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1.0 Harm Reduction Definition

Harm reduction (HR) is a set of principles, practices and approaches to care that aims to minimise negative health, social, and legal impacts associated with sexual activity, sex work, illicit and licit substance use, substance use policies, and drug laws. Harm reduction is an integral component of the health promotion and illness prevention, treatment, and care continuum, encompassing community actions, service delivery, programs, and policies.

Harm reduction does not require that people stop using substances as a precondition of support. It is grounded in evidence, justice, and human rights; it respects, and represents the right of people to self-determination, and ensures equitable access to services and supports that protect their health.

2.0 Policy Statement

In British Columbia, harm reduction practice goes beyond the distribution and recovery of harm reduction supplies and includes approaches to community engagement and service delivery that can be applied in any community, health, or social services setting. Effective harm reduction policy and programming is cost effective, reduces health and social deficits, and has a positive impact on individual, community, and public health. For harm reduction programming to be successful, it must be a collaboration between Health Authorities, health and social services, community partners, and people with lived and living experiences with substance use and harms related to sexual activity (PWLLE). It also requires buy-in and support from law enforcement and all levels of government.

Together, these stakeholders must collaborate to develop and implement policies, programmes, and services that address the health, social and community conditions that increase susceptibility to harms. This includes addressing social determinates of health (SDOH) and identifying and challenging the drivers of stigma and discrimination within health and social service systems and society. This requires that stakeholders question existing policies and practices that increase the risk of harms for PWLLE. (E.g., challenging institutional or community policies and practices that stigmatize or marginalize PWLLE, or raising awareness about the community’s willingness to tolerate a high level of overdoses from a toxic street drug supply and advocating for a safe and legal supply of substances). Harm reduction programs must also work to accommodate the needs of diverse population groups within their cultural and social settings, such as lesbian, gay, trans, bisexual, queer, and two spirited (LGTBQ2S), or Black, Indigenous, and people of colour (BIPOC).

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1. https://www.hri.global/what-is-harm-reduction
Core harm reduction services are based on a respectful relationship between service providers and people who access health and social services. They focus on positive and supportive exchanges, working with people where they are, without judgement, coercion, or discrimination. They are grounded in human rights and dignity, adhering to basic ethical principles such as fairness, doing good for others, not harming others, and respecting peoples’ autonomy. Harm reduction service providers must develop competence\(^4\) in harm reduction service delivery by aligning their harm reduction practices with the principles of harm reduction.

Harm reduction recognizes that substance use may have a mix of benefits and risks for some people. It does not presuppose that reducing or stopping substance use is an objective—although this may be the case for some people. People who access harm reduction services are diverse and have been historically underserved, stigmatized, and discriminated against. The meaningful involvement of PWLLE in the development, implementation, and evaluation of harm reduction services is essential to ensuring those services are effective, accessible, and acceptable to the people they serve. It is vital to the success of harm reduction services that PWLLE have culturally and socially safe opportunities to actively participate in the development and implementation of harm reduction policies and practices as peer workers (Peers, or experiential workers)\(^5\). This ensures that services are responsive to the specific needs encountered within the diverse and unique population groups within a community.

### 3.0 Scope

These guidelines support provincial harm reduction strategies and services pertaining to substance use and sexual health in collaboration with the British Columbia Centre for Disease Control’s (BCCDC’s) Harm Reduction Strategies and Services Program (HRSS)\(^6\). Their purpose is to support Harm Reduction programs and services to reduce the health and social harms resulting from substance use and sexual activity.

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\(^4\) See Appendix 2 for HR worker Competencies.
\(^5\) Please see [https://towardtheheart.com/peer-engagement](https://towardtheheart.com/peer-engagement) for more information on engaging Peers in HR work
4.0 Education

Evidence and competency-based\(^7\) harm reduction education builds the knowledge, skills, attitudes, and judgement required to provide and most effectively achieve individual and community benefits from harm reduction services. The relevance and reach of harm reduction education and training is improved through collaboration with PWLLE and Peer groups. This includes encouraging and including the meaningful involvement of Peers as experts in the design, development, and delivery of harm reduction education.

To be effective, it is important that harm reduction education meets the needs of the different groups and populations within the community. For example, Indigenous cultural safety and humility training, or learning about the unique needs of LGBTQ2S, men using alone\(^8,9\), and youth\(^10\) populations would enhance the delivery of harm reduction services to the people in those groups. Health Authorities and organizations providing harm reduction services can improve access to educational and capacity building opportunities by maintaining an up-to-date list of available resources and learning opportunities that PWLLE and service providers can access.

Collaboration between Health Authorities and organizations providing harm reduction services ensures that harm reduction education is available to stakeholders in the community. Potential collaborators include:
- People who use harm reduction services
- Direct providers of harm reduction services in the community
- Peer support groups and programs
- Drug user organizations and PWLLE networks
- Health and social services whose work intersects with harm reduction services (e.g., hospital staff, social workers, financial aid and housing workers, community support workers, and police)
- People working in industries that benefit from harm reduction training in the workplace (e.g., construction, hospitality and commerce)
- Members of the larger community within which harm reduction services are provided

\(^{7}\) See Appendix 2 for Standards of Practice and Competencies for Peers and HR workers in British Columbia.
\(^{10}\) See Appendix 3: Mature Minors policy.
4.1. **People who use harm reduction services.** As an integral part of harm reduction supply distribution practice, each harm reduction service can provide education for clients regarding:

- Overview of harm reduction approaches and practices
- Safer injection practices including discussion about vein health, and prevention of blood borne and other infections;
- Safer substance smoking practices
- Overdose prevention and response (including “overamping”\(^{11}\))
- Overview of how and when to use different supplies
- Supplies for hormone therapy
- Perinatal substance use and supports and services
- Safe needle return, collection and/or disposal
- Safer sex practices, including harm reduction practices for people who do sex work
- Principles of general health and wellness
- Information on poly-substance use and associated risks and harm reduction strategies
- Accessing, navigating, and advocating for health care and social services
- Connection to culture through Indigenous organizations

4.2. **Harm reduction service providers.** All staff, Peers, and volunteers who provide harm reduction services should receive an appropriate orientation\(^{12}\) and training\(^{13}\) in harm reduction strategies and service delivery. Topics and approaches to service provider education include:

- Overdose prevention and response
- Peer engagement principles and best practices\(^{14}\)
- Harm reduction principles and practices\(^{15}\)
- Health promotion and illness prevention
- Public health ethics
- Connection and communication
- Health equity and inclusion
- The psycho-social and historical roots of substance use
- Trauma and violence-informed practice
- Mental health and crisis support (e.g., supporting someone who is grieving; de-escalation practices)
- Distribution and recovery of harm reduction supplies
- Safe handling of biohazardous material
- Working with youth

\(^{11}\) [http://stopoverdose.org/docs/OverAmping.pdf](http://stopoverdose.org/docs/OverAmping.pdf)


\(^{13}\) Consult with Health Authority HR Coordinator regarding HR education programs that are currently available.

\(^{14}\) [https://towardtheheart.com/peer-engagement](https://towardtheheart.com/peer-engagement)

- Completion of Indigenous cultural safety and humility training
- Unconscious bias training
- The relationship between social determinants of health and harms from substance use
- Change management principles and practices

4.3. **Peer support groups and programs.** Peer support groups advocate and provide support for the Peer community. They also liaise and collaborate with harm reduction service providers to ensure that harm reduction services are designed and delivered to meet the needs of PWLLE in the community.

Peer support groups grow stronger, and individuals build competence, confidence, and resiliency through education and training opportunities. Collaboration between Health Authorities, contracted agencies, PWLLE, and Peer support groups will enhance the design, development, and delivery of training for Peer support group members and health authority staff.

4.4. **Other health and social services workers.** Health Authorities and contracted agencies can ensure that health and social services accessed by PWLLE have information and support available to develop policies and service delivery models that align with harm reduction principles.

4.5. **Broader community in which harm reduction services are provided.** Harm reduction services are more likely to succeed when there is support for them within the larger community or municipality. Health Authorities, local, provincial, and national governments, and community-based harm reduction services promote this by providing information to members of the broader community. This can include proactive engagements with municipal governments to provide information about harm reduction principles and practices. It can involve engaging the non-drug using community in improving safety, such as safe handling, storage, and disposal of illicit substances or used syringes, or how to handle a needle-stick injury\(^\text{16}\).

5.0 Distribution, Recovery, and Safe Disposal of Harm Reduction Supplies

The Health Authority and the agencies providing harm reduction services within its boundaries must collaborate with local municipalities, Peers, and community stakeholders to formulate and implement a community plan for distribution, recovery, and safe disposal of used harm reduction supplies. This includes:

- Determining the appropriate location of distribution and recovery sites
- Identifying who will be involved in harm reduction supply recovery
- Protocols (e.g., handling biohazardous material)
- Training in preventing occupational exposure to blood and body fluids, and how to respond to a blood and/or body fluid exposure

Health Authority and community agencies will describe approaches to how supplies are distributed, recovered, or otherwise disposed of, as well as efforts undertaken to reduce inappropriately discarded supplies. Health Authorities will be responsible for ensuring that this information is made available to community partners.

5.1. Distribution: The BC Harm Reduction Strategies and Services (HRSS) recommends that harm reduction programs and services strive to achieve maximum reach of harm reduction supplies according to best practices\(^\text{17}\). Service providers must ensure clients can access harm reduction supplies quickly and easily with low-to-no barriers. Access to harm reduction supplies should extend to whoever needs them, regardless of the person’s age\(^\text{18}\), sex, gender, ethnicity, income level, substance-using status, substance of choice, sexual practices, or place of residence. This includes promoting the full range of harm reduction services (including needle and syringe distribution) in all health care settings, community and social services, shelters, and prisons.

Limits should not be set on the quantity of supplies provided. This ensures that people can access all necessary harm reduction supplies to prevent harms as and when needed. To maximise access to harm reduction supplies, sites may consider innovative distribution modalities, including vending machines and self-service models. HRSS encourages agencies to provide supplies for peer-to-peer distribution to reach people who may not be able to access harm reduction distribution sites (e.g., for health reasons, or due to legal prohibitions like rezoning, or the distance of their residence from the HR site).

\(^{17}\) Please refer to the Best Practice Recommendations for Canadian Harm Reduction Programs: https://www.catie.ca/sites/default/files/2021-11/3382_CATIE_CarolStrike_BestPracticeRecommendations_2021-EN-Final.pdf.

\(^{18}\) See Mature Minor Policy, Appendix 3
5.2. **Recovery and safe disposal:** Public health units and agencies that receive supplies from HRSS must ensure that used harm reduction supplies are safely collected\(^\text{19}\), handled, and disposed\(^\text{20}\) of. Harm reduction stakeholders should collaborate to develop community and health authority plans that outline how used supplies will be collected, transported, and disposed of. It should outline approaches to establishing and supporting Peer-led used supply collection.

Used harm reduction supplies must be accepted at all harm reduction services sites, community health and public health sites, and at community pharmacies (where possible). Plans should be developed for discreet and appropriate opportunities for people to dispose of used harm reduction supplies. Transport of used syringes is made safer when small sharps containers are available to people who use drugs for personal use and large sharps disposal containers are situated in key locations throughout the community. Peer needle recovery programs (such as community needle sweep programs) can be utilized to collect used syringes, as required. Some communities also arrange to have used harm reduction supplies picked up either through the Health Authority or by peer-based programs.

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\(^{19}\) [https://towardtheheart.com/resource/safe-needle-pick-up/open](https://towardtheheart.com/resource/safe-needle-pick-up/open)

6.0 Overdose Prevention

Overdose prevention strategies and services are essential for preventing death and lifelong health challenges. BC’s illicit drug supply is increasingly toxic and adulterated. In 2016, BC’s Provincial Health Officer declared a public health emergency in response to the significant increase in illicit drug overdose deaths. Since then, thousands of people have died of overdose in BC, making it the leading cause of unnatural death in BC.

The sharp escalation in overdose deaths is largely attributed to the increased presence of fentanyl and its analogues in the illicit drug supply, including in depressants and stimulants. These are sometimes mixed with benzodiazepines, which has resulted in changes in the signs and symptoms of an overdose: some of these presentations are unusual or complex and may be more challenging to identify as an overdose (e.g., dyskinesia rigidity, or prolonged sedation, but still breathing). These unusual presentations could result in delayed response to the overdose, especially if the person unknowingly used an opioid.

Sites providing harm reduction and overdose prevention services may also offer drug checking services. These services can indicate if a substance contains adulterants, contaminants, or if it is a different substance than anticipated. This provides people who use substances with information about the potential effects and harms of using the tested substance and the ability to make informed decisions regarding their substance use.

All sites providing harm reduction services must offer information or training on preventing, recognizing, and responding to overdose. Harm reduction services should have a plan in place to ensure that everyone who uses drugs can access appropriate overdose prevention and response services. This includes offering overdose prevention and response training, having Take-Home Naloxone (THN) kits on site, providing referrals to nearby sites that operate a THN program, and facilitating access to safer drug supplies. Where possible, sites distributing harm reduction supplies should work with nearby agencies to facilitate referrals to appropriate services and participate in the THN program. Information about THN training and training materials are posted on the Toward the Heart website.

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22 https://www.cmaj.ca/content/190/2/E35.short
26 Sites where THN training and kits are available can be identified through the online site-finder at http://towardtheheart.com/site-locator
27 http://towardtheheart.com/naloxone
A significant number of opioid overdoses happen among people who use drugs alone. Harm reduction services can reduce this by providing education, information, and support to people who may be at greater risk of using alone, such as access to technologies like the Lifeguard app. Information and training resources about responding to different types of overdoses can be found on the Toward the Heart website\textsuperscript{28}, along with alerts about adulterated drugs in BC.

7.0 Facilitating Access to Other Services

Harm reduction services exist within a continuum of health and social services delivery. People who access harm reduction services may require supports for challenges to any of the Social Determinants of Health. Access to health and social services that PWLLE need is improved when harm reduction services collaborate across sectors and work with Peers.

When health and social services accessed by PWLLE have policies and practices that align with harm reduction principles, and are congruent with the local context, they become socially, psychologically, and culturally safer places for people to address their health and wellness, and social needs. Harm reduction service providers can promote these safer and supportive environments by collaborating with Peers and PWLLE to build relationships across health and social service sectors, assisting them to re-orient their policies and approaches service delivery.

Harm reduction services that are familiar with the current health and social services and resources operating in a community will be better able to refer PWLLE to the services they need.

Examples of health services referrals include:
- Clinics for communicable disease, vaccination, and other public health services
- Primary care clinics and/or clinicians who are familiar with the PWLLE population and substance use issues
- Sexual health specific services
- Counselling and screening services for mental health and substance use
- Cultural supports, including Elders, Traditional Healers, and land-based healing programs\textsuperscript{29}
- Take home naloxone training and kits
- Access to safer supply of opioids
- Substance use treatment services

\textsuperscript{28} https://towardtheheart.com/
\textsuperscript{29} https://www.fnha.ca/what-we-do/mental-wellness-and-substance-use/overdose-information
Examples of social support service and referrals include:
- Aboriginal friendship centers
- Aboriginal Patient Liaison/Navigator workers
- Native court worker and counselling services\(^{30}\)
- Métis Nation Regional Health coordinators
- Housing and income support
- Supports for people who do sex work.
- Food and nutrition support services.
- Gender-specific services
- Parenting assistance
- Youth services
- Legal services/survivor services

\(^{30}\) [https://nccabc.ca/](https://nccabc.ca/)
8.0 Glossary

Note: The meanings of some of the terms in this glossary are contested. These definitions are meant specifically for this document and may be updated over time.

Aboriginal
A legal term to identify the first inhabitants of Canada, and includes First Nations, Inuit, and Métis people. In Canada, this term is not favored by Indigenous people, as popular usage originates in the constitution and for some, represents terminology imposed on first peoples by settlers.

BIPOC
Refers to people who are Black, Indigenous, and people of colour. The rationale for adding Black and Indigenous to POC (People of Color) is to bring attention to the systemic and structural racism and the specific experiences of colonialism experienced by Black and Indigenous peoples. If you know the community you are specifically referring to, please be specific.

Competence
The attitudes, knowledge, skills, and judgement required for a person to contribute to, and participate in, an area of practice efficiently and effectively. Competence can be gained through lived experience and/or formal education, and gaining it is an active, life-long process.

Cultural safety and humility
Cultural safety and humility is the ideal result of respectful engagement. Its aim is to address power imbalances in the healthcare system. A culturally safe environment is free of racism and discrimination, where all people feel safe when receiving health care. It is for the patient to decide whether they are receiving culturally safe care, rather than for the provider.

Cultural humility is a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another’s experience.\(^{31}\)

Equity
The actions or processes required to balance the imbalanced. In society this means recognizing both historical and current experiences that disadvantage, prevent, or actively discourage certain people or groups of people from opportunities. Equitable care addresses the impacts of social determinants of

health and focuses on “pursuing the highest possible standard of health and healthcare for all people, paying special attention to those in the context of greater risk of poor health, and taking into account broad social, political, and economic influences and access to care”32.

**Experiential workers**
People whose expertise in their field of work is formed in part from lived experiences with substance use or sexual experiences (including sex work). Often used interchangeably with Peer Workers or Peers.

**First Nations**
Refers to Aboriginal peoples who are neither Métis nor Inuit. Adopted in the 1970s to replace “Indian”, which is rooted in colonialism and racism, and is considered offensive.

**Health Promotion**
The personal, organizational, social, and governmental actions required to improve the health of people in a community.

**Health Service Delivery Area (HSDA)**
Distinct regions within a Health Authority where organizations and programs collaborate to meet health services requirements of the local population.

**Illicit**
In substance use, illicit refers to using substances in a way that they either were not intended, is illegal, or is not socially accepted33.

**Indian**
The legal term used to identify First Nations people registered under the Indian Act34. In Canada, outside of this strict legal context, this term is offensive to many Indigenous people.

**Indigenous**
Term popularly used to refer to all First peoples in Canada. Includes First Nations, Inuit, and Métis peoples.

**Inuit**
Indigenous people who live in or originate from the far northern regions of Canada.

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34 [https://laws-lois.justice.gc.ca/eng/acts/i-5/](https://laws-lois.justice.gc.ca/eng/acts/i-5/)
Métis
Métis are Indigenous peoples whose social structure, culture, and identity evolved from the blending of European and Indigenous people and cultures. From this emerged a unique culture, traditions, and language (Michif) that are distinct from other Indigenous populations.

Overamping:
Overdosing on stimulants that may result in feeling unsettled, or in hyper-alertness and hyper-activity. In extreme cases can cause seizures, heart attacks, or strokes.

Peers
In harm reduction practice, this refers to people who bring their lived and living experiences to their community engagement, activism, or work. Often used interchangeably with Experiential Workers, or Peer Workers.

People with Lived and Living experience
Community members whose current or past life experiences with drug use informs their knowledge about the personal, social, legal, and health impacts – including benefits and harms – associated with substance use. PWLLE may or may not work as Peers or experiential workers.

Population Health
An approach to health that identifies unique characteristics of distinct populations within society, and identifies steps required to improve the health and reduce health inequities within those populations.

Social Determinants of Health
The conditions in the environments where people are born, live, learn, work, and play that affect a wide range of health outcomes.

Syndemic
A set of connected health or social problems that act together to intensify the negative health outcomes for the individual or population.
9.0 Recommended Reading


British Columbia Centre for Disease Control. Respectful Language and Stigma: https://towardtheheart.com/assets/uploads/1502392191GWLGqDb5w5GiajwRuiq4IPoSyhSoMkp3T7rL5ml.pdf


Canadian Centre on Substance Abuse. Addiction and mental Health Care: Resources to Support Collaboration. https://www.ccsa.ca/addiction-and-mental-health-care-resources-support-collaboration-0


Appendix 1: Receiving, Satellite and One-Off Harm Reduction Supply Distribution Site Policy

Purpose
The purpose of this appendix is to define distribution sites that receive publicly funded safer sex and drug use supplies, to provide guidance on establishing these sites, and to explain the process to be completed for receiving sites, satellite sites, or one-off event to receive supplies.

Receiving Site/ Satellite Site Definitions

**Receiving site** - a site such as a Health Unit that orders supplies directly from BCCDC and receives those supplies directly from the central distributor. This site may also order supplies on behalf of an authorized satellite site(s).

Decision to designate a receiving site is made by:
Health Authority (HA) HRSS Representative in collaboration with BCCDC Harm Reduction lead(s).

**Satellite site** - a site that picks-up or is sent their supplies from a receiving site (as defined above).

Decision to designate a satellite site is made by:
Receiving site manager in consultation with the HA HRSS Representative.

Note: it is important that HRSS representatives and BCCDC know how to contacts satellite sites with important/time sensitive information/alerts and for tracking supply distribution.

Receiving / Satellite site designation distinctions

<table>
<thead>
<tr>
<th>Decision factor</th>
<th>Receiving site</th>
<th>Satellite site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independency</td>
<td>Can operate independently because:</td>
<td>Cannot operate independently because the site needs regular contact/follow up with receiving site to verify accountability and training of staff</td>
</tr>
<tr>
<td></td>
<td>• proven accountability</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• trained staff</td>
<td></td>
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<tr>
<td></td>
<td>• ensures ongoing compliance with policies/best practices of the Regional HA and of the HRSS Committee.</td>
<td></td>
</tr>
<tr>
<td>Quantity of Supply</td>
<td>Large supply quantity for each requisition*:</td>
<td>Small supply quantity for each requisition:</td>
</tr>
<tr>
<td></td>
<td>• shipping cost is justified</td>
<td>• shipping cost is not justified</td>
</tr>
<tr>
<td>Remoteness</td>
<td>Remote access: Regular pick-up trips to a larger receiving site is not economically justifiable or otherwise feasible</td>
<td>Proximity to a receiving site: Regular pick-up trip to receiving site is feasible or other types of supplies sent/picked up from receiving site. Increase in shipping cost is not justified</td>
</tr>
</tbody>
</table>

*Please see the notes on minimum order size on the Supplies Requisition Form located on the web at https://towardtheheart.com/resource/hr-req-form/open
Duties of receiving site (with regards to satellite site)

- Performs due diligence before authorizing satellite site and initiates processes to ensure ongoing compliance with policies/best practices of the HRSS Committee and of the Regional HA where they operate.
- Forwards/updates satellite site contact information to BCCDC by email (harmreduction@bccdc.ca)
- Keeps close contact, aligns strategies, and trains satellite site staff.
- Communicates/trains satellite site regarding change in harm reduction policies and new products.
- Regularly reviews annual supply orders with satellite site.
- Receive requisitions from satellite site in a timely manner to enable inclusion of quantity in receiving site requisitions.
- Submit harm reduction supply distribution reporting as required by HA and BCCDC (contact HA representative for more information).

Duties of satellite site

- Complies with HRSS policies and aligns strategy with receiving site and Regional HA.
- Informs receiving site about supply needs in a timely manner.
- Completes the SATELLITE SITE SUPPLY REQUISITION FORM supplied by their Health Authority Harm Reduction Coordinator.
- Stores supplies appropriately and manages inventory.
- Ongoing supply quality assurance processes in place (i.e., checks condition and expiration dates of supplies)

Required Information Needed by Receiving Site to Establish a Satellite Site

<table>
<thead>
<tr>
<th>ITEM</th>
<th>INFORMATION</th>
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</thead>
<tbody>
<tr>
<td>SITE Name</td>
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<tr>
<td>Health Service Delivery Area</td>
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<tr>
<td>Street-Address</td>
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</tr>
<tr>
<td>Street-City</td>
<td></td>
</tr>
<tr>
<td>Street-Postal Code</td>
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<td>Mailing-Address</td>
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<tr>
<td>Mailing-Postal Code</td>
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</tr>
<tr>
<td>Operating Hours</td>
<td></td>
</tr>
<tr>
<td>Contact Person</td>
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</tr>
<tr>
<td>Contact2</td>
<td></td>
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<tr>
<td>Phone</td>
<td></td>
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<tr>
<td>Phone2</td>
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<td>Fax</td>
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<tr>
<td>Email</td>
<td></td>
</tr>
<tr>
<td>Email2</td>
<td></td>
</tr>
</tbody>
</table>
Harm Reduction Supplies: Distribution Process Algorithm

**Site Ordering and Receiving HR Supplies**
1. Determines supplies needed for next three months.
2. Completes HR supply requisition form.
3. Sends supply requisition form to BCCDC

**BCCDC**
4. Receives supply requisition form.
5. Processes requisition (once a week on Tuesday).
6. Sends purchase order to central distributor.
7. Receives and pays invoices
8. Negotiates supply price and monitors quality and alignment with best practices and user preferences.

**Supply Vendor**
9. Receives purchase orders.
10. Processes purchase order
11. Ships products to health unit, primary site, or authorized sites (on Thursday)

**Site Ordering and Receiving HR Supplies**
12. Receives shipments.
13. Compares shipped products to supplies ordered.
15. Ensures product is stocked following FIFO principles.
16. Stores product according to expiration dates

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1. Cut off time for HR supply orders is end of day Monday, or end of day Friday if the upcoming Monday is a holiday.
2. FIFO (First In, First Out) is an inventory valuation method that ensures goods or supplies that are ordered or produced first are utilized first, in order to prevent wasting or expiration of the goods.
Appendix 2: Standards of Practice and Competencies for Peers and Harm Reduction Workers in BC

Standards of Practice and Competencies for Peer Support Workers

The following standards of practice are written for peer support workers to guide their practice. They are also meant to be a guide for organizations and leaders to support the oversight of peer services. Organizations can use these standards as they develop programs, lead staff, and create job descriptions in the field of peer support.

A: Peer Specialized Proficiencies

- Demonstrates understanding that there is no one-size-fits-all approach to wellness and wholeness. Each person needs to discover what goals, values, and beliefs work for them. Peer Supporters recognize that others’ paths may be quite from their own.
- Demonstrates an awareness and understanding of self-determination and can apply it to the peer relationship. Understands that advice-giving and fixing are antithetical to self-determination.
- Peer support is based on mutuality. However, the peer supporter acknowledges and recognizes that there can still be a power differential when in a formal role. The peer supporter actively works to create mutuality, and equality, while honouring boundaries, and deeply respecting the well-being of the recipient of the services.
- Chooses to self-disclose and share aspects of personal story in a way that supports the building of the relationship, connection, and inspiring hope. Understands the importance of avoiding the sharing of traumatic details that can trigger a stress response in someone else.
- Engages in active ongoing learning.

B: Principles of Supporting Wellness, Wholeness, Recovery and Social Belonging

- Actively creates and engages in self-care practices that support one’s own well-being.
- Demonstrates awareness of their own stressors and triggers and has a plan to support their well-being through the challenge.
- Actively chooses to practice empathy and compassion in interactions.
- Recognizes the importance of clear, well-defined boundaries. Practices co-creating boundaries with the person they are supporting.
- Demonstrates knowledge of recovery-oriented practices, including but not limited to, harm reduction, trauma-informed care, and the importance of person-first language.
- Supports peers to discover strengths, explore new possibilities, and continue to build resilience.
C. Diversity, Inclusion, and Equity

- Is aware of and actively reflects on one’s own set of values and beliefs.
- Is mindfully aware of the fact that they have a set of personal biases, and actively makes space for different perspectives.
- Understands and can apply intercultural sensitivity towards all cultural groups. Works to avoid stereotyping.
- Understands the harmful effects of colonization and privilege and works to reduce the harm.
- Understands how the Social Determinants of Health and stigma can affect someone’s life experience.
- Respects a diversity of modalities and interventions, even if different than their personal approach.

D: Facilitating Communication and Connection

- Demonstrates an understanding of and sensitivity towards the effect of personal communication style on others.
- Communicates clearly, respectfully, and effectively through spoken, written, and electronic modalities.
- Recognizes the importance of and chooses to use person-first language.
- Understands the importance of community and belonging that is needed for one’s sense of well-being and supports community inclusion.
- Actively practices compassionate and empathetic communication.

E: Collaboration and Ethical Practice

- Works respectfully and effectively with clinical and community staff, and as well with the peer’s personal supporters.
- Demonstrates and understanding of the non-negotiable nature of the Code of Conduct.
- Effectively collaborates with stakeholders in a way that supports the overall appearance and respect of peer support in the province.
- Works respectfully and effectively with clinical and community staff, and as well with the peer’s personal supporters.
- Demonstrates and understanding of the non-negotiable nature of the Code of Conduct.
- Effectively collaborates with stakeholders in a way that supports the overall appearance and respect of peer support in the province.
General Competencies for Harm Reduction Workers in BC

**Competencies:** The essential knowledge, skills, judgment, and attitudes necessary for individuals to perform in their given role -OR- sets of intellectual, personal, and social and emotional proficiencies that learners need to develop to engage in learning.

**SCOPE:** These Harm Reduction Competencies are neither comprehensive nor prescriptive. Their intent is to serve as a resource for educators and trainers to draw from when offering information and support to people engaged in harm reduction work. They may be used as a foundation for the development of programs, workshops, staff, and volunteer training, and may be used by organizations to tailor their specific needs.

The Competencies are directed towards those who work with people at risk of harms related to substance use, sexual practices, and limiting or punitive social and legal contexts. This can include regulated and non-regulated health care providers (including allied health), ‘Peers’ (typically defined as people with lived experience in the related context), and community outreach workers.

<table>
<thead>
<tr>
<th>Attitude/Principles</th>
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<tbody>
<tr>
<td>• Values accountability.</td>
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<tr>
<td>• Understands that personal values and beliefs impact the relational engagement process.</td>
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<tr>
<td>• Acknowledges assumptions, vulnerabilities, triggers, and limitations.</td>
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<tr>
<td>• Values continued education/learning to enhance work (place) performance and development.</td>
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<tr>
<td>• Embodies personal and cultural safety and humility through trauma and violence-informed practice.</td>
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<tr>
<td>• Understands that harm reduction is both set of practices and a movement for health justice.</td>
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<tr>
<td>• Respects and recognizes diversity.</td>
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<tr>
<td>• Acknowledges individuals are at different places and on their own healing journey.</td>
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<tr>
<td>• Recognizes and respects Indigenous peoples’ rights to self-determination, to be governed by their own institutions, and to maintain their own cultures and practices - all of which may influence their approaches to harm reduction.</td>
</tr>
<tr>
<td>• Respects agency, autonomy, knowledge, experience, and right to (or not to) participate.</td>
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<tr>
<td>• Emphasizes the dignity and inherent value of each person.</td>
</tr>
<tr>
<td>• Values the personal autonomy of the client and works to uphold it.</td>
</tr>
<tr>
<td>• Understands and acts in accordance with the principles of harm reduction.</td>
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</tbody>
</table>
### Knowledge

**Harm reduction:**
- Definition(s) relevant to harm reduction and its practice.
- Harm reduction best practices.
- Specific harm reduction strategies, services, or practices.
- Awareness of community-specific issues and responses.
- Scope of harm reduction services and practice (organizational, local, and jurisdictional).
- Core principles and policies relevant to harm reduction.
- Historical context as it pertains to harm reduction (e.g., War on Drugs, experience, and influence on Indigenous peoples).
- Legislation and laws relevant to harm reduction practice(s).

**Professional and/or Practice Standards:**
- Organizational policies and procedures as they relate to harm reduction practices.
- Professional associations’ standards and scope of practice as they relate to client and community-centred care and, if applicable, harm reduction.
- Evidence-based and informed decision making to improve practice and range of services offered.
- Implications of harm reduction policies, procedures, services on practice.

**Population and Public Health:**
- Epidemiology (e.g., trends, burden of disease in a population).
- Social, cultural, and economic conditions impacting and contributing to individual’s accessing services and/or the potential to sustain vulnerability.
- Syndemic model of health.
- Populations and peoples influencing and affected by harm reduction policies, procedures, and services (e.g., Indigenous peoples, migrant populations, youth, LGBTQ2S).

**Engagement:**
- Factors that lead an individual to seek and/or engage in harm reduction services (e.g., theories of addiction, physical, emotional, spiritual, and/or mental health, intersecting identities, and oppressions).
- Barriers and facilitators to accessing services (e.g., availability, accessibility, social protection).
- Stigma, discrimination, misconceptions, and assumptions for individuals involved with or accessing harm reduction services.

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35 The focus on the biosocial complex, which consists of interacting, co-present, or sequential diseases and the social and environmental factors that promote and enhance the negative effects of disease interaction.
### Skills

#### Relational Engagement in Client-Centred Care:
- Building of trust and rapport to provide and engage individuals in harm reduction services (e.g., non-transactional engagements, leading with your heart).
- Understanding individuals may mistrust and/or reject harm reduction services.
- Validation of feelings and experiences.
- Supporting and celebrating goals, efforts, and accomplishments (e.g., strength-based approach).
- Inclusion of creativity and flexibility in one’s role.
- Cultural inclusion (e.g., assisting individuals in including or re-introducing culture back into their lives, connecting individuals to culturally appropriate services or people(s)).
- Language (e.g., non-judgemental, person-first, trauma-informed, anti-oppressive).

#### Recognition and Assessment:
- Signs and symptoms of opioid overdose and/or stimulant effects.
- Need for wound and/or vein care.
- Need for referral to acute care, community care, and/or treatment services.
- Awareness of emerging drug toxicity issues and available harm reduction strategies at the community and provincial levels.

#### Planning and Implementation (Response):
- Tailor services to individuals’ needs (e.g., outreach services).
- Engaging individuals in community and peer based or run resources.
- Overdose reversal.
- Wound or basic first-aid care.
- De-escalation/conflict resolution.
- Drug contamination alerts.

#### Evaluation:
- Adjusting approaches according to need.

### Judgement

- De-escalation use and techniques (e.g., signs of harm or stress).
- When to refer and/or consult.
- Determining approach and collaborating strategies to assist people based on need.
- Optimization of teachable moments.
- Ethical decision making.
- Advocacy strategies including when and which type to use (e.g., in challenging policies and practices that cause unnecessary harm – like criminalization of drug use, refusal of medical care, and/or lack of adequate housing).
Appendix 3: Guidelines for Providing Harm Reduction Services to Mature Minors in BC

3.1. Purpose
This appendix has been developed as a guide for harm reduction service providers when engaging with mature minors who are seeking harm reduction supplies and services.

3.2. Population of concern
A mature minor is anyone under the age of 19 who has the capacity to make their own health care decisions independent of their parents’ or guardians’ wishes. Mature minors are a highly underserved population that requires specific consideration in the planning and delivery of harm reduction services.

Intersecting experiences can increase harms and impact the severity and duration of substance use for youth. Risks and drivers for substance use and substance related harms include being homeless or largely absent from home and being disconnected from school and adult caregivers. Potential harms include blood-borne pathogen transmission, sexually transmitted infections, sexual abuse and assault, exploitation, victimization, gender-based violence, physical abuse and assault, drug overdose, and death.

Youth face the same barriers to accessing harm reduction services that adults do (e.g., limited coverage, stigma, and criminalization), which are further compounded by factors such as a lack of funding for youth-focused services. A lack of accessible harm reduction services can lead to harms such as transmission of blood-borne viruses or other preventable diseases and higher rates of fatal opioid overdoses.

Colonialism, racism, discriminatory laws and policies, residential schools, and theft of territory have contributed to a breakdown of traditional social supports within Indigenous communities and has resulted an enduring mistrust of institutions and services by many Indigenous people. This separation from sources of aid and support intensifies the risks of substance-related harms for Indigenous youth.

3.3. Rationale
Youth requesting access to harm reduction supplies and services require thoughtful and intentional consideration, including additional supports and service referrals unique to their needs. While they are not inherently more susceptible to the harms experienced by adults, youth are at increased risks for exploitation due to their potential social and financial dependence on others. Providing harm reduction supplies and services to

38 https://www.hri.global/files/2012/09/04/Chapter_3.2_youngpeople_.pdf
youth is critical to preventing illness, injuries, infections, and overdose events and death. Including youth in harm reduction service delivery also empowers them to participate in supporting their communities and taking actions to improve their health.\textsuperscript{40}

3.4. **Principles**

- Knowledge of the unique nature of youth, potential harms youth may experience, and harms that may arise if youth are not able to access harm reduction services will ensure focused and relevant approaches.
- Every person’s situation and needs are different and should be considered individually on its own merits.
- Many youths harbor a mistrust of institutions. Services are more accessible and trusted if they are based on care providers establishing and maintaining consistent and helpful relationships with clients.
- Because of historical and present-day colonialism and discriminatory treatment, Indigenous youth are underserved by the health system, and thus are less likely to access it\textsuperscript{41}.
- Some mature minors may not have the autonomy to make their own decisions due to power issues, being manipulated by an older person, or lack of access to the information and supports required to make informed decisions about their health and wellness.
- Youth may experience greater socio-economic hardship, homelessness, and other challenges related to social determinants of health. This is exacerbated for LGBTQ2S youth. Through positive and rewarding support from harm reduction providers, mature minors can develop the knowledge and problem-solving skills to navigate these lived experiences.
- Youth who have been using substances for a shorter period may be more amenable to harm reduction support and interventions to address social determinants of health. Early intervention also provides opportunity to prevent transition to substance use practices that carry additional risks for overdose and sexually transmitted and blood borne infections.

3.5. **Guidelines:** Please use the following guidelines if you are approached by a person who appears to be a youth under 19:

a) When engaging youth, the primary focus should be on providing consistent and reliable services. This requires care providers to invest time and effort to establish rapport and earn their trust. Service providers should strive to cultivate an atmosphere of support, enhancing coping skills, promoting wellness, with the goal to minimizing harms from substance use.

\textsuperscript{40}https://www.researchgate.net/publication/11104627_Involving_Street_Youth_in_Peer_Harm_Reduction_Education_The_Challenges_of_Evaluation

b) Harm reduction providers should carefully assess a youth’s readiness to engage in harm reduction services. Every effort should be made to follow the youth’s lead, providing them with appropriate and expedited wrap-around care. Where appropriate, this may include referrals to primary health care, addictions care, sexual health services, shelter/housing, and/or mental health, cultural supports, or other services.

- The BC Infants Act states that a minor may consent to health care if the care provider has explained the risks and benefits of the health care and has made reasonable efforts to determine, and has concluded that, the health care is in the young person’s best interest\(^\text{42}\).
- Informed consent consists of ensuring the youth understands the health service or care they are receiving, including the risks and benefits, and addressing any questions and concerns the youth has about that care.
- Consult and partner with Indigenous organizations and communities to ensure culturally appropriate care, support, and harm reduction services for Indigenous youth\(^\text{43}\).
- Take advantage of opportunities to reach youth through low-to-no barrier service models such as the Take Home Naloxone (THN) program, Supervised Injection/Consumption Services (SIS/SCS), Overdose Prevention Sites (OPS), and overdose prevention services.

c) When providing harm reduction supplies, assess a youth who appears to be under the age of 19 to determine immediate or potential health associated harms.

- Following the lead of the youth, attempt to connect them to appropriate youth services, including access to food and shelter, health care, addictions, and mental health support services.

3.6. **Duty to Report**

- Any care provider who has reason to believe that a youth or child under 19 years old has been, is, or is likely to be abused or neglected must report this to the Ministry of Children and Family Development (MCFD)\(^\text{44}\). According to the Child, Family and Community Service Act, MCFD or the police should be contacted if child protection or other immediate risk issues are determined at the point of contact\(^\text{45}\).
- Only make a report to MCFD if duty to report criteria have been established. If you are unsure if the mature minor is at risk, contact and consult with MCFD

\(^{42}\) [https://www.bclaws.ca/civix/document/id/complete/statreg/96223_01#section17](https://www.bclaws.ca/civix/document/id/complete/statreg/96223_01#section17)

\(^{43}\) See Call to Action #22: [https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/indigenous-people/aboriginal-peoples-documents/calls_to_action_english2.pdf](https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/indigenous-people/aboriginal-peoples-documents/calls_to_action_english2.pdf)


\(^{45}\) [https://www.bclaws.ca/civix/document/id/consol23/consol23/00_96046_01#section27](https://www.bclaws.ca/civix/document/id/consol23/consol23/00_96046_01#section27)
anonymously (i.e., no personal information about the youth provided) or consult the Duty to Report handbook\textsuperscript{46}.

- Accessing harm reduction supplies or Take-Home Naloxone is not an indicator of immediate risk of harm.
- Reporting to authorities such as police or MCFD should be undertaken with caution. A mature minor has a reasonable expectation of privacy and confidentiality when accessing health services\textsuperscript{47}, and a trusting and therapeutic relationship could be damaged by premature or inappropriate reporting, as could their future decisions around connection to health or social services.
- If there is evidence the youth is being, or has been abused, and/or appears unable to make an informed decision, talk to them about the need to make a report with MCFD. Assure the youth that you will be fully transparent with them about what will be shared with MCFD.
- Collect as much information as possible.
- Assist the youth in accessing necessary services.

3.7. Who Can I Call?
For more information about Duty to Report, call your local district MCFD office Monday to Friday, 8:30 a.m. to 4:30 p.m.:
- Vancouver, North Shore Richmond, (604) 660-4927
- Lower Mainland, Burnaby, Delta, Maple Ridge, Langley, (604) 660-8180
- For the rest of the province, call toll-free 1-800-663-9122
Or call the Helpline for Children (310-1234 - no area code needed),

After Hours Line:
For emergencies outside office hours, call the Helpline for Children. Dial 310-1234 (no area code needed). Your call will be answered by a trained child protection worker.

3.8. Other Inquiries about Mature Minor Cases
If a harm reduction service provider has ethical concerns they should connect with a regulatory body or other available resources. Your health authority harm reduction representative may be able to help you to identify additional resources.

\textbf{Note: There is NOT a duty to report that a minor is, or may be using substances, or is requesting harm reduction supplies, contraceptive advice, or STI testing.}

\textsuperscript{47} https://www.bclaws.ca/civix/document/id/complete/statreg/08028_01#section91
https://www.bclaws.ca/civix/document/id/complete/statreg/03063_01#section17