Youth under the age of 19 will access the OPS only when the youth shows obvious signs of physical addiction to injectable narcotics. When a youth presents at the OPS the supervisor performs the following assessment:

Determination whether the youth has a history of injection drug use and has previously bought injectable narcotics with the intention of self-use, and

Provision of appropriate and expedited referrals to primary health care, addictions care, shelter and/or mental health services as indicated by information gathered, demonstrated symptoms, and/or desire to access appropriate addictions care.

Determination that the youth understands: the need for supervised consumption, what supervised consumption involves; and the benefits and risks of supervised consumption.

For those youths under the age of 19 who request access to the Overdose Prevention Site but do not meet the above criteria, as well as those youths under 19 who are at immediate risk other than that associated with their physical addiction to injectable narcotics, expedited referrals to local care is recommended (youth addictions, mental health services).

## D) Non-Self-Injectors

### Background

Often individuals are unable to inject themselves and rely on others to perform this challenging procedure. Some have never learned how to inject themselves; others cannot because of a physical disability such as blindness or paraplegia.

This is an important population to engage as research has demonstrated a significantly heightened risk for HIV infection associated with this practice. Issues of power are often linked to this practice and most often, it is women that rely on a man to inject them. In street-entrenched communities, this service is often provided in exchange for money, drugs or sexual favors.

Ideally only self-injection occurs in the OPS; however, sites should consider the local context and aim not to turn away highly marginalized clients who are requesting support from another participant for injection purposes. Service providers may not administer an injection.

### Protocol

Non-self-injectors will be identified and assessed whether the barrier to self-injection is education or a physical disability.

If the barrier is education, then trained OPS staff may provide education to support the participant to self-inject in a safer manner.

If the barrier is physical disability, the OPS staff will determine whether any physical supports, not directly related to the provision of the injection, might assist in self-injection.

All efforts will be made to connect non-self-injectors with safe support services.

## E) Overly Intoxicated Participants

### Background

Intoxicated persons present unique problems due to the likelihood of even higher risk of needle-sharing, fatal overdose, assault or otherwise unsafely injecting.

### Consideration

If overly intoxicated individuals are denied access to clean equipment and a safe location with on-site supervision this likelihood of harmful outcome is compounded. However, allowing intoxicated individuals to inject when they are clearly at greater risk for overdose also presents certain problems. It is left to the discretion of OPS staff to determine the harm versus benefit (for the individual and other participants using the OPS) in allowing access to a person who is overly intoxicated.

## Appendix K: Physical Space for Injecting and Ventilation Requirements

Ventilation for OPS sites should meet the Canadian standard for air changes, which is dependent on occupancy (see below).

### Ventilation

9.41 (1) Each personal service room and food preparation area shall be ventilated to provide at least two changes of air per hour

- (a) by mechanical means, where the room is normally used by 10 or more employees at any one time; or
- (b) by mechanical means or natural ventilation through a window or similar opening, where the room is used by fewer than 10 employees if
  - (i) the window or similar opening is located on an outside wall of the room, and
  - (ii) not less than 0.2 m<sup>2</sup> of unobstructed ventilation is provided for each of the employees who normally use the room at any one time.

(2) Where an employer provides ventilation by mechanical means in accordance with paragraph (1)(a), the amount of air provided for a type of room set out in Column I of an item of the schedule to this Part shall be not less than that set out in Column II of that item.

(3) Where an employer provides for the ventilation of a food preparation area or a lunch room by mechanical means in accordance with paragraph (1)(a), the rate of change of air shall be not less than nine litres per second for each employee who is normally employed in the food preparation area at any one time or for each employee who uses the lunch room at any one time.

SOR/88-632, s. 38(F).

## Appendix L: Activities that Require Extreme Caution: Supporting Safer Injection

\*Undertake with extreme caution, by trained staff only and when other options have been exhausted\*

The following are considered activities that require extreme caution:

- Removing tourniquet after participant injects to prevent vein damage and blood leakage from the injection site (risk of needle stick injury to staff).
- Supporting the participant to stabilize the syringe or vein while injecting (risk of needle stick injury to staff)
- Directing the participant to adjust the angle of the syringe while the syringe in body (risk of needle stick injury to staff).
- Supporting the participant to cook/prep drugs (risk of spillage and blame)
- This includes changing syringes
- Supporting removal of the syringe from the body in emergency situations (risk of needle stick injury)

When participating in these activities staff should:

- Always keep their hands behind the syringe, never in front of the syringe tip/needle
- For support in anchoring the vein:
  - Place hands behind and below the syringe, on the opposite side of the limb, away from the syringe
  - Use a tongue depressor to gain further distance between staff hands and the syringe
  - \*The best way to anchor a vein is to educate the participant in vein anchoring techniques

If participant is lucid and stable → make a verbal agreement with them:

- To give verbal notice if, in the process of receiving injection support, they are going to move their rig (i.e.: re-landmark)
- While the participant adjusts the syringe, staff will remove themselves from booth

When directly supervising injections:

- Self-injection should take place in the participant's assigned booth with participant seated in chair
- This minimizes risk of needle-stick injury related to:
  - Participant and/or staff positioning
  - Unpredictability of participant movements
  - Stand/sit on the side of the participant that is furthest from the hand holding the syringe.

Authorized Activities – By Trained Staff only:

- Verbally explain all steps in safer injection process (Harm Reduction Education)
- Educate participants to self-anchor their veins and syringes.
- Palpate participant's arm for veins to assist land marking. This is an important part of vein care
- Identify potential injection sites, including physically guiding participant's hand to the appropriate injection area

- Encourage hand washing as a measure to prevent infection
- Swab participant's arm with alcohol swab to reduce infection from unclean injection practices
- Demonstrate how to tie off the participant's arm
- Physically demonstrate all steps in safer injection process using separate set of clean equipment and own body (mock injection only)

NOTE: PWID who cannot prepare their own substances are likely to seek “doctoring” from another PWID, which increases the potential for unsafe injection, and transmission of blood borne pathogens.

## Appendix M: Injecting into the Jugular Vein (Jugging)

**BACKGROUND:** Those who use and inject illicit drugs are at high risk for soft tissue infections, and more serious infections such as endocarditis. These infections and other serious medical problems can occur from injection at into any vein. The jugular veins pose higher risk for the following reasons.

- The anatomical location of the jugular is very close to large blood vessels (including arteries), nerves, the trachea and the esophagus
- An abscess in close proximity to these structures could cause compression of nerves, and vessels supplying blood to the brain
- A large abscess on the jugular line could potentially cause compression or narrowing of the airway
- Jugular infection could travel easily to the brain or heart
- Air embolus can easily enter the blood stream from jugular injection and travel into the heart and coronary arteries (heart attack) or the brain (stroke) or to the lungs (pulmonary embolism). Air is more likely to enter through injection into the Jugular vein because of the lack of valves and because of the negative pressure in the jugular, associated with inspiration

Trained OPS staff can provide injection education in the context of harm reduction, with regards to injecting into the jugular vein.

- Constantly monitoring the OPS space for both overdose **and** opportunities for education, while performing daily tasks
- OPS staff may offer participants who are noted to be injecting into the jugular education. If the participant indicates they require support - determine the following:
  - i) Participant's rationale for using the jugular, and participant's knowledge of risks of injecting into the jugular
  - ii) Whether the participant has any visible or palpable venous access other than the jugular
  - iii) Whether the participant can inject their drugs intramuscularly

Based on the above assessment, in priority sequence:

1. Explore with the participant, the possibility of self-injecting into a different vein
2. Educate the participant regarding other alternatives, e.g. "muscling" (self-inject intramuscularly)
3. Educate the participant on the risks involved with injecting into the jugular
4. Educate the participant to safely self-inject into their Jugular vein, IF and only IF participant determined to do so
5. Document appropriately and accurately on the database.

**OPS RN Staff:** Nurses are ethically obligated to provide proper and adequate education as outlined in the CNA Code of Ethics “Promoting and Respecting Informed Decision-Making” and the CRNBC Practice Standard “duty to Provide Care” This includes:

- Education on the risks involved (clot or obstruction, embolus, infection, overdose, heart attack/stroke, embolus, compression of vital structures in the neck)
- How to minimize these risks (Harm Reduction Education)
- How to landmark the vein for injection and other safe-injection education

## Appendix N: Management of abscesses and cellulitis related to injection drug use (PHS, 2016)

This section is for information purposes only. If participants express or present with any of the following health concerns refer to a primary care or emergency room for evaluation.

### Abscesses and Cellulitis

- An **abscess** is an enclosed collection of purulent liquid, known as “pus”. It can form in skin, muscle, or other soft tissue in the body.
- **Cellulitis** is an infection of skin or soft tissue.
- Bacteria cause abscesses and cellulitis. Bacteria are often introduced because the skin is not cleaned properly prior to the injection of drugs.
- There are four signs of inflammation / infection:
  - Heat
  - Swelling
  - Redness
  - Pain
- Participants with an abscess should be encouraged to seek medical attention as soon as possible. Their infection may need antibiotics and/or need to be drained. Abscesses may also benefit from frequent application of clean hot compresses, hot tap water in a nitrile glove is a simple and cost effective intervention.

## Appendix O: Protocol for providing Oxygen Therapy and Use of Bag Valve Masks

### Use of Oxygen: Principles

- Oxygen is only to be used in response to an overdose.
- Do not give oxygen unless the person is unconscious.
- Oxygen saturation should be checked before administration of oxygen, if possible. If the layperson is not familiar with pulse oximeters or one is not available, the person should receive assisted ventilation or O<sub>2</sub> until a higher level of care arrives.
- In an emergency in which a person is unconscious and experiencing respiratory collapse (not breathing, low oxygen saturation, blue skin) use a bag-valve mask (ambu bag) with high-flow oxygen at 15 litres/min which will deliver approximately 75-100% oxygen.
- The mask should be held firmly over their face using a C-hold to ensure a good seal.
- Continuously monitor the person's oxygen saturation level with a pulse oximeter.
- In cases of suspected cardiac arrest that CPR with rescue breathing should be commenced. There is reasonable consensus it will cause no harm even if the patient has intrinsic low flow cardiac output.
- When 911 is activated the rescuer will be given instructions over the phone by the 911 call taker to ventilate and if appropriate perform CPR in suspected cardiac arrest.

For patients with chronic conditions such as COPD, a high concentration of oxygen is usually contraindicated. However, if the person is unconscious from an opioid overdose, oxygen is indicated to keep their saturation above 90% until paramedics arrive. In an acute respiratory arrest or OD situation there is no harm in applying O<sub>2</sub> to patients with COPD while they are assisted and until they are breathing on their own. Once the paramedics arrive a reassessment can then be done to determine the need for continued supplemental oxygen.

### Overdose Response Procedure if Oxygen Therapy Available:

1. Call 911
2. Insert the oral airway or head tilt and chin lift
3. Set the O<sub>2</sub> at 15L/min and provide ventilation at 1 breath every 5 seconds
4. If available, follow BVM procedure outlined below
5. Administer naloxone (as described above)
6. Evaluate, (continue to provide breaths, 1 every 5 seconds) while waiting 3-5 minutes before giving another dose of naloxone.
7. Provide continuous oxygen.
8. If there is no response after 3-5 minutes, GIVE A 2ND DOSE OF NALOXONE (as described above)
9. Wait 3-5 min, continue to give oxygen and breaths
10. Continue to give naloxone as described above every 3-5 minutes (while rescue breathing) until the person responds OR paramedics arrive
11. Document and Debrief
12. Restock crash kit and oxygen supplies

#### BVM Procedure:

Use of a bag valve mask is recommended when two people are available to respond to an overdose. Using a bag valve mask takes practice. It is important to learn to skillfully seal the mask to the face of the patient without crushing it onto the face. The patient's face should be pulled up.

1. Gather your equipment (if available): a pulse oximeter, oxygen source, bag-valve mask device, cushioned rim mask, airways (if available and trained)
2. Head tilt-chin lift is done by using one hand to apply downward pressure on the forehead, while the other hand lifts the chin.
3. If oxygen is available, the bag-valve mask unit should be attached to high-flow oxygen at 15 liters per minute, at which a typical device delivers about 75% oxygen.
4. If trained and available, insert airway
5. Obtain an adequate seal using the 'EC' hand position using the thumb and index finger holding the mask and the upper and lower mask borders, respectively. The other three fingers hold the jaw while performing the jaw thrust. If using the two-provider technique, one person should hold the mask with both hands, while the other provider bags the patient. A common location of air leak is located around the nasal bridge, which should be detected when attempting ventilation.
6. Once the position and seal are obtained, "bagging" can commence. The rate of ventilation for an adult is 10-12 breaths per minute or, approximately 1 bag squeeze every 5-6 seconds.
7. The bag should be depressed for a full 1-2 seconds and then released. Chest rise should be seen. Appropriate oxygenation and ventilation should be reflected by pulse oximetry readings.

Common pitfalls of BVM ventilation include inadequate positioning, improper mask holding, and failure to use an oral or nasal airway. Providers tend to hyperventilate patients. The emergency medicine literature has demonstrated that hyperventilation can be harmful by increasing intra-thoracic pressure, which decreases venous blood to the heart and subsequently decreases cerebral and coronary perfusion.

## Appendix P: Law Enforcement and OPS Sites

Adapted from Harm Reduction: a British Columbia community guide. British Columbia Ministry of Health.  
[www.health.gov.bc.ca/prevent/pdf/hrcommunityguide.pdf](http://www.health.gov.bc.ca/prevent/pdf/hrcommunityguide.pdf)

Public Health and law enforcement are both concerned with reducing drug-related harms. While the contexts and mandates may differ, both sectors are responsible for public safety and there is considerable overlap and mutual benefit in working together. Both Public Health and law enforcement should recognize the possible positive and negative ramifications of their operations may have on a community: Police enforcement activities may influence health harms such as overdoses and the spread of blood-borne diseases; and Public Health programs may influence crime and public nuisance complaints. Mutual understanding of each other's mandates, jurisdictions, operations and legal and organizational limitations is essential to optimizing access and outcomes for OPS clients and ensuring support from local communities and governments.

Policing practices in many jurisdictions have changed over the past few decades. They have become less reactive and more proactive, intelligence driven, and concerned with implementing best practice. This has required a greater understanding and use of crime prevention strategies, which is a similar approach to health promotion and protection. Harm reduction based approaches to law enforcement complement public health efforts by seeking to reduce the net harm experienced by drug users and the community. Examples of these enforcement practices include greater use of discretion by police, provision of harm reduction training for police, direct involvement of police in harm reduction activities, and partnerships between police and health agencies. The use of discretion in attending overdoses (e.g. police not attending non-fatal overdoses) is well established and has reduced the reluctance of drug users to call ambulances, resulting in fewer deaths. Other accepted discretionary practices are the use of warnings or cautioning and the use of referrals to appropriate health and social services as alternatives to arrest and confiscation of injection equipment.

Health care providers should recognize that laws change and evolve to reflect societal values. The royal assent of the Good Samaritan Drug Overdose Act in May 2017 provides an exemption from charges of drug possession for people who call 911 for themselves or another person suffering an overdose, as well as anyone who is at the scene. While this act codified an existing discretionary police practice to reduce barriers to emergency care, others legal barriers may be slower to change or may persist indefinitely, and law enforcement may have less discretionary power in some cases.

While police as first responders may frequently be involved with overdose resuscitation efforts, there is evidence that police can reduce harm by maintaining adequate distance from health services used by drug users, so as not to deter access, and by not interacting with drug users during the injection process. According to a report by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), supervised consumption site staff and neighbourhood committees are working in partnership with local police to minimize public nuisance and increase the efficacy of overdose prevention strategies. The Vancouver Police Department was a partner in establishing Insite and supports the facility as part of the four-pillar integrated approach to substance use in Vancouver. Police have reported public order benefits in the wake of the opening Insite.

The Canadian Centre on Substance Use and Addictions (CCSA)'s guideline on the role of police in harm reduction suggests:

- Police should avoid unnecessary visits and enter only with permission from operators unless they are in active pursuit of a suspect
- Police Services should be actively involved with the planning and development of overdose prevention sites and be supportive of the role it plays as a public health initiative.
- Police services should actively refer drug users who are injecting in public to local overdose prevention sites and supervised consumption services along with treatment and support.

OPS staff should recognize that police officers may need to enter facilities to perform law enforcement duties and should make every effort to cooperate. Health care workers and Public Health officials involved in OPS activities are encouraged to proactively engage local law enforcement in all stages of planning and operations and to maintain ongoing dialogue with local detachments to address client and community issues.

## Appendix Q: Cleaning Check List Template for OPS Space

| Overdose Prevention Site |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Doors                    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Floor mopped             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Counters                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Sinks                    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Phones                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Garbage out              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Restock towel            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Cupboard doors           |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Clean mirrors            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Phones                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Walls                    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |