Expanding Access to Assisted Injection of Unregulated Substances

An Overview of Ethical Considerations

Provincial Health Services Authority

BC Centre for Disease Control
Provincial Health Services Authority

Acknowledgements

The BC Centre for Disease Control (BCCDC) works to improve the health and wellbeing of all people and communities living on the territories of many distinct First Nations in what is colonially known as British Columbia. The BCCDC head office is located on the unceded and ancestral territories of the xʷməθkwəy̓əm (Musqueam), Skwxwú7mesh (Squamish), and səl̓ílwətaʔ (Tsleil-Waututh) Nations. As a provincial agency, the BCCDC operates on the unceded, traditional, and ancestral territories of First Nations Peoples and serves a diverse population, including First Nations, Métis, and Inuit Peoples. We acknowledge the existence of systemic racism within the healthcare system and recognize our shared responsibility to eradicate Indigenous-specific racism and to promote culturally safe and equitable care.

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Executive Summary

Assisted injection of unregulated substances falls within a much broader spectrum of observed consumption (OC) harm reduction services. Access to assisted injection is currently highly restricted even though some people who use substances require assistance injecting to avoid situations of greater harm. Furthermore, those requiring assistance often include women, people with disabilities or illness, and other populations experiencing vulnerability. The purpose of this document is to consider the equity and other ethical implications of the current restrictions on assisted injection of unregulated substances as a component of OC.

After briefly outlining some of the arguments around harm reduction as an approach and situating assisted injection within the broader spectrum of OC services, we conduct 3 ethical analyses examining the implications of the current restrictions on assisted injection of unregulated substances as a component of OC services at the client, provider, and population levels. These analyses carefully consider the varied perspectives and interests involved and highlight the importance of continuing to collect and review evidence to support evidence-based practice.

We conclude that there is an **ethically defensible argument for increasing access to assisted injection** by regulated and non-regulated providers working in sites specializing in observed consumption services as an option where this is **the least harmful option for the individual**.

This document offers recommendations to support the significant and challenging shift towards targeted access of assisted injection of unregulated substances. Each recommendation is explicitly tied to ethical values with particular emphasis on cultural humility and safety in both process and outcomes.

Overview & Context

Background

Observed consumption (OC) is an evidence-informed, proven harm reduction strategy. OC is one important option to support the health of people who use substances, especially in the context of British Columbia's ongoing unregulated drug poisoning emergency. Yet, health care providers do not have professional guidance on OC and providers who offer these services may be vulnerable to civil, criminal, and professional liabilities.

Practice guidelines recently developed by British Columbia Centre for Disease Control (BCCDC) help to mitigate these legal liabilities (and associated fears or uncertainty) by providing increased clarity on scope of services and best practices. This clarity is an important step in addressing a pressing need: supporting providers to deliver high quality, culturally safe, equitable, person-centered care that creates meaningful access to health and harm reduction services and, ultimately, health itself. However, this clarity highlights an important gap: people who need direct assistance with injection due to various personal circumstances have unequal access to OC.

OC happens with regulated (e.g., injectable opioid agonist therapy (iOAT)) and unregulated substances (e.g., unregulated fentanyl). Regulated and unregulated substances have very different practical, legal, and ethical considerations that need to be discussed separately.

This ethical analysis examines the **implications of current restrictions on assisted injection of unregulated substances** at the client, provider, and populations levels.[1]

To be clear, this analysis does not address assisted injection of regulated substances (i.e., iOAT), which is considered medication administration. Moreover, because the challenges and risks associated with expansion of assisted injection of unregulated substances would vary significantly depending on practice setting, this analysis is limited to sites specializing in OC services (i.e., supervised consumption sites (SCS) and overdose prevention sites (OPS)).

Where the law may authorize or restrict some services, this ethics analysis aims to weigh the benefits, burdens, and harms of assisted injection to consider whether the benefits outweigh the burdens and potential harms. Ethical analysis in this context can provide recommendations affecting individuals, groups, and populations.[1]

Harm Reduction as a Foundation for Substance Use Care

Although the focus of this paper is specifically on assisted injection, a brief pause is merited to situate this discussion within harm reduction more broadly. This paper builds on the premise that harm reduction approaches are important in substance use care. While not without some important counter-arguments, consideration of these is beyond scope here.[2] Harm reduction is evidence informed, reduces the harms associated with substance use (in the current context of injection substance use, this includes a reduction in injection related injuries, blood-borne infections, and drug poisoning), and advances the health and dignity of people who use substances.[3]

The commitment to harm reduction and creation of supportive and welcoming environments for OC services is also integral to cultural humility, cultural safety, and the priority goal of designing services to be trauma- and violence-informed and culturally safe specifically for Indigenous peoples, including strategies to eradicate anti-Indigenous racism. Indigenous peoples—including First Nations, Inuit, and Métis peoples—have been disproportionately impacted by the unregulated drug poisoning emergency because of intersecting factors including Indigenous-specific racism, settler-colonialism, and intergenerational trauma. The death rate from the unregulated drug poisoning emergency is 6.7 times higher for First Nations individuals compared to non-First Nations of what we now know as British Columbia, and 11.6 times higher for First Nations females compared to other females in BC.[4] The restrictions on assisted injection may further perpetuate these systemic impacts and worsen the disproportionate burden and harmful outcomes among First Nations, Inuit, and Métis peoples.

Finally, in addition to cultural humility and cultural safety, other ethical values support harm reduction and are likewise essential to uphold. Key among these include humanism, pragmatism, respect for autonomy, individualism, incrementalism, and accountability without penalization or termination. Descriptions around these values related to harm reduction can be found in Appendix 2.

In conclusion, while only touched on very briefly here, there are diverse arguments that OC as a harm reduction strategy supports safer substance use, and one that is particularly important in the context of the toxic unregulated drug supply to help save lives, decrease stigma, and promote culturally safer, trauma- and violence-informed care.

Contextualizing Assisted Injection of Unregulated Substances: A Subset of OC

The BCCDC Observed Consumption Best Practice Guidelines define OC as a general term that includes supported and assisted consumption. Very briefly and as described further in Table 1 below:

- **Supported consumption** refers to assistance provided to support safer consumption of substances and includes a wide range of activities such as handling safer substance use supplies, cleaning the injection site, applying the tourniquet, and providing coaching and education on safer substance use practices.
- **Assisted consumption** refers to hands-on assistance to directly administer the substance. As noted specifically in the guidelines, "due to the nature of assisted substance use, assisted consumption generally refers to injection substance use, called assisted injection. Assisted injection includes: (i) assistance with accessing a vein and (ii) assistance with administration."[5]

As components of OC services, supported consumption[6] and assisted injection[7] are points along a continuum of support, and not substantively different activities. They may, however, be approached differently ethically, legally, and professionally. As described in the guidelines[8], supported consumption is a routine harm reduction service that can be delivered across diverse settings by regulated and non-regulated health care providers who are appropriately trained and equipped. In contrast, assisted injection of unregulated substances is much more restricted and, at least formally, only available depending on the willingness of informal peer providers. A summary of relevant OC services, whether it is legal, and what restrictions exist for different providers and locations are listed below in Table 1. A description of regulated, non-regulated, and peer providers is summarized in Table 2.

This ethical analysis focuses on assisted injection of unregulated substances, specifically in the context of sites specializing in OC services, rather than acute care settings, for example.

Table 1. Comparison of Supported Consumption and Assisted Injection of Unregulated Substances

Services	Is it Legal?	Provider Type	Location
Supported Consumption			
• Observing substance use • Offering safer substance use education • Preparing or handling regulated supplies • Cleaning the injection site • Applying the tourniquet • Monitoring after using • Intervening if a drug poisoning happens	Routinely available from health care providers with appropriate training and equipment	Formal health care providers (regulated and non-regulated, including experiential workers)	Varied: • Federally regulated SCSs • Provincially managed OPSs • Episodic overdose prevention services (eOPS): OC delivered outside of SCS or OPS
Assisted Injection			
• Assisting with delivering the substance itself, specifically puncturing the skin and/or pushing the plunger	Strict restrictions on both location and providers	Peer providers only*	• SCS with exemption (only 2 in BC)[9,10] • OPS if a supervisor determines certain conditions are met[11] and there is a willing peer provider. OPS are largely peer run and aim to be lower barrier than SCS.[12]

* The SCS regulatory exemption only permits assistance from peers and explicitly does not permit SCS staff to assist. The situation for OPS staff is less clearly established, although existing guidelines tend to echo SCS restriction[13]:

1. Stipulate that staff must teach safer injection practices to peers who provide assistance, and

2. Include a statement under "safer injection practices" that staff "do not insert rig into participant's vein nor inject the drug for them." Read together, this guideline suggests that assisted injection is to be provided only by peers who are not employed by the OPS.

Table 2. Descriptions of Regulated, Non-regulated, and Peer Providers

Formal providers	**Regulated providers**	Individuals who are members of a regulated health-care profession (e.g., physicians, nurses, nurse practitioners, social workers) and are employed to provide OC services at SCS, OPS, and eOPS.
	Non-regulated providers	Individuals who are not members of a regulated health care profession (e.g., Outreach and Experiential or Peer Workers) and are employed to provide OC services at SCS, OPS, and eOPS.[14] Experiential (or Peer) Workers are people with lived and living experience of substance use. They use that experience to inform their professional work. They work in a variety of settings (e.g., shelter and housing agencies, stand-alone SCS, and OPS).
Informal providers	**Peer providers**	Individuals who are not employed to provide OC services. They agree to provide injection assistance to another person who is unable to self-inject. They may be other OC clients, friends of the person seeking assistance, etc. For the purposes of this analysis, the term peer provider is limited to those providing assisted injection without expectation of any payment and excludes those peers who would provide assisted injection for a fee, traded substances, etc...

Based on a review of the literature and relevant operation manuals or guidelines, as well as anecdotal accounts shared as this document was prepared, and in comparison, with SCS, assisted injection seems somewhat more available at some peer run OPS[15], depending on peer willingness and site supervisor discretion.[16]

Assisted Injection: Disproportionally Accessed by Key Populations

It is well established that some subgroups of people who inject substances have more difficulty self-injecting (as detailed below). People may require assistance injecting for a variety of reasons, including but not limited to: not knowing how to inject, limited vision, limited dexterity or other physical disabilities, problems with veins, and experiencing active withdrawal.[17]

Being unable to self-inject has potentially serious health and other consequences due to street-based peer injection that is less safe. Research out of Vancouver has found, for example, that street-based, peer-assisted injection "is a highly prevalent practice known to be associated with severe health complications in our setting, including HIV infection and overdose"[18]. As described in that study, such assistance is often transactional, commonly given in exchange for money, substances, or sex work. In addition to risks of exploitation, street-based assisted injection also brings significant concerns that

one's syringe will be unknowingly swapped, or substances will be stolen. Being injected with a syringe of unknown origin further heightens risk of disease transmission and overdose.

> Some Canadian reports suggest **14 - 49%** of people who inject unregulated substances **need assistance with injection**.

It is difficult to determine exact numbers of people who need assistance injecting. However, the way in which assisted injection is understood or defined varies widely from assistance with the actual injection to a broader range of support (e.g., steadying the syringe, assistance pushing the plunger).[19] Using the narrower definition of assistance with the actual injection, research from a Toronto OPS found that 8.3% of clients received assisted injection (471 out of 5,657 visits) within a 6-month period.[20] It is also worth noting that the unregulated drug poisoning emergency has increased the numbers of people who use substances living with physical and cognitive disabilities from drug poisoning related hypoxic brain injuries.[21] It is reasonable to expect that this, in turn, may be contributing to greater numbers of people requiring assistance with injection.

Importantly, restrictions on assisted injection as a component of OC create barriers to accessing supervised injection services[22]. These restrictions may disproportionately impact certain groups including women[23], youth, people with disabilities, and people who experience homelessness. These populations are more likely to require such assistance.[24] Health Canada has acknowledged that self-injection is a challenge for some people and has also pointed out concerns about equity, noting "that those requiring peer assistance often include women, people with disabilities or illness, and other vulnerable populations."[25] As noted above, in an attempt to address these concerns, SCS may now apply for a peer assistance exemption that allows clients who need assistance to get this help from friends or other clients. However, as indicated in Table 1, employees of an SCS are not allowed to assist with injecting unregulated substances.[26]

In contrast to the impact of restricting assisted injection, and while evidence is still limited, accommodating assisted injection as part of OC sites has been associated with some important benefits. For example, availability of assisted injection at OC sites may support service engagement among people who require injection assistance, provide protection against violence and coercion, and increase individual autonomy over substance use.[27]

Balancing Necessary Standards that Create Barriers to Assisted Injection

As outlined above, the literature and research suggest that restrictions on assisted injection create barriers to accessing OC and the benefits of these harm reduction services.[28] Restrictions on regulated health care staff providing assisted injection tend to be explained in terms of:

- Accountability to minimum safety standards for pharmacotherapy,
- Concerns of legal exposure in criminal and civil law,
- Professional liability (including falling outside of an established scope of practice), and
- Potential for the employer to be held vicariously liable.[29]

Restrictions on unregulated workers (e.g., experiential or peer workers) are presumably similarly rooted in concerns of potential criminal and civil legal exposure for both the individual peer as well as the site.

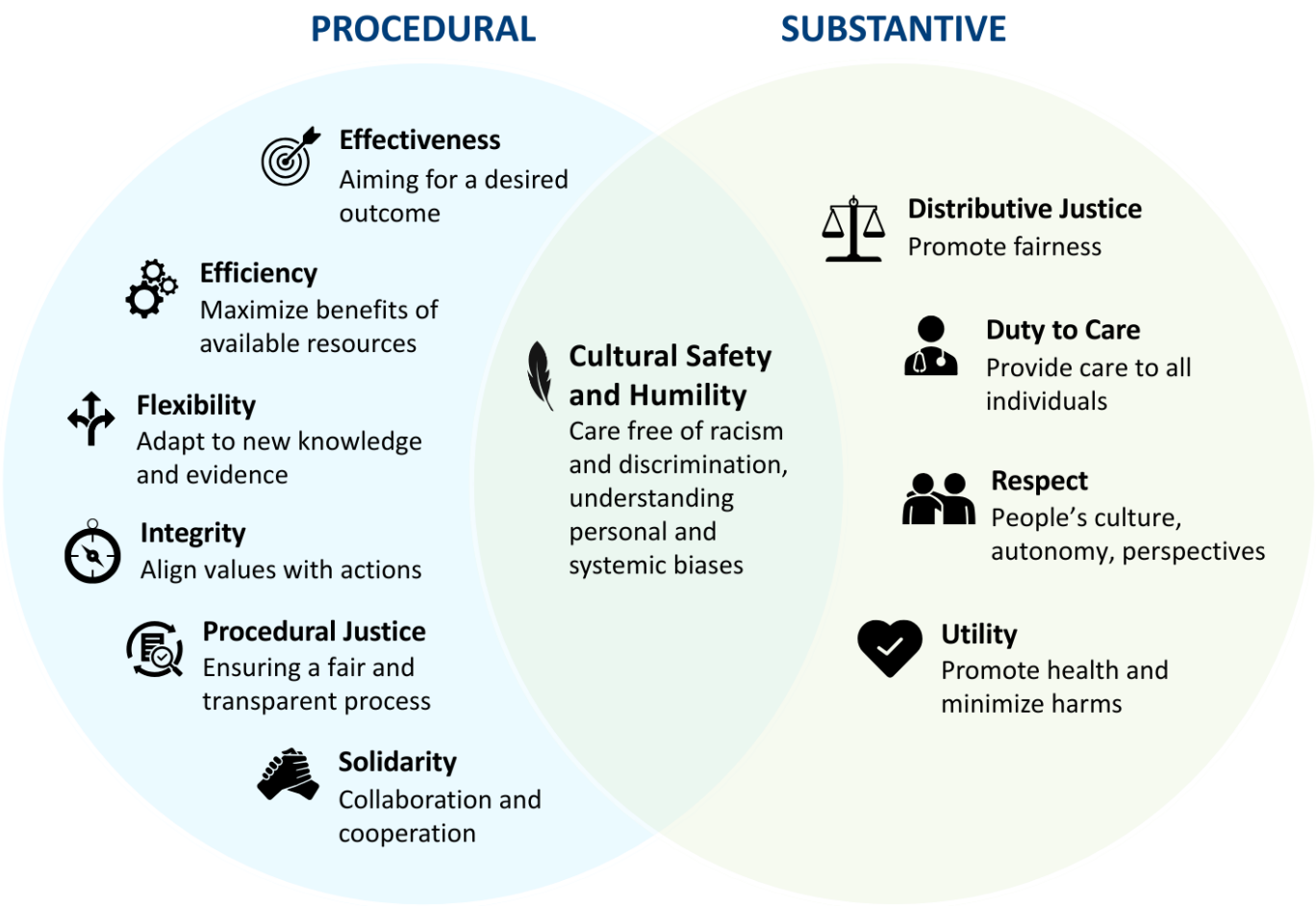
It is likely that these restrictions are also responding to the risks of harm inherent in injection substance use itself (e.g., risks of infection, vein damage, disease transmission, receiving a higher dose than anticipated, drug poisoning) that assisted injection mitigates but does not eradicate for the client, and the potential toll for the provider of the service. For example, providing assisted injection to a client who then experiences drug poisoning could have devastating consequences for the client, but also significant emotional and psychological toll for the person assisting.[30] Additionally, in the context of an evolving, labour intensive, and controversial service, there may also be other concerns, including that such an approach may not be an efficient way to deliver services, or that clients may come to depend on assisted injection services, which may not always be consistently available for various reasons such as funding, legal challenges, or societal acceptance.

In light of such risks, existing standards and concerns are laudable and generally an integral part of providing safe, high-quality care, maintaining public trust in the health-care system, and using a harm reduction approach to care. Unfortunately, these standards and concerns also risk exacerbating or contributing to harms for people who use substances and disproportionately impact already marginalized subgroups of this population. Careful thought and scrutiny to meaningfully balance risks and benefits is necessary.

Ethical Analysis

This ethical analysis examines the **implications of current restrictions on assisted injection of unregulated substances** that are a part of OC services at the client, provider, and populations levels.[1]

Public health ethics involves a systematic process to clarify, prioritize and justify possible courses of public health action based on ethical principles, values, and evidence. This analysis explores ethical questions by drawing on established public health ethics frameworks and literature.[31] The specific values and principles utilized in this analysis include:



Please see the Appendix for more information about these values and principles.

In general, these principles and values fall into 2 categories:

- **Procedural:** how we make decisions and work together throughout the decision-making process, and
- **Substantive:** what goals or ends we should pursue and how we weigh these principles and values against one another to determine the best decision or outcome, all things considered.

Substantive values and principles may conflict or be in tension when applied to assisted injection. When it is not possible to uphold all values (e.g., values are in conflict with one another), justification is provided for trade-offs that must be made and values that are prioritized.

Cultural safety and **cultural humility** are cross-cutting values that are both procedural and substantive in nature. These values are relevant to each of the other values and principles and should be applied throughout each analysis.

Scope of Analysis

This ethical analysis considers the ethical tensions resulting from current OC service restrictions on assisted injection of unregulated substances.

Potential harms are explored at 3 levels:

- Harms to clients: to people who inject substances,
- Harms to providers at OPS or SCS: to regulated staff, unregulated staff, and peer providers, and
- Population-level harms: what are the impacts on public health.

The analysis also reviews the ethical justifiability of expanding access to assisted injection within specialized OC service settings (i.e., SCS and OPS), in the context of the ongoing unregulated drug poisoning emergency.

Analysis 1

What ethical tensions result from current restrictions on assisted injection of unregulated substances from the standpoint of people requiring this assistance?

Values and Principles

Discussion

In general, and in alignment with values of **utility** and **distributive justice**, ethical public health decisions for individuals and populations should seek to:

- Reduce harms or risk of harm,
- Increase benefits, and
- Promote equitable distribution of risks, harms, and benefits.

Ethical decisions should proactively seek to address inequities resulting from systemic and structural discrimination, not just avoid further burdening marginalized and underserved populations. Where some groups face more risks or harms over others in the population (e.g., as a result of a policy, program, or service restriction), there should be a clear rationale, and the risks and harms should be reduced as much as possible. In public health emergencies such as the unregulated drug poisoning emergency, policymakers and health care providers must make decisions with the best available evidence and information, which may be preliminary or emerging. As a result, **flexibility** is also important. Decisions may change as additional data and information becomes available.

OC programs aim to uphold the **duty to care** and reduce substance use related harms by:

(1) Increasing access to **effective** treatment and support,
(2) Reducing morbidity, and
(3) Preventing deaths.

These programs also aim to provide service equity and care that helps address the stigma faced by those who use substances.[32] Research involving people with lived and living experience has found benefits of OC for people who use substances.[33]

However, clients who need help injecting may experience barriers to accessing these services. Research suggests that individuals who require assistance injecting (e.g., women, people with disabilities or illness, and other key populations[34]) are less likely to access OC services.[35] Even where clients do visit an OC site and try to self-inject, they can suffer vein damage, related harms, and frustration despite receiving education and other efforts to support self-injection.[36] Ultimately where they are unable to inject, clients urgently seeking relief from substance use are likely to leave to get injected by someone else in a riskier, less controlled environment. These individuals then must navigate the risks of unregulated substance use without supportive harm reduction services.[37] As a result, these individuals are at greater risk of harms from:

- Equipment-sharing,
- Injection-related injuries,
- HIV and HCV infection,
- Drug poisoning,
- Coercion,
- Theft,
- Exploitation, and
- Street-related and gender-based violence.[38]

This additional barrier to accessing services likely makes current inequities worse. These inequities are particularly concerning for First Nations, Inuit, and Métis Peoples who are already disproportionately impacted by oppressive colonial policies. Historic and ongoing settler-colonialism have caused intergenerational trauma, structural and systemic racism, and mistrust of health services and providers. Research also suggests that women requiring assistance injecting are at a high risk of violence and abuse because of gendered power dynamics and other structural risks. It is reasonable to expect that barriers to accessing provider assisted injection increase this risk.[39]

Collectively, this evidence suggests that restrictions on assisted injection disproportionately impact some people who inject substances. Moving forward, health care services and providers must ensure this population has access to the harm reduction benefits of OC, while not creating a disproportionate burden for themselves or others.[40] As part of this process, it is important to explore other approaches that **effectively** and **respectfully** meet the individual requiring injection assistance where they are at. The underlying goal is to support the person in mitigating risks of their substance use. Important aspects of this include supporting access to services that align with client-directed substance use health goals (e.g. treatment services, cultural supports) and, when appropriate, building capacity and supporting the person to learn safer injection skills so that they can better rely on themselves and not be dependent on others to inject. In weighing and implementing such approaches, consideration should also be given to the equitable distribution of any burdens that may be associated with them, so as to avoid disproportionately impacting certain individuals or groups - especially those already disadvantaged, underserved, or marginalized.

One possible option may be expanding access to assisted injection as an option of last resort by increasing number and types of providers who can assist. That is, providers would assist with the injection only after exploring and exhausting all other reasonable efforts to encourage cessation of substance use by injection and increase independence and self-reliance (e.g., giving education or support on safer injection skills, offering props or physical supports such as reading glasses to help see veins, a pillow for additional stability, or getting a pill crusher etc.). However, and despite best efforts, in some situations of disability or other circumstances the person will choose to continue to use substances by injection, the barriers to self-injection will persist and the individual will require assistance injecting. Even when considered as an option of last resort to be used only where it is the least harmful option for the individual requiring assistance, this option shifts the burden and has a direct impact on another group: those providing the injection. It is important to carefully consider the nature and extent of this shifted burden and how it will also vary among different groups of providers - regulated, non-regulated, and peer providers. These considerations will be discussed in Analysis 2.

Conclusion

Restrictions on assisted injection may disproportionately burden certain groups (e.g., women, youth, people with disabilities), many of whom are already from one or more marginalized or underserved populations. These restrictions may also compromise the delivery of - and access to - trauma and violence informed, patient centered, culturally safe care. Efforts to reduce any unjust and disproportionate burden carried by these groups must address:

- Equity considerations,
- The impact of intersectionality[41], and
- The importance of cultural humility and cultural safety both in process and outcome.

In 2018, the Registered Nurses Association of Ontario called for Health Canada to allow nurses and peers to provide assisted injection without criminal prosecution. They stated: *"the capacity to inject should not prevent the most vulnerable people from accessing SCS (supervised consumption services)"*[42]. While this supports expanded access to assisted injection, it may also create a range of potential burden or harms to the regulated, unregulated, and peer provider groups who would provide assisted injection.

In the next section we compare anticipated burdens that may arise for providers if access to assisted injection is expanded, with the current burdens these groups experience under present restrictions and consider other alternatives.

Analysis 2

What ethical tensions result from current restrictions on assisted injection of unregulated substances from the standpoint of those providing injection assistance? How do these compare with ethical tensions that would result from expanding access to assisted injection?

Values and Principles

Discussion

Analysis 1 explored the impacts of assisted injection restrictions on those requiring assistance. Analysis 2 considers the impacts of these restrictions and proposed alternatives on informal and formal providers of OC who may be asked to provide assisted injection of unregulated substances.

Impacts of Current Restrictions on Providers

Formal Providers

Providing assisted injection of unregulated substances is an issue that raises a number of ethical tensions. For example, there are varying perspectives on a provider's **duty to care** and how to demonstrate **respect** for individual autonomy for clients and providers alike. Further, as compared to

other forms of support (e.g., observation, education) injecting an unknown substance for a person, even at their request, is a more direct role in the person's substance use and one that may lead to drug poisoning. These outcomes may result in personal, moral, professional, and criminal liability for the provider who assisted with the injection and employers.

While provision of assisted injection is certainly fraught, front-line providers are also impacted by the restrictions on assisted injection that are meant to protect them. Although evidence in this area is limited, it has been noted, for example, that "we know, anecdotally, that nurses experience moral distress when they cannot provide this form of direct assistance because clients leaving means greater risks to their health and safety, including the risk of overdosing and dying alone."[43] Such distress and impact is likely part of what fuels the longstanding and ongoing calls for assisted injection to be more widely available at SCS.[44]

Employers typically do not support regulated and non-regulated providers to provide assisted injection. Even in OPS where assisted injection may be more accessible, the nature of guidelines may mean staff are not always clear on their role. Outright restrictions (i.e., in SCS where no specific exemption is in place) and uncertainty about what is allowed may negatively impact providers. Where such restrictions and limitations are experienced as conflicting with a provider's professional and moral duty to provide culturally safe, unbiased, non-discriminatory, trauma and violence informed care[45], providers may experience moral distress[46,47]. Moral distress may worsen if the restrictions are perceived as lacking a clear, ethically defensible justification.

If not addressed and properly managed, moral distress can lead to moral injury. Moral distress can have profound impact on the well-being of the provider and their ability to provide high quality, patient centred care.[48] Moreover, research shows that moral distress contributes to burnout and can result in health care providers leaving the work force.[49]

Restrictions on assisted injection may also have broader implications. For instance, while assisted injection requires more provider time compared to observation or offering supplies, limiting this service could hinder providers' capacity to assist other clients while in some cases not ultimately yielding benefit to those requiring enhanced support.[50] Under current restrictions, providers often spend significant time helping clients who require injection assistance, attempting to facilitate self-injection. Successful coaching can lead to reduced long-term support needs, but physical limitations or similar obstacles may prevent some clients from self-injecting despite best efforts. When unsuccessful, clients may turn to seeking assistance on the street, potentially reducing future engagement with observed consumption services and increasing their risk of harm.[51] This not only affects the specific client but also impacts service **efficiency**, **utility**, and **equity** by reducing provider availability for other clients seeking care, which can increase workload and stress levels among care providers. While such

time investment would still be involved where assisted injection is made available as an option of last resort, the distress (a) for the client of ultimately needing to seek support on the street when education and other permitted supports are unsuccessful, and (b) for the provider upon being unable to effectively support the client, would be addressed.

Creating conditions for trust, safety and appropriate, timely support is an important component of the duty to provide quality person-centered, trauma and violence informed care that formal providers are ethically and professionally obligated to offer. Where formal providers are restricted from creating these conditions, the result may be a lack of safety and trust of the services for potential and existing clients. Leaving or avoiding OC services is a worrying issue which may be heightened for Indigenous Peoples. First Nations, Inuit, and Métis peoples are disproportionately harmed by health system mistrust arising from oppressive colonial policies, and intergenerational trauma rooted in ongoing structural and systemic racism. As such, any additional barriers for First Nations, Inuit, and Métis peoples to accessing culturally safe and trauma and violence informed care raise particularly acute concerns.

Informal Providers

Restrictions on formal providers' ability to provide assisted injection also have a direct impact on informal providers (as defined in Table 2 above) who step in to provide this support. Many of the burdens of providing assisted injection that impact regulated and non-regulated providers discussed above also may apply to "informal" providers, defined as peers who are not employed by SCS or OPS but who may provide assisted injection without the expectation of payment or personal gain. For example, peers report that they provide assistance injecting both to help someone who is suffering and because they find it rewarding.[52] The same research also notes that providing this service can be a heavy responsibility and burden. Peers providing this help often reported hesitation or reluctance to assist because they were afraid of causing harm or being held responsible.[53] These fears align with the risks that regulatory bodies and employers attempt to reduce for their members through restrictions and practice guidelines, but informal providers do not have this support.

Other research highlights that peer workers provide critical harm reduction care while at the same time living with, and navigating, significant socio-structural barriers (such as housing instability, poverty, criminalization, and stigma) and other challenges .[54] This research explores the ways in which women who use substances, and particularly women with intersecting gender-, class- and race-based identities are at increased risk of harm. Some women who use substances fill public service gaps, engage in caregiving work, reduce drug poisoning risks, and other substance-related harms. These tasks, however, may negatively impact their physical, mental and emotional health and wellness. Most importantly for this discussion, women who use substances acknowledged the significant need for

assisted injection in their communities but were also often reluctant to help because of the same fears as previously noted.

> "feelings [of women who use substances] towards assisted injection are noteworthy, as the level of concern participants express subverts pervasive stereotypes of women who use substances as self-serving and incapable of caring for others. Instead, women who are capable of performing assisted injection may **experience an increased burden of care**." [55]

Addressing the Impacts of Current Restrictions on Providers

Although the evidence - as well as Health Canada's SCS peer assistance exemption - recognize a need for assisted injection, less is understood about how to address this need. Moving forward, policymakers and harm reduction site operators should engage with those who need assistance to better understand and reduce this need as much as possible by other means (e.g., connection to services that support decreased substance use offering ongoing injection education and physical supports if available, suggesting alternative means of consumption). At the same time, where there is a clear need for assistance, this responsibility should not disproportionately fall to a single subset of providers, especially those informal providers who often face significant socio-structural barriers themselves and do not have institutional support such as workplace wellness, established professional mentoring relationships, and professional liability protection.

While increased access to programs and services is the substantive goal, **cultural humility** and **cultural safety** are both substantive and procedural principles. All work related to provider assisted injection should be in partnership with First Nations, Inuit, and Métis leaders and approached with **cultural humility**. These efforts should prioritize the cultivation of **cultural safety** for First Nations, Inuit, and Métis peoples and acknowledge the disproportionate impact of the unregulated drug supply on Indigenous populations. Respectful engagement with First Nations, Inuit, and Métis leaders and communities is vital to identify and address challenges of integrating assisted injection into a broader continuum of care that includes holistic perspectives on wellness. These engagements may help develop culturally safer options that address systemic oppression, Indigenous-specific racism and ongoing settler-colonialism in the health care system.

One option might be to expand access to assisted injection with formal providers (e.g., regulated providers and non-regulated peers employed to provide observed consumption services). This option, while complex and fraught, would help ensure that the burdens inherent to this service are more equitably distributed among formal and informal providers. Another option may be to reduce need for

assisted injection of unregulated substances by offering a regulated substance that meets needs (i.e., iOAT). Both options presume that every reasonable effort has been made to support the client's self-identified substance use goals, whether that is decreasing, stabilizing, or ceasing substance use.

In the next section we discuss some of the anticipated implications and challenges of these two options.

Option 1: Expanding Access to Assisted Injection of Unregulated Substances

As previously outlined, a subpopulation of people who use unregulated substances are at an increased risk of harm due to their dependence on others to inject for them. This risk of harm is further compounded by restrictions on assisted injection. Restrictions on assisted injection also create certain burdens for regulated, non-regulated, and peer providers. Health services must respond to these issues. However, the burdens or risks of harm of providing assisted injection for both individual providers and professions must be weighed when considering various response options.

Expanding access to assisted injection from formal providers would involve an exemption from Health Canada under the Controlled Drugs and Substances Act.[55] Even with this exemption, health care providers may still be exposed to professional liability and moral distress or injury.

A foundational part of health care is accountability to medication safety standards.[56] Balancing the harms and benefits of pharmacotherapy depends on a complex web of biological, physiological, and social factors. At times, these factors are impossible to accurately predict. Adverse prescribed medication events are estimated to cause thousands of deaths per year in Canada.[57] Therefore, we must consider if expanding access to assisted injection may affect regulated safety standards of pharmacotherapy inherent to quality health care services. This impact on safety standards may arise from a formal provider preparing or administering an unknown and unregulated substance by injection upon a person's request. According to medication administration safety standards[58], providers who engage in preparing and administering an unknown, potentially harmful substance would be acting in opposition to their **duty to care**, their obligation to obtain informed consent, and their commitment to reduce the harmful effects from medication use.

In the context of the unregulated drug poisoning emergency, a great deal of evidence suggests that unregulated substances purchased from unregulated sources have a high risk of containing toxic ingredients which can cause death.[59] In contrast, while there is developing evidence supporting the practice of assisted injection and its benefits[60], such evidence is still being established. Public health emergency responses must often be decided before robust information and clear evidence is available, which requires **flexibility** and ongoing adjustments as situations and evidence evolve. It is important to recognize the real tensions this creates and take steps to mitigate them where possible. In the context

of the unregulated drug poisoning emergency, one such tension is that regulatory support for individual provider decisions to knowingly inject a potentially dangerous unknown substance into a person—in absence of clear evidence supporting the benefits of this—may significantly undermine public trust, damaging therapeutic relationships.

Morally, health care providers share a common commitment to prevent harm to clients. As a result, providers must assess whether their harm reduction efforts may cause more harm than benefit, according to their personal and professional commitments and the context of the person seeking assistance. Health care providers face a moral tension between their duty to provide client-centered care in harm reduction services and their duty to ensure safety and "do no harm". There is a tension in attempting to balance the duty to reduce overall harm to the client while not actively inflicting harm to the client. The lack of clear evidence to support assisted injection exacerbates this tension at least in part by making assessing utility more difficult. The lack of evidence may also fuel disagreement and divisiveness between providers who are supportive of this practice and those who are not, and contribute to feelings of moral distress on all sides.

As previously discussed, unresolved moral distress from such moral conflicts can eventually create moral injury. Lasting personal and professional harms from moral injury are well documented. These harms may result in negative consequences for employment, finances, mental and physical health, and personal relationships.[61]

Option 2: Expanding Access to Chemically Comparable Regulated Substances

An additional option to help further mitigate limited access to assisted injection might be expanded access to regulated alternatives to the unregulated drug supply in cases where the client is unable to self-inject. Offering to inject or otherwise provide a chemically comparable, regulated substance could address the person's need while not subjecting the provider to the legal, professional, and moral complexities of a request to inject an unregulated substance.

However, encouraging expanded access to regulated substances has many practical and logistical obstacles. While it may be a reasonable and effective solution for some clients, it will be less acceptable for others. For example, and as outlined by members of the working group, regulated alternatives may be more difficult to access (particularly in certain areas of the province). Expanding demand for regulated alternatives specifically to reduce requests for assisted injection of unregulated substances may potentially worsen the situation if it increases demand for substances that are already in short supply. On a related note, where regulated alternatives such as injectable opioid agonist therapy (iOAT) programs may be provided without cost (unlike the unregulated substances) there is an incentive to access the no-cost option regardless of one's ability to inject. While this practical challenge might - at least in theory - be mitigated through requiring a trade-in or exchange for

unregulated substances or alternatively instituting a cost for regulated substances-these solutions raise their own concerns (e.g., continued contact with illegal market in the former, and pricing issues and increased barriers to access which may most impact the least well off in the latter). Moreover, many people who do have access to regulated substances reported that these do not meet their needs. Some clients may have a strong preference for a specific unregulated substance or find that the regulated option does not give them the desired effect.

These concerns and challenges would need to be addressed before expanded access to regulated alternatives can be part of the solution to this issue. However, even with the most diligent and effective education efforts, indirect supports, and expanded access to regulated options, clients using unregulated substances may still need assistance injecting.

So, where does this leave us?

As suggested, providers should prioritize exploring and exhausting measures to reduce the need for assisted injection. The literature shows that formal and informal providers have made progress with reducing the need for assisted injection through tireless education, support and mentoring efforts.[62]

Upon careful consideration of many perspectives and interests involved, we find there is an ethically defensible argument for increasing access to assisted injection by formal (regulated and unregulated) providers working in sites specializing in OC services as an option of last resort where this is the least harmful option for the individual. In addition to the impact of current restrictions on those requiring injection assistance, other key components that support this argument are:

- The recognized need (illustrated for example by federal exemption for peer assistance),
- The current heavy reliance on informal peer providers to meet this need, and
- The resulting inequitable burden on these informal providers.

Looking forward, if the decision was made to expand access to assisted injection, there are many necessary steps that would need to happen (e.g., legislative, regulatory, policy, etc.). The health care and legal systems would need to address civil, criminal and professional liability concerns for those who choose to provide such assistance. It would be critical to continue gathering evidence and building the knowledge base to support this practice. Moreover, the issue of provider choice would be paramount. If implemented, assisted injection should not be mandated because:

1. This shift would mark a significant departure from current practice standards,
2. There would (at least initially) be limited direct evidence available to support (or counter) this approach, and

3. The potential for providers to feel distress, which could lead to incidents that could harm the client.

Instead, if this were optional, then providers:

1. Should offer assistance at their discretion and based on a "point of care" assessment, and
2. Must consider their **duty to care** for the client separately from their personal views.

While some providers may feel comfortable engaging in assisted injection, other providers may not. When a provider feels compelled to transition care to another provider, if available, they must ensure that this decision does not affect the client's ability to access care.

Balancing provider well-being with client preferences meets ethical and public health goals as it:

1. Is a key action toward stewardship, **efficiency**, and sustainability of the work force,
2. Reflects **integrity**, and
3. Can be considered an additional action to counteract the deadly public effects of the unregulated drugs supply.

Conclusion

Protective measures, like the current restrictions on assisted injection, should not create more harm than they seek to prevent. The line that has been drawn between supported consumption activities and assisted injection has a significant impact on the clients needing this assistance and also on providers. In keeping with the ethical principle of **integrity**, decision-makers should recognize that executive decisions affect those who implement the decisions on the ground (e.g., regulated, nonregulated, and informal peer providers of OC services). Given the recognized need for assisted injection and the current inequities in how this need is being met, options such as expanding access to assisted injection should be considered through an ethical approach. Key procedural and substantive values and principles for consideration in this process would include **procedural justice**, **cultural safety and humility**, **distributive justice**, **solidarity**, **respect**, and **utility**.

If assisted injection was authorized for regulated and non-regulated providers, the health care system would need to address and reduce the consequences that could follow. For example, the impact on public trust may be reduced by:

- Clearly communicating measures taken to exhaust other alternatives,

- Explaining that this intervention is provided only in situations where it is the least harmful option, all things considered, and
- Collecting and reviewing data to identify and understand any unintended harms and ensure that these do not outweigh the benefits of this approach.

It is also important to recognize that some burdens are unavoidable. Unavoidable burdens arising from the unregulated drug poisoning emergency should be equitably distributed, with care taken not to perpetuate existing disparities and harms. Further research is needed to identify and understand these burdens, and then to reduce these as much as possible for all affected parties.

Analysis 3

What ethical tensions result from current service restrictions on assisted injection of unregulated substances from a broader population public health perspective?

Values and Principles

 **Effectiveness**

 **Distributive Justice**

 **Utility**

Discussion

Harm reduction measures, including OC, have implications for individuals and specific subpopulations, as well as broader societal and public health impacts. Therefore, any barriers to accessing these services (such as restrictions on assisted injection discussed in this document) will likewise affect not only individuals and subpopulations, but the broader population as well.

As noted, OC is an evidence-informed, proven harm reduction strategy and an important option to support the health of people who use substances, particularly in the ongoing unregulated drug poisoning emergency. Notwithstanding concerns of possible harms and costs associated with normalization of substance use[63], evidence suggests that OC services have these public health benefits[64]:

1. Reduced substance use equipment sharing and disease transmission (e.g., hepatitis and HIV),
2. Reduced drug poisoning deaths and other early deaths among people who use substances,
3. Reduced harms and costs of managing disease due to unsafe injection practices such as extensive skin injections, sepsis, chronic lung disease, and endocarditis,
4. Reduced burden on emergency services,
5. Reduced illegal activities or behaviours,
6. Increased opportunities for education about safer substance use practices, and reduced frequency of use, and
7. Increased referrals to, and uptake of, treatment programs and other health and social services.

We previously described how the subpopulation of people who engage in injection substance use but cannot self-inject may avoid observed consumption services because of the restrictions on assisted injection. A discouraged person who no longer seeks OC will be at risk for less safe injection and will not receive the above listed benefits. As a result, the restrictions on provider assisted injection create burdens on individuals and inequities between different populations of people who use substances.

However, more generally this also arguably means that societal benefits, such as having lower levels of circulating communicable diseases and lower likelihood of transmission for all, are not fully realized. Likewise, possible system level savings - for example from reduced costs of managing disease due to unsafe injection practices and which could result in more money being available to support other clients and health related services - are likely to be reduced.

Finally, and as already discussed, the populations who are most likely to require assistance injecting often also experience intersecting inequities such as poverty, relational power dynamics, and other sources of systemic oppression. That these already disadvantaged populations are then likely to be disproportionately impacted by elevated incidents of disease transmission[65] and other risks associated with street-based substance use is a significant **distributive justice** concern and supports calls to address these inequities and reduce their impact.

Conclusion

BC is striving to achieve population level benefits by supporting progressive harm reduction approaches and building public trust through trauma and violence informed, culturally safe, and inclusive services. The restrictions on assisted injection undermine that goal and perpetuate disproportionate harms on persons who already live with significant challenges accessing and benefiting from health services.

Recommendations Arising from Analysis 1, 2, and 3

As outlined above, this analysis concludes that it is ethically justifiable to increase access to assisted injection of unregulated substances in sites specializing in OC services as an option of last resort where this is the least harmful option for the individual. The following recommendations are intended to support this significant and challenging shift moving forward:

1. *Cultural Humility, Cultural Safety, Utility, Distributive Justice, and Harm Reduction:* Settings where OC occurs (i.e., SCS, OPS) should engage with clients to better understand the need for assisted injection and what measures might reduce the need for assisted injection. Careful consideration should be given to the disproportionate harms of the unregulated drug supply on Indigenous populations. Engagement with First Nations, Inuit, and Métis peoples should be approached with cultural humility and in a way that creates cultural safety. Additional priorities should include equitable access to care and not further burdening a population who are already some of the most at risk and disadvantaged people who use substances.

2. *Cultural Humility, Cultural Safety, Distributive Justice, Effectiveness, Flexibility, and Integrity:* Other options such as expanding access to assisted injection should be considered. This must be done with cultural humility, creating cultural safety, and not perpetuating the current disproportionate burden on informal peer providers. If health and social policy makers start exploring regulatory and legislative adjustments, they should be particularly aware of gaps and deficits in equity that are impacted by intersectionality among people who require injection assistance.

3. *Cultural Humility, Cultural Safety, Procedural Justice, Effectiveness, and Solidarity:* Create assisted injection guidelines that explain how to reduce the need for assisted injection and how to approach assisted injection as an option of last resort where this is the least harmful option for the individual. Write these guidelines in partnership with formal and informal providers, mental health and addiction specialists, ethicists, College regulators, decision makers, Indigenous groups including First Nations, Inuit, and Métis peoples, and those with lived and living experience. These collaborative consultations will provide valuable information on what strategies will reduce the need for assisted injection and how to integrate the best available evidence, cultural safety and humility, harm reduction, intersectionality, trauma and violence informed practice and wise practices.

4. *Cultural Safety, Cultural Humility, Effectiveness, and Procedural Justice:* At all stages of the process, involve people with lived and living experience in the design and operation of OC and assisted injection services. This must include First Nations, Inuit, and Métis populations who experience disproportionate oppression, racism, and discrimination while accessing health services, which builds mistrust and leads to poor population health outcomes. Use open, transparent dialogue and partnership to plan creative ways to mitigate the harms faced by First Nations, Inuit, and Métis peoples and others who are unjustly excluded from access to care.

5. *Flexibility, Effectiveness, Utility, and Harm Reduction:* Build a knowledge base to support practice where access to assisted injection is increased. This is especially important because there is limited evidence about the actual risks associated with expanded access. Establish ongoing monitoring and reporting requirements to accurately measure the need for assisted injection and impact of this service on the client, various provider groups and public perception. In gathering and evaluating such data, established approaches and measures for introducing and evaluating public health measures should be followed and upheld. If, over time, evidence reveals that the harms associated with assisted injection outweigh the benefits, this strategy should be reviewed.

6. *Integrity, Solidarity & Distributive Justice:* Ensure adequate education and support for all provider groups-including addressing and managing moral distress. For regulated providers, work with relevant regulatory bodies to ensure that providers are well aware of any changes regarding assisted injection, including the ethical justification behind this strategy. To help address health care providers' concern that assisted injection enables substance use, highlight the broader goals of assisted injection. As far as possible, providers who offer assisted injection should be located around the province to reduce geographic inequities. For non-regulated and peer providers, acknowledge the central role of people with lived and living experience in providing OC, and work with these provider groups to better understand from them the impact of their role and what supports they need to reduce the burden that comes with providing such assistance. Research focusing on how power and privilege create advantages for regulated providers and disadvantages for non-regulated and informal providers, and how to effectively address this, should be considered.

7. *Integrity:* Develop resources to support the wellness of all providers. These should include resources that support those struggling with moral distress and acknowledge that moral distress may come with both providing and restricting access to assisted injection. Attend to provider concerns about workload, moral distress, and professional impacts (where relevant) associated with current restrictions and alternatives including expanded access through engagement, consultation, and mitigation planning. This will ensure that service program capacity and individual provider health do not deteriorate, protecting against harm to providers, and promoting access to care for those in need.

8. *Cultural Humility, Cultural Safety, Procedural Justice, and Utility:* If access to assisted injection were to be expanded as part of OC, the potential impact on public trust must be acknowledged and addressed. The public should receive clear communications about measures taken to ensure this intervention is one of last resort provided only in situations where it is the least harmful option, all things considered. Moreover, ongoing data collection and evaluation efforts to identify and understand any unintended harms, and to ensure that these do not outweigh the benefits of this approach, should be publicly shared.

Appendix 1: Ethical Values, Principles, and Approaches Informing this Analysis

Public health ethics involves a systematic process to clarify, prioritize, and justify possible courses of public health action based on ethical principles, values, and beliefs of impacted parties, and scientific and other information. The principles and values in this analysis were selected from multiple recognized approaches that support everyday ethical practice and respond to ethical challenges in public health. In general, the values and principles used in this analysis fall into two categories: procedural and substantive, and are defined and applied below. Cultural safety and cultural humility are cross-cutting values that are both procedural and substantive in nature. These values are relevant to each of the other values and principles and should be applied throughout the ethical analysis. Under each principle and value listed below is a definition followed by a description of how that ethical principle or value is applied in health care.

Cultural Safety and Cultural Humility[66]

Cultural safety definition: Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health-care system. It results in an environment free of racism and discrimination, where Indigenous people—including First Nations, Inuit, and Métis peoples—feel safe when receiving health care.

Cultural humility definition: 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.

Application in health care ethics: Refers implicitly to the relationships between Indigenous and Settler peoples and social systems. Cultural humility is a practice that can lead to cultural safety, which is an outcome that can only be measured by Indigenous people.

Procedural Values and Principles: How do we Make Decisions and Work Together?

Note: All procedural values and principles must be upheld through decision-making processes.

Effectiveness

Definition: Assess how well something produces an indented goal(s).

Application in health care ethics: Assess the extent to which desired outcomes or objectives are achieved as a result of an intervention or initiative.

Efficiency

Definition: Maximize the benefit of available resources and avoid waste.

Application in health care ethics: Streamline local, regional, and provincial infrastructure to ensure: (1) there is no duplication of work, and (2) personnel with the appropriate authority and expertise are in place.

Flexibility

Definition: Adapt to new knowledge and evidence.

Application in health care ethics: Modify strategy in response to health care system needs and considering client, public, and health care provider needs.

Integrity

Definition: Align decision-makers' prioritized values with their decisions and actions.

Application in health care ethics: Promote trust by implementing decisions that uphold prioritized values. Address moral distress and well-being support for decision makers and those carrying out the decisions.

Procedural Justice (fair process)

Definition: Ensure a fair and transparent process throughout the planning and implementation of decisions.

Application in health care ethics: Uphold:

1. *Transparency:* Act openly and honestly, in a manner that ensures decision making and actions can be understood by people not involved in these activities. Any planning, policy, and action is transparent and open to participants' input as well as available to the public as much as possible.

2. *Inclusiveness:* Involve interested individuals to the greatest extent possible, address barriers that may impede engagement and promote trust.
3. *Accountability:* Accept responsibility for one's actions and document and describe the rationale for the decisions made or not made.
4. *Reasonableness:* Confirm decisions are rational, bias-free as possible, evidence-informed, defensible, guided by appropriate process, timely, practical, and open to review and appeal.
5. *Consistency:* Respond in the same manner to similar circumstances and justify any changes to the ethical decision-making process, guidance, analyses, or rationale.

Procedural justice includes recognition of reciprocal accountabilities with First Nations, and inclusion of Indigenous leadership through all phases of the process.

Solidarity

Definition: Adopt collaborative approaches to understand each other's needs and cooperate in formulating strategic responses.

Application in health care ethics: Promote cooperation among communities and between local, regional, provincial, and federal decision makers to promote fair and just responses.

Substantive Values and Principles: What Goals or Ends Should we Pursue and How Should Principles and Values be Weighed Against One Another?

Note: When it is not possible to uphold all substantive values, it is necessary to justify, communicate and document trade-offs and prioritizations.

Distributive Justice

Definition: Promote equitable distribution (fairness): Everyone matters equally, but not everyone may be treated the same.

Application in health care ethics: Consider two factors for equitable delivery of care and services that must be balanced based on the issue under consideration:

1. *Equality:* Individuals ought to be treated with equal concern and respect. Those with similar situations should have similar access to health-care resources. Resource allocation decisions must be made consistently across populations and among individuals regardless of their human condition (e.g., race, age, disability, ethnicity, ability to pay, socioeconomic status, pre-existing health conditions, perceived obstacles to treatment, past use of resources, etc.), and

2. *Equity:* Health measures should: (a) not place unfair burdens on particular individuals and/or populations, (b) not perpetuate systemic or structural inequities (e.g. underserved populations who face systemic or structural health inequities, social policies or processes and/or geographic obstacles that create barriers to accessing resources, etc.), and (c) attempt to reduce inequities.

Duty to Care

Definition: The health-care provider's professional responsibility or legal obligation to provide care to all individuals in their care.

Application in health care ethics: Uphold the health-care provider's duty to care as the situation requires and as circumstances reasonably permit.

Respect

Definition: Promote, consider, and recognize culture, autonomy, and perspectives of people, as much as possible.

Application in health care ethics: Uphold:

1. Cultural respect: Approach all individuals, families, and communities with respectful inquiry of their unique identity, culture, worldview, and lived experiences. Environments should strive to be socially, spiritually, physically, emotionally, and psychologically safe. Ensure that individuals are respected, supported and will not be judged for their beliefs, values or way of being.
2. Dignity: Respect the intrinsic worth of every person and community
3. People-centered care: Provide care that responds to individual preferences, needs and values
4. Self-determination: Engage with individuals or communities so they can guide their future through responsible and informed decision-making that supports autonomy and independence.

Utility (Weigh harms and benefits)

Definition: Uphold a positive balance of overall harms and benefits.

Application in health care ethics: In general, make decisions that promote health and minimize the overall harms as much as possible.

Table 3. Approaches Supporting Ethical Practices

Approach	Description
Harm Reduction	In the context of substance use, harm reduction is an evidence-based approach to addressing the harms of substance use and/or any other behaviours considered high risk. Harm reduction advances health and human rights of people who use substances. It focuses on reducing and preventing harms instead of preventing substance use/risk behaviors itself. Harm reduction has been proven to benefit individuals, families and communities. Of particular importance for this conversation, harm reduction is proven to reduce barriers to accessing health care for people who use substances.
Intersectionality	Intersectional bioethics focuses on the unique forms of oppression and the structural and systemic barriers experienced by those with marginalized and intersecting identities (e.g., Black, disabled, transgender, woman). Integrating intersectionality into bioethics involves self-reflection, examining biases, challenging assumptions and understanding how health-care equity, access and interactions are shaped by institutions, policies, and social identities.
Trauma and Violence Informed Practice	An approach to care that acknowledges that a complete picture of a client's life situation — past and present — must be understood in order to provide effective health-care services with a healing orientation.
Wise Practices	Effective and culturally appropriate actions, tools, principles or decisions that contribute significantly to the development of sustainable and equitable conditions and practices. These Wise Practices produce optimal results for Indigenous Peoples.

Appendix 2: Description of Key Ethical Values Listed in This Document as Providing Support for a Harm Reduction Approach

Humanism - Providers accept and support patient's choices regardless of moral or societal norms.

Pragmatism - Not everyone is able or willing to adopt optimal or ideal health-related behaviors. Therefore, abstinence should not always be a focus or a priority of health-care interactions. Care messages will be about actual risks and harms related to choices and not moral or societal standards.

Respect for autonomy - In recognizing the dignity of the person, key goals are patient driven care, shared decision making and reciprocal learning.

Individualism - Each person is unique and so are their health care needs. No assumptions are made. Standardized care messaging and treatment protocols are abandoned in favor of tailored care that meets individual needs.

Incrementalism - Achieving a state of health can take time and the journey often involves a mixture of steps forward and backwards as well as plateaus. While backwards movement should be planned for, messages from health-care providers should celebrate forward movement and focus on positive reinforcement.

Accountability without penalization or termination - Clients own their choices. A health care provider's role is supporting, understanding, and mitigating consequences of those choices. Accountability does not mean punitive consequences or termination of therapeutic relationship due to those choices.

These values, on their own, at least arguably provide a compelling moral justification for harm reduction strategies - albeit one that is rooted in a deontological (or duty based) approach, largely focusing on how we treat each other in terms of respecting autonomy and dignity of the person, as opposed to a more consequentialist (or outcome based) approach.[67]

[1] It is also relevant contextually to note that the substance use landscape continues to evolve in ways that could impact the extent of the role assisted injection may have in the broader harm reduction landscape. For example, provincial data indicates that inhalation has replaced injection as the preferred means of substance consumption, with rates of injection substance use decreasing since 2018 as inhalation rates increase. See BC Coroners Service Death Review Panel: A Review of Illicit Drug Toxicity Deaths. Report to the Chief Coroner of British Columbia Release Date: March 9, 2022. Available at: https://www2.gov.bc.ca/gov/content/life-events/death/coroners-service/death-review-panel

[2] A review of various public health approaches to substance use- and specifically a comparison of abstinence-based approaches with harm reduction approaches-is beyond the scope of this paper. Very briefly, there is for example concern around the effectiveness of harm reduction measures because of the high numbers of drug poisonings and deaths associated with unregulated drug emergencies. Responses to such concerns often point out that, these rates would be significantly higher without harm reduction interventions. Other key arguments against harm reduction are often rooted in concerns about condoning dangerous or "undesirable" behaviours, impacts on crime and neighbourhood disorder, and enabling addiction. See for example: Rapid Response Service. Rapid Response: Public Perception of Harm Reduction Interventions. Toronto, ON: Ontario HIV Treatment Network; December 2012: https://www.ohtn.on.ca/wp-content/uploads/rapid-response/RR63-2012-Public-Perception-HR-Interventions-1.pdf; Larson et al (2018) Supervised consumption facilities: A review of the evidence available at: LarsonS_PHLReportOnSCF_Dec2017 (dbhids.org);

[3] http://www.bccdc.ca/our-services/programs/harm-reduction

[4] First Nations Health Authority: FNHA-First-Nations-and-the-Toxic-Drug-Poisoning-Crisis-in-BC-Jan-Dec-2024.pdf

[5] British Columbia Centre for Disease Control. Observed Consumption Best Practice Guidelines. 2025.

[6] In this document we are focusing on injection; however, OC is also relevant to other substance consumption methods including smoking, where supported consumption activities include: offering mouthpieces, inserting screens, pipe replacement. For a more detailed description of the range of OC services and distinction between supported and assisted consumption please see the BCCDC Observed Consumption Best Practice Guidelines (Supra, note 6).

[7] While this analysis adopts a narrow definition of assisted injection that applies broadly to all categories of providers, other potential forms of injection assistance would have specific implications for regulated providers- such as using vascular access devices (e.g., saline locks, central lines) to administer substances. Such forms of assistance are likewise not permitted under current legislation and professional and practice standards, and present additional potential benefits and harms for clients and nuances for regulated for providers that would be important to consider as part of a broader conversation considering the future of assisted injection. See for example, Chase, J., et al (2022). Self-injecting non-prescribed substances into vascular access devices: a case study of one health system's ongoing journey from clinical concern to practice and policy response. Harm Reduct J 19, 130; Gagnon, M., et al (2022). Nurse-Assisted Injection: A Path to Equity in Supervised Consumption Services. Canadian Institute for Substance Use Research, Victoria, BC. Available at : https://www.uvic.ca/research/centres/cisur/assets/docs/report-nurse-assisted-injection-final-version.pdf.

[8] British Columbia Centre for Disease Control. Observed Consumption Best Practice Guidelines. 2025.

[9] As described by Pilj et al (2021), "as of March 2020, peer assistance has become an official and regulated optional service at SCSs across the country. SCSs are not proactively exempted for peer assistance; they must apply to the Office of Controlled Substances for peer-assistance authorization. Currently, 20 of the 39 operating SCSs in Canada are exempt to offer peer assistance." Pijl, E., Oosterbroek, T., Motz, T. et al. (2021) Peer-assisted injection as a harm reduction measure in a supervised consumption service: a qualitative study of client experiences. Harm Reduct J 18, 5. https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-020-00455-3

[10] SafePoint in Surrey and the Harbour in Victoria are the two SCS operating in BC with a peer assistance exemption: https://www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/status-application.html#a1 (This website provides up to date numbers. It was last accessed July 9, 2024).

[11] For example VCH OPS stipulates a supervisor may permit assisted injection where (a) there is no way for the person to self-inject through education or available physical assistance, and (b) certain rules are followed (e.g., peer assisted injection cannot be in exchange for money, goods or services, etc.). https://www.vch.ca/en/media/13086.

[12] https://www.pivotlegal.org/scs_ops_map

[13] See VCH OPS guidelines available at: https://www.vch.ca/en/media/13086

[14] http://www.bccdc.ca/our-services/programs/harm-reduction

[15] Kennedy MC, et al (2020). Assisted injection within supervised injection services: Uptake and client characteristics among people who require help injecting in a Canadian setting. Int J Drug Policy. Oct 8;86:102967.

[16] https://www.vch.ca/en/media/13086

[17] See for example: Mitra,S. et al (2022). Requiring help injecting among people who inject drugs in Toronto, Canada: Characterising the need to address sociodemographic disparities and substance-use specific patterns. Drug Alcohol Rev., 41: 1062-1070. https://doi.org/10.1111/dar.13473; McNeil R, Small W, Lampkin H, et al (2014). "People knew they could come here to get help": an ethnographic study of assisted injection practices at a peer-run 'unsanctioned' supervised drug consumption room in a Canadian setting. AIDS Behav, 18, 473–85.

[18] Fairbairn, N., Small, W., Van Borek, N. et al.(2010). Social structural factors that shape assisted injecting practices among injection drug users in Vancouver, Canada: a qualitative study. Harm Reduct J 7, 20. https://doi.org/10.1186/1477-7517-7-20

[19] Gagnon, M., et al. (2022). Nurse-Assisted Injection: A Path to Equity in Supervised Consumption Services. Canadian Institute for Substance Use Research, Victoria, BC. Available at : https://www.uvic.ca/research/centres/cisur/assets/docs/report-nurse-assisted-injection-final-version.pdf.

[20] Kolla G, et al. (2020). Help me fix: The provision of injection assistance at an unsanctioned overdose prevention site in Toronto, Canada. Int J Drug Policy. Feb;76:102617. doi: 10.1016/j.drugpo.2019.102617.

[21] See for example: https://news.gov.bc.ca/releases/2023MMHA0029-000802; https://www.canada.ca/en/health-canada/services/opioids/opioid-related-hospitalizations-anoxic-brain-injury.html; http://www.bccdc.ca/Health-Professionals-Site/Documents/Harm-Reduction-Reports/Neurological%20Injury_ODC_2020_01_03.pdf

[22] Ibid., and see also Kennedy MC, Milloy MJ, Hayashi K, Holliday E, Wood E, Kerr T. Assisted injection within supervised injection services: Uptake and client characteristics among people who require help injecting in a Canadian setting. Int J Drug Policy. 2020 Oct 8; 86:102967. doi: 10.1016/j.drugpo.2020.102967.

[23] Much of the research and literature informing this document refers to "women", however, it is reasonable to assume that the disproportionate impacts of patriarchal systems being described and referenced are also experienced by those who identify as women, non-binary and/or as members of the LGBTQ2+ community.

[24] Mitra,S. et al (2022). Requiring help injecting among people who inject drugs in Toronto, Canada: Characterising the need to address sociodemographic disparities and substance-use specific patterns. Drug Alcohol Rev., 41: 1062-1070. https://doi.org/10.1111/dar.13473; E. Pijl et al., "Peer-assisted injection as a harm reduction measure in a supervised consumption service: A qualitative study of client experiences," Harm Reduction Journal 18(1) (2021).

[25] Health Canada: Supervised Consumption Sites Status of Applications (glossary): https://www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/status-application.html#a3 accessed July 11, 2023.

[26] Health Canada: Supervised Consumption Sites Status of Applications (glossary): https://www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/status-application.html#a3 accessed July 11, 2023

[27] McNeil R, Small W, Lampkin H, et al (2014). "People knew they could come here to get help": an ethnographic study of assisted injection practices at a peer-run 'unsanctioned' supervised drug consumption

[28] See for example: Fairbairn, N., Small, W., Van Borek, N. et al. Social structural factors that shape assisted injecting practices among injection drug users in Vancouver, Canada: a qualitative study. Harm Reduct J 7, 20 (2010). https://doi.org/10.1186/1477-7517-7-20.

[29] That is, the organization could be held responsible if an employee provides assisted injection and causes harm to the client.

[30] To this point, it is notable that some data suggest there may be an increased chance of non-fatal drug poisoning among people who receive assistance injecting at an observed consumption site. Researchers of one such study concluded this was most likely because sites accommodating assisted injection may attract individuals who are already at heightened risk of overdose (as opposed to such a service promoting riskier substance use practices, for example). See Kennedy MC, Milloy MJ, Hayashi K, et al (2020). Assisted injection within supervised injection services: Uptake and client characteristics among people who require help injecting in a Canadian setting. Int J Drug Policy. Oct 8;86:102967. doi: 10.1016/j.drugpo.2020.102967.

[31] See for example: Provincial COVID-19 Task Force. (2020). COVID-19 Ethical Decision-Making Framework. https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/covid-19/ethics_framework_for_covid_march_28_2020.pdf; Public Health Agency of Canada (2017). Framework for ethical deliberation and decision-making in public health: A tool for public health practitioners, policy makers and decision-makers. https://www.canada.ca/content/dam/phac-aspc/documents/corporate/transparency/corporate-management-reporting/internal-audits/audit-reports/framework-ethical-deliberation-decision-making/pub-eng.pdf

[32] mmha_substanceuseframework_dec2022.pdf (gov.bc.ca)

[33] Kennedy, M.C., Karamouzian, M., & Kerr, T. (2017). Public health and public order outcomes associated with supervised drug consumption facilities: A systematic review. Current HIV/AIDS Reports, 14, 161–183.

[34] Health Canada: Supervised Consumption Sites Status of Applications (glossary): https://www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/status-application.html#a3 accessed July 11, 2023.

[35] Fairbairn N, Small W, Van Borek N, et al (2010). Social structural factors that shape assisted injecting practices among injection drug users in Vancouver, Canada: a qualitative study. Harm Reduct J 7:20; Small W, Shoveller J, Moore D et al (2011) Injection Drug Users' Access to a Supervised Injection Facility in Vancouver, Canada: The Influence of Operating Policies and Local Drug Culture. Qual Health Res. 21(6):743–756;

[36] Fairbairn N, Small W, Van Borek N, et al (2010). Social structural factors that shape assisted injecting practices among injection drug users in Vancouver, Canada: a qualitative study. Harm Reduct J 7:20;

[37] See for example R. McNeil et al. (2014), "'People knew they could come here to get help': an ethnographic study of assisted injection practices at a peer-run 'unsanctioned' supervised drug consumption room in a Canadian setting," AIDS and Behavior, 18(3) 473–485; Mitra,S. et al (2022). Requiring help injecting among people who inject drugs in Toronto, Canada: Characterising the need to address sociodemographic disparities and substance-use specific patterns. Drug Alcohol Rev., 41: 1062-1070. https://doi.org/10.1111/dar.13473; E. Pijl et al.(2021), "Peer-assisted injection as a harm reduction measure in a supervised consumption service: A qualitative study of client experiences," Harm Reduction Journal 18(5); Fairbairn,N et al (2010). Social structural factors that shape assisted injecting practices among injection drug users in Vancouver, Canada: a qualitative study. Harm Reduct J 7, 20 https://doi.org/10.1186/1477-7517-7-20.

[38] See for example: Kennedy MC, et al(2020). Assisted injection within supervised injection services: Uptake and client characteristics among people who require help injecting in a Canadian setting. Int J Drug Policy. Oct 8;86:102967. doi: 10.1016/j.drugpo.2020.102967. R. McNeil et al.(2014), 'People knew they could come here to get help': an ethnographic study of assisted injection practices at a peer-run 'unsanctioned' supervised drug consumption room in a Canadian setting," AIDS and Behavior, 18(3): 473–485; Small et al., (2011)"Injection drug users' access to a supervised injection facility in Vancouver, Canada: the influence of operating policies and local drug culture," Qualitative Health Research (21)743–56.

[39] HIV Legal Network (2022) Provider-Assisted Injection in Ontario's Supervised Consumption Services FREQUENTLY ASKED QUESTIONS, available at: https://www.hivlegalnetwork.ca/site/provider-assisted-injection-in-ontarios-supervised-consumption-services-frequently-asked-questions/?lang= en. While specific evidence is not available, it is likely that other subgroups of people requiring assistance injecting, including youth, non-binary individuals, people with diverse abilities and those who are unhoused are also similarly likely to be at higher risks of violence and abuse.

[40] While out of scope for this analysis, when considering what may constitute disproportionate burden for providers, a recent article by J Dunsford may offer some guidance. For example, and while in a different context than is currently being discussed, Dunsford suggests that the level of vulnerability within a therapeutic relationship depends on the unique personal factors of the provider and the client involved. Thus, a disproportionate burden could not be prescribed by anyone but the provider and client themselves in the particular circumstances. These considerations may be particularly relevant in this context which involves such a wide range of providers. Dunsford, J.(2022) Nursing violent patients: Vulnerability and the limits of the duty to provide care. Nursing Inquiry, 29(2), e12453.

[41] The way in which multiple sources of oppression--race, class, gender identity, sexual orientation, neuro-divergence, etc.--can operate together and exacerbate each other. See Appendix for further description. This term was initially coined by: Crenshaw K, Demarginalizing the intersection of race and sex: a Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics in: Bartlett K Feminist legal theory. Routledge, New York, NY1991; See also: Chellappa, SL (2023) Intersectional inequities in academia. The Lancet (Correspondence), 401:10382 (April 01). https://doi.org/10.1016/S0140-6736(23)00229-5

[42] Registered Nurses of Ontario, 2018. Best practice guideline: Implementing supervised injection services. Retrieved from https://rnao.ca/sites/rnao-ca/files/bpg/Implementing_supervised_injection_services.pdf

[43] Gagnon, M., et al. (2022). Nurse-Assisted Injection: A Path to Equity in Supervised Consumption Services. Canadian Institute for Substance Use Research, Victoria, BC. Available at: https://www.uvic.ca/research/centres/cisur/assets/docs/report-nurse-assisted-injection-final-version.pdf

[44] See for example Gagnon M.(2017). It's time to allow assisted injection in supervised injection sites. CMAJ; 189:E1083–e4.

[45] As stated in the International Consensus Statement on the Role of Nurses in Supervised Consumption Sites (https://jmhan.org/index.php/JMHAN/article/view/35), nursing practice in OC services is informed by a broad philosophy of care that encompasses harm reduction, health equity, cultural safety, relational care, social justice, and anti-oppression. While this Statement is in relation to nurses, and while the scope of practice for assisted injection would differ between regulated and nonregulated providers, it is reasonable to expect that such philosophy informs regulated and unregulated OC service providers alike.

[46]Moral distress is a term that describes the various harms that arise from feeling morally compromised and when people are unable to make decisions or act according to their core values. Moral distress includes avoiding wrongdoing or causing harm. PHSA Ethics Services Moral Distress Guide, 2023, available at: http://www.phsa.ca/our-services/programs-services/ethics-service#Resources

[47] Gagnon, M., Gauthier, T., Cleveland, E., Ditmars, M., Gregg, K., Hlady, K. & McLaughlin, K. (2022). Nurse-Assisted Injection: A Path to Equity in Supervised Consumption Services. Canadian Institute for Substance Use Research, Victoria, BC. Available at: https://www.uvic.ca/research/centres/cisur/assets/docs/report-nurse-assisted-injection-final-version.pdf

[48] PHSA Ethics Services Moral Distress Guide, 2023, available at: http://www.phsa.ca/our-services/programs-services/ethics-service#Resources

[49] Arnold TC. Moral distress in emergency and critical care nurses: a meta-ethnography. Nurs Ethics 2020; https://doi.org/10.1177/0969733020935952.

[50] Gagnon, M., Gauthier, T., Cleveland, E., Ditmars, M., Gregg, K., Hlady, K. & McLaughlin, K. (2022). Nurse-Assisted Injection: A Path to Equity in Supervised Consumption Services. Canadian Institute for Substance Use Research, Victoria, BC. https://www.uvic.ca/research/centres/cisur/assets/docs/report-nurse-assisted-injection-final- version.pdf

[51] Fairbairn N, Small W, Van Borek N, et al (2010). Social structural factors that shape assisted injecting practices among injection drug users in Vancouver, Canada: a qualitative study. Harm Reduct J 7:20; R. McNeil et al.,(2014), "'People knew they could come here to get help': an ethnographic study of assisted injection practices at a peer-run 'unsanctioned' supervised drug consumption room in a Canadian setting," AIDS and Behavior, 18(3): 473–485

[52]Pijl, E., Oosterbroek, T., Motz, T. et al. Peer-assisted injection as a harm reduction measure in a supervised consumption service: a qualitative study of client experiences. Harm Reduct J 18, 5 (2021). https://doi.org/10.1186/s12954-020-00455-3

[53] Same reference as previous.

[54]Austin, T., Lavalley, J., Parusel, S. et al.(2023) Women who use drugs: engagement in practices of harm reduction care. Harm Reduc J 20, 49. Available at: https://doi.org/10.1186/s12954-023-00775-0

[55] https://laws-lois.justice.gc.ca/eng/acts/c-38.8/, and see also description of legal exposure provided by Ontario HIV Legal Network, available at: https://www.hivlegalnetwork.ca/site/download/22658/?tmstv=1687981631. This document provides a helpful overview of the legal landscape, although in a BC context there would be some differences (e.g. in terms of relevant legislation governing professions and court precedents)

[56] Before performing any medication-related activity, nurses know the medication's: therapeutic use/indications, expected effects, dosages, precautions, contraindications, form and route of administration, interactions/side effects/adverse effects, the client related information and context, know how to best prepare to administer, monitor and possibly intervene in the event of an adverse event, and must know these things to provide information on risks, benefits and likely outcomes in the process of gaining informed consent for the medication from the client receiving it. https://www.bccnm.ca/RN/PracticeStandards/Pages/Medication.aspx.

[57] https://www.ismp-canada.org/download/presentations/SystemsApproach_ISMPCanada_18Nov2015.pdf

[58] BCCNM Medication Practice Standard, 2023 https://www.bccnm.ca/NP/PracticeStandards/General%20Resources/NP_PS_Medication.pdf

[59] https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/death-review-panel/review_of_illicit_drug_toxicity_deaths_2022.pdf

[60] See for example: Pijl, E., Oosterbroek, T., Motz, T. et al. Peer-assisted injection as a harm reduction measure in a supervised consumption service: a qualitative study of client experiences. Harm Reduct J 18, 5 (2021); Kennedy MC, Milloy MJ, Hayashi K, Holliday E, Wood E, Kerr T. Assisted injection within supervised injection services: Uptake and client characteristics among people who require help injecting in a Canadian setting. Int J Drug Policy. 2020 Oct 8;86; Kolla, G., Kenny, KS., Banerman, M. et al. "Help me Fix: The Provision of Injection Assistance at an Unsanctioned Overdose Prevention Site in Toronto, Canada," International Journal of Drug Policy 76 (2020) 2; McNeil, R., Small, W., Lampkin, H. et al "People Knew They Could Come Here to Get Help": An Ethnographic Study of Assisted Injection Practices at a Peer-run 'Unsanctioned' Supervised Drug Consumption Room in a Canadian Setting." AIDS Behav 18.3 (2015): 473-85;

[61] PHSA Ethics Services Moral Distress Guide, 2023, available at: http://www.phsa.ca/our-services/programs-services/ethics-service#Resources

[62] See for example, Austin, T et al. (2023) Women who use drugs: engagement in practices of harm reduction care. Harm Reduc J 20, 49 Available at: https://doi.org/10.1186/s12954-023-00775-0; Z. Marshall, M.K. et al (2015). Peering into the literature: A systematic review of the roles of people who inject drugs in harm reduction initiatives. Drug and Alcohol Dependence 151, pp 1-14; Wood R,et al (2008). Nurse delivered safer injection education among a cohort of injection drug users: evidence from the evaluation of Vancouver's supervised injection facility. Int J Drug Policy; 19:183–8.

[63] As noted earlier (see footnote 3 and related text), this analysis builds on the premise that OC and other harm reduction approaches are important in substance use care. Consideration of counterarguments (including for example harms that may be associated with normalization of substance use) exceeds present scope.

[64] See for example KG. Card, K. Urbanoski, B. Pauly. (2020) "Supervised Consumption Sites Are Necessary Public Health Services." Canadian Institute for Substance Use Research for a recent compilation and review of evidence addressing these public health benefits; as well as Kennedy, M.C., Karamouzian, M., & Kerr, T. (2017). Public health and public order outcomes associated with supervised drug consumption facilities: A systematic review. Current HIV/AIDS Reports, 14, 161–183.

[65] For example, because women are more likely to need and seek injection assistance from males in dominant relational positions, they tend to be injected second—so more likely to have disease transmission. See, McElrath K, Harris J. (2013) Peer injecting: implications for injecting order and blood-borne viruses among men and women who inject heroin. J Subst Use. 18(1):31–45 and related research as cited by Pijl, E., Oosterbroek, T., Motz, T. et al. (2021) Peer-assisted injection as a harm reduction measure in a supervised consumption service: a qualitative study of client experiences. Harm Reduct J 18, 5. https://doi.org/10.1186/s12954-020-00455-3

[66] First Nations Health Authority, Creating a Climate for Change Cultural Humility Resource Booklet. https://www.fnha.ca/Documents/FNHA-Creating-a-Climate-For-Change-Cultural-Humility-Resource-Booklet.pdf

[67] Adapted from Hawk et al (2017). Harm reduction principles for healthcare settings.Harm Reduct J 14, 70, https://doi.org/10.1186/s12954-017-0196-4. See also, Stoljar, N. (2020) Disgust or Dignity? The Moral Basis of Harm Reduction, Health Care Analysis 28:343–351.