

January 2019

HARM REDUCTION SERVICES

RECOMMENDATIONS FOR OVERDOSE PREVENTION AT
MEETINGS AND EVENTS
2019

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Introduction

As a means to increase inclusivity and accessibility, this document is intended as a guide to offer Overdose Prevention Services (OPS) onsite while hosting substance-use specific peer engagement events. We acknowledge that many people may or may not identify with the term peer and invite everyone to respect and honour the way people self-identify. With that in mind and for the purpose of this document, people with lived experience and peer will be used interchangeably. To add, the term peer is not solely used within substance use communities, rather is a term that can take on many different forms. In the context of this document, peer refers to anyone with past or present use of substances (including cannabis and alcohol) and are considered experts in the field.

Additionally, OPS in the context of this document is a temporary space for illicit drug use and we recognize that people use drugs in different ways. If possible, having designated spaces both indoors and outdoors for illicit drug use separate from cigarette smoking areas is recommended; as well designating areas for people who do not use, or are not currently using to hang out during break times. Unfortunately due to current Provincial (WorkSafeBC) and National smoking regulations, smoking of substances is not permitted inside and continues to create disparate hierarchies in access to OPS.

It is important to note that peer-run, supported, and evaluated OPS are considered optimal in offering quality services. While nurses may play a role in Overdose Prevention Services, people with lived experience are the experts and we are to take the lead from them. This document primarily concerns and references onsite services for hosting harm reduction supply distribution and illicit drug use in venues for meetings and events; and is not necessarily applicable within all community settings^{1,2}. Please connect with local peer groups for assistance in creating OPS in your community. Alternatives may include collaboration and taxi vouchers or transportation to and from local OPS.

In 2016, the BC Minister of Health declared a Public Health Emergency as a result of increasing overdose deaths.^{3,4} This declaration preapproves the creation of overdose prevention sites, and entails that an organization no longer needs to seek a Health Canada exemption to run OPS. This is a temporary measure that will last until the public health crisis is over.

Overdose Prevention Services offer a designated space to provide support and intervention in the event of an overdose. This facilitates more inclusive and accessible environments for people with lived experience to take part in decision-making along with rapid intervention if an overdose occurs.

For an overview of OPS protocols and recommendations, see BCCDC's BC Overdose Prevention Services Guide.⁵

1. Ti, L., Tzemis, D. & Buxton, J.A. (2012) Peer engagement in the context of policy and program development: A review of the literature Retrieved from: <http://www.substanceabusepolicy.com/content/7/1/47>
2. Marshall, Z., Dechman, M.K., Minichiello Alcock, A.L. & Harris, G.E. (2015). Peering into the literature: A systematic review of the roles of people who inject drugs in harm reduction initiatives. *Drug Alcohol Dependence*, 151(0), pp. 1–14.
3. BC Government News Release (2016). Provincial health officer declares public health emergency, retrieved from: <https://news.gov.bc.ca/releases/2016hlth0026-000568>
4. BC Government News Release (2016). Ministerial order supports urgent overdose response action, retrieved from: <https://news.gov.bc.ca/releases/2016HLTH0094-002737>
5. BC Centre for Disease Control (2017). BC overdose prevention services guide. Retrieved from: <http://www.bccdc.ca/resource-gallery/Documents/BC%20Overdose%20Prevention%20Services%20Guide-Final%20October%202,%202017.pdf>

Introduction

Overdose Prevention Services (OPS) differ from Supervised Injection/Consumption Services (SIS/SCS) in two main ways; 1) they do not require a Health Canada section 56 exemption and 2) they are short-term, for example, at peer engagement meetings and events. A separate provincial guideline has been produced and should be referred to by [SIS/SCS sites approved by Health Canada](#).⁶

The duration of OPS for meetings and events generally lasts from one to two days, opening just before event begins and remaining open long enough for people to access services after the event has ended (without feeling rushed). It is important to note that while this document provides guidance for the majority of circumstances service providers may encounter, knowledge and practice are always evolving and in order to maintain context-specific work, foundations of creativity and flexibility are encouraged. It would also be helpful to connect regularly with your local Harm Reduction services, Regional Harm Reduction Program leads and Medical Health Officers to ensure services meet local needs.⁷

Overdose Prevention Services

The primary goal of OPS is to provide a space for people to use previously obtained substances in a setting where trained staff are able to respond to overdoses and provide support in respectful ways.

The three principles of OPS are harm reduction, improved population health and integrated services. Core services include:⁷

- Provision of a designated monitored space for drug use including supply distribution⁷
- Intervention for drug overdoses⁷
- Harm reduction teaching, training and referral services when appropriate⁷

Equity Oriented Care

Equity oriented services are of utmost importance due to the imbalance of power and privilege within community based engagements. Equity-oriented services are tailored to context and are responsive to inequities through the practice of [harm reduction](#).⁸



Vancouver Coast Health, 2018

6. BC Centre for Disease Control (2017). BC overdose prevention services guide. Retrieved from: <http://www.bccdc.ca/resource-gallery/Documents/BC%20Overdose%20Prevention%20Services%20Guide-Final%20October%20202017.pdf>
7. BC Government News Release (2016). Ministerial order supports urgent overdose response action, retrieved from: <https://news.gov.bc.ca/releases/2016HLTH0094-002737>
8. <https://equiphealthcare.ca/equip/wp-content/uploads/2018/04/HRT-Apr-17-2018.pdf>

Introduction

Overdose Prevention Services should also provide culturally safe and trauma-and-violence-informed care that goes beyond creating a welcoming environment. In order to provide these services, OPS should actively pursue creating a safer space where people can be themselves.

While harm reduction is discussed at length within this document, integrating a [trauma-and-violence informed](#)⁹ and culturally safe approach will ensure higher levels of comfort and confidence with the service, will decrease stigma over time, and has the potential to improve quality of life and enhance positive experiences with health and government related services.¹⁰



Atypical Overdose Presentations

Since fentanyl has been introduced into the drug supply we are seeing more and more atypical overdose presentations. A common atypical presentation called fentanyl-induced muscle rigidity, also known as “chest wall rigidity” or “wooden chest syndrome”, is a complication of intravenous injection of fentanyl, commonly seen amongst hospital populations receiving anesthesia.¹¹⁻¹³

Symptoms typically occur after rapid injection of high doses of fentanyl, and are characterized by jaw clenching interfering with oral airway insertion, chest or torso rigidity interfering with ventilation, and fist clenching and finger stiffness interfering with oxygen saturation monitors¹¹⁻¹⁶. The literature, community, Insite, and emergency health services report that rigidity responds quickly to naloxone.^{12,13}

Other atypical presentations

- Unusual movement of the arms and legs
- Staring gaze
- Walking or awake while not getting enough oxygen
- Unusual movements of the arms and legs
- Vomiting

9. <https://equiphealthcare.ca/toolkit/trauma-and-violence-informed-care/>
10. EQUIP Health Care. (2017). Key Dimensions of Equity-Oriented Care: 10 Strategies to Guide Organizations in Enhancing Capacity for Equity-Oriented Health Care. Retrieved from www.equiphealthcare.ca
11. Dimitriou, V., Zogogiannis, I., Wambi, F., Tawfeeq, N., Koumi, A. & Geldhof, G. (2014). Impossible mask ventilation after unusually low dose fentanyl-induced muscle rigidity in a patient with essential tremor: a case report and review of the literature. *Middle East Journal of Anesthesiology*, 22(6), p.619-22.
12. Ahmad, M. & Raza, T. (2017) “Jaws of steel” after very low dose of fentanyl during prebronchoscopy sedation. *Journal of Bronchology and Interventional Pulmonology*, 24(1), p. e9-e10.
13. Coruh, B., Tonelli, M.R. & Park, D.R. (2013). Fentanyl-induced chest wall rigidity. *Chest Journal*, 143(4), p. 1145-6.
14. Burns, G., DeRienz, R.T., Baker, D.D., Casavant, M. & Spiller, H.A. (2016). Could chest wall rigidity be a factor in rapid death from illicit fentanyl abuse? *Journal of Clinical Toxicology*, 54(5), p.420-3.
15. Buxton, J.A., Gauthier, T., Mai-Lei Woo, K. & Goodwin, J. (2018). A 52-year-old man with fentanyl-induced muscle rigidity. *Canadian Medical Association Journal*, 190(17). p. E539-E541
15. Zesiewicz, T.A., Hauser, R.A., Freeman, A., Sullivan, K.L., Miller, A.M. & Hallim, T. (2009). Fentanyl-induced bradykinesia and rigidity after deep brain stimulation in a patient with Parkinson disease. *Journal of Clinical Neuropharmacology*, 32(1), p.48-50
16. Roy, S. & Fortier, L.P (2003). Fentanyl induced rigidity during emergence from GA potentiated by venlafaxine. *Canadian Journal of Anesthesia*, 50(1), p.32-5.



ESTABLISHING AN ONSITE OPS



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Before the meeting

Biannual Harm Reduction Strategies and Services (HRSS) Provincial Meeting Model

Overdose Prevention Services have been piloted successfully onsite at the HRSS provincial meetings as well as the Overdose Action Exchange. They were successfully hosted in-house both at the BCCDC as well as offsite venues with risk management approval. It is through the HRSS committee that onsite OPS during meetings have been possible, and continue to grow outside of the BCCDC.

- ✓ Book suitable spaces for indoor and outdoor OPS well in advance of the meeting, considering the privacy and safety of event participants. Include the following considerations: near the meeting space, appropriate size (comfortable for 3-4 stations, 2 staff and supplies), limited foot traffic that passes by room to optimize privacy and confidentiality.
- ✓ Ensure that relevant parties are notified (e.g. risk management of venue, your organization's first aid team, leadership members within the vicinity of the OPS and meeting, local Medical Health Officers, local law enforcement/RCMP detachment, etc.), see Appendix 1.A.
- ✓ Create or update an evaluation for both participants and staff of the OPS to ensure ongoing improvements, see Appendix 1.B.
- ✓ Check in with the event organizers to identify any pertinent health needs for attendees that may require extra support throughout the event (including physical accessibility needs).
- ✓ Ensure supplies are fully stocked, see Appendix 1.C.
- ✓ Provide training as needed to prepare staff so they are adequately supported for the role including the purpose of the meeting, what Overdose Prevention Services are, the supplies that will be available, overdose identification and intervention, as well as relationship building with people using the service.
- ✓ Create a schedule ensuring the OPS site is staffed with two people, and adequate time for breaks. Staff should be trained and feel comfortable to provide support and intervene in the event of an overdose (see Resource and Training Manual for an example of curriculum for training).
- ✓ Communicate to all attendees that OPS will be available for use.
- ✓ Develop a list of local OPS & SCS/SIS sites, recent drug and overdose alerts, local AA & NA meetings including location, times, and transportation availability, as well as any other relevant resources attendees may find helpful. This is helpful to include in pre-meeting packages.
- ✓ Closer to the meeting day, communicate with OPS staff details of the event including accessibility of venue, see Appendix 1.D.

Day of the meeting

- ✓ Set up OPS in a way that will create privacy and safety for participants.
- ✓ For participant documentation requirements, use an alias and document the time they came in to keep track of how often the OPS is used.
- ✓ Ensure there are sharps containers in all nearby bathrooms.
- ✓ At the beginning of the meeting, notify participants where the various sites for the OPS and smoking are; this includes separate areas for smoking cigarettes and illicit substances. This may involve dis-alarming emergency exit doors so folks can easily come and go from outside.
- ✓ Complete routine bathroom checks for people who may require support as well as possible used supplies that require disposal.
- ✓ Clean up areas after each use (see recommendations below).

To date there have been no confirmed overdoses or toxicity from occupational exposure to fentanyl, and overall risk is near impossible. When cleaning, it is recommended to use a solution that both effectively breaks down the drug residuals and disinfects the presence of possible blood and/or body fluids. Illicit drug residue on localized surface areas is generally low, but accumulation is possible over time and low porous tables are recommended in terms of longevity and resiliency to stronger cleaning agents (i.e. stainless steel over laminate). In addition, it is encouraged to avoid touching exposed skin with gloved hands during cleaning procedures.^{19, 20}



Recommendations for cleaning the OPS

Solution: 5-10% hydrogen peroxide with a pH between 0.5-1.5.

This particular solution has the ability to not only clean the surface but to break down any residuals left on surfaces

Cleaning instructions

- Apply gloves
- Sweep surface to remove visible residue
- Clean surface with solution
- Wipe dry
- Wash hands with soap and water (preferred over hand sanitizer)

19. Lem, M et al., (2018). Quantification of fentanyl exposure to health care workers: Environmental sampling in overdose prevention and supervised consumption service sites. BCCDC Overdose Rounds, April 25, 2018.

20. Leung, V. & Lem, M. (2018). [Fentanyl surface cleaning assessment report]. Unpublished raw data

After the meeting

- ✓ Pack up supplies
- ✓ Clean all surfaces based on cleaning procedures
- ✓ Place an order to replenish stock
- ✓ Tidy the room to leave it cleaner than how you received it
- ✓ Invite staff and participants to complete the evaluation form
- ✓ Review evaluation forms and make changes as recommended



APPENDIX 1



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Notification of OPS and meeting (example)

“I wanted to share with the leadership team that on insert date, the your organization will be hosting a meeting of insert meeting title, including people who use substances. We will be providing Overdose Prevention Services (OPS) alongside the meeting in order to maintain meaningful engagement with people living in the overdose emergency, and to bring their voices to the decision-making table to ensure our work aligns with the needs of the community. Hosting OPS is in direct compliance of the December 2016 Ministerial order to implement overdose prevention sites across the province. Further, OPS are aimed to preventing overdose deaths among people who attend meetings from out of town. Our meeting will be held in the insert meeting location on insert meeting date. The site will be staffed by nurses and harm reduction team members who have received training to work in the OPS, and there is no anticipated impact on routine operations. We will not be sending out an all staff notice, however, we wanted to inform you in case any questions come up from your staff.”



Appendix 1B

OPS Site Feedback and Evaluation Form (example)

Please take a moment to fill out the following Evaluation form. Your feedback will be helpful for planning in the future.

Date: _____

Item	Met Needs and/or expectations					
	N/A	1 NO	2	3 OK	4	5 YES
Did you find this service met your overall needs?						
Was the space warm and well-lit?						
Did you feel the space supported your privacy?						
Did the OPS have all the supplies you like to use?						
Were the sharps containers easily accessible?						
Was the space clean and ready for you to use?						
Was there enough space in the room?						
Was the staff kind and non-judgmental?						
Was the staff helpful when you needed them?						
Did the staff provide you with enough space to come and go as you needed?						
Do you prefer to have the OPS location near the meeting room?						
Were smoking locations clearly explained?						
Were smoking locations easy to find?						
Are you interested in working at future OPS when meetings are held?						
What worked well in the OPS?						
What didn't work so well?						
What are some ways we could make this service better?						
What are some ways we can be more inclusive with our services?						
Was there anything you thought would be nice to have or see before the meeting that would have improved your overall experience?						
Additional Comments:						

Appendix 1C

Supply List

The following list is extensive and stocking your OPS will be dependent on resources as well as what is available in your region.

Substance use supplies for use and distribution	
Crack pipes	Sterile cookers and filters (cotton)
Meth pipes	Alcohol swabs
Screens	Ascorbic acid
Push sticks	Tourniquet
Vinyl tubing	Straws
Foil	Matches
Syringes with needle attached 1cc	Lighter
Syringes with needle attached 0.5cc	Mirror
Sterile water	CPR Mask
	Portable lighting to use under surface areas
Signage & Resources	
SAVE ME ¹²	List of local OPS & SCS/SIS sites
Safer Injecting ¹³	List of local AA & NA meetings including location, times, and applicable considerations
Safer Smoking ¹⁴	List of local resources and services including counselling
Opioid Overdose Awareness ¹⁵	Local drug alerts and overdose activity
Stimulant Overdose Awareness ¹⁶	Alcohol Overdose Awareness ¹⁷
OPS Supplies	
Sharps containers (one per station and one per washroom)	Hand sanitizer
2 bi-fold poster boards per station	Surface cleaning agent
Telephone	Industrial gloves
First aid kit	Small brush and dust pan
Naloxone kits	Oxygen
Taxi vouchers for people to access local OPS sites	<u>Colouring</u> and other activities
Snacks and juice boxes	Music

12. <https://towardtheheart.com/assets/uploads/1507916536ssEsbKnqp0TI7Tt0qWGbER6XrMCSY9PKjBhqfTB.pdf>

13. http://www.fraserhealth.ca/media/20151127_Harm_Reduction_Safe_Injection.pdf

14. http://www.fraserhealth.ca/media/20151127_Harm_Reduction_Safer_Smoking.pdf

15. <https://towardtheheart.com/opioid-od-awareness>

16. <https://towardtheheart.com/stimulant-od-awareness>

17. <https://towardtheheart.com/alcohol-od-awareness>

Appendix 1C

Supply List cont.

Naloxone Training Materials	
Device to watch training video	Mock kit to practice (make sure not to mix with real kits)
Extra naloxone kits	Supplies to replenish mock kits <ul style="list-style-type: none"> ▪ Vanish point syringes ▪ Water-filled ampules ▪ Alcohol swabs ▪ Gloves
SaferSex Supplies	
Internal condoms	Lubricant
External condoms (regular, non-lubricated, large, latex-free, etc.)	Dental dams and gloves
OPS Resource Manual & Training Guide (SEE OPS Guide for Institutional and Engagement Setting: Resource and Training Manual)	



Overdose Action Exchange OPS, 2018



Vancouver Coastal Health, 2018

Appendix 1D



Communicate event details to OPS staff (example)

Hi everyone!

Thanks again for offering your time to work in the OPS this week at *Insert meeting name here*. This is such an important service and I'm filled with gratitude for your generosity.

Attached are *insert any attachments* that will help orient people to the purpose of the meeting such as a meeting guide/agenda, venue maps, additional attachments that might be useful. There is also going to be lots of food and snacks and extra support in case you need help or relief for a break.

Address:

Schedule:

Room Locations:

Washrooms: include information re: single stall or multiple stall-style setup, gender inclusive and gendered washroom locations, and wheelchair accessibility

Let me know if you have any questions, comments, concerns etc.

Thank you!

The background is a collage of images. The top half is a blue-tinted photograph of a nurse in a white coat and cap, holding a young child. The bottom half shows a mural on a wall, featuring a dragon-like creature and a colorful flower. The text 'APPENDIX 2' is overlaid on the blue-tinted section.

APPENDIX 2

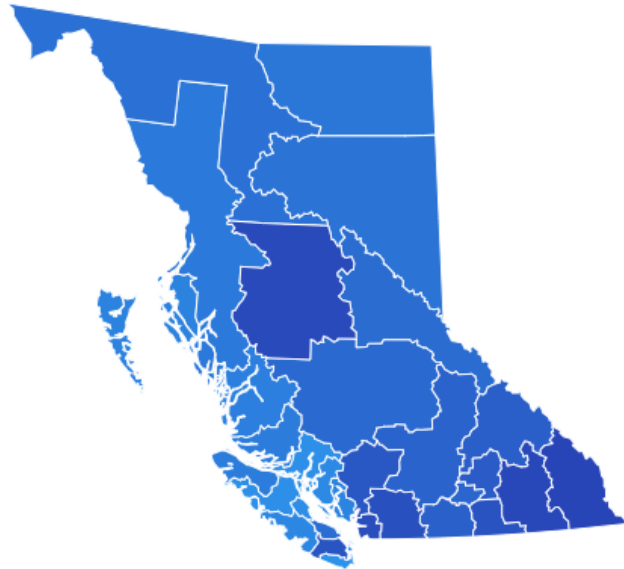


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Appendix 2 background

Brief Overview of Current State

In 2016, an overdose crisis was called due to an increasingly poisoned drug supply. According to the BC Coroners Service there was been a marked increase in 2017 from years previous.²¹ It is also worth noting that while First Nations peoples comprise only 3.45% of the Canadian population, their overdose rates are disproportionately higher. First Nations peoples comprise 14% of all overdose events and 10% of all overdose deaths. Data reports First Nations women are 8x more likely to experience an overdose event and 5x more likely to experience overdose death than non-First Nations women; and First Nations men are approximately 2.5x more likely to die from an overdose than First Nations women, and 3x more likely to experience overdose events than non-First Nations men.²²



Public Health Emergency

On April 14, 2016, the BC Provincial Health Officer declared a Public Health emergency under the Public Health Act in response to increasing overdoses and overdose deaths¹⁴. This emergency was continues to be responded to with a rapid expansion of community-based naloxone distribution, Ministry involvement, increasing access to opioid substitution therapies, increasing public education campaigns, and the establishment of more SIS/SCS/OPS locations.²³

Provincial Response

On December 8, 2016 under the Health Emergency Services and Health Authorities Acts, and advised by the Provincial Health Officer as part of the provincial response to the overdose emergency, the BC Minister of Health ordered overdose prevention services (OPS) to open BC-wide. This order will last for the duration of the Public Health emergency and gives BC Emergency Health Services and Regional Health Authorities the ability to provide overdose prevention services as necessary and on an emergency basis. That being said, it is the responsibility of each individual health authority to assess the need in their region and provide such emergency services in a manner consistent with federal legislation. It is through this provincial response that we are able to provide OPS onsite at meetings to ensure accessibility for all people attending.²⁴

Appendix 2 background

Legislation & Regulation of Naloxone

On March 22, 2016 Health Canada revised their Federal Prescription Drug List to have the prescription status for naloxone removed when used outside of a hospital setting. This change has made naloxone more accessible in support of efforts to address the growing number of opioid overdoses.²⁵

In September 2016, the College of Pharmacists of British Columbia changed the scheduling of emergency use naloxone from Schedule II to unscheduled. As a result, this increased access to naloxone made it available for sale/purchase anywhere. Due to the increased access of naloxone, the Health Professions General Regulation under the Health Professions Act was amended to enable any person in a community or acute care setting to administer naloxone and first aid to another person if they suspect that person is experiencing an overdose.²⁶

More recently, in April 2018, the First Nations Health Authority (FNHA) and National Inuit Health Branch (NIHB) added naloxone nasal spray to their drug supply list for people with either Indian or Inuit Status. These populations are able to access the nasal naloxone at their local pharmacy, but because this is a newer initiative, it is recommended individuals call their local pharmacies ahead of time to make sure they have it in stock. FNHA also states that local health centres should continue to access the intramuscular formulation of naloxone, as contained within the Take Home Naloxone Program to ensure both services are readily available for people.²⁷

21. BC Government News Release (2016). Provincial health officer declares public health emergency, retrieved from: <https://news.gov.bc.ca/releases/2016hlth0026-000568>
22. First Nations Health Authority (2017). Overdose data and First Nations in BC: Preliminary findings. Retrieved from: http://www.fnha.ca/newsContent/Documents/FNHA_OverdoseDataAndFirstNationsInBC_PreliminaryFindings_FinalWeb.pdf
23. BC Government News Release (2016). Ministerial order supports urgent overdose response action, retrieved from: <https://news.gov.bc.ca/releases/2016HLTH0094-002737>
24. BC Government News Release (2016). Ministerial order supports urgent overdose response action, retrieved from: <https://news.gov.bc.ca/releases/2016HLTH0094-002737>
25. Government of Canada (2016). Notice: Prescription Drug List: Naloxone, Retrieved from: <https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/prescription-drug-list/notice-naloxone.html>
26. College of Pharmacists of British Columbia (2016). Non-prescription naloxone now available outside pharmacies, retrieved from: <http://www.bcpharmacists.org/news/non-prescription-naloxone-now-available-outside-pharmacies>
27. McDonald, S (2018). Nasal naloxone listed as a health benefit for First Nations in BC. Retrieved from: <http://www.fnha.ca/about/news-and-events/news/nasal-naloxone-listed-as-a-health-benefit-for-first-nations-in-bc>

APPENDIX 3



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Appendix 3 take home naloxone

BCCDC Take Home Naloxone Program

The Take Home Naloxone (THN) program started in BC in 2012 and has grown since its inception. In 2016, the THN program distributed 21,218 naloxone kits through 454 participating sites, and 3,939 kits were reported to have been used to reverse overdoses in that year.²⁸

In 2017, THN distribution sites expanded by an additional 539 sites to total 993 sites across the province; that same year, naloxone kit distribution more than doubled to 61,000 kits distributed and there were more than 15,000 overdose reversals through the use of these kits. Since then, the addition of community pharmacies in early 2018 has increased distribution sites to over 1,400.



The THN program distributes kits containing naloxone to individuals who are at risk of having or witnessing an overdose. Each kit comes in an easily identifiable case and contains: three 1-ml ampoules of naloxone in a labeled medication bottle, three vanish-point syringes, alcohol swabs, a pair of non-latex gloves, and a CPR face shield. Each kit also contains a SAVE ME instructional sticker with an overdose administration form. In the event someone uses a naloxone kit, the overdose administration form provides valuable information that informs the THN program and people are encouraged to return the form to BCCDC when a kit has been used.

Further information about the Take Home Naloxone program and more recent statistics are available at: <http://towardtheheart.com/resource/thn-program-timeline/open>

28. BC Centre for Disease Control (2017). BC Harm Reduction Strategies and Services committee: Policy indicators report, p. 30-33. Available from: <http://www.bccdc.ca/resourcegallery/Documents/2017%20HRSS%20Indicators%20Report%20final.pdf>



APPENDIX 4



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Appendix 4 harm reduction strategies and services

Harm Reduction Strategies and Services

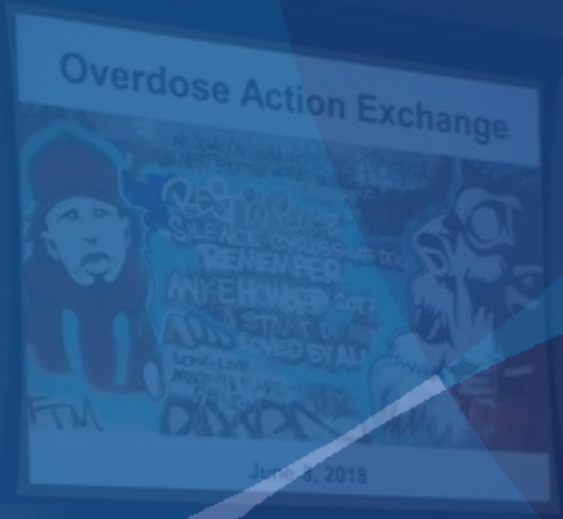
The BC Harm Reduction Strategies and Services (HRSS) Committee was created to support people who use drugs, their families, and communities. In recent years, HRSS committee has predominantly directed their work towards: Provincial Harm Reduction Supplies Program, best practices and supply distribution recommendations, provincial guideline development and dissemination, and community capacity building across the province. Reporting to the BC Communicable Disease Policy Committee, the HRSS committee is made up of people with past or present lived experience and harm reduction coordinators from BC regional health authorities, the BCCDC, First Nations Health Authority (FNHA), Health Officer's Council of BC, and the BC Ministry of Health. Its four main goals are as follows:

- To reduce incidence of drug-related health and social harms, including transmission of blood borne pathogens
- To promote and facilitate referral to primary health care, addiction and/or mental health services, and social services
- To reduce barriers to health and social services, including activities to reduce stigma and discrimination and raise public awareness of harm reduction principles, policies, and programs among those in the health systems, municipalities, and the general public
- To ensure full and equitable reach of harm reduction programs to all vulnerable British Columbians who use drugs, to provide education about health promotion and illness prevention to inform decision making

The list below contains policy documents created by HRSS:

- BC Overdose Prevention Services Guide Oct 2017
 - Harm Reduction Strategies and Services Committee Indicators Report Aug 2017
 - Harm Reduction Strategies and Services Policy Dec 2014
 - Harm Reduction Strategies and Services Committee Terms of Reference Sept 2012
 - History of Harm Reduction in British Columbia Aug 2012 (updates in progress)
-
- 29. BC Centre for Disease Control (2017). BC Harm Reduction Strategies and Services committee: Policy indicators report, p. 5. Available from: <http://www.bccdc.ca/resource-gallery/Documents/2017%20HRSS%20Indicators%20Report%20final.pdf>
 - 30. <http://www.bccdc.ca/resource-gallery/Documents/BC%20Overdose%20Prevention%20Services%20Guide-Final%20October%20,%202017.pdf>
 - 31. <http://www.bccdc.ca/resource-gallery/Documents/2017%20HRSS%20Indicators%20Report%20final.pdf>
 - 32. <http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/Other/BCHRSPolicyandGuidelinesDecember2014.pdf>
 - 33. http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/Other/TORSept2012_final.pdf
 - 34. http://www.bccdc.ca/resource-gallery/Documents/Educational%20Materials/Epid/Other/UpdatedBCHarmReductionDocumentAug2012JAB_final.pdf

APPENDIX 5



Appendix 5 overdose action exchange

Overdose Action Exchange

“Perhaps the most important message coming out of the meeting was that this is more than just a drug problem. The impact of overdose crisis to families, friends, and communities has been massive and the scars will be with us for many years to come. The urgency for real change expressed so eloquently by the people who are experiencing the losses firsthand needs to be heard and acted upon.”

-BCCDC’s Executive Medical Director, Mark Tyndall

Overdose Action Exchange happens once a year, and is a coming together of people province and sector wide. From the front lines to people embedded in institutions and policymaking, the purpose of this annual gathering is to generate ideas that challenge the status quo and lead to a new set of innovative strategies in our overdose crisis. During the 2017 meeting, the second of its kind, there were 10 key priority actions to address the unprecedented rise in overdose deaths over the past two years.

The **ten key actions**³⁶ are as follows:

1. Engage peers in program development and leadership
2. Address contamination of the drug supply
3. Support appropriate pain management strategies
4. Build on the success of overdose prevention sites
5. Expand and improve addiction treatment
6. Align law enforcement efforts with public health
7. Reform drug laws
8. Address structural barriers and upstream factors
9. Counter stigma against people who use drugs
10. Implement targeted research, data collection & evaluation initiatives



While there has been an incredible amount of work and resources put into the overdose response over the last two years, we still face a serious health emergency that shows no signs of slowing. The overdose crisis in its current state continues to marginalize people who rely on unregulated drug markets to ease experiences of addiction, pain, trauma, mental illness and social isolation. The solution is in the key priority actions outlined at the Overdose Action Exchange.³⁴

35. Tyndall, M (2017). BC overdose action exchange II: Meeting report. Retrieved from: <http://www.bccdc.ca/resource-gallery/Documents/bccdc-overdose-action-screen.pdf>

36. <http://www.bccdc.ca/resource-gallery/Documents/bccdc-overdose-action-screen.pdf>



APPENDIX 6



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

Appendix 6 peer engagement

Peer Engagement – BCCDC Initiatives

Peer engagement within the context of the BCCDC and HRSS is defined as the active participation of people with lived experience of substance use in different research, program, and policy decision-making processes. Peer engagement, when done in accordance with the [Peer Engagement Best Practices](#), is mutually beneficial in promoting health equity within programs and policies, while building capacity for both people with lived experience and health authority representatives at the same time.



Peer engagement practices are not limited to one-on-one participation; they include careful deliberation in the preparation, engagement, support, and conclusion stages of peer engagement processes. We encourage promoting peer engagement within your health authority and other community agencies to improve the involvement and uptake of the voices and expertise of those with lived experience in all stages of service planning and policy development in BC.³⁷

PEEP - Peer Engagement and Evaluation Project

The Peer Engagement and Evaluation Project (PEEP) began as a research initiative to facilitate a network of focus groups of people with lived experience across the province to discuss challenges, barriers, benefits and successes of accessing harm reduction services in their local communities. The goal of PEEP’s research includes the development of best practice recommendations so service providers could begin the work required to better meet local needs.

A full list of resources developed by the PEEP team, including past presentations, can be accessed on [BCCDC's Peer Engagement and Evaluation](#)³⁷ page.

PEEP Consultation and Advisory Board

The PEEP Consultation and Advisory Board is the continuation of the Peer Engagement and Evaluation Project, and acts as a provincial consultant team advising on harm reduction services and peer initiatives. The goal of the PEEP Consultation and Advisory Board is to inform and enhance peer engagement with best practice recommendations so service providers BC-wide can work with people in their communities to better meet local needs. This board builds on existing relationships and explores new ways forward for meaningful and ongoing connection between service providers and community partners with people who have lived experience at the forefront.

37. <https://towardtheheart.com/assets/uploads/1516141269o4KkCMkq2ytmhxVygjcQ9DSWtUoI1d8FLnzYdlv.pdf>

38. <http://www.bccdc.ca/our-services/programs/peer-engagement>

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CIE Compassion, Inclusion and Engagement (CIE)

The Compassion, Inclusion and Engagement initiative (CIE) exists as a result of the PEEP research initiative. As a provincial collaboration between FNHA and BCCDC, CIE works in community to facilitate and foster connection between people with lived experience and their local service providers. With the intent each community will take the work forward, CIE assumes the role of bridging networks across sectors to promote accessible, inclusive and culturally safe harm reduction services urgently needed within local contexts.

CIE recognizes that some people experience multiple barriers when accessing services such as racism, poverty, and struggles with their physical and mental health; and recognizes that peer work is about community and acknowledging that each community is different, with different resourcing and ways of engaging in this work. CIE also recognizes that multiple levels of engagement and commitment are required by everyone in order for peer work to move forward.



