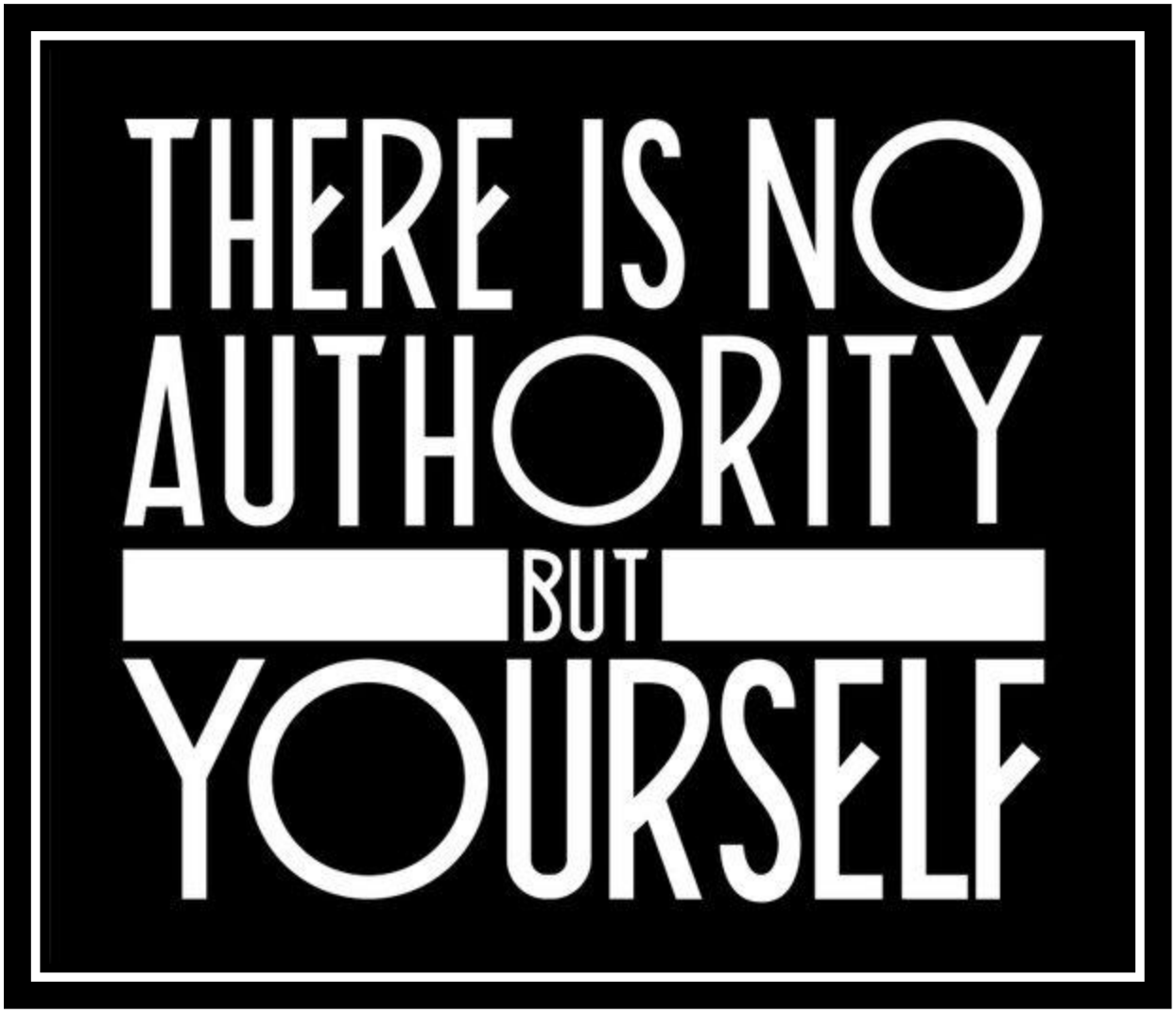

A Reader and Guide to Drug User Self Determination and Organizing

Version 0.2

Compiled by the Coalition of Peers Dismantling the Drug War

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-Created by the Canadian Association of People who Use Drugs

Don't be deceived when they tell you things are better now. Even if there's no poverty to be seen because the poverty's been hidden. Even if you ever got more wages and could afford to buy more of these new and useless goods which industries foist on you and even if it seems to you that that you never had so much, that is only the slogan of those who still have much more than you. Don't be taken in when they pat you paternally on the shoulder and say that there's no inequality worth speaking of and no more reason to fight because if you believe them they will be completely in charge in their marble homes and granite banks from which they rob the people of the world under the pretence of bringing them culture. Watch out, for as soon as it pleases them they'll send you out to protect their gold in wars whose weapons, rapidly developed by servile scientists will become more and more deadly until they can with a flick of the finger tear a million of you to pieces.

Jean Paul Marat, died 1793

I – Harm Reduction and You

When people hear the words “harm reduction,” personal beliefs and misunderstandings can hide its meaning. From a social and medical view, harm reduction is a central piece of our healthcare system. Harm reduction accepts that people have engaged in drug use and sexual activity across cultures and over time—even if there is some risk of harm from these activities. Due to this fact, harm reduction looks at how to reduce harms from drug use and sexual activity by empowering and supporting people to be as safe and healthy as possible. It also provides them with healthcare services and referrals, and reduces the effect risky behaviours have on communities. Supporters of harm reduction have a firm belief in the value of all human life. They believe that every person has the right to the best health possible. They believe people should be treated with respect, regardless of their lot in life. Often, harms linked with substance use aren’t the users fault. The harms may have direct connection with the judgment of others, and the outlawing of people who use substances. Although it is easy to shame folks for engaging in risky behaviour, harm reduction is central to individual and community safety.

An example of a research based harm reduction program is needle distribution. Needle distribution programs collect used needles and hand out sterile ones. This helps keep individuals and communities safe by keeping the risk of HIV, hepatitis C, and other infections very low. Some programs provide users with an on-site nurse. Many teach users how to take care of their bodies. Others provide referrals for detox, rehab, and mental health services. In B.C., many needle distribution programs work with the Take Home Naloxone Program to help hand out narcan (naloxone). Narcan training helps drug users, their friends, and their family prevent opiate related overdose death. From a healthcare angle, needle distribution programs have the goal of stopping the spread of Hep C, HIV and other diseases. In the past, some programs required an exchange of a single used needle for a sterile one. This practice has proven ineffective. Evidence shows that a one-to-one exchange of needles increases the chance of people sharing or re-using needles, which increases the risk of infection. There is no evidence that a needle distribution program increases the amount of needles found in community. In reality, to lessen the amount of community needle stick incidents, needle distribution programs can help through needle pick up days. Needle pick up ensures fewer needles are on the sidewalk, and in parks and playgrounds.

Another example of research based harm reduction services that help keep communities safe are supervised injection facilities. These are safe spaces where people can go to use drugs. They keep people who use drugs off the street, and prevent overdoses and the use of broken or dirty supplies. These spaces offer a chance for treatment referrals and a central place to dispose used supplies. They also offer a way to engage people with healthcare and naloxone training. Not only is this much safer for people who use substances, but is safer for the entire community.

The war on drugs has continued for over a century. Today, there are more drugs available for cheaper, and more people using them than ever before. Clearly our restrictive strategies have not been effective in reducing drug use and creating safer communities. It is time to find a different approach. BC is currently facing a public health emergency and it is time that everyone works together to create safe spaces and save lives.

II – The Overdose Crisis

On April 14, 2016, British Columbia's (BC) Minister of health declared a public health emergency. This called for quick action in the healthcare system to stop people from dying. Fentanyl, a strong opioid present in 5% of overdose deaths in 2012, increased in presence to 85% in 2018. To date, communities have put a lot of time and effort in overdose prevention services. This includes: Take Home Naloxone; involving people who use drugs in healthcare planning; a focus on indigenous wellness; anti-stigma campaigns; drug testing; and access to lower barrier treatment options. Despite these efforts overdose deaths have continued to increase each year since 2012. By mid-2015 overdose deaths surpassed those in the 1997-1998 public health emergency. Opioid-related overdose is now the leading cause of death among those aged 30-39. One thing we know for sure is that the main cause of continued death is the lack of access to a regulated and safe drug supply.

To meet community need for health and safety, we need to shift the way we approach drugs and the people who use them. Drug use is often a response to pain, trauma, and social isolation. Treating our current public health emergency as a health issue rather than a criminal issue is a step in the right direction. When we criminalize drugs and people who use them we create stigma. This stigma forces people to conceal their unsafe drug use and further isolates them.

Currently, 4 people a day die from overdose in BC. According to the BC Coroner's Report the number of overdose deaths is 13 times higher than the rate of homicide. Despite our best efforts in prevention, we still have not seen a cut in death rates or in rates of overdose. We are in limbo, employing Band-Aid solutions to bigger issues that harm us and the people we love. Our best research has shown that the only way to stop the overdoses is for people to have access to a safe and regulated drug supply. Evidence shows that a safer supply decreases the death and crime rate, lowers health care costs, and decreases the rate of problematic substance use.

No matter how progressive and available our care and treatment programs are, we continue to push illegal drug use to the margins and make it difficult for people to access services when and where they need them. Decriminalization of all drug possession is now seen as a critical component of a complete response to the overdose crisis. Safe supply options for people who use drugs are another key component. Without addressing the toxic supply of drugs, our efforts to combat the crisis will remain futile.

Providing services to help deal with the underlying traumas and challenges facing people who use drugs is an important part of the provincial response to our public health crisis. With this said, we have not responded to the new reality—the street drug supply is toxic. The combination of a lack of access to a safe supply, isolation caused by stigma, and not having access to sterile drug use equipment leads to death and disease. Our only way out is to provide a safe and regulated drug supply along with services to help our loved ones deal with underlying traumas.

III – Safe Supply

Imagine a world where prohibition, or the ban on the sale of legal alcohol, never ended. It's Friday night and you're having a nice time watching the big game with your friends. What could possibly make this day better? "I know", someone suggests. "Let's have an adult beverage." They turn to their liquor cabinet and pour you a drink from an unmarked bottle. The bottle resembles a bottle that you had seen before, so you assume that it's safe to drink. "All right!" you think, "nothing like a cold one to chase away the blues." Little did you know that the drink contained methyl alcohol, causing you to die hours later. It turns out that your friend had acquired the alcohol illegally. What is wrong with this picture? Ultimately, it is that criminal prohibition has increased the risk of toxins and other impurities in alcohol due to illicit manufacturing.

Many studies indicate that alcohol is more damaging to the individual, and to society, than any other drug, Yet it remains legal. Why is this? It is because during prohibition, the toxicity of alcohol increased simultaneously to the rate of crime. It is no surprise that individuals had to use alcohol secretly and were less likely to seek help for their problematic use because of the criminal consequences of their drinking. People against prohibition claimed that too many people were ignoring the law and drinking illegally, and that prohibition contributed to the expansion of organized crime and violence. The new slogans became 'Moderation' and 'Government Regulation.' Instead of treating problematic drinking as a criminal issue, the "war on alcohol" shifted in tone to becoming a medical issue.

The history of the prohibition on alcohol is very similar to the history of the war on drugs. An illegal market has created inflated prices and more organized crime. People continue to use drugs despite the criminal consequences and the criminalization of drugs makes people afraid to reveal their use and seek treatment. More recently, many drugs have become contaminated with the opiate fentanyl. Although drugs have always been dangerous, people have not died at such unprecedented rates from drug toxicity until quite recently. As 4 people die a day in BC from the toxicity of the drug market, we need to reconsider our approach to drug policy.

What many healthcare professionals are advising in response to the current drug poisoning crisis is what is called a safe supply of drugs. This means that individuals would be allowed to safely acquire drugs in a regulated way from a dependable legalized source. Ideally, instead of criminalizing drug use, drugs would be fully legalized and available in much the same way as alcohol. The immediate benefit of such a project would be an end to overdose death from toxic drugs. Research shows that other consequences would include a lower crime rate, increased rates of recovery from problematic use, and a lower overall rate of drug use. Individuals would also face less social stigma, because of the decline in the notion that drugs are bad.

Canada is a society that is built around the idea that individuals have the individual freedom to use their bodies and possessions how they choose. Some folks may choose the path of finding happiness in a bottle or in a vial. Others may wish to help them if their choices result in patterns of dependence. However, society should not criminalize people's freedom to consume substances. The criminalization of the drug market does not carry the guarantee of abstinence. It does bring with it the guarantee of human corruption and misery.

IV – Colonialism and the Drug War

If we know that the solution to the overdose crisis lies in a safe and clean supply of drugs, we must ask why drugs are illegal. What we call "addiction" finds its basis rooted in attempts to self-medicate trauma. A person is more likely to have problems with substance use if they have experienced trauma, whether early in life or later. When talking about substance use, we punish the moral failure of an individual. We do not focus on social conditions that may induce mental and physical trauma. The question as to why drug use is considered a criminal issue and not a public health issue can only be answered if we look at the history of drug policy.

This history of the criminal prohibition of drugs is smattered with the overtones of racism. While many institutions, including the Independent Scientific Committee on Drugs have shown that alcohol is more dangerous than heroin, alcohol remains legal while other narcotics do not. Current drug policy is less sculpted by science than by illegal narcotics' historic relationships to non-white races and the popular turn of the century theory of Social Darwinism, an application of the theory of natural selection to social, political, and economic issues. This theory was used to promote the idea that the white European race was superior to others, and therefore, required preservation from the corruption of so-called "degenerate races". Although one would assume that prohibition and punishment for narcotic offenses are underpinned by rationality and best medical practice, the case is the opposite. Most laws against drug user find their origins in prejudice against the peoples who use them.

For example, Canada was one of the first countries to ban opiates for personal, non-medicinal use, starting with the Opium Act of 1908, which made it an offence to import, manufacture, possess or sell opium for non-medical reasons. This legislation was passed in response to the public campaign for Chinese exclusion and moral panic about drug use and its impact on race mixing and gender roles. Anti-Asian sentiment led to labour riots against Chinese and Japanese workers in Vancouver in 1907, and the ban on opium was seen domestically as a response to the "Chinese problem" and internationally as leading the way on the "opium problem." Although opium smoking was a habit enjoyed by all races, ¾ of the arrests made under the amended Opium and Drugs Act were against the Chinese. Current prohibitions on heroin find their genealogical origin in these acts, and it is no surprise that the media frequently blames the Chinese for the current fentanyl epidemic rather than on prohibitionist government policy. Moreover, if we further examine drug policy, it is quite explicit that similar prohibitions on cocaine have historically targeted black individuals, while prohibitions on cannabis were initially aimed at those from Mexico.

The criminal prohibition of drugs finds its origins underpinned more by immigration concerns and fears of race mixing, than actual scientific or social research. Although problematic substance use remains a social issue, the criminalization of substances has historically been linked to increased consumption levels and problematic use. By penalizing drug users, and creating an illicit market, society creates an environment where people who use drugs are forced to use in secret, under fear of arrest, and creates an environment where treatment and support are more difficult to access due to stigma. However, with a toxic drug supply and mounting death toll, now is not the time to be driving drug use further underground. Insisting on morals-based laws and policies contrary to science and evidence is illogical and wrong.

Guidelines for the Inclusion of People who use Drugs

This document was taken from Peerology: A Guide By and for People who use Drugs on how to get Involved

Available Here: http://www.cdnaids.ca/wp-content/uploads/Peerology-Final-PDF-with-Image.pdf

The ADDICQ is a project of AQPSUD (Quebec's Association for Health Promotion of People who Use Drugs). The ADDICQ Project advocates for the rights of people who use drugs. In 2011, ADDICQ members collectively organized a task force on the mobilisation of people who use drugs in all five regions of Quebec. We wrote an assessment based on our observations to help our members better mobilize in order to be heard and to help them assert their position and take a stand for a better quality of life.

Since the inclusion of people who use drugs is one of our main war horses, we came up with 11 recommendations to improve the inclusion of people who use drugs in community-based organisations as well as policy, research and other service settings. We hope that these recommendations are helpful to those who are interested in including people who use drugs in decisions that affect us so that we can work together to promote health and provide services which are better adapted to our needs.

1st Recommendation: Give us the means

As people who use drugs, we are the ones who are in the best position to talk about our reality and find answers adapted to our needs. If you want us to participate in your discussions and decisions on services and other concerns, you have to allow us to do so.

That is why our 1st recommendation is: Please give us the means to take our place at your meetings but without taking us by the hand and doing it for us.

This implies:

- being clear about the goals of your meetings and the process in which we are embarking;
- that the guidelines for the meeting are clear, understood and respected;
- being sure that information for the meeting is available, accessible and that we know where to find it;
- being well informed before meetings;
- taking the time to explain the meeting to us;
- building our capacity by mentoring us in the different aspects of participating in committees (writing minutes, facilitation, discussions and decision-making, etc.); and
- providing access to different resources so that we can fully participate (computers, agendas, bus tickets, calling cards, etc.).

2nd Recommendation: Include us in a Meaningful Way

If you want to include us, it is important to do it fully. There is nothing more frustrating than having the impression that we are there as tokens and that our opinion is not sought, not listened to and not taken seriously.

That is why our 2nd recommendation is: Please include us in a meaningful way.

This implies:

- clearly explaining your goals for including people who use drugs in your meetings or committee;
- giving everyone space to participate in the meeting;
- listening well and considering what is said; and
- mostly, not involving people who use drugs as tokens, PLEASE !

3rd Recommendation: Keep it Simple!

If you want people who use drugs to participate in committees and other settings, it is important to not complicate matters more than they already are.

That is why our 3rd recommendation is: Keep it simple!

This implies:

- that meetings should not be too long and too formal;
- having breaks and predetermined end times;
- being well prepared to ensure that time is well spent and that we will not lose participants!

4th Recommendation: Adapt to our life conditions

We often live in precarious conditions (for example, poverty, unstable housing, health issues, etc.), so if you want to include us, you must change your common way of doing things.

That is why our 4th recommendation is: Adapt to the realities of people who use drugs.

This implies:

- using the phone instead of using e-mail to communicate with us since it is not always easy for us to access the internet;
- reaching us where we are (for example, at community-based organisations, on the street, etc.); and
- customizing your approach to better reach us.

5th Recommendation: Inviting two of Us is Better!

For many reasons, it may happen that we cannot attend a meeting we had committed to going to.

That is why you should avoid giving all the information and all the responsibilities to only one person. Indeed, you must not overload us so that we may stay involved longer. At the same time, you must also allow us to have someone replace us when we cannot attend ourselves. Finally, having two of us attend meetings together will make us feel more at ease with other participants.

That is why our 5th recommendation is: Always invite at least two people who use drugs to a committee or a meeting.

6th Recommendation: Emphasize Good Deeds

It is always good to know that what we did was appreciated and that it is worth continuing to be involved.

Moreover, encouragement makes us feel good, especially when we are often badmouthed and rejected.

That is why our 6th recommendation is: Highlight the accomplishments, achievements and successes of our inclusion.

It is important to remember our brothers and sisters who have left us, to remember their contribution to encourage us to carry on.

7th Recommendation: Take Action

It is nice to get together, to share information and ideas, to find solutions to our problems, but if those meetings are not followed up by actions, we lose interest and that discourages us from getting involved. Also, meetings are not necessarily the most exciting part of promoting health and improving our life circumstances.

Be aware that we are personally invested and have strong emotions about issues that affect us so please do not discourage us from expressing ourselves, since we are the ones facing the issues we are collectively trying to solve!

That is why our 7th recommendation is: Don't just have meetings, take action!

8th Recommendation: Thoroughly Train Allies to Understand and Support our Inclusion

To support inclusion, we need allies who are aware of our realities and who are comfortable to work with us. We already have to deal with prejudice from the population and that makes us impatient sometimes. We want people who work with us to be aware of our problems and continue to support our mandates.

That is why our 8th recommendation is: Good training for our allies to understand and support our inclusion in decisions that affect us.

9th Recommendation: Recognize our expertise

We are experts of our reality and lived experience, and that is why we are asked to participate in committees and meetings and why we want to be invited. Since we are the main stakeholders, we are the ones who are best suited to talk about our reality and find solutions to issues that affect us. But as we said, we want more than just to be present at a table.

That is why our 9th recommendation is: Recognize our Expertise.

This implies:

- inviting us not only to focus groups;

- having enough confidence in us to do more than give an opinion (for example, give us the means to take on different tasks, integrate us in group workshops, let us work in committees from start to finish, etc.).

10th Recommendation: Compensate Us for our Time

We are the experts, but we often are the only ones around a table who are not paid. Sometimes people are uncomfortable paying people who use drugs, fearing that they will use the money to buy drugs. But are we questioning how salaried persons spend their pay? And should we? We do not think so, and you should not either.

That is why our 10th recommendation is: Compensate us for our time.

This implies:

- offering us money, food or anything useful to compensate us for our time.

11th Recommendation: Support organizations of people who use drugs to support inclusion

To support the inclusion of people who use drugs, it must be acknowledged that there are organisations of people who use drugs across Canada that have a mandate of inclusion. We are there to help you work with us.

That is why our 11th recommendation is: Support organizations of people who use drugs to support inclusion.

This implies:

- providing us with financial support; and
- acknowledging the importance of the role of organizations of people who use drugs in supporting the inclusion of people who use drugs.

To conclude:

It is important that people understand that at the ADDICQ project, we work for the inclusion of all people who use drugs. Since we have hundreds of advocates in different regions of Québec, we are well placed to support community-based organisations and other settings that want to include people who use drugs in their committees and meetings. Although the inclusion of people who use drugs sometimes upsets ways things are usually done and takes some effort, we are convinced that it is an investment that can only be beneficial for everyone.

At the ADDICQ project, we are not here to put a spoke in the wheels of the people who provide services to us, but rather to help them ensure that their services are well suited to our needs. Together, we can work to improve the lives of people who use drugs and to ensure that we are truly recognized as full citizens, to make our society more inclusive and fair!

Useful Resources on the Inclusion of People who Use Drugs

- **Principles for participation and self-representation. See Collectiv**e Voices Effecting Change: Final Report. National Meeting of Peer-run Organizations of People who Use Drugs, Victoria, BC, Oct 16-17, 2013. Available at http://solidvictoria.org/article/capud-report
- **Nothing About Us, Without Us: A manifesto by people who use illegal drugs. Ava**ilable on the Canadian HIV/AIDS Legal Network's website at aidslaw.ca
- **Nothing About Us Without Us – Greater, Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical, and Human Rights Imperative. A**vailable on the Canadian HIV/AIDS Legal Network's website at aidslaw.ca.
- **VANDU Manifesto for a Drug User Liberation Movement. Available** on CAPUD's website at capud.org.
- **VANDU. Research and Drug User Liberation. Ple**ase contact VANDU for more information. Their contact information is available in Appendix A – Directory of Organizations of People who Use Drugs at the end of this document.

How to Involve People Who Use Drugs

We Have a Lot of Experience So Please...

Do invite several of us

Do invite a peer-based group to select representatives

Do invite people who actively use drugs

Do invite people who formerly used drugs, in addition to people who actively use drugs

Do listen to and integrate our answers

Do financially support peer-based organizations if you expect representatives to consult with members of their community before the meeting

Do give us information about what the meeting is about, what our role will be, and how we can contribute

Don't invite just one of us

Don't hand-pick the same person you know and are comfortable with every time

Don't only invite people who formerly used drugs – it is OK to invite them and they have lots to offer, but they are not the same as people who are actively using drugs, who also have a perspective that is valuable and needs to be heard as well

Don't ask a question or invite us to your meeting just because it is politically correct

We May Not be Used to Your Style of Meetings So Please....

Do provide us with training and a support person

Do ask us to help define groups expectations

Do show flexibility with meeting styles (times, agenda, level of participation)

Do ask us what we need

Do train us for ongoing or future committee or board events

Do acknowledge that you may have needs, too, and that unfamiliarity may make you uncomfortable

Do consider providing oppression informed training specific to the issue of peer involvement, and ask us to particiate

Do ask for our participation in planning sessions for consultations or meetings

Don't run your committee or board meetings without considering that it may be the first time for us to be on a committee or board

Don't hold a meeting or consultation just the way you are used to; work with peers to make it inclusive

Don't hold a meeting at 9 a.m. or on cheque issue day

Don't be afraid to ask for support from a peer committee or group that have experience

Don't assume that we are the problem and the only ones who need to learn

Don't think that you can't learn how to integrate us and our experience

Don't think that we cannot do more, such as work for you in a paid position

Adapted from: 2005 Canadian HIV/AIDS Legal Network Nothing About Us Without Us; modified with extensive peer input through the Peer Engagement and Evaluation Project
Updated: December, 2017

How to Involve People Who Use Drugs

We are NOT Very Mobile or Wealthy So Please...

Do hold a meeting or consultation in a low-key setting or in a setting where people who use drugs already hang out

Do provide a stipend – contrary to most people who attend your meetings, we are not paid to attend by our jobs, but still need to look after our needs

Do give us money in cash

Don't hold meetings in a government building

Don't assume that we don't need a stipend or would just spend it on drugs
(or that it wouldn't be justified even if we did)

Don't write us a cheque or give us a coupon

Don't ask us to come and meet you in Ottawa unless you provide us with adequate support and compensation

We Value Our Privacy So Please ...

Do guarantee and protect confidentiality

Do let us know who else will be at the table including law enforcement, social workers, parole officers, religious groups and city officials

Don't identify what a particular person said in the proceedings of the meeting

Don't require us to disclose: HIV (or other health) status, exposure to trauma, or proof of income when involving us or as a requirement for participation

If You Want Us to Travel Please ...

Do help with arranging Methadose carries and Suboxone or opioid replacement medication

Do arrange for advice from a local person who uses drugs – drugs may be more dangerous in a different city and travelling puts us at risk

Do provide accommodation close to the meeting space

Do have a healthcare provider available to support us

Don't invite us at the last minute and assume we can deal with this alone

Don't just leave us on our own in cities we don't know

Don't assume we have identification (or credit cards) to check into hotels or board flights

BC Centre for Disease Control 655 West 12th Avenue Vancouver, BC V5Z 4R4

E-mail: outreach@towardtheheart.com

Adapted from: 2005 Canadian HIV/AIDS Legal Network Nothing About Us Without Us; modified with extensive peer input through the Peer Engagement and Evaluation Project
Updated: December, 2017

Needle Exchange Program

Safer Injecting

heroin | crack/coke

What you need to inject safer:


Sterile needle


Sterile water

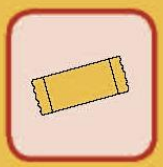

Alcohol swabs


Cotton filter or tampon (unscented)


Cooker or spoon


Rubber tie


Lighter or candle


Ascorbic acid/ vitamin C (crack only)


Clean hands

the **user-friendly** series

What to expect

heroin

The high

- A high that lasts 20 minutes – 2 hours
- Feeling intense pleasure and reduced pain
- Warm skin, dry mouth, heavy feeling arms and legs
- Nausea, vomiting and severe itching
- Slow, shallow breathing

Coming down

- Feeling restless, sweaty, stomach cramps and diarrhea
- Muscle spasms and bone pain
- High blood pressure
- Strong cravings for more heroin

⚠ Note: combining substances can be dangerous. Proceed with caution.

crack/coke

The high

- A high that lasts 15–45 minutes
- Feeling an intense, euphoric rush
- Warm skin, dry mouth
- Feeling thirsty, not hungry
- Rapid heartbeat and breathing
- Auditory hallucinations, delusions

Coming down

- Feeling restless, sweaty and twitchy
- Sensitivity to noise and light
- Feelings of paranoia
- Strong cravings for more crack

Signs of overdose

heroin overdose

Feels like:

- You can't stay awake
- You don't have any energy or strength
- You can't walk, can't talk

Looks like:

- Slow pulse or no pulse
- Slow breathing or no breathing
- Skin looks pale and blue, feels cold
- Can't wake up or talk
- Pupils are pinned or eyes are rolled back
- Vomiting
- Body is limp

crack/coke overdose

Feels like:

- Your heart is pumping fast
- You're short of breath
- Your body is hot, sweaty and shaky
- You have chest pain
- You can't talk, can't walk

Looks like:

- Fast pulse or no pulse
- Fast or no breathing
- Hot and sweaty skin
- Confusion, hallucinations, unconscious
- Can't talk, can't walk
- Vomiting
- Seizures

What to do if someone ODs

1. Call out for help – **do not leave the victim**
2. If they've OD'd on heroin, try to get them awake and moving

   If they've OD'd on crack/coke, try to get them to slow down and relax
3. Call 9-1-1 for an ambulance, send someone to seek help and report back
4. Tell paramedics as much as you can about what happened

Ready to detox? Help is just a phone call away.

Call Access Central at 1-866-658-1221, seven days a week from 9am to 7:45pm for detox, residential addiction services and addiction housing.

1·866·658·1221

For more copies, go online at **http://vch.eduhealth.ca** or email **phem@vch.ca** and quote Catalogue No. **DB.500.S34**

Your peers created this harm reduction pamphlet for you. **Be safe.**

Vancouver Coastal Health
Promoting wellness. Ensuring care.

Needle Exchange Program

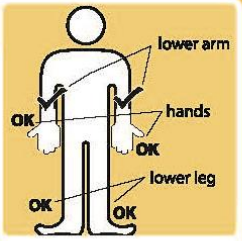
Make it your 9-1-1

How to inject safer

1

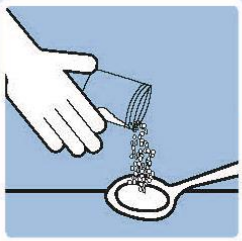
Clean your hands with soap and water or alcohol swabs

2



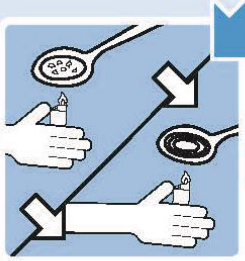
Choose your injection site (lower arm is safest. If you have to inject elsewhere, lower leg then hand are OK)

3 Prepare your drugs – heroin



Pour drugs in cooker/ spoon

Pour sterile water in cooker/spoon



Heat until drug becomes liquid

Take cotton filter/piece of unscented tampon and place in drugs

Place needle in filter

Draw liquid into needle

3 Prepare your drugs – crack/coke

coke

Pour coke into cooker/spoon

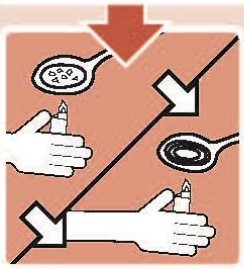
crack

Pour in just enough ascorbic acid to dissolve crack

Pour sterile water into cooker/spoon

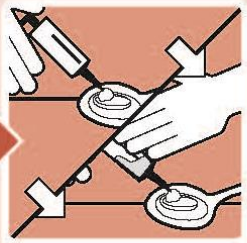
Using clean, capped needle, grind crack and ascorbic acid to mix

Using clean, capped needle, grind coke to mix – NO NEED TO HEAT



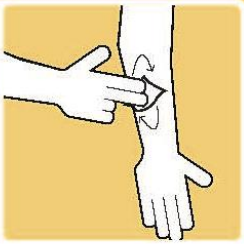
If crack mixture is cloudy or has sediment, heat as needed – DO NOT BOIL

Place cotton filter / piece of unscented tampon in drugs



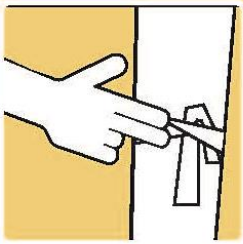
Place needle in filter and draw liquid into needle

4



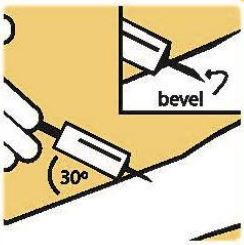
Clean your injection site with an alcohol swab

5



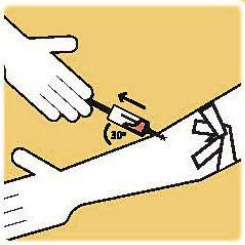
Tie off with a rubber tie using a quick release

6



Insert your needle with the bevel up, at a 30 degree angle towards your head

7

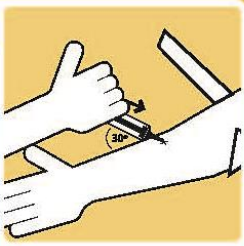


Flag your needle: push needle in a little and pull back on plunger until you see blood in the needle

8

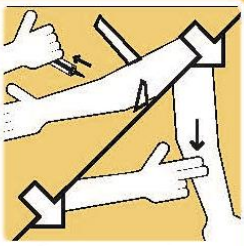
Loosen your tie

9



Inject your drug slowly

10



Pull out and with clean hands, apply pressure to injection site

11

Safely dispose of all equipment – make it your gig to return your rig

Safer injection tips

- Taste your drugs before you use
- Always use with a buddy
- Use a new needle for each injection
- Please don't break off the tip of your needle or re-cap it – it's not safe
- Remember: two holes in your arm are better than one in the ground. If you haven't used in a while, reduce your dose.
- Protect yourself and your community – always dispose of your equipment safely

injecting

- The most dangerous place to inject is your neck
- To make your veins more visible: jog on the spot or do push-ups before tying off
- If you can't see the bevel, look for the numbers on the side of your needle, they often line up with the bevel

filters

- Unscented tampons are safe to use as filters – do not use cigarette filters
- Use a filter once only – using it more than once can lead to "cotton fever"

ties

- Ties should be on for two minutes maximum
- If your hand falls asleep or arm turns red while tied off, the tie is too tight, or has been on too long

abscesses and wounds

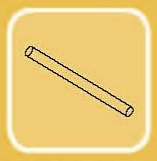
- Keep injection sites clean and watch for abscesses – they can happen anywhere on the body, not just where you inject
- If you have an abscess, do not pop it
- Seek medical care for treatment of abscesses or wounds – they can lead to dangerous infections

Needle Exchange Program

Safer Smoking

crack crystal

What you need to smoke crack safer:

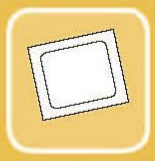

Shatterproof Pyrex Pipe


Re-useable mouthpiece


Five wire screens


Wooden push stick


Lighter


Alcohol swabs

What you need to smoke crystal safer:


Shatterproof Pyrex Pipe


Lighter


Alcohol swabs

the **user-friendly** series

What to expect

crack

The high

- A high that lasts 5–30 minutes
- Feeling an intense, euphoric rush
- Warm skin, dry mouth
- Feeling thirsty, not hungry
- Rapid heartbeat and breathing
- Auditory hallucinations

Coming down

- Feeling restless, sweaty and twitchy
- Sensitivity to noise and light
- Feelings of paranoia
- Strong cravings for more crack

⚠ Note: combining substances can be dangerous – proceed with caution

crystal

The high

- A high that lasts 4–24+ hours
- Feeling alert and energetic
- Not feeling hungry or tired
- Dry mouth
- Faster breathing and heart rate
- Feeling restless, anxious or paranoid and unable to sleep

Coming down

- Feeling extremely tired, unable to sleep, anxious, hungry and thirsty
- Clenched jaw
- Strong cravings for more meth

Signs of overdose

feels like:

- Your heart is pumping fast
- You're short of breath
- Your body is hot, sweaty and shaky
- You have chest pain
- You can't talk, can't walk

looks like:

- Fast pulse or no pulse
- Fast or no breathing
- Hot and sweaty skin
- Confusion, hallucinations, unconscious
- Can't talk, can't walk
- Vomiting
- Seizures

⚠ Reminder: using condoms and lube during sex will reduce your risk for HIV and other infections.

Your peers created this harm reduction pamphlet for you. **Be safe.**

What to do if someone ODs

1. Call out for help – **do not leave the victim**
2. Try to get them to slow down and relax
3. Call 9-1-1 for an ambulance, send someone to seek help and report back
4. Tell paramedics as much as you can about what happened

Ready to detox? Help is just a phone call away.

Call Access Central at 1-866-658-1221, seven days a week from 9am to 7:45pm for detox, residential addiction services and addiction housing.

1·866·658·1221

For more copies, go online at **http://vch.eduhealth.ca** or email **phem@vch.ca** and quote Catalogue No. **DB.500.S341**

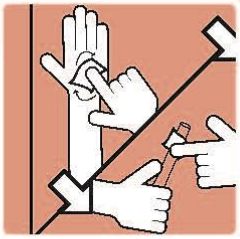
Vancouver Coastal Health
Promoting wellness. Ensuring care.

Needle Exchange Program

Make it your 9 1 9 no matter your age

Safer crack smoking

1

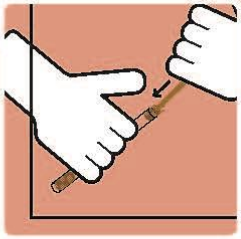


Clean your hands and mouthpiece with alcohol swabs

2

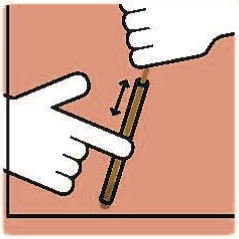
Twist each of your five wire screens into the shape of a cone

3



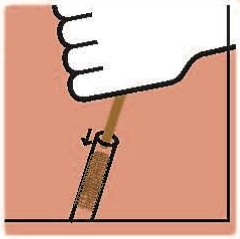
Using your wooden push stick, insert the screens one at a time into the pipe

4



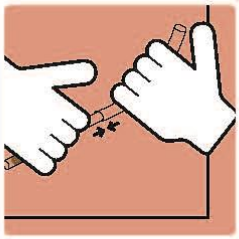
Use your wooden push stick to gently tamp down the screens

5



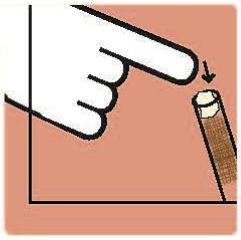
Nudge the screens back to make room for the crack

6



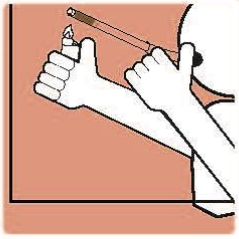
Fit your mouthpiece onto your pipe

7



Tilt the pipe up and place the drugs on top of the screens

8



Apply heat, inhale slowly, then exhale immediately

safer crack use tips

- Smoke in a safe place with people that you trust
- Take vitamins and eat something before you smoke – you won't feel like eating after
- Have condoms with you – you may want to have sex while high
- Pipe will be very hot once used – handle it with care
- Don't be alarmed by feelings of extreme depression once you're sober – it's your body reacting to the drug

mouth care

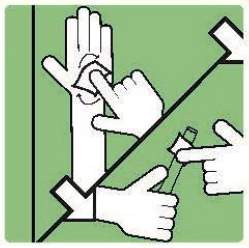
- Don't share: use your own mouthpiece to avoid infection and mouth burns
- Drink water or fruit juice to keep your mouth moist and reduce cracks and blisters
- Moisten your lips with lube or lip balm
- Chew gum to keep your mouth moist and healthier

wire screens vs. brillo

- Wire screens are much safer than brillo
  - Brillo's toxic coating can make you sick
  - Brillo can break apart and be inhaled, burning your mouth and throat
- If wire screens aren't available and you can only use brillo, be sure to:
  - Burn the coating off and change it frequently

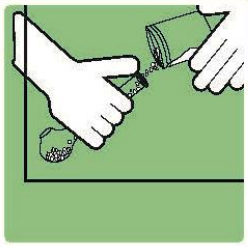
Safer crystal smoking

1



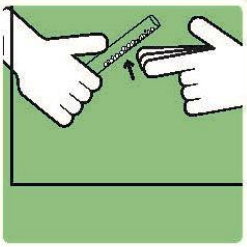
Clean your hands and pipe with alcohol swabs

2



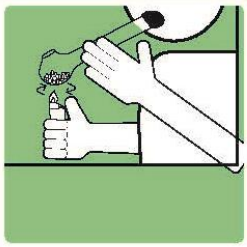
Pour crystal into your pipe

3



Tap your pipe to move the drugs into the bowl

4



Holding your pipe halfway down the stem, apply heat to the bowl, keeping the heat source moving

5

Heat will vaporize the drugs, filling your pipe with smoke

6

Inhale slowly then exhale immediately

safer crystal use tips

- Smoke in a safe place with people that you trust
- Inhale slowly and exhale immediately – don't hold it in
- Know your limits – once you're high, stop smoking
- Take vitamins and eat something before you smoke – you won't feel like eating after
- Have condoms with you – you may want to have sex while high
- Keep your pipe clean by burning off the residue and then scrubbing it with alcohol swabs
- When coming down, eating will help you sleep
- Don't be alarmed by feelings of extreme depression once you're sober – it's your body reacting to the drug

mouth care

- Avoid infection by using your own pipe – don't share
- Drink water or fruit juice to keep your mouth moist and reduce cracks and blisters
- Chew gum to keep your mouth moist and reduce clenching

Language matters...

4 guidelines to using non-stigmatizing language

1 Use People-first language

 Person who uses opioids	vs.	Opioid user OR Addict	

2 Use language that reflects the medical nature of substance use disorders

 Person experiencing problems with substance use	vs.	Abuser OR Junkie	

3 Use language that promotes recovery

 Person experiencing barriers to accessing services	vs.	Unmotivated OR Non-compliant	

4 Avoid slang and idioms

 Positive test results OR Negative test results	vs.	Dirty test results OR Clean test results	

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toward THE heart .com
WORKING TOGETHER REDUCING HARM

CREATED BY BCCDC HARM REDUCTION TEAM

Adapted from Broyles et al. Confronting Inadvertent Stigma and Pejorative Language in Addiction Scholarship: A Recognition and Response. Substance Abuse 2014

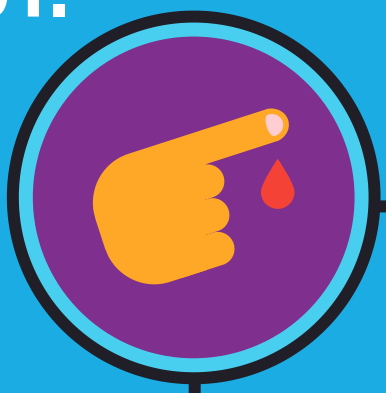
BC Centre for Disease Control
An agency of the Provincial Health Services Authority

Last Updated: December 6th 2017

Accidental Needlestick Injury

What to do in the event of an accidental community needlestick injury

001.



Allow it to bleed freely

Injuries are usually superficial

Do not squeeze where you were poked by the needle. This may damage the tissues and increase risk of infection.

002.

Wash the area

With soap and warm water

Do not apply bleach or alcohol to the area. This may damage the tissues and increase risk of infection.

003.

Stay Calm

And visit your local ER as soon as you can

- The care providers at the hospital will determine any follow-up care you may need based on your specific situation.
- Bloodwork will be done at this visit with follow-up over the next three months to monitor your health and provide you any necessary support.

www.towardtheheart.com

05-Dec-2018

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BCCDC HARM REDUCTION SERVICES

Facts About Community Needlestick Injuries

Debunking Common Myths and Misunderstandings

Rare

Community needlestick injuries are rare.

Extremely Low Risk

The risk of acquiring HIV, hepatitis C, or hepatitis B is very low.

No Documented Cases

There have been no documented cases of HIV from community needlestick injuries.

Hepatitis B Vaccine

If you haven't already, getting the hepatitis B vaccine will decrease your risk of acquiring Hep B.

Risk Depends on Setting

Community needlestick injuries carry different risks than those in hospital settings. This is because:

- The injury does not occur immediately after needle use.
- The needle rarely contains fresh blood.
- Any virus present has been exposed to drying and temperatures outside the normal range for our bodies.
- Injuries are usually not very deep.

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

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BCCDC HARM REDUCTION SERVICES

MYTH BUSTED:
Needle Distribution Model vs. Needle Exchange Model

We didn't encourage exchange until we noticed these things!

Needle Exchange: a one-for-one form of syringe distribution where individuals are not given new sterile needles unless they return their used needles.

Needle Distribution: a form of syringe distribution where individuals are given new sterile needles whenever they need them, regardless of whether or not used needles are returned at the same time.

Myth - Limiting the Number of Needles is Better for Overall Public Health.

Fact: Limiting the number of needles distributed increases the tendency for clients to share and re-use the same drug injection equipment; thus increasing transmission of HIV, hepatitis C and other infections.

Myth - Reusing Needles is Fine if you Aren't Sharing Them.

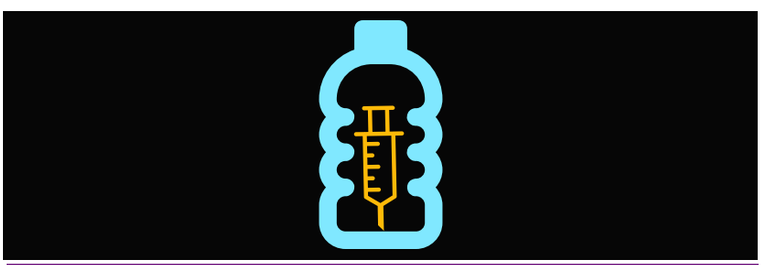
Fact: With multiple uses, the tip of the needle becomes weakened and can break off and stuck under the skin. Also, a reused needle becomes dull and doesn't inject as easily as a new one and can cause pain, bleeding, bruising, and infections.

Myth - A Needle Exchange Program will Prevent Needles from Ending Up In Community.

Fact: Studies show that rates of return for needle distribution programs are higher than needle exchange programs. The greater the access to syringes and easy disposal, the more likely people are to dispose of them in safe locations.

Myth - Provincial, National, and Global Best Practices Supports Needle Exchange Programs.

Fact: The Canadian Best Practice recommendations considers needle exchange to be "outdated and unsatisfactory". The BC Centre for Disease Control (BCCDC) has promoted needle distribution and safe disposal since 2002.



Myth - Safe Needle Disposal isn't as Important with Exchange Programs

Fact - Harm reduction education programs help to remove discarded syringes from the community. It achieves this through public support, and community and staff education. This process is necessary regardless of the style of needle program. BCCDC Harm Reduction Services provides personal sharps containers; communities provide publicly accessible community needle drop boxes, needle disposal advice for the public, and pick-up of discarded drug injection equipment.

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BCCDC HARM REDUCTION SERVICES

WHAT TO DO IF YOU FIND A DISCARDED NEEDLE?

Needle pick-up is safe and easy!

1. Find a rigid plastic container with a secure lid (e.g. plastic drink bottle with a wide mouth, liquid laundry bottle).

- Remove the lid and place the container on the ground beside the needle.
- Do not break or recap the needle.

2. Pick up the needle by the centre of the syringe barrel with care.

- Use work or latex gloves if available, and tongs if you prefer.
- Always point the sharp end of the needle down and away from you.

3. Put the needle in the container, sharp-end first, and secure the lid.

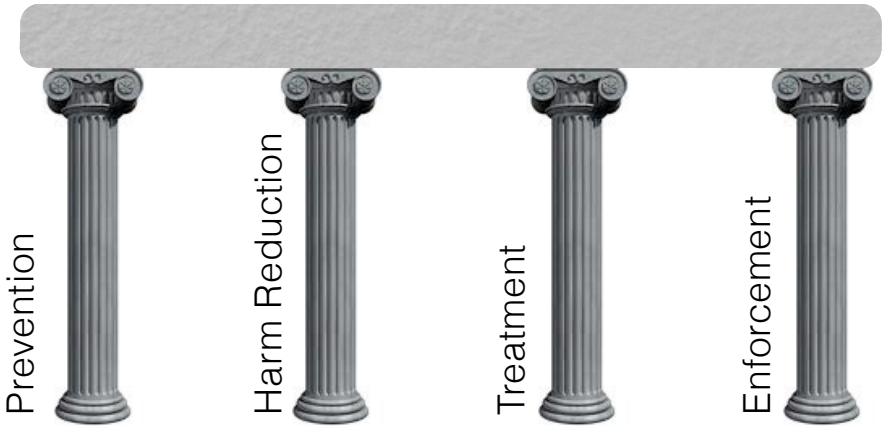
- While doing this step, the container should be on the ground; do not hold it in your hand.

4. Remove gloves and wash hands thoroughly with soap and water.

- Drop off the sealed container at a local health unit, pharmacy or community drop box.

Indigenizing Harm Reduction

With staggering rates of HIV, HCV and IDU amongst Indigenous peoples, it is clear that current mainstream models may not be meeting Indigenous peoples where we are at. What could harm reduction look like outside of urban centers in rural, northern and remote communities?



Pillar Model

The 4 pillar model is familiar to many harm reduction workers, academics and health policy analysts. While not the only theory on how to counteract harms caused by substance use, the interpretation and implementation of these pillars can sometimes also uphold colonial ideals of health, power and oppression.

Moving Beyond 4 Pillars

Indigenous peoples have experience reducing harm in many ways, especially the violence of colonialism for the last 500 years. Mainstream harm reduction models and practices while certainly a step in the right direction, do not always fit in northern, rural, or remote communities. Indigenous peoples have many Nation-specific understandings, traditions and needs that mainstream services often ignore or interrupt.

By shifting our focus from interpretations of these pillars like policing, prisons, court mandated care and assuming 'risk' is individual instead of systemic, we offer a critical analysis of what reducing the harm of colonialism can look like. **This is not a 'one size fits all' approach** but an opportunity to reinterpret these ideas in community specific ways that recognize the diversity of Indigenous peoples.

Four Fire Model

By centering community wellbeing and the restoration of different Indigenous knowledge systems, life ways, ceremonies, culture and governance structures Indigenous peoples of many Nations and cultures can reduce the harm we experience in our lives.

Cultural Safety

"Acknowledge the power differences that exist between service provider and client/ patient. Allowing and creating spaces for Indigenous peoples to feel safe to be our whole selves when receiving care"

Sovereignty

"Principles like non-interference teach us to support and meet people where they're at, ex. not forcing treatment"

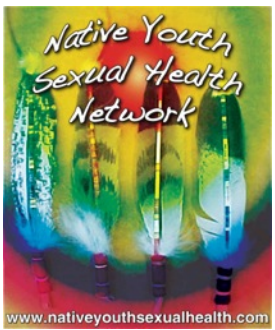
Reclamation

"Colonialism uprooted and distorted many structures and ways of life within our communities, reclaiming cultural practices can strengthen us"

Self-determination

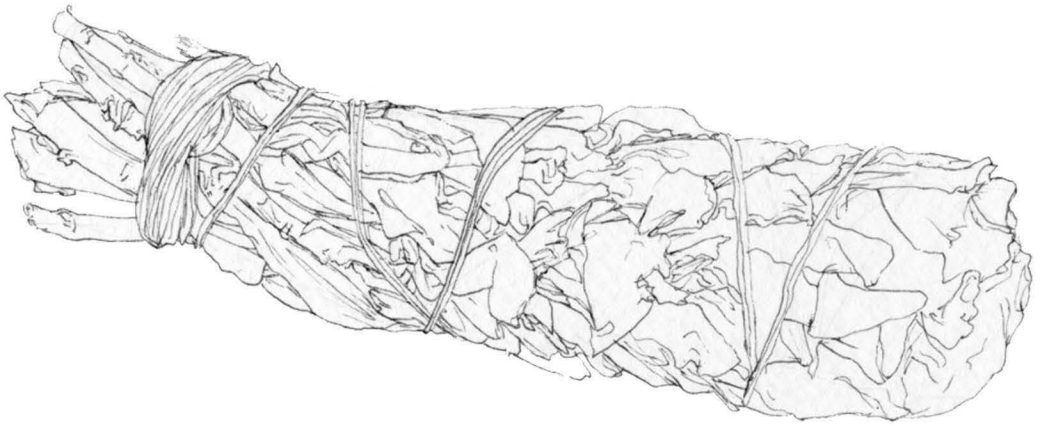
"Allowing individuals, communities and Nations to decide specifically for ourselves what works best for us"

What would these fires looks like on the ground while understanding the importance of the central home fire?



Native Youth Sexual Health Network 2014

decolonization 101



This zine was conceived and authored on the beautiful unceded island of Tiohtià:ke, traditional meeting place of many nations, cared for by the Kanien:keha'ka nation of the Haudenosaunee Confederacy.

We want to acknowledge and appreciate the many, many people who have contributed to this zine, and the ongoing relationships of learning and reciprocity that have enriched our lives. For the wonderful conversations, the support & solidarity, the love & friendship, kinanâskomitinâwâw.
You inspire us every day.

Cover art "Smudge" by Hallie Rose Taylor
hallierosetaylor.tumblr.com

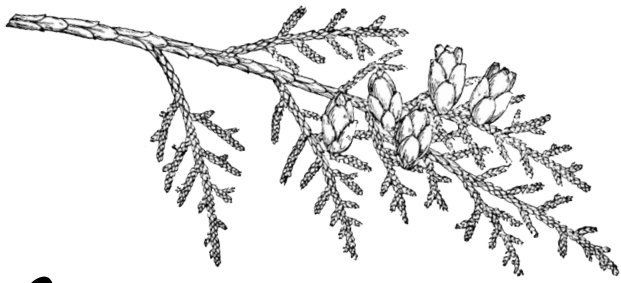


Table of Contents

intro

aka we're not doing your work for you

tanisi kahkiyaw awiyak, Molly Swain êkwa Lindsay Nixon nitisiyakâsonân, Molly otipêmsiw-iskwêw ôma wiya otôskwanihk ohciw, Lindsay anishnaabekwe/nêhiyaw-iskwêw ôma wiya Tootinaowaziibeeng Nation ohciw. nikîhokêwinân onatowêw-askîy êkwa pîtos nêhiyawak-askîy. osihchikawak Indigenous Women and Two-Spirit Harm Reduction Coalition. namoya wi-yôski-pikîskwawak.

Welcome to the Decolonization 101 Zine! The purpose of this text is to introduce you to some of the history, ideas, and realities of Indigenous peoples living on Turtle Island (the Western continents). This zine draws on our own experiences and work, as well as the work of some amazing Indigenous women and Two-Spirits (Indigenous queer and/or trans folks), people who have often had the least space and fewest opportunities to talk about our realities. Centering our voices has been one act of resistance to colonization, and you reading and listening to them is another.

What does it mean to be a settler and go to McGill? McGill was built and exists on unceded Haudenosaunee land, and was established by and named after a slave-owner and fur trader who exploited and profited off of the resources, bodies, and labour of Indigenous and Black folks. James McGill in many ways represents the quintessential colonizer, and his influence is still felt on campus today. McGill University has approximately 36,000 students at any given time, and only about 150 of those self-identify as Indigenous,

that's only 0.42% of the student body, whereas Indigenous peoples represent nearly 5% of "Canadians!" How many of your profs are Indigenous? How many classes about Indigenous issues or Indigenous-settler relations are taught by non-Native and white profs? What opportunities do you have at this university to learn in depth about particular nations and their histories, ontologies, and successes? In my years at McGill, students, professors, and administrators have left me enraged and on the verge of tears because of their outright racism and insensitivity, sometimes on a weekly or even daily basis. It is hard enough to juggle loans, jobs, classes, extracurriculars, friends, and home and family life without the added stress of colonial ignorance and hostility.

This zine is not meant to be a comprehensive "How-To" guide, nor is it going to give you all the answers. Instead, we want to open the door for you to start working on decolonizing yourself and your interactions with the Indigenous peoples you encounter and the Indigenous lands you inhabit, and it's your job to go through that door, to continue learning, and to build and maintain respectful, reciprocal relationships.

kinâkatêyimowewinan

Note: Please don't be a capitalist grammar policer and criticize our use of capitalization. Consider instead the political reasoning behind what we chose to capitalize and not capitalize throughout this zine.

Terminology
aka Who are Indigenous Peoples?

In the settler-colonial nation-state known as "Canada," there are three common terms for Indigenous peoples: First Nations, Métis, and Inuit. Some words that we Indigenous peoples use for ourselves include Natives, Aboriginals, ndns, Indians, redskins, Half-Breeds & Bois-Brûlés (for the Métis), the names of our nations (Anishnaabe, Tsuu T'ina, Haudenosaunee, Innu, Dene, Gitxsan, etc.). Some of these words, like Indian or Half-Breed, we have reclaimed for ourselves, and some, like ndn, were created by us and should only be used by us.

Names that are appropriate for settlers to refer to us as are: Indigenous, First Nations, Métis, Inuit, names of our nations. Words that settlers shouldn't use: Indian (even though this is a legal term, ie: The Indian Act, it is both inaccurate and a slur when referring to Turtle Island Indigenous peoples), redskin (a slur), injun (a slur), squaw (a gendered slur, NEVER use), redman (slur), ndn (ours, not yours), Half-Breed (slur), Eskimo (slur).

Words that you can use but aren't the best: Native, Native American/Canadian (many Indigenous peoples don't consider ourselves Canadian, or think of ourselves instead as belonging primarily to our specific nations), Aboriginal. We recommend you stick with Indigenous.

The term 'First Nations' refers to Indigenous peoples who are neither Inuit nor Métis, such as the Blackfoot, Cree,

Saulteaux, Oneida, etc. Métis (also known as Michif) are Indigenous peoples with First Nations and European heritage. It is important to understand both that Métis ARE Indigenous, with unique culture and languages, and that not every mixed-European and Native person is Métis. Finally, Inuit (Inuk is the term for a single person) are peoples that live in the North, all across the Arctic parts of Canada, the US, and Greenland. These distinctions do not reflect the vast differences within and between our many cultures, traditions, and languages, nor the cultural similarities and sharing that happen between our peoples.

Speaking of, you should never talk about "Indigenous culture," "Indigenous language," or "Indigenous spirituality." There are hundreds of nations on Turtle Island, and so hundreds of cultureS, languageS, spiritualitIES, and peopleS. Don't homogenize us, the Cree are as different from the Haida as the Spanish are from the Japanese!

Decolonizing History

Indigenous peoples have been on Turtle Island for tens of thousands of years. Our traceable histories extend far beyond the debunked "Bering Strait Land Bridge" theory settlers have been trying to push on us, and we had highly advanced cities and technologies - did you know the largest pyramids in the world aren't in Egypt, but in the southern half of Turtle Island? That Africans and Turtle Islanders were trading, marrying, and kicking ass together well before Columbus was even born? And that one of the world's biggest cities at the start of the 16th century was in what is now known as Minnesota? Indigenous peoples are keepers of scientific, navigational, medicinal, historical, ecological, sociological, mathematical, and economic knowledges that remain far beyond even current European and Euro-colonial societies. This is not a joke or an exaggeration; despite what we've all been taught about the "primitives" of the "undiscovered Americas," Indigenous peoples had vast international trading networks and cultural exchanges, huge political confederacies and alliances, massive social and scientific gatherings, and settler colonial societies have always 'Columbused' (claimed to have discovered something Indigenous peoples, Black folks, and People of Colour have been doing or have invented) Indigenous knowledge when it's convenient, and dismissed or devalued it when it suits the narrative of "uncivilized savages" who benefit from the importation of superior European (or Canadian, American, Australian, etc.) ideas. Part of decolonization is giving credit where credit is due, and resisting bullshit narratives of European cultural and technological superiority.

Use of the term "settler"

People use the term settler in many different ways but here's how we are using the term.

If you are settled on Turtle Island and you are not from an Indigenous Nation you are a settler. This is a fundamental positionality which must be addressed in "solidarity" relationships between Indigenous and settler folks, especially if you are a white settler. White privilege is a positionality which pervades all social relations. Reciprocal relationships with Indigenous folks means recognizing where you are coming from and whose lands you are on. White settlers need to be accountable to the fact that their existence on these lands and apparent claim to these territories was facilitated through genocide; a genocide for which they are still complicit.

White privilege : A violent set of social systems and attitudes that centre, celebrate, and protect white people's bodies, actions, and culture at the expense and depreciation of all other peoples. The humanizing of white people and the dehumanizing of all others. The framing of the white person as subject and all others as objects.

The use of settler is of course very complicated. Colonialism is a global process: A global history of conquest, genocide, and brutality. Black folks stolen from their home territories and brought to Turtle Island against their will as part of the global slave trade could never be considered settlers. White settlers

were also colonizers of Black Nations like Africa. In South America it has been argued that there is a Black Indigenous community; peoples having already migrated pre-European contact and integrated into Indigenous communities. We know that Indigenous and African populations were likely making contact long before European settler-colonialism. Furthermore, there are also folks who identify as Black Indigenous across Turtle Island.

Also, what of migrated folks forced off their home territories due to global processes of colonialism and capitalism. Many peoples have been forced out of their own home territories and onto Turtle Island due to violent colonial processes. Global migration influenced by colonialism and capitalism has also resulted in generations of people with diasporic identities. Peoples who come from families which migrated to Turtle Island but have no connection to a "home territory" other than Turtle Island, the only home they've ever known.

The use of the term "settler" is contested and complicated. That said, it's still an important mark of solidarity between Indigenous folks and non-Indigenous folks. Settler individuals must be critical about the fact that their body existing within Turtle Island is a perpetuation of settler colonialism, a continuation of colonial processes, and reinforces the dispossession of Indigenous territories.

Because I have previously used the term "settler" and offended white settlers, as if I were using a slur, I want to make clear that the term settler is meant to highlight a position of complicity within settler-colonialism. It is not an offensive term but simply a reality settlers need to be conscious of. Colonialism pervades contemporary social relations between Indigenous folks and settlers, especially white settlers who are privileged by this dynamic, and settlers must be accountable to this when attempting to be in

solidarity with Indigenous peoples.

Recognizing ones positionality as a settler is of paramount importance to understanding how colonial relations manifest in violent ways for Indigenous peoples. For example, how settlers are complicit in gendered violence against Indigenous women, girls, and Two-Spirit folks. The subjugation of Indigenous women, girls, and Two-Spirit peoples was critical to the success of economic, cultural, and political colonization. The historical contexts of rape, racism, and colonialism continue to impact the contemporary lives of Indigenous women, girls, and Two-Spirit peoples on Turtle Island. We can see this history present in the rate of violence against Indigenous women, girls, and Two-Spirit folks. Andrea Smith talks more about this in her book Conquest: Sexual Violence and American Indian Genocide.

It's important to be accountable to Indigenous communities and recognize your positionality within the colonial context. Historical processes of colonialism continue to manifest in our communities; on our bodies. So, though understanding your positionality should be an ongoing, constant, and consistent process, at the very least it is harm reduction in relationships between Indigenous folks and settler folks which are imbued with ongoing colonial structures of violence.

Appropriation and Redskins/Redmen

I've stopped going out on Halloween, and there are two main and overlapping reasons: the rampant cultural appropriation and inevitable racist caricatures they represent. They're prevalent throughout most of the year, but become shockingly ubiquitous around Halloween, and it's a lot less upsetting to just stay home and miss out on the "fun," rather than go out and be confronted with the level of dehumanization Halloween has come to embody.

The issue of cultural appropriation has been kind of a big deal in mainstream media for a few years now, and it's good to see folks start to take it seriously. If you don't already know, cultural appropriation is the adoption of certain restricted cultural items or traditions by someone from another culture. What do I mean by restricted? A university degree, for example, is a restricted item in settler culture. You have to earn a degree through years of hard work and training, and that diploma represents something about your accomplishments. Not just anyone can stick a fake medical degree on the wall and call themselves a doctor—there would be serious repercussions. No one would argue that they actually just really, really respect the medical profession, and that's why they have that fake Harvard MD in the living room. But that's exactly what we Indigenous folks hear when people try to justify wearing a fake headdress, or eagle feathers, or when they talk about their 'spirit animals.' They really "respect" us, they want the "Native experience."

Of course so much of this racism is bound up in capitalism. Urban Outfitters will sell you stolen "Native" prints on the cheap, some asshole on Etsy will sell you a chicken feather

headdress, you can pay to take a test that will tell you what your "spirit animal" is. Capitalism and colonialism are complicit in centuries of ongoing genocide against Indigenous peoples. This has included banning many of our ceremonies, sacred items, and cultural practices, and now they are being repackaged as cheap knock-offs so settlers can play-act some fantasy of the historical "Indian" while our lands continue to be stolen, our children continue to be taken, and our women and girls continue to be murdered. Cultural appropriation is a big fuckin deal, so don't be surprised if we get pissed off!

And yeah, Indigenous cultures have created some gorgeous stuff. And not everything is restricted! Moccasins, for example, are an unrestricted item and they're comfy as hell and if they're authentic will often have absolutely gorgeous beading. If you want mocs, go authentic. Seriously. They are expensive, but save up or go without, if you want to engage with some of our cultural items the least you can do is get them from us and appreciate the incredible craftsmanship that goes into their creation. Real Indigenous artists will not try to sell you restricted items, and if you're not sure, ask!

Check out apihtawikosisan's excellent piece on cultural appropriation here for an expanded discussion:
http://apihtawikosisan.com/2012/01/the-dos-donts-maybes-i-dont-knows-of-cultural-appropriation/

Now on to Redmen and Redskins!

In case you skipped the "Terminology" section of this zine, redman and redskin are slurs! So why are McGill's men's sports teams called the Redmen (they used to be called the Indians)? Why are there professional sports teams called the Redskins? The answer, unsurprisingly, is racism. Settler-colonialism loves the idea of Indigenous peoples, but hates actual living breathing ones. Caricatures and stereotypes of Indigenous folks have been around just about as long as settlers have, and they have been used simultaneously to position Indigenous peoples as extinct or dying out (the only thing left is this smiling red face), and to dehumanize Indigenous peoples—just about every Indigenous person has a story (or dozens of stories) about being told that they "just don't seem like a REAL Indian," because of course, "real Indians" are supposed to live in tipis and hunt with a bow and arrow, not play too much Candy Crush and love Star Trek (actually that may just be me).

There are of course many other stereotypes that Indigenous peoples are faced with: the Noble Warrior, the Squaw, the Pocahottie/Sexy Indian Princess (a Halloween favourite!), the Shaman, the Drunk Injun, the list goes on and on and none of these are even remotely ok. For example, the sexualization of Indigenous women seen in Sexy Indian Princess costumes is resultant of "Squaw" narratives. Squaw narratives ascribe terra nullius on our lands to our bodies, marking our bodies as available for conquest by settlers and thereby rapable and disposable. These narratives actually condone ongoing sexualized violence against Indigenous women, Two-Spirit peoples, and girls. So, when you wear a Sexy Indian Princess costume at Halloween you are in fact enacting gendered and sexualized violence against Indigenous women.

Would you just stand by and accept it if McGill's team name was a racist slur against another group? Wouldn't you be embarrassed and angry? My point is that racism against

Indigenous peoples is so normalized and engrained that it's not even on people's radars, or it is and they just can't be bothered to care. There has been lots of good writing on how stereotypes of Indigenous peoples are emotionally and materially harmful, so do that research and educate yourself and those around you! There are "Change the Name" campaigns and lawsuits being filed to pressure racist institutions to get their acts together. It's well past time for McGill to follow suit, and as a student or Montréal community member you are very well positioned to start shaming them for their apathy and racism.

So yeah, as Halloween rolls around, skip the redface and institute a 'no racist costumes' policy at your party. Then maybe I'll be able to join you this year.

Land Acknowledgement Protocol

Do you know the name of the Native peoples on whose territory you live?

When living in "Edmonton" I started becoming more radicalized around my Indigeneity and was simultaneously engaging in predominantly white-dominated radical queer communities. I was often frustrated by the tokenizing and ignorant attempts at "Indigenous solidarity" that existed in white radical spaces in the form of land acknowledgements. At most, folks would do an extremely simplified land acknowledgement and at least they would include a line of writing in their event descriptions like, "we acknowledge that this event is happening on traditional Indigenous territories."

The idea that an event being organized is held on Indigenous territories should be obvious. This just feels like decolonization light. Settlers have literally done the least amount of work possible to acknowledge their occupation of stolen lands and their contribution to ongoing genocide.

Another common land acknowledgment I would hear was the assertion that Edmonton was on "Treaty 6" territories. This is defining Indigenous land entitlement on the colonist's terms. I've heard people say they do this because, "It was an agreement between settlers and Indigenous folks and is therefore about creating community solidarity." The reality is that Treaties were achieved through genocidal policies implemented by the settler-colonial nation state which

had nothing to do with the sovereignty or well-being of Indigenous Nations. Through the state-sponsored extinction of the buffalo, strategized famine, germ-warfare, and the destruction of traditional ways of being and knowing, Indigenous peoples were forced to assimilate or die. In nêhiyaw and Anishinaabe territories out West, among many other territories, Indigenous peoples were forced to sign the treaties with the crown. It's important to recognize that many Indigenous Nations had no choice in signing treaties. They were literally forced to sign treaties so they wouldn't starve, die, or be conveniently eradicated by the illegitimate settler colonial state. So, when you base your land acknowledgements in treaty recognition, you're actually legitimizing the colonial project of genocide.

Remember is that land acknowledgement has absolutely nothing to do with settlers. Land acknowledgment isn't about the folks who settled these lands. It's about recognizing the Indigenous peoples who these territories belong, who existed here, and who used these lands long before settlers arrived. Decolonization is not a metaphor.

Historically speaking, the land "Edmonton" sits on was occupied and used largely by the nêhiyaw. The nêhiyaw called these territories amiskwaciwâskahikan. There are several First Nations which still reside on reserved lands within these territories. In fact, the "edmonton capital region" is home to the Enoch Cree Nation. This how I define these lands.

This is not meant to spoon feed you how to do land acknowledgements. You, as a settler, need to do the work to figure out exactly whose lands you're on. Also, the assertion that this is too tedious or hard is settler privilege. In fact, the settler-colonial state is contingent on you refusing to acknowledge whose territories you are on. Indigenous peoples have to navigate the reality of our territories being

occupied everyday. Your settler privilege, which makes it so easy to ignore whose territories you reside on, is facilitated by the ongoing genocide of the Indigenous peoples.

It's important to remember that land protocols don't end with simply defining the lands you reside on. Protocols can be seen as a set of house rules that change depending on who's house you're at, or whose nation or traditional territories you are in. As such, your fulfillment of these protocols should extend to meaningful, and reciprocal relationships with the Indigenous peoples and communities on whose land you reside. Talk to people and figure out what your duties are as a respectful and conscientious inhabitant or visitor on other people's lands. This is part of your responsibility as an occupier and settler.

Creating Reciprocity with Urban Indigenous Peoples

I want to preface this section by saying I think that Indigenous land defense is super important and fucking necessary. Indigenous land defenders are fighting for their survival, the survival of their communities, and the survival of future generations. They need support and external allies to help carry out land resistance. However, there are many aspects to warrior societies only one of which is land defense. It's really interesting to me that when settlers think of resistance and solidarity strategies they only seem to think of land defense.

I feel like activists and community organizers often romanticize land defense because it looks the most like anarchism or manifestations. I get that land defense is ongoing but what can you contribute if: a) You're not an Indigenous person; b) You're not coming from these communities and probably have no understanding of their histories, language, and cultural practices; c) There is so much happening in the urban spaces you occupy and many other opportunities for solidarity work within your own urban communities. Unless of course the communities themselves are asking directly for support in land defense from outside parties or you're an Indigenous person conceptualizing ways to do solidarity work with communities engaging in land defense.

Is it because urban Indigenous folks are struggling in a very visible way that makes settlers uncomfortable? Why are settlers ignoring and refusing to lend their energies to urban strategies within the communities where they actually live?
My Indigenous feminism acknowledges that native bodies are just as important as land. Europe didn't just colonize through military power, it also colonized by imposing oppressive hierarchies and forcibly restructuring our social systems.

Basically, if we get the land back Euro-patriarchy has still been internalized within our Nations. Colonialism functions through and is compounded by structures of patriarchy, heteronormativity, and cisnormativity. There is still astounding rate of abuse and disappearance amongst our women, Two-Spirit peoples, and children. There's still addiction, poverty, and other intergenerational traumas. Indigenous children are still being removed from their homes and put into foster care at soaring rates. Indigenous youth and adults

are more likely to be incarcerated, and for longer periods. Indigenous peoples have one of the highest rates of suicide. Indigenous youth are also the highest rising demographic of new HIV/AIDS infections. It's clear that sovereignty and decolonization doesn't end with land reclamation and that addressing these intersecting oppressions is just as much of a survival issue because women, Two-Spirit folks, and children aren't surviving.

There is so much resurgence happening within Indigenous communities right now dealing with the day-to-day oppression Indigenous peoples face. So, why the decided focus on land defense strategies as decolonization amongst settlers? Also, as a settler, how are you going to claim that you are supporting land resistance when you are still occupying stolen lands? Once again, decolonization is not a metaphor. If you want to support or show solidarity to Indigenous peoples and the only thing you're focusing on is land, your solidarity is falling short.

"I wish people would put their bodies on the line for 2Spirit/ Queer Indigenous youth who are extracted into prison, like extraction on land."

- Erin Marie Konsmo, Land Is Life Panel, Montreal, 2014

Solidarity or Appropriation?

Alright guys, I'm gonna get a little gritty here. I'm about to talk about a very real and ongoing violence in my life. Too long have settlers appropriated the struggle of my communities for their own gain. I'm not here to pacify settlers, I'm here to speak to mine and my communities' truths.

More often than not solidarity organizing is violent and colonialist. I've become very critical of Indigenous solidarity organizing because I've witnessed far too many appropriative groups who cloak their appropriation in language of "solidarity". For example: There is a settler organization in Montreal organizing around the issue of missing and murdered Indigenous women, a collective on which there is not one Indigenous person. Throughout this section I will use my interactions with this group as an example of bad solidarity actions but I want to be clear that there are many other groups engaged in appropriative solidarity work. My interactions with the group stem from attending one of their meetings, them approaching me and other Indigenous folks in incredibly tokenizing manners, and hearing stories from other Indigenous folks who attended their meeting but left when they felt uncomfortable.

This group has a proven track record of tokenizing Indigenous communities and community organizers (ie. by asking them to show up to their events to lend credibility

to their actions). However, outside of these tokenizing attempts at solidarity, they do not have sustained, reciprocal relationships with the Indigenous peoples whose land they are on. They are responsible to no one including the Indigenous communities they supposedly serve. Yet, they still continue to uncritically take up the most space in the conversation of missing and murdered Indigenous women in Montreal, an issue that is extremely visceral and intense for our communities. Arguably, an issue only our own communities know how to deal with responsibility. They have straight up copied or appropriated Indigenous organizing throughout the city by stealing themes and knowledge from Indigenous organizing to lend legitimacy to their own organizing. This group has been called out be several Indigenous organizers and have refused to be accountable to our communities or change their tactics.

Indigenous organizers who have attended and spoke at their events were promised payment and childcare, neither of which were followed through on. When one individual inquired about the promised payment the group guilted her, saying no one else was getting paid so why should she. So, they are literally hoping to profit off the free labour of Indigenous women.

They give workshops using narratives of vulnerable families who have had their daughters, aunties, cousins, etc. stolen with little accountability to these families outside of appropriating their stories. In fact, they commodify these narratives into a quick 1 hour workshop to then give to settlers uncritically.

They continually appropriate what they conceive to be "Indigenous spirituality" and erase Two-Spirit peoples from their analysis at their events. I've witnessed their lead organizer do a "land acknowledgment" at two events

which didn't at all acknowledge whose land they were on, appropriated Indigenous spirituality, and which was basically fluffy feminist oneness politic bullshit that said nothing inherently political or real about the realities of Indigenous peoples in these territories.

IW2SHRC was even approached by an Indigenous woman who went to one of their meetings but left when her feelings about an inquiry were not heard or respected. Instead, the group chose to forward their own stance on the inquiry as if their feelings on the issue were at all equal to that of the Indigenous woman.

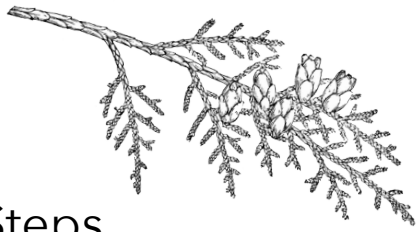
I hope this was a clear enough example of where solidarity organizing can fall short. When enacting organizing in solidarity with Indigenous peoples always ensure that Indigenous peoples are present (can't believe I even need to say this). Nothing for us or about us without us. Ensure that you are centring the organizing of Indigenous folks and not simply competing for airtime with Indigenous

organizing. One way to do this is to lend your support and resources to organizing actually led by Indigenous folks. Or, lending resources to empower Indigenous organizers in your own community.

For example, Walking With Our Sisters in a national collective who have organized a massive commemorative art installation comprised of 1,763+ pairs of moccasin vamps (tops) plus 108 pairs of children's vamps created and donated by hundreds of caring and concerned individuals to draw attention to this injustice. Each pair of vamps (or "uppers" as they are also called) represents one missing or murdered Indigenous woman. The unfinished moccasins represent the unfinished lives of the women whose lives were cut short. The children's vamps are dedicated to children who never returned home from residential schools. Together the installation represents all these women; paying respect to their lives and existence on this earth. They are not forgotten. They are sisters, mothers, aunties, daughters, cousins, grandmothers, wives and partners. They have been cared for, they have been loved, they are missing and they are not forgotten (from the WWOS website: http://walkingwithoursisters.ca/).

WWOS is constantly looking for support and recently led a crowdsourcing campaign selling t-shirts to fund their work. Supporting Indigenous led organizing like WWOS over settler organizations appropriating Indigenous organizing is a way to enact meaningful solidarity work.

Conclusion



aka Next Steps

There are a lot of things we didn't cover in this zine. Histories of our territories and that of the peoples whose lands we're currently living on. The staggering levels of criminalization and incarceration of Indigenous folks. Missing and murdered Indigenous women and girls. How Residential Schools, the Sixties Scoop, and current Child Welfare policies are all part of ongoing genocide. Intergenerational trauma. The Indian Act. The sterilization of Indigenous women. Language resurgence. Acts of resistance. Reclaiming our cultures and ceremonies. Solidarity across our nations and the fake borders imposed by settler-colonial states. Land-based education and healing. The incredible work of our Elders, youth, women, artists, and leaders. How proud, dynamic, and incredible we are as peoples.

As we said in the introduction, this zine is meant to open a door for you—not to feel guilty or frustrated, but to feel responsible and committed to decolonization. Stepping through the door will lead you on a long path of questioning, learning, and action. Take this path humbly, live and act reciprocity, respect, and generosity, be prepared to make mistakes and learn from them, put yourself out there, take the lead from Indigenous folks, talk to everyone about colonialism and the importance of decolonization, be on the land, resist the racism you've been socialized into, and above all, listen.

êkosi

How to Register as a Harm Reduction Site

1. Get Approval By Your Regional Health Authority

We recommend you connect with your local Harm Reduction Coordinator before signing up as a harm reduction supply distribution site. This is to ensure there are built in supports for your organization to distribute supplies, and to offer local guidance along the way.

REGIONAL HARM REDUCTION COORDINATORS CONTACT INFORMATION

Health Authority	Name	Phone	Email
First Nations	Janine Stevenson	604-693-6964	Janine.Stevenson@fnha.ca
Fraser	Erin Gibson **(Fraser South)**	604-930-5404 Ext 765862	Erin.Gibson@fraserhealth.ca
	Katherine Moriarty **(Fraser North)**	604-930-5404 Ext 765717	Katherine.Moriarty@fraserhealth.ca
	Lianne Radmore **(Fraser East)**	604-702-4909	Lianne.Radmore@fraserhealth.ca
Northern	Reanne Sanford	250-991-7571	Reanne.Sanford@northernhealth.ca
Interior	Jessica Bridgeman	778-257-5711	Harmreduction.coordinator@interiorhealth.ca
	Jennifer Driscoll	250-320-5710	Harmreduction.coordinator@interiorhealth.ca
	Lesley Coates	250-306-2149	Harmreduction.coordinator@interiorhealth.ca
Vancouver Coastal	Kimberly Murphy **(Vancouver)**	604-862-0317	Kimberly.Murphy@vch.ca
	Rebecca Thomas **(Outside Vancouver)**	604-729-9210	Rebecca.Thomas@vch.ca
Vancouver Island	Jenny Peters	250-739-5788 Ext 53065	Jennifer.Peters@viha.ca
	Tracey Thompson	250-370-8111 Ext 33431	Tracey.Thompson@viha.ca

2. Fill Out the Harm Reduction Receiving Site Registration Form

Once you have received approval from your regional harm reduction coordinator, you can submit a registration form to the BCCDC. This can be done by **fax to 604-707-2516**, or **emailed to harmreduction@bccdc.ca**.

HARM REDUCTION RECEIVING SITE REGISTRATION FORM

Please use this form to register a new Harm Reduction receiving site or to update site contact details.

Please FAX: 604-707-2516. Please print CLEARLY with a dark colored pen.

BASIC SITE INFORMATION

1. Site Contact Details					
Site Name					
Site Address	Street:				
	City:			Postal Code:	
Phone Number		*Hours of Operation*			
2. Site Access (Please indicate if you would like this site to be publically listed on the Toward the Heart site finder)					
☐Yes, public may access site (*Select all that apply*) ☐Safer Sex Supplies ☐Safer Drug Use Supplies					
☐No, site services clients only. Do not map.					
3.Supply delivery address (If different from above)					
Shipping Address	Street:				
	City:			Postal Code:	
Phone Number		*Delivery Hours*			
Special Delivery Instructions (ex. buzzer #)					

SITE PERSONNEL INFORMATION

1. Site Coordinator(s) (max. 2)

	First Name	Last Name	Phone Number	Email	Preferred Mode of Communication
Coordinator					☐Phone ☐Email
Coordinator					☐Phone ☐Email

SATELLITE SITES

1. Please list details of satellite sites names receiving supplies from this receiving site.

Satellite Site Name	Phone Number	List Site on Toward the Heart Site Finder?
		☐Safe Sex Supplies ☐Safer Drug Use Supplies ☐Do Not Map
		☐Safe Sex Supplies ☐Safer Drug Use Supplies ☐Do Not Map
		☐Safe Sex Supplies ☐Safer Drug Use Supplies ☐Do Not Map
		☐Safe Sex Supplies ☐Safer Drug Use Supplies ☐Do Not Map
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		☐Safe Sex Supplies ☐Safer Drug Use Supplies ☐Do Not Map
		☐Safe Sex Supplies ☐Safer Drug Use Supplies ☐Do Not Map

3. Complete the Supply Requisition Form

We recommend that you order in bulk every 3 months or longer to meet the Minimum Order Size. The distributor charges additional handling fees for small orders. If you failed to meet the Minimum Order Size, BCCDC might fax back the form with instructions to "increase your order" and your order might be delayed. Harm reduction supply orders are processed Tuesday mornings, so the cut-off time for submission is Monday by midnight.

You can find the order form on our website https://towardtheheart.com/resource/hr-req-form/open or below:

HARM REDUCTION PROGRAM : SUPPLY REQUISITION FORM

E-MAIL orders to harmreduction@bccdc.ca

If you don't have e-mail, fax to (604) 707-2516

Orders must meet Minimum Order Quantity
(refer to Page 2)

BC Centre for Disease Control
AN AGENCY OF THE PROVINCIAL HEALTH SERVICES AUTHORITY

Receiving Site: _____ Date Submitted: _____

Contact Name: _____ Delivery Days: _____

Shipping Address: _____ Delivery Times: _____

_____ _____

Postal Code: _____ **Email:** _____

Phone Number: _____ **Fax Number:** _____

This form is only for RECEIVING sites authorized by Health Authority representatives. If you are not an authorized site, please contact your Health Authority representative as shown on Page 2.

Please allow up to 2 weeks delivery.

Products	Description	Notes	Unit Of Issue	Quantity Ordered
Safer Sex				
Condoms	Lubricated		(1440/Box)	**Boxes**
Condoms	Non-Lubricated	**ORDER MULTIPLES OF 5**	(144/Box)	**Boxes**
Condoms	Flavoured		(144/Box)	**Boxes**
Insertive Condoms		**Call us if request < 100 (ea)**	(100/Bag)	**Bags**
Aqua Lube	3 mL per packet	144/bag, 8 bags/box	(1,152/Box)	**Boxes**
General Safer Use				
Alcohol Swabs		20 boxes/case	(200 swabs/box)	**Boxes**
Water Vials	3 mL		(1000/Case)	**Cases**
Safer Injection				
Syringes with needle attached	1 cc insulin syringe & needle	5 boxes/case	(100/Box)	**Boxes**
Syringes with needle attached	1/2 cc insulin syringe & needle		(100/Box)	**Boxes**
Ascorbic Acid	100 mg sachets		(1000/Box)	**Boxes**
Disposable Cookers (Stericups)	Multicolour (with filter)		(1000/Box)	**Boxes**
Tourniquet			(100/Box)	**Boxes**
Syringe without needles	3 cc		(200/Box)	**Boxes**
Syringes without needles	5 cc		(125/Box)	**Boxes**
Needle, disposable	18g x 1 1/2"		(100/Box)	**Boxes**
Needle, disposable	22g x 1"		(100/Box)	**Boxes**
Needle, disposable	22g x 1 1/2"		(100/Box)	**Boxes**
Needle, disposable	25g x 5/8"		(100/Box)	**Boxes**
Needle, disposable	25g x 1"		(100/Box)	**Boxes**
Needle, disposable	26g x 1/2"		(100/Box)	**Boxes**
Needle, disposable	27g x 1/2"		(100/Box)	**Boxes**
Sharps collector - 1 quart	1L		(60/Box)	**Boxes**
Sharps collector - Mini	500mL - holds <10 needles		(100/Box)	**Boxes**
Safer Inhalation				
Cutter for vinyl tubing			(each)	**Each**
Plastic mouth piece - Vinyl Tubing	1/4" x 3/8" - small diameter		(100 feet/roll)	**Rolls**
Plastic mouth piece - Vinyl Tubing	5/16" x 7/16" - medium diameter		(100 feet/roll)	**Rolls**
Plastic mouth piece - Vinyl Tubing	3/8" x 1/2" - large diameter		(100 feet/roll)	**Rolls**
Screens		10 brass screens/envelope	(200 env/Bag)	**Bags**
Wooden push sticks			(144/Bag)	**Bags**

Updated: 2018 Dec 18

Harm Reduction Supply Ordering at the BCCDC

Health Authority contacts for site authorization

To receive harm reduction supplies, each distribution site must be pre-authorized by the health authority representative below:

Health Authority	Name	Phone	Email
First Nations	Janine Stevenson	604-693-6964	Janine.Stevenson@fnha.ca
Fraser	Erin Gibson **(Fraser South)**	604-930-5404 Ext 765862	Erin.Gibson@fraserhealth.ca
	Katherine Moriarty **(Fraser North)**	604-930-5404 Ext 765717	Katherine.Moriarty@fraserhealth.ca
	Lianne Radmore **(Fraser East)**	604-702-4909	Lianne.Radmore@fraserhealth.ca
Northern	Reanne Sanford	250-991-7571	Reanne.Sanford@northernhealth.ca
Interior	Jessica Bridgeman	778-257-5711	Harmreduction.coordinator@interiorhealth.ca
	Lesley Coates	250-306-2149	Harmreduction.coordinator@interiorhealth.ca
	Jennifer Driscoll	250-320-5710	Harmreduction.coordinator@interiorhealth.ca
Vancouver Coastal	Kimberly Murphy **(Vancouver Harm Reduction)**	604-862-0317	Kimberly.Murphy@vch.ca
	Rebecca Thomas **(Vancouver Naloxone, Outside Vancouver All Services)**	604-317-1153	Rebecca.Thomas@vch.ca
Vancouver Island	Jennifer Peters	250-739-5788 Ext 53065	Jennifer.Peters@viha.ca
	Tracey Thompson	250-370-8111 Ext 33431	Tracey.Thompson@viha.ca

General Notes about Supplies

- Any changes to supplies will be posted on towardtheheart.com and made to the Supply Requisition Form
- When possible, supplies are provided in accordance with the Best Practice Recommendations for Canadian Harm Reduction Programs, which can be viewed at: www.bccdc.ca/prevention/HarmReduction/CdnBestPractices.htm
- Use older supplies first. Remember: **First In, First Out (FIFO)**

BCCDC Weekly Processing

- To order supplies, fill out Harm Reduction Supply Requisition Form above and fax it to the number on the form.
- BCCDC will **process requisitions in batches on Tuesday AM**, so please submit your order by the end of the day on Monday. All orders received after Monday will be processed the following week **and delivery will be delayed.**
- Please ensure your Health Authority rep is informed of changes to contact information to avoid the requisition form from not being processed.

Minimum Order Size

- We recommend that you order in bulk every 3 months or longer to meet the Minimum Order Size; the distributor charges additional handling fees for small orders. For instance, the following orders would be large enough to avoid an additional handling fee:

1 box Aqua Lube – carton	(1,152 per box)	or	20 boxes of 1cc syringes	(100 per box)
10 boxes assorted flavored condoms	(144 per box)		1 case of water vials	(1000 per case)
5 boxes non-lubricated condoms	(144 per box)		8 boxes of condoms	(1000 per box)
2 boxes lubricated condoms	(1000 per box)		1 box of Aqua Lube	(1152 per box)
2 bags insertive condoms	(100 per bag)		10 boxes of alcohol swabs	(200 per box)

- If you failed to meet the Minimum Order Size, BCCDC might not process your order and will fax back the Requisition Form with mention "increase your order". Your requisition might not be processed until the next Thursday and your delivery delayed.

Notice of Volume Increase

- Programmatic changes at an authorized receiving site that would increase supply orders by more than 30% compared to the previous year must be communicated to the appropriate health authority representative at least 6 months before the changes take effect,
- Failure to notify the health authority in time threatens the financial stability of the BC HR Supply Distribution Program and may result in inequitable distribution to other regions
- For this reason, large increases in supply orders that have not been communicated in advance may be refused by BCCDC and/or the health authorities. This will be dealt with on a case by case basis and we strive to be as equitable as possible.

Receiving Supplies and Questions

Please check your order. Ensure that you receive the correct quantity and that the supplies reach you in good condition. If you notice any discrepancy, or have any questions or concerns about the distribution of harm reduction supplies please email **harmreduction@bccdc.ca**

Updated: 2018 Dec 18

Training Manual
Overdose Prevention, Recognition and Response

Table of Contents

Welcome

Thank you for taking the time to review this manual which provides education about the use of naloxone, an opioid antidote, to address the morbidity and mortality associated with opioid overdoses.

An overview of naloxone, how it works and other details related to the Take Home Naloxone program in BC (including how to become a Take Home Naloxone site) can be found at http://towardtheheart.com/naloxone/

If you are interested in additional training, or qualify for a Take Home Naloxone kit, you can search for a registered Take Home Naloxone site here: http://towardtheheart.com/site-locator

Who should use this training manual?

This training manual has been created to support any person interested in learning how to prevent, recognize and respond to opioid overdoses, and includes the key knowledge and competencies required to administer naloxone. This manual is intended for interested members of the general public and for educators in the Take Home Naloxone or Facility Overdose Response Box programs.

Learning Objectives

After reviewing this training manual, you will have an understanding of:

1) Factors that can increase or decrease the risk of an overdose
2) How to recognize depressant (including opioid) and stimulant overdoses
3) How to respond to an overdose using the SAVE ME steps, including:
    a) how to put someone in the recovery position
    b) how to communicate with 911 and why it is important to call
    c) how to prepare and administer naloxone
    d) how and when to evaluate and if and when to administer further doses of naloxone and
    e) How to support the person who has overdosed after they regain consciousness
4) The Take Home Naloxone Program

Basics of Psychoactive Substances

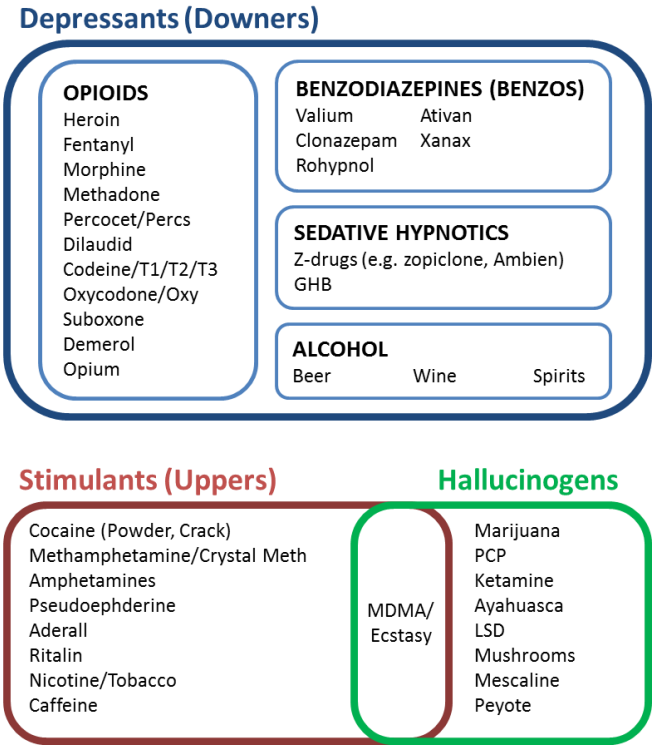
Psychoactive substances can be classified based on the effect they have on the body. The diagrams on the right show the classification of some common substances.

Depressants (or downers) tend to slow the body down (including breathing) and can make people sleepier.

Opioids are a special class of depressant. They may be prescribed or used illegally to reduce pain, manage opioid dependence or produce a state of euphoria/relaxation. Common opioids include heroin, fentanyl, morphine, methadone, codeine and oxycodone.

Stimulants (or uppers) tend to speed the body up (including heart rate) and can make people feel more alert.

Hallucinogens are drugs that can cause hallucination.



Most people have taken depressants and stimulants at some point in their life, and many use them regularly (e.g. alcohol and coffee (caffeine) and alcohol).

Overdose Risk Factors and Prevention

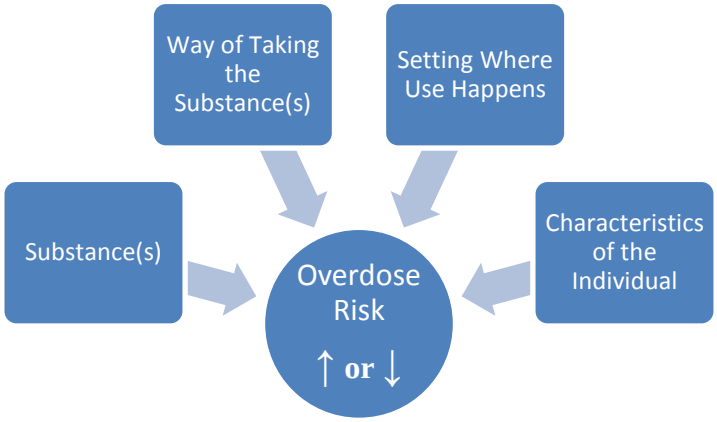
What is an overdose?

An overdose (OD) is when the body is overwhelmed by exposure to a toxic amount of a substance or combination of substances. The body becomes unable to maintain or monitor functions necessary for life, like breathing, heart rate, and body temperature regulation. Not everyone who overdoses will die; however, there can be long term medical impacts from overdose, such as brain damage from lack of oxygen.

> *Anyone can overdose regardless of their substance use history.*

Anyone can overdose regardless of their substance use history (including prescription substances). Overdose risk is complicated and depends on interaction between several factors. Overdose risk can increase or decrease depending on the substance(s) taken, how the substance is taken, the setting where use occurs and characteristics of the individual. Risk is very individualized. If several different people use the same amount of the same substance, it might affect them all differently.

The risk factors for drug overdose are shown in the diagram to the right. One of the most common risk factors for overdose is lower tolerance for a drug, which can occur because someone is new to use, or has not be using as much recently (e.g. has recently been released from prison or detox/treatment or hospital). Tolerance is discussed in more detail on pages 5-6.



Risk Factor – The Substance(s) Taken

Mixing

Taking more than one substance (including alcohol and over the counter and prescription medications) over a short period of time substantially increases overdose risk. In fact, the majority of unintentional fatal overdoses involve multiple substances, including alcohol and prescribed medications.

People may mix substances because they are unaware of the risk, or because it intensifies their high. Taking more than one downer (including opioids, alcohol and prescription benzodiazepines (benzos) like Xanax) increases the risk of an overdose. All drugs in this class decrease the rate of breathing. Despite common beliefs, stimulants will not cancel out the effects of depressants. In fact, people who use speedballs (mix uppers and downers) are at higher risk because the body has to process more drugs. Stimulants cause the body to use up more oxygen and depressants reduce the breathing rate.

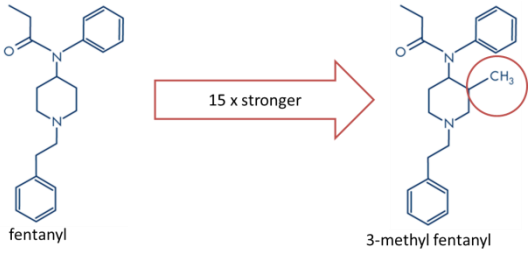
> Despite common beliefs, stimulants do not cancel out the effects of depressants.

Quantity Taken

Overdose can occur if the drugs taken (including alcohol) build up faster than the body can break them down (metabolize). This can occur by taking too much, or too frequently, or if someone is unaware of how long a specific drug lasts in the body. Some drugs are harder to measure a specific dose (e.g. GHB) or may have varying time release mechanisms (immediate vs. extended). Most benzodiazepines have at least a 12 hour half-life, and the half-life of methadone can be 24 hours or more. Many opioids come in both immediate release and sustained release formulations – however, the rate at which the drug is "available" may differ depending on the route of administration (e.g. injecting a sustained release medication may have a more toxic effect than swallowing it). Finally, the actual amount of the active drug may vary depending on how much it has been cut or buffed, making it hard to determine quantity from sample to sample.

Strength

Substances can have unknown content/adulterants due to processing (e.g. PMMA sold as MDMA). Other substances can be added before sale to the consumer either to expand the amount of product or to enhance the effects of the drugs. However, sometimes drugs are not cut prior to sale. A specific substance can have "analogues" – substances that have similar chemical structure but may differ in strength. For example, some analogues of fentanyl (e.g. 3-methylfentanyl) are stronger, while others are less strong. It is impossible to tell what is present in the drugs you purchase without scientific equipment.



THE SUBSTANCE(S) TAKEN

Risk Factor	Overdose Prevention Tips
Mixing	• use one drug at a time • if you intend to mix, use opioids before alcohol or benzos, and reduce the amount of each substance you take • let people around you know how much and what you are taking
Quantity Taken	• wait before taking another dose, knowing it can take longer to feel the effects of some drugs • not all opioids are created equal - practice caution when substituting or transitioning from one opioid for another
Potency/ Quality/Cut	• test your drugs by doing small amount at first, "two in the arm is better than one in the ground, [in the grave]". • take the tourniquet off before depressing plunger, stop half way to see the effects, inject less if it feels too strong.

Risk Factor – The Way the Substance is Taken

Regardless of how you take a drug, if you use enough of that drug in a short period of time overdose is possible. However, some ways of taking drugs are more likely to result in an overdose than others. In general, the faster a drug hits blood stream (i.e. injecting or smoking), the greater the risk of overdose. A fast injection into the vein will affect the body more quickly and intensely than ingesting (i.e. taking by mouth or swallowing); however, you can still overdose even if you don't inject.

> *Regardless of how you take a drug, if you use enough of that drug in a short enough period of time OD is possible.*

THE WAY THE SUBSTANCE IS TAKEN

Risk Factor	Overdose Prevention Tips
Route of Administration	• Be careful when changing routes – you may not be able to handle the same amount. • Consider snorting or ingesting if you are using alone or may have decreased tolerance.

Risk Factor – Individual Characteristics

Tolerance

Individuals have lower tolerance (and higher risk of overdose) when they have:

- taken a break from using (or have not been using as much or as often as usual)
- recently been in detox/treatment
- recently been incarcerated
- recently been in hospital
- recently started using
- lung, liver & other health issues (e.g. asthma, Chronic Obstructive Pulmonary Disease (COPD), Hepatitis C)

Health Status

The health of an individual can increase risk for overdose. For example, the following conditions can increase overdose risk:

- liver, kidney, and respiratory problems (e.g. hepatitis, COPD, asthma, smoking)
- compromised immune system (e.g. HIV)
- high blood pressure, heart disease, diabetes,
- infections
- sleep deprivation, dehydration, malnourishment, and
- mental health status can all play a part in overdose situations.
- had a recent overdose

INDIVIDUAL CHARACTERISTICS

Risk Factor	Overdose Prevention Tips
Reduced Tolerance	• use less • do testers • change route of administration (injecting to snorting or swallowing drugs) until tolerance is developed
Health Status	• eat, drink fluids like water, sleep • seek health care regularly as appropriate • go slow, • use less when you have been sick, lost weight, or feeling down – doing more to "feel better" is a risk factor for overdose

Risk Factor – Setting of Use

Research shows using alone or in an unfamiliar environment can increase the risk for a fatal overdose. Potential for risk is created and heightened by social-structural environments; homelessness, having to inject in public, poverty, irregular drug supply, incarceration, and unsupported mental health all put people at greater risk for overdose.

General Prevention Messages

- Get overdose prevention, recognition, and response training; carry naloxone
- Don't use alone. Make a plan and have a buddy who can call for help if needed
- Know your tolerance. If you are sick or had a time of abstinence or reduced use, use much less
- Don't mix drugs or mix drugs with alcohol
- Test a small amount first and go slow "start low and go slow"
- Use in a supervised site if possible (InSite in Vancouver)
- Call 911 right away if someone ODs
- Administer naloxone if someone ODs (it will not cause harm, and if the overdose is due to a mixture of substances, naloxone will take any opioid out of the picture)

Overdose Recognition and Response

An overdose is when the body is overwhelmed by exposure to something, in this case a toxic amount of drug or combination of drugs which cause the body to be unable to maintain or monitor functions necessary for life. These are functions like breathing, heart rate, and regulating body temperature.

Calling 911 is an important part of responding to any suspected overdose.

Calling 911 is an important part of responding to any suspected overdose. There are lots of reasons why people might not call 911; they may be afraid of legal consequences or stigma, they may believe that giving naloxone will be enough, or they may not have access to a phone. However, BC Emergency Health Services now have a policy that they will not routinely call police to respond to a suspected overdose. While there may be understandable fears about calling 911, it is important to remember that the person could die or suffer long-term consequences of an overdose if they do not receive adequate medical treatment, and if they are actually having a medical emergency that is not an opioid overdose, naloxone will not help.

Stimulant Overdoses

If the individual ***is conscious*** and experiencing "over-amping", or mental distress (i.e. crashing, anxiety, paranoia) linked to stimulant use and sleep deprivation from stimulant use:

- stay calm, remain with them, encourage them not to take any more substances, and move away from activity and noise.
- be careful not to over-hydrate, but give water or other non-sugary, non-caffeinated drink to help replace lost electrolytes
- place cool wet cloths on forehead, back of neck, armpits.

If the individual has symptoms of stimulant toxicity, including rigid or jerking limbs, in and out of consciousness, seizures, rapidly escalating temperature and pulse, or chest pains – this is a medical emergency. ***Call 911 immediately****.*

If the individual has symptoms of ***stimulant toxicity***, including rigid or jerking limbs, in and out of consciousness, seizures, rapidly escalating temperature and pulse, or chest pains – this is a medical emergency. Call 911 immediately. The person needs immediate medical attention!

While waiting for the ambulance to arrive:

- Stay with the individual for support, encourage hydration, and stay calm.
- Do not give them anything by mouth if they are unconscious.
- If they are having a seizure make sure there is nothing around them that can hurt them. Do not put anything in their mouth or restrain them.

There is no antidote to stimulant overdose. Naloxone will not help. If the heart has stopped provide chest compressions. Tell medical professionals as much as possible so they can give the right treatment to prevent organ damage and death.

Opioid Overdoses

Opioid overdoses may involve the following signs and symptoms:

- **Slow, shallow, irregular or no breathing** – less than 1 breath every 5 seconds
- **Unresponsive** – can't be woken up
- Unusual snoring, gurgling sounds, choking
- Blue lips or nails, pale cold or clammy skin
- Tiny pupils

What is naloxone?

Naloxone, previously known as Narcan®, is an antidote to an opioid overdose. It temporarily reverses the life-threatening slowed breathing from an opioid overdose. It does not work for non-opioid overdoses (like cocaine, ecstasy, GHB or alcohol). However, if an overdose involves multiple substances, including opioids, naloxone helps by temporarily removing the opioid from the equation. You can give naloxone by injection (into a muscle, vein, or under the skin) or intranasally (sprayed into the nose). In BC, the Take Home Naloxone program supplies injectable naloxone – a detailed description of how to administer an intramuscular injection of naloxone will follow this section of the manual.

> Naloxone acts fast (usually within 3-5 minutes), and the protective effect lasts for 20 to 90 minutes.

Both naloxone and opioids bind to the same sites in the brain, and these sites affect breathing. However, naloxone binds more tightly than the opioids, knocking the opioids off the receptors and restoring breathing (see picture). Naloxone acts fast (usually within 3-5 minutes), and the protective effect lasts for 20 to 90 minutes. The body will have broken down some of the opioids during that time, but naloxone does not destroy the opioids. So, if large doses of highly toxic opioids (like fentanyl), or long-acting opioids (like methadone) are involved, or the individual has liver damage, more doses of naloxone may be needed. Thus, each take home naloxone kit contains three doses of naloxone, and it is always important to call 911 when someone overdoses.

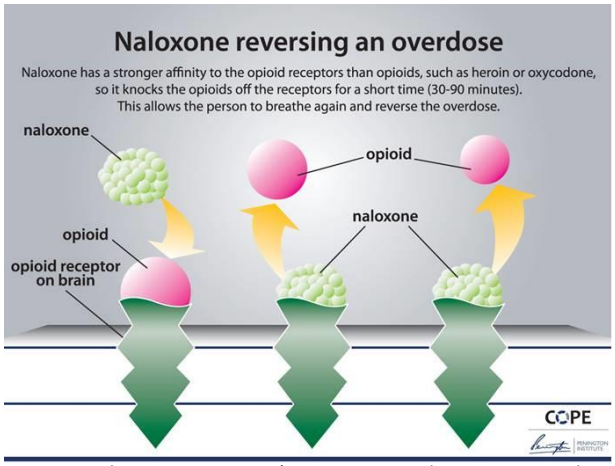


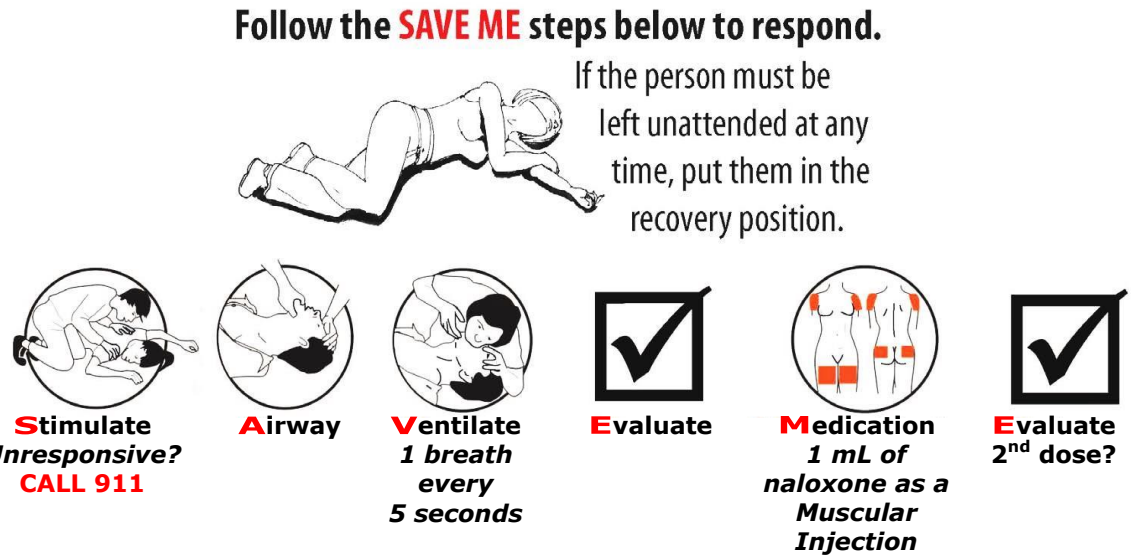
Image Credit: Penington Institute's Community Overdose Prevention and Education (COPE) Project. Adapted from artwork by Maya Doe-Simkins.

Naloxone is light sensitive, so should be stored out of the sunlight and at room temperature. Don't put it in the refrigerator.

Check the expiry dates of the naloxone periodically, it lasts about 2 years. If the naloxone gets close to the expiry date, you should return with your kit to a Take Home Naloxone site to replace the naloxone. The expiry date can be found on a sticker on the outside of the kit, or on the ampoule (see image to right).

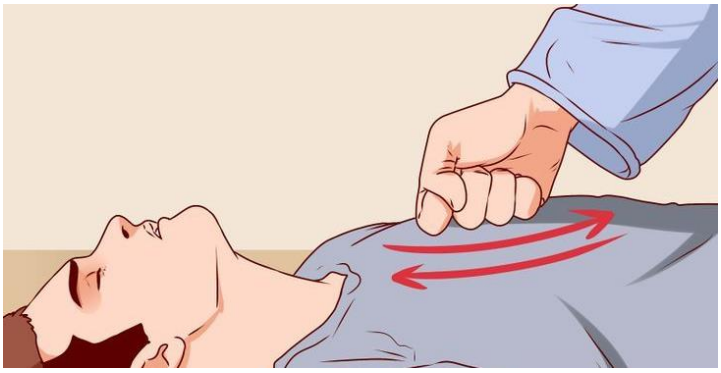
Responding to Opioid Overdose: SAVE ME

The steps involved in responding to an opioid overdose follow the SAVE ME acronym. The image below is reproduced on the inside lid of a Take Home Naloxone kit, in case you need a reminder. The SAVE ME steps will now be described in greater detail below and summarized in the diagram on page 12.

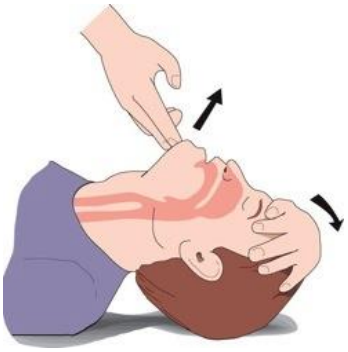


***S**timulate*

If you suspect someone might be having an opioid overdose, start by stimulating them to confirm that they are unresponsive. **Shout** at them – use their name if you know it. Next do a **sternal rub** (make a fist and rub your knuckles along the person's breast bone) or pinch the webbing between their thumb and fingers to see if they respond to pain. You should always tell someone what you are going to do before you touch them. If the person does not respond to sound or pain, then it is a medical emergency. **Call 911**. If you are alone, you can put the phone on speaker.



***A**irway*



Next, check the person's mouth for any obstructions. Items like gum, dentures, or a syringe cap could be preventing the person from breathing properly. Remove any obstructions. Once you've confirmed the mouth is clear, tilt the person's head back – this opens their airway.

***V**entilate*

The next step is to breathe for the person. Opioid overdoses slow breathing decreasing oxygen to the brain. By doing rescue breathing throughout the overdose response, you help keep oxygen going to the person's brain until the naloxone takes effect. A mask is available in the Take Home Naloxone kit to provide a barrier – you can use a piece of clothing instead if you do not have a mask. To give breaths, keep the person's head tilted back, pinch their nose, and give them 2 breaths. You should be able to see their chest rise with each breath. Continue to give 1 breath every 5 seconds until the person is breathing on their own or first responders arrive. If you are responding by yourself and do not have naloxone, or do not feel confident about administering naloxone, breaths are more important. Breaths are crucial to the overdose response. They keep the brain alive.

Breaths are crucial to the overdose response. They keep the brain alive.

If you witness someone overdose, it is likely that their heart is still beating, and only rescue breathing is necessary. If you come across someone who has overdosed and you do not know how long they have been unconscious and not breathing you should give chest compressions in addition to giving breaths. Any first aid provider can teach you how to perform chest compressions.

If you do not have naloxone, you can still save the life of someone who has overdosed on opioids. Stimulate to confirm they are not responsive, and call 911. Check their airway, and provide breaths, 1 every 5 seconds, until first responders arrive.

***E**valuate*

Sometimes giving some breaths is enough for the person to regain consciousness. If they are still unresponsive, it is time to give naloxone, if you have it. If you do not have naloxone, you can still save the life of someone who has overdosed on opioids. Stimulate to confirm they are not responsive, and call 911. Check their airway, and provide breaths, 1 every 5 seconds, until first responders arrive.

***M**uscular Injection*

Naloxone comes in glass ampoules that need to be opened. Hold the ampoule by the top and swirl to bring all the medication to the bottom. Gently but firmly snap the ampoule top off away from your body. The plastic amp snapper is there to protect your fingers. You can watch a video on how to open a naloxone ampoule here: https://vimeo.com/178537637

Remember – someone should be doing rescue breathing.

Draw up all of the liquid into the syringe – make sure the needle tip is at the bottom of the ampoule so you get all the medication. To remove the air, turn the syringe so the needle is pointing up and push the plunger in until most of the air is gone. It is OK to leave a little air because you are injecting into a muscle. Firmly put the needle straight into a large muscle (preferably the thigh, but the upper arm and butt are also OK) at a 90 degree angle. The needle will go right through clothes. Push the plunger in until you hear it click – this is the needle retracting into the syringe.

***E**valuate*

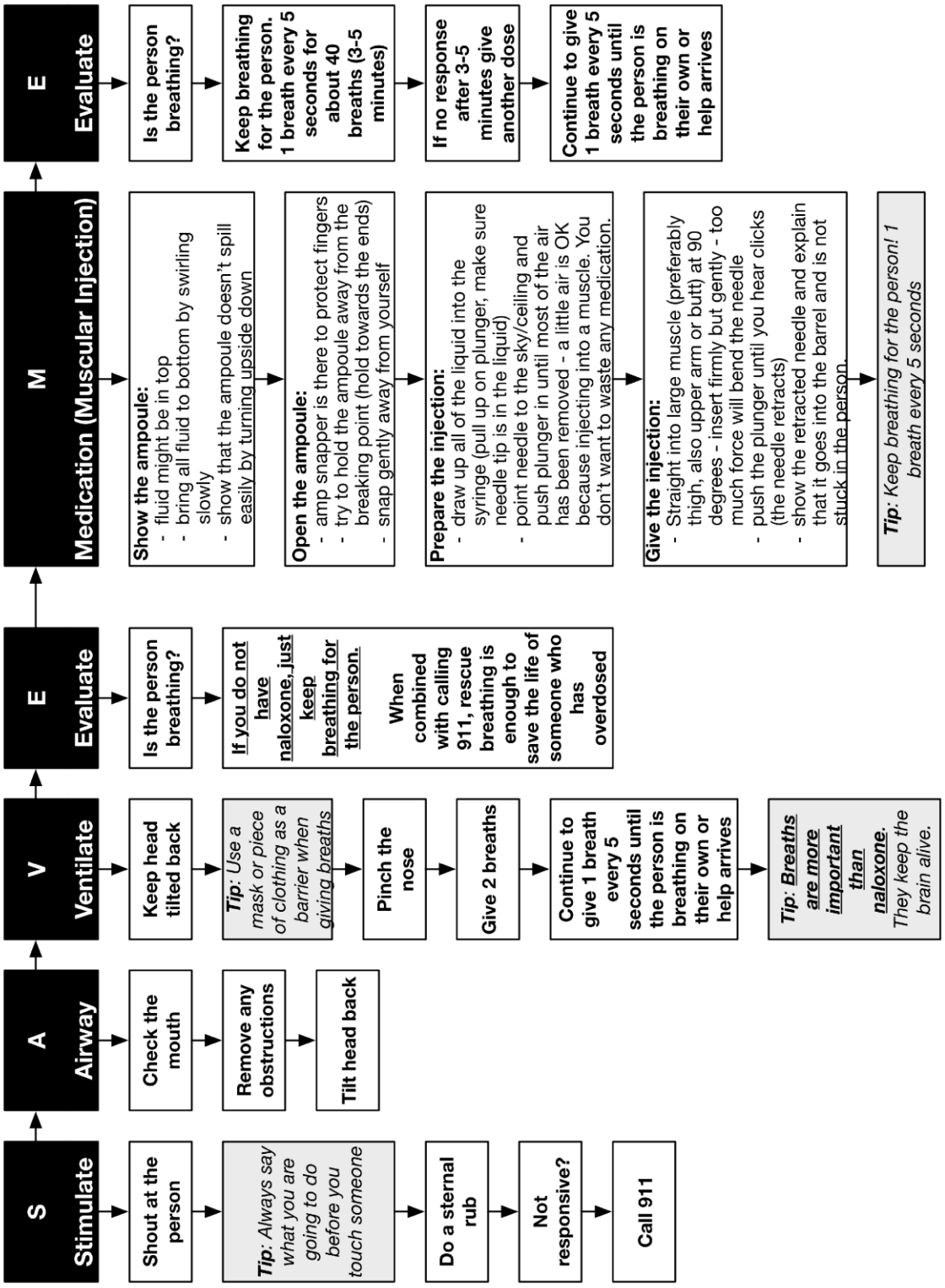
Monitor the person to see if they respond to the naloxone. Do they start breathing again? Do they regain consciousness? Keep giving 1 breath every 5 seconds.

If the person has not regained consciousness by 3-5 minutes (give approximately 40 breaths) then you can give a second dose of naloxone.

Monitor the person after each dose is given, for 3-5 minutes (approximately 40 breaths) before giving additional doses.

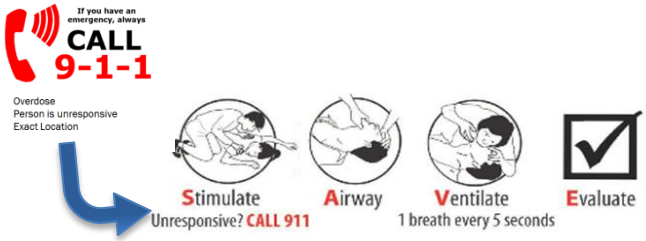
While naloxone is a safe medication, individuals that are dependent on opioids may experience unpleasant withdrawal symptoms like pain, sweating, agitation and irritability. For this reason, it is important to give the lowest dose of naloxone required to reverse the overdose. Naloxone can take 3-5 minutes to work, so waiting 5 minutes between doses is important.

This diagram explains step by step how you would respond to an opioid overdose using SAVE ME, including detailed instructions on how to administer naloxone.



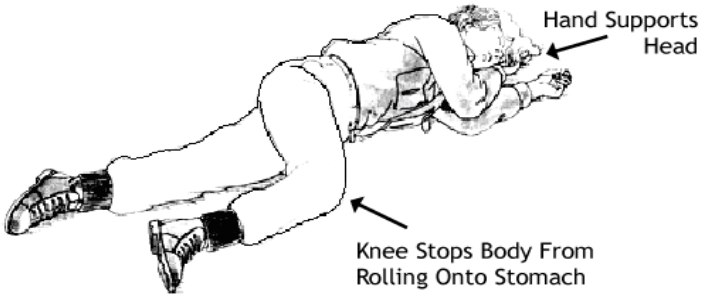
Responding to a non-opioid depressant overdose

Non-opioid depressant overdoses (e.g. Xanax, alcohol, GHB) look like opioid overdoses (since opioids also act as depressants). If you are certain that someone has not taken any opioids, support the person similarly to an opioid overdose without the administration of naloxone. In other words, respond with the SAVE steps until the help arrives. Calling 911 is very important. Naloxone has no effect on depressant overdoses that do not involve opioids. However, if the overdose involves multiple substances including opioids, it will temporarily take opioids out of the picture and if opioids are not involved, administering naloxone will not be harmful (it will have no effect).



The Recovery Position

If you have to leave an unconscious/unresponsive person at any point, put them in the recovery position. This helps to keep the airway clear from their tongue or vomit allowing them to breathe properly. During an opioid overdose, slowed breathing can cause the lungs to fill up with excess fluid – if you are not actively working on an individual (giving breaths or administering naloxone) put them in the recovery position.



To put someone in the recovery position, hold the leg and arm on the side of their body closest to you and **roll them away from you**. In the picture above it is the **right leg** and the **right arm** that get bent

Aftercare

It is important to stay with someone who has overdosed after giving naloxone because:

- when the person wakes up they may have no memory of overdosing or receiving naloxone – explain to them what happened
- the person should be discouraged from using more opioids for at least 2 hours. Symptoms of withdrawal sickness if they occur will start to wear off in half an hour. Using more opioids will be a “waste”. While naloxone is in their system it blocks opioids from getting to receptors and they will continue to feel sick; using more opioids will also make the overdose more likely to return
- to tell the emergency response team as much as you know – what they took and what you have done so far

Should you give breaths or compressions?

> *If you come across someone who is unresponsive and not breathing, and you do not know how long they have been unconscious, you should give chest compressions in addition to breaths.*

The CPR Guidelines recently changed to "hands-only" CPR in Canada and US. However, where the individual is a child or an adult who has stopped breathing (choking, strangulation, drowning, or other respiratory issues) mouth-to-mouth improves survival. Most overdose response programs recommend giving breaths in an opioid overdose because the person is lacking oxygen in their blood. When someone is overdosing due to opioids it is the breathing that is first affected and the heart is still beating therefore it is important to get oxygen into the blood

Only if the person has been oxygen deprived for a long time or are without a heartbeat should they receive chest compressions. If you come across someone who is unresponsive and not breathing, and you do not know how long they have been unconscious you should give chest compressions in addition to breaths.

Videos

Watch any or all of the following instructional videos to review the content covered in this manual.

- **Naloxone Saves Lives** (12:49 min) **https://vimeo.com/164669763**
- **Naloxone Wakes You Up** *(youth focused)* (6:29 min) **https://vimeo.com/180116125**
- **SAVE ME Steps to Save a Life** (3:21 min) **https://vimeo.com/185012011**

Introduction to BC Take Home Naloxone Program

The BC Take Home Naloxone kits contains:

- SAVE ME instructions in the lid.
- Alcohol Swabs
- Gloves and a breathing mask to protect the responder
- 3 Vanishpoint® syringes
- Pill bottle containing 3 ampoules of naloxone
- An overdose response information form to be completed after the naloxone has been used.

Legal Considerations

A bystander who provides emergency first aid, including administration of naloxone is protected from liability by the BC Good Samaritan Act.

Liability related to various aspects of naloxone is a common concern. There are no known cases of legal action related to naloxone. In fact, a bystander who provides emergency first aid, including administration of naloxone is protected from liability by the BC ***Good Samaritan Act***.

Everyone, including healthcare professionals, first responders, social workers, and laypeople are legally permitted to administer naloxone to someone appearing to be suffering from an opioid overdose outside of a hospital setting. Also, the *Health Professionals Act* was recently amended allowing all regulated health professionals to administer naloxone; previously, they were not supported to do so by their regulations.

Where can you get naloxone?

As of March 22, 2016, naloxone is an unscheduled medication in BC which means there are no restrictions on where it can be sold, and individuals purchasing it do not have to provide their name.

Everyone who is interested in learning how to save a life is encouraged to receive overdose prevention, recognition and response training.

- Anyone can purchase naloxone from a pharmacy or other provider.
- In order to receive a naloxone kit at no charge from a BCCDC-approved take home naloxone site, a person must have completed the Take Home Naloxone training and be "most likely to witness and respond to an opioid overdose."
- The BC Facility Overdose Response Box program is one way people can get naloxone for use at their workplace, if they work at non-profit sites where people who use opioids attend or reside.
- Everyone who is interested in learning how to save a life is encouraged to receive overdose prevention, recognition and response training.

Resources

- **Information on the BC Take Home Naloxone Program:** http://towardtheheart.com/naloxone/
- **Paperwork for Registered Take Home Naloxone Sites:** http://towardtheheart.com/naloxone/thndocumentation/
- **Educational Materials:** http://towardtheheart.com/naloxone/siteresources/
- **Training Videos:**
    - Naloxone Saves Lives (12:49 min) https://vimeo.com/164669763
    - Naloxone Wakes You Up *(youth focused)* (6:29 min) https://vimeo.com/180116125
    - SAVE ME Steps to Save a Life (3:21 min) https://vimeo.com/185012011

Learning Objectives Checklist

Here is a checklist that summarizes material covered by this manual.

☑	TOPIC	IMPORTANT DETAILS
☐	**Overdose Prevention**	• **MIXING**: opioids with downers OR opioids with uppers (Prevention: don't mix, or if do, use drugs before alcohol) • **TOLERANCE**: also taking Rx drugs, after periods of non-use or lower use e.g. jail, detox/abstinence, hospital, new use (Prevention: use less at these times) • **QUALITY OF STREET DRUGS**: unpredictable (Prevention: do testers, go slow, use a consistent reliable dealer) • **USING ALONE**: behind closed locked door when no-one knows (Prevention: tell someone before you use, leave door unlocked) • **HEALTH**: liver, breathing problems, lack of sleep, dehydration, infections (Prevention: eat, drink, sleep, see doctor, carry inhaler)
☐	**Signs and Symptoms of Opioid OD** *(Naloxone only works for opioid OD – NOT for non-opioid depressants like alcohol or benzos BUT if you don't know, naloxone won't hurt)*	• e.g. heroin, morphine, fentanyl, oxy, Dilaudid, T3, methadone • opioid OD = too much drugs, breathing slows, not enough oxygen to the brain **(less than 1 breath every 5 seconds)** • **Key feature: UNRESPONSIVE & SLOW/SHALLOW/IRREGULAR BREATHS** • May also observe: (1) blue lips/ fingernails; (2) snoring/gurgling
☐	**Signs and Symptoms of Stimulant Overdose** *(or 'overamping')*	• e.g. crystal meth, cocaine, crack, MDMA, caffeine, nicotine • Chest pains, dizziness, rapid heartbeat, extreme agitation • Lots of sweat or no sweat • Seizures/convulsions, foaming at the mouth • Paranoia, delusions, psychosis • **MEDICAL EMERGENCY – CALL 911 – NALOXONE WON'T WORK**
RESPONDING TO AN OPIOID OD		
☐	**CONFIRM UNRESPONSIVE**	• **Stimulate** with: **Noise** (shout, use their name), **Pain** (ex. sternal rub) – Remember, tell person what you are doing before you touch them
☐	**CALL 911**	• Put person in the recovery position if you have to leave them alone
☐	**CLEAR AIRWAY & GIVE BREATHS**	• Clear airway (is there anything in their mouth?), tilt head, lift chin • Pinch nose and give 2 breaths. • Continue **1 breath every 5 seconds until person is breathing again** • If you do not know how long someone has been unconscious and not breathing, you should give both chest compressions and breaths.
☐	**GIVE INTRAMUSCULAR NALOXONE** *(demonstrate if possible)*	• Swirl ampoule, snap top off, draw up all of the naloxone, remove most of the excess air • Inject into large **muscle** – **THIGH**, upper arm or butt • Inject at 90°, push plunger until you hear a click (needle will retract)
☐	**EVALUATE EFFECTS (for 4-5 minutes) & GIVE MORE NALOXONE IF NEEDED**	• **Continue to give breaths FOR 3-5 MINUTES** (**about 40 breaths**) OR until they respond (are breathing again on their own). • **After 5 minutes, if still unresponsive, give a 2nd dose of naloxone** • **Continue breaths** until person breathing OR paramedics arrive
☐	**AFTERCARE**	• Naloxone wears off in 20-90 minutes • Person will not remember ODing – explain what happened • If person does NOT go to hospital monitor at least 2 hours and do NOT allow them to take more opioids (could OD again)
☐	**CARING FOR NALOXONE**	• Naloxone should be stored out of the light at room temperature • Be aware of the expiry date – it is on the ampoule

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TAKE HOME NALOXONE PROGRAM PACKAGE

This package includes all of the documents needed to help you and your community register with the Take Home Naloxone (THN) program.

This Package Includes:

- [ ] **Program Overview**
  General information on naloxone, the two different ways you can administer naloxone, how to access it if you are Status First Nations, and how you can register as a Take Home Naloxone site.
- [ ] **Registration Checklist**
  Step by step checklist that helps guide you in becoming a new Take Home Naloxone site
- [ ] **New Site Registration Form**
  When you become a distribution site, you can provide injectable naloxone kits to people in your community to have on hand to respond to an overdose.
- [ ] **Order Form**
  To have naloxone kits and training supplies delivered to your site, once you become registered
- [ ] **Distribution Record**
  to keep track of how many naloxone kits that have been distributed, it is helpful if a copy of this form is faxed or emailed to the BCCDC for our records and to keep the program running.
- [ ] **Additional Resources**
  Naloxone Frequently Asked Questions
  Overdose Brochure
  Training Materials

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PROGRAM OVERVIEW

Contents

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1 - Introduction

This package provides information about:

- The medication Naloxone (also known as Narcan®),
- How to access naloxone if you are Status First Nations or Inuit,
- The two different types of naloxone,
- How you can register as a Take Home Naloxone (THN) site,
- And additional resources that may be useful to you.

2 - What is Naloxone?

Naloxone is medication that reverses an opioid overdose. Opioids are considered a depressant also known as downers. These types of drugs slow down the body and some examples include dilaudid, morphine, heroin, and oxycontin. When taken in higher doses, opioids can slow breathing and in some cases even stop it. It is helpful to know that overdoses from alcohol, non-opioid depressants, and stimulants (e.g. crack, meth) have different presentations and are reversed in different ways. In the case of an opioid overdose when naloxone is given, it blocks the effects of any opioids someone has in their system. If someone is unconscious and not breathing due to an opioid overdose, naloxone will reverse the effect opioids have on breathing patterns and helps return it to normal. However, it is extremely necessary to give breathes during this process as someone who is unconscious and not breathing for any length of time can easily get brain damage.

For more information, please see the **Naloxone FAQ** resource included in this package.

3 - How has Access to Naloxone Changed?

Access to Naloxone has changed a lot (and quickly) over the past 4-5 years. Initially only doctors could prescribe the medication to be dispensed at a pharmacy, much like other types of medications. As a workaround to limitations of prescription naloxone, nurses advocated for it to be a part of their dispensing practice and the province agreed. This was helpful to restructuring access to naloxone as nurses were able to take on the responsibility of training and dispensing naloxone without needing a doctor or pharmacy to be involved.

More recently, when the public health emergency was declared in 2016 due to opioid overdose deaths, naloxone access changed significantly. Under the new health regime naloxone no longer requires a prescription, and anyone can be trained to give, and train others to give, injectable naloxone in the event of experiencing or witnessing an overdose. ‘Take Home Naloxone’ soon became more rapidly available at different sites across the province.

4 - Two Different Administration Routes

Currently, there are two ways naloxone can be administered – via intramuscular injection and as a nasal spray. Injectable naloxone is available to the general public through participating sites of the BC Centre for Disease Control (BCCDC) naloxone ordering program; also called the 'Take Home Naloxone Program' or THN Program for short. Sites involved in the program must register before they can distribute Naloxone. There are 'Take Home Naloxone Sites' (THN Sites) all across the province which can distribute injectable naloxone.

For people who have First Nations Status, intranasal naloxone is also available at no cost through the First Nations Health Benefits (FNHB) at a local pharmacy.

I - Injectable Naloxone

Injectable Naloxone (also called Intramuscular or IM naloxone) is administered by injecting the medication into a large muscle in the body, such as the upper arm, thigh or buttocks.

How Do I get Injectable Naloxone (Individuals)?

Injectable naloxone is provided inside all BC Take Home Naloxone (THN) kits. These kits can be obtained for administration, at no cost, within your community without a prescription from 'Take Home Naloxone Sites' across the province, including registered community pharmacies.

You can find THN Sites near you here: https://towardtheheart.com/site-finder

About the Take Home Naloxone (THN) Injectable Naloxone Kits

THN kits provide **injectable** naloxone medication and everything you need to give the injection.

Each Take Home Naloxone Kit Includes:

- 3 x Naloxone, 0.4 mg/mL, 1 mL ampoule in capped and labelled amber medication bottle
- 3 x Vanish Point® 3 mL syringe
- 3 x Alcohol Prep Pad
- 1 x pair of non-latex gloves
- 1 x Individual breathing mask in pouch
- 1 x SAVE ME Steps instructional sticker
- 1 x Overdose Administration Form*

The overdose administration form is included inside every THN kit. These forms provide valuable information to the BCCDC about the ways and how often naloxone is used, which helps to inform our program; however the completion and return of these forms are **optional.*

II - Nasal Naloxone

Nasal naloxone (also called Intranasal or IN naloxone) has the same effect as injectable naloxone but may be more appropriate for individuals who are not comfortable using needles. Nasal naloxone is administered by spraying the medication into an individual's nostril.

About the Nasal Naloxone Kits

When pharmacies provide **nasal** naloxone medication, it should include and everything you need to respond to an overdose.

This includes:

- 2 x Naloxone 4 mg nasal spray devices
- 1 x pair of non-latex gloves
- 1 x Individual breathing mask
- Carrying Case

How do I get Nasal Naloxone (Individuals)?

Nasal naloxone is **not** currently available for ordering through the BCCDC's THN program however it may be obtained from a local pharmacy.

Intranasal is covered by First Nations Benefits where a **status card** and **personal health number** are provided.

- Individuals may request kits for themselves, for friends, and loved ones.
- While the individual does not need to specify who the naloxone is for, it will be billed to the FNHB program under the name of the person requesting it.
- Training can be obtained at the pharmacy

It is **important to note** that because nasal naloxone is newly listed, it is best to call the pharmacy ahead of time as nasal naloxone may not always be available. That being said, the pharmacy is able to order the medication for anyone requesting it.

Additional Resources

You can learn more about Nasal Naloxone here:

- http://www.fnha.ca/Documents/FNHA-Nasal-Naloxone-Fact-Sheet.pdf
- and here: https://www.narcannasalspray.ca/en

And you can find more information on naloxone coverage here:

- http://www.fnha.ca/wellnessContent/Wellness/FNHA-Naloxone-Info-for-Community.pdf

5 - What is involved in Registering a THN Site?

There are a few things to consider before registering as a site:

- Firstly, we recommend you connect with your local Harm Reduction Coordinator before signing up as a Take Home Naloxone site. This is to ensure there are built in supports for your organization to distribute naloxone, and to offer local guidance along the way.

Health Authority	Name	Phone	Email
First Nations	Janine Stevenson	604-693-6964	Janine.Stevenson@fnha.ca
Fraser	Erin Gibson **(Fraser South)**	604-930-5404 Ext 765862	Erin.Gibson@fraserhealth.ca
	Katherine Moriarty **(Fraser North)**	604-930-5404 Ext 765717	Katherine.Moriarty@fraserhealth.ca
	Lianne Radmore **(Fraser East)**	604-702-4909	Lianne.Radmore@fraserhealth.ca
Northern	Reanne Sanford	250-991-7571	Reanne.Sanford@northernhealth.ca
Interior	Jessica Bridgeman	778-257-5711	Harmreduction.coordinator@interiorhealth.ca
	Lesley Coates	250-306-2149	Harmreduction.coordinator@interiorhealth.ca
	Jennifer Driscoll	250-320-5710	Harmreduction.coordinator@interiorhealth.ca
Vancouver Coastal	Kimberly Murphy **(Vancouver Harm Reduction)**	604-862-0317	Kimberly.Murphy@vch.ca
	Rebecca Thomas **(Vancouver Naloxone, Outside Vancouver All Services)**	604-729-9210	Rebecca.Thomas@vch.ca
Vancouver Island	Griffin Russell	250-739-5777 Ext 53065	Griffin.Russell@viha.ca
	Tracey Thompson	250-370-8111 Ext 33431	Tracey.Thompson@viha.ca

- Secondly, we have found it is helpful if you identify whether your site (organization) is already registered as a site. You may not even need to register at all as the address of your organization may already be on file. To find out you can call 604-707-2736 and **ask to speak with the Harm Reduction Team** or email naloxone@bccdc.ca.

If your location is not already considered a site and you would like to register **and** you have connected your local Harm Reduction Coordinator, please refer to the **Registration Checklist** below. A new site needs to complete a form to become registered. Once registered you may place orders for injectable naloxone THN kits and training supplies directly from the BCCDC.

Kits can be provided to individuals at risk of experiencing an overdose, or those likely to witness an overdose including family, friends, and other community members.

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6 - What are Distribution Records?

All participating THN sites are encouraged to provide the BCCDC with **Distribution Records** that includes non-identifying information about individuals receiving a kit. This helps us keep track of how much naloxone is going out and being used across the province, and helps keep our program going.

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TAKE HOME NALOXONE: DISTRIBUTION RECORD
Once full, FAX this form to 604.707.2516

Site ID# ________ Full Site Name ____________________ City ____________

DATE KIT GIVEN OUT	KIT RECIPIENT DESCRIPTION: OD RISK	GENDER	AGE RANGE (YRS)	1ST KIT OR REPLACEMENT	NOTES **Optional Site Use** (not required by BCCDC)
MM/DD/YYYY	☐ At risk of OD ☐ Not at Risk	☐ Male ☐ Female ☐ Other	☐ < 19 ☐ 19-30 ☐ 31-60 ☐ > 60	☐ 1st Kit ☐ Replacement (Last Kit Used) ☐ Replacement (Other Reason)	
MM/DD/YYYY	☐ At risk of OD ☐ Not at Risk	☐ Male ☐ Female ☐ Other	☐ < 19 ☐ 19-30 ☐ 31-60 ☐ > 60	☐ 1st Kit ☐ Replacement (Last Kit Used) ☐ Replacement (Other Reason)	
MM/DD/YYYY	☐ At risk of OD ☐ Not at Risk	☐ Male ☐ Female ☐ Other	☐ < 19 ☐ 19-30 ☐ 31-60 ☐ > 60	☐ 1st Kit ☐ Replacement (Last Kit Used) ☐ Replacement (Other Reason)	
MM/DD/YYYY	☐ At risk of OD ☐ Not at Risk	☐ Male ☐ Female ☐ Other	☐ < 19 ☐ 19-30 ☐ 31-60 ☐ > 60	☐ 1st Kit ☐ Replacement (Last Kit Used) ☐ Replacement (Other Reason)	

I - Are Distribution Records Mandatory?

While we encourage the completion of distribution records, questions should not present a barrier to anyone wishing to be given a kit. Completing the date field will count as a record if no further information is provided.

The BCCDC will not suspend a site's participation in the program of distribution records are not completed. For inventory purposes only, the BCCDC may be in contact periodically to ask your site to estimate any undistributed kits on-site.

TAKE HOME NALOXONE REGISTRATION CHECKLIST

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☐ STEP 1: COMPLETE THE REGISTRATION FORM

- Complete the **New Site Registration Form** included in this package
- Please include details for delivery including an address, phone number and hours for delivery
- Please include a contact name or email so that we can keep you informed of any important program updates.

☐ STEP 2: COMPLETE THE ORDER FORM

- Complete the Order Form included in this package
- For your first order, we recommended an amount of 10-20 kits.
- Orders are processed weekly (Thursdays) and you may order as frequently as needed.
- We recommend allowing 10 business days for delivery

☐ STEP 3: SEND THE COMPLETE FORMS TO THE BCCDC:

⇨ **By Fax:** 604-707-2516

⇨ **By Email:** naloxone@bccdc.ca

⇨ **By Post:** Harm Reduction Team
BC Centre for Disease Control
655 12th West Avenue
Vancouver, BC
V5Z 4R4

WHAT HAPPENS NEXT?

Once the BCCDC has received your forms, we will contact your site to confirm receipt and provide you with a 4 digit site number. We request that this number be used on future **order forms** and on completed **distribution records.**

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TAKE HOME NALOXONE:

New Site Registration Form

SITE DELIVERY/COMMUNITY DETAILS *Note that kits can NOT be mailed to a PO Box or Bag								
Site/Community Name:								
Address	Street #		Street Name:		Street Type:		Direction:	
	City:					Postal Code		

SITE CONTACT (Who will be the main site contact for the program/contact for BCCDC correspondence)				
	First Name	**Last Name**	**Phone Number**	**Email *(recommended)***
Contact 1				
Contact 2				

DELIVERY INSTRUCTIONS					
Phone Number		*Special Delivery Instructions (ex. buzzer #)*			
Hours of Operation (For Delivery)	Monday:		Closed for Lunch:		
	Tuesday:		Closed for Lunch:		
	Wednesday:		Closed for Lunch:		
	Thursday:		Closed for Lunch:		
	Friday:		Closed for Lunch:		

Note: *Delivery Hours are Monday to Friday between 9am and 5pm. Please indicate availability between these hours.*

OPTIONAL: *You may map your site/community for the* ***public*** *in the searchable site finder at www.towardtheheart.com.*

☐ *If* ***YES****, please confirm:*

- ***Public Street Address:*** _____
- ***Public Phone Number:*** _____

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TAKE HOME NALOXONE : SUPPLY ORDER FORM
Registered Sites Only

E-mail form to naloxone@bccdc.ca - If you don't have e-mail, please fax to 604-707-2516

Email naloxone@bccdc.ca for queries, follow-ups or changes to orders.
Please allow 10 working days for delivery and plan ahead to avoid shortages.

BC Centre for Disease Control
AN AGENCY OF THE PROVINCIAL HEALTH SERVICES AUTHORITY

Site # **Site Name**:	**Date Submitted:**
Contact Name:	**Delivery Days & Times:**
Shipping Address:	**Phone/Email:**

Products	Contents	Unit of Issue	Quantity Ordered
Completely Assembled THN Kit	1 x Black case 3 x Naloxone, 0.4 mg/mL, 1 mL ampoule 3 x Vanish Point® 3 mL syringe 1 x 1 x Amber medication bottle with label 3 x Plastic ampoule breakers 1 x Pair of non-latex gloves 3 x Alcohol swabs 1 x Individual breathing mask in pouch	1 kit	_____**Kits**
Naloxone Replacement Bottles (to refill used kits)	3 x Naloxone, 0.4 mg/mL, 1 mL ampoule 1 x Amber medication bottle with label 3 x Plastic ampoule breakers Kit ID stickers for re-labelling existing kit	1 bottle	_____**Bottles** (Kit Refills Only)
Mock Kit (for training purposes)	1 x Black Case 3 x Water ampoules, 1 mL 3 x Vanish Point® 3 mL syringe 1 x Amber medication bottle with label 3 x Plastic ampoule breakers 1 x Pair of non-latex gloves 3 x Alcohol swabs 1 x Individual breathing mask in pouch	1 kit	_____**Kits** maximum: 5
		Circle Quantity Required	
Loose Supplies (for replacement kits or training purposes)	Vanish Point® 3 mL syringe	100 200 300	
	Plastic ampoule breakers	100 200 300	
	Water ampoules, 1 mL	100 200 300	
	Individual breathing mask in pouch ***(Available only for kit refills only, quantity ordered should match quantity of 'Naloxone Replacement Bottles' ordered)***		
	OD Survival Guide Brochure - English	50 100 150 200 250 300	
	Box non-latex gloves		

This form is only for approved sites participating in the Take Home Naloxone program.

- Naloxone Saves Lives - https://vimeo.com/164669763
- Naloxone Wakes You Up - https://vimeo.com/hellocoolworld/review/180116125/5bbda65390

Take Home Naloxone Supply Ordering at the BCCDC

To receive Take Home Naloxone supplies, sites must be registered in the program. To learn more, visit http://towardtheheart.com/naloxone/.

General Notes about Supplies

- Any changes to supplies will be posted on towardtheheart.com and made to the Supply Requisition Form
- Use older supplies first. Remember: First In, First Out (FIFO)
- Naloxone has shelf-life of ~2 years. Check the expiry of your kits before dispensing to clients
- Naloxone within 3 months of expiration should not be dispensed to clients. Order new naloxone for replacement

BCCDC Weekly Processing

- To order supplies, fill out the attached Take Home Naloxone Supply Requisition Form and fax it to 604-707-2516.
- For timely processing, we recommend submitting your order by Wednesday. All orders received after the cut-off time of 11:59pm on Wednesday will be processed the following week and delivery will be delayed.
- The supplies will be packaged at the BCCDC pharmacy during the week following the placement of the order. The packages will then be shipped out to the site. **Delivery time is expected to be 10 working days.**
- To avoid disruption of services, plan ahead and place an order before you run out of stock.
- Please ensure the THN program coordinator is informed of changes to contact information to avoid the requisition form from not being processed.

How Much to Order

- Sites are encouraged to order no more than once a month
- Naloxone has a shelf-life of ~2 years. To ensure that clients are given naloxone kits that have the longest possible shelf-life, we encourage sites to order enough supplies to distribute for 2-3 months.
- Typical order sizes:
    - Smaller sites: 20 kits
    - Larger sites: 50 kits
    - New sites: 10 kits
- BCCDC staff may need to follow up with the sites placing unusually large or small orders
- We recommend ordering 1 syringe, 1 water ampoule and 1 OD survival guide brochure for every kit ordered. Sites training a large number of staff or family/friends of clients should order additional training supplies as needed. Smaller sites may order smaller quantities of loose supplies.

Receiving Supplies and Questions

- Please check your order upon receipt. Ensure that you receive the correct quantity and that the supplies reach you in good condition. If you notice any discrepancy, or have any questions or concerns about the distribution of take home naloxone supplies, please email naloxone@bccdc.ca

towardTHEheart.com
BCCDC HARM REDUCTION SERVICES

TAKE HOME NALOXONE: DISTRIBUTION RECORD

Once full, FAX to 604-707-2516 or email to naloxone@bccdc.ca

Site ID# ________ **Full Site Name** ______________________________ **City** ______________

DATE KIT GIVEN OUT	KIT RECIPIENT DESCRIPTION				NOTES **Optional Site Use** (not required by BCCDC)
	OD RISK	GENDER	AGE RANGE (YRS)	1ST KIT OR REPLACEMENT	
MM/DD/YYYY	☐ At risk of OD ☐ Not at Risk	☐ Male ☐ Female ☐ Other	☐ < 19 ☐ 19-30 ☐ 31-60 ☐ > 60	☐ 1st Kit ☐ Replacement (Last Kit Used) ☐ Replacement (Other Reason)	
MM/DD/YYYY	☐ At risk of OD ☐ Not at Risk	☐ Male ☐ Female ☐ Other	☐ < 19 ☐ 19-30 ☐ 31-60 ☐ > 60	☐ 1st Kit ☐ Replacement (Last Kit Used) ☐ Replacement (Other Reason)	
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A PROJECT OF THE PROVINCIAL HARM REDUCTION PROGRAM

TAKE HOME NALOXONE: DISTRIBUTION RECORD

Once full, FAX this form to 604.707.2516

Site ID# ________ **Full Site Name** ______________________________ **City** ________________

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Running a Pop-Up Overdose Prevention Service Site

(Injection or Smoking)

Version 1.0 – February 27, 2019

Acknowledgement

The BCCDC would like to gratefully acknowledge and thank our colleagues at ARCHES (Lethbridge, AB), Vancouver Coastal Health, and Insite (Vancouver, BC) for their generosity and assistance in sharing their policies, procedures, and protocols.

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1 – INTRODUCTION

I - Objectives

Pop-Up Overdose Prevention Service (OPS) Sites consist of a tent or other enclosure where people can be supervised when injecting or smoking drugs and receive emergency overdose response as needed. Although not technically legal, "pop-up" sites are supported by the B.C. Ministry of Health. At an OPS Site, peers or other (typically non-nursing) staff can monitor people who have used drugs for signs of overdose. When an overdose occurs, there can be rapid intervention using naloxone or providing oxygen if needed. Generally Overdose Prevention Service Sites have the following objectives:

1. Reduce non-fatal and fatal overdoses;
2. Improve the physical health and social well-being of people who consume drugs;
3. Reduce unsafe consumption practices that increase risk for injury and disease transmission (HIV, HCV & blood borne infections) and other drug related health harms;
4. Increase uptake into health and social services, including drug treatments and therapies;
5. Reduce the use of health services, including hospitalization, by preventing infections, and communicable disease transmission associated with having to consume drugs in unsafe, unhygienic environments, sharing needles, and following unsafe needle practices under stress;
6. Increase community safety by reducing some of the public safety harms associated with drug use (e.g., public drug use, discarded injection equipment).

II – Goals

In general, the central goals of a Pop-Up OPS Site are to reduce the harms associated with drug use and promote the health of People Who Use Substances (PWUS) by:

1. Providing a supervised and hygienic facility to use drugs, under the supervision of a health care professional.
2. Reducing the risk of overdose and the number of overdose deaths in the community.
3. Increasing access to low barrier services.
4. Reducing ambulance calls for overdose (also reducing the duration of EMS attendance by intervening very early in the OD).
5. Reducing the transmission of blood borne pathogens including HIV and hepatitis C.
6. Reducing the incidence of potentially serious infections leading to conditions such as endocarditis and osteomyelitis requiring hospitalization.
7. Reducing the incidence of soft tissue injuries, including abscesses and cellulitis.

8. Providing access to injection and inhalation equipment.
9. Providing referrals to other health and service providers in the area.
10. Connecting clients with peer support services,

III – Guiding Principles

Although every organization guiding principles will be slightly different, some guiding principles groups may want to consider are:

1. The obligation of the healthcare system to create a place where drug users have access to health care services when they require them.
2. The improvement to population health through increasing access to health care.
3. The Harm Reduction Model, which encourages people to reduce the risks involved in their drug use activities/behaviours, while respecting choices they make.
4. The necessity of offering equitable supports and services to all clients
5. The necessity on an entry point where people can begin accessing health care and be supported in moving along the continuum in a coordinated and supported way
6. The importance of work with other community organizations to provide a continuum of care and ensure folks accessing the OPS Site have support and access to services as needed.

Folks who access Overdose Prevention Services develop trusting relationships, seek support, accept advice, discuss referrals and even obey rules not because they are expected to do so, but because the preconditions are made possible by staff attitudes and behaviours.

In general, an approach that is tailored to each individual, rather than a “one-size fits all” approach, must be adopted. Having staff tailor their approach to fit individuals is a way of levelling the playing field so that a wide variety of vulnerable people can obtain and maintain access to an OPS Site.

Ultimately, this work is about building trust and recognizing and respecting the fundamental humanity in all of us.

Relationship-building is foundational to harm reduction and is an on-going process. Essential staff attributes include:

- A sensitive working knowledge and understanding of the local community and the history of the site.
    - A capacity to accept and respect people in this population.
- Self-awareness, an open mind and an ability and willingness to acknowledge one's own triggers.
- An ability to set and maintain one’s own boundaries as well as to respect the boundaries of others.
- An ability to accept that all people make progress in their own way and at their own time.
- A capacity for sympathy.
- An ability to properly assess and disengage should an intervention not be successful or welcomed.
- A willingness to work as a team and be responsive to changing approaches as necessary.
- A sense of humour.
- Good personal support networks and habits of self-care.

IV – Pop-Up Overdose Prevention Sites and Legality

Before moving forward, it is important to remember that without a *Section 56 Exemption*, despite the Ministerial Order, Overdose Prevention Service Sites are technically breaking the law due to the definition of possession of prohibited drugs under the Controlled Drugs and Substances Act (CDSA).

If we look at Canada (Attorney General) v. PHS Community Services Society (available here: https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/7960/index.do), it's apparent that OPS Sites requires a Section 56 exemption to Section 4 of the CDSA for OPS Site staff to totally avoid potential possession charges. If we specifically look at section 88 and 89 of the judgement:

> ***[88]*** *The actions of the staff at Insite could be construed as the offence of possession. The definition of possession of prohibited drugs under the CDSA is broad enough to encompass the activities of staff at Insite. "Possession" in the CDSA is defined with reference to s. 4(3) of the Criminal Code, R.S.C. 1985, c. C-46 , which provides:*
>
> **4. . . .**
>
> **(3)** For the purposes of this Act,
>
> **(a)** a person has anything in possession when he has it in his personal possession or knowingly
>
> **(i)** has it in the actual possession or custody of another person, or
>
> **(ii)** has it in any place, whether or not that place belongs to or is occupied by him, for the use or benefit of himself or of another person; and
>
> **(b)** where one of two or more persons, with the knowledge and consent of the rest, has anything in his custody or possession, it shall be deemed to be in the custody and possession of each and all of them.
>
> ***[89]*** *I conclude that, without a s. 56 exemption, s. 4(1) applies to the staff of Insite because, by operating the premises — opening the doors and welcoming prohibited drugs inside — the staff responsible for the centre may be "in possession" of drugs brought in by clients. They have knowledge of the presence of drugs, and consent to their presence in the facility over which they have control.*

To apply for a section 56 exemption is a somewhat high barrier process, although drug user groups and other institutions can do it. In general, police have said they will not arrest folks at OPS for simple possession, although this is not anywhere in writing. Medical Health Officers have recommended that Pop-Up OPS Sites get groups to receive permission from whoever owns the property on which or in which the OPS will be operating. Without that permission there is the possibility that the property owner will ask police to shut it down.

2- SETTING UP THE POP-UP OPS SITE

I – The Physical Site

Every Pop-Up OPS Site will vary in what it is seeking to do, and which types of drug users it is seeking to cater to (i.e. injection users; smoking users; both). However, there are some general rules and pieces of equiment that are integral to running a Pop-UP OPS:

- Some sort of structure to contain the OPS Site within – this can be as simple as a tent with tarps for walls or as permanent as a storage container.
- Table and chairs that have non-permeable, non-flammable surfaces, which can be easily cleaned with hospital grade cleaning supplies.
- In most cases it will be necessary to run a generator to keep the space well lit and warm.
    - In a pinch, the space could be warmed by gas heaters and lit by battery powered lights.

The free following supplies should be available onsite:

- Sharps disposal boxes
- Puncture resistant and liquid resistant gloves
- Tongs or a small dustpan or brush
- Syringes
- Alcohol swabs
- Filters
- Sterile water
- Disposable cookers
- Medical tubing
- Push sticks
- Brass Screens
- Matches
- Tea light candles
- Tourniquets
- Gauze
- Band aids
- Cavicide wipes or other form of ammonia based cleaner
- Naloxone
- A fire extinguisher
- Oxygen (if available and staff are trained)
- Glass pipes (if available and permitted by funding)

II – Eligibility Criteria

Once supplies have been gathered and a space has been fround, it is important to consider who can accesss the site. In gnereal, such eligibility criteria have historically been developed with the philosophy of low threshold access to health care services, bearing in mind the legal and ethical implications of restricting access to health care services.

An example of eligibility criteria may include:

- A previous history of drug use
- A willingness to sign and adhere to a Participation Agreement **(See Appendix A)**
- Not be exhibiting overly aggressive behaviour
- Not having been barrer or on a temporary prohibition/service limitation

In addition, complex etheical dilemmas come up in relation to protocol thats guide the access to the site for clients in specific circumstances. This may include:

- Pregnant users

- Youth
- Overly intoxicated individuals
- Non-self-injectors
- Individuals with their children

Although service provision to these individuals may carry complex ethical dimensions, it is important to recognize that folks do need access to safe injection services if they are at risk of overdose. However, to ensure the safety of all in the OPS Site, staff must retain the authority to refuse entry and to ask ineligible folks to leave. Upon request, individuals should be able to obtain information that explains how to initiate an appeals process and regain entry to the spa ce.

III – Ground Rules for the Space

The final step in setting up you Pop-Up OPS Site, will be figuring out specific ground rules for your space. Here are some example ground rules:

- Staff will try to ensure that the OPS Site is a quiet and safe place for both clients and staff. Clients will use drugs only in booths.
- When a booth/room becomes available, eligible individuals will be directed by staff in the order in which they arrived, and assigned to an empty booth/room.
- Each individual, upon entering the OPS Site will be provided with all necessary injection or inhalation equipment, such as a tray, a syringe, an alcohol swab, filters, sterile water, a disposable cooker, matches, a tourniquet, a 2X2 gauze and a spot band aid, pipe, brass filters, push stick, clear PVC tubing, and straws. Additional supplies should be available bat a client's request.
- Only one client is permitted per booth. Clients must remain in their booths to complete their use.
- Individuals will be encouraged to use only one dose per visit. Some clients may choose to use part of their dose first to test it, and then finish it a few minutes later, or use two different substances separately. These practices are permitted.
    - If folks are observed to be using multiple doses, staff will encourage them to "take a break" and come back again. This practice is permitted.
- In the event of an individual nodding off, flailing, or otherwise spending more than 30 minutes post consumption, OPS Site staff will gently encourage the client to sit with another worker when resources permit.

Other important considerations may include:

- Where are belongings being stored?
    - Will the site store belongings for folks – what will you do if stuff is left behind at closing.
- How many staff are required to run the site and how will staff breaks occur?
- Will folks working at the site have breaks and if so, for how long?
- How will supplies be ordered and by whom?
- Who will set the schedule for the OPS Site and when/where will it be available?
- What is the OPS Site relationship to the neighbourhood?
    - Are staff scheduling regular meetings with neighbours?
    - Do you have a clean-up line to respond to needle debris pick up?
    - Are you doing a daily sweep and if so how wide is the radius?

Remember to try and post a list of site rules in a simple and accessible way so that individual's accessing the site's services can understand what the expectations are surrounding their behaviour.

For example:

Welcome to the Our OPS Site!

Maximum allotted time for use is ½ hour.

Four use spaces available at a time. 8 people max in the tent.

You are responsible for your own belongings inside the tent.

Please dispose of your supplies properly.

No smoking cigarettes.

Please respect our space!

IV – Statsistical Collection

Different groups may want to collect/may be required to collect different types of statistics on who is accessing your space, what types of drugs they are using, and wether or not they overdose.

Some OPS may be able to do this by running an anonomous model while others may require folks accessesing their services to be assessed for eligibility by staff.

It may be necessary for folks accessing the OPS to sign a Participation Agreement form prior to first accessing the OPS Site.

Please see Appendix A/B/C for examples of Participation Agreement Forms and anonymous statistical collection forms.

---

3 –RUNNING THE SITE

A - Basic Protocol

1) When individuals arrive at the OPS site, they will Individuals will sign--in using whatever protocol the OPS Site is using.

2) SCS staff will want provide harm reduction supplies for OPS Site users, specifically:

Safer Injection Supplies

- 1cc and 0.5cc sterile needles (choice in size varies by preference)
- Sterile cookers and filters (such as cotton) to filter the substance and reduce the amounts of harmful contaminants
- Sterile water for cooking
- Alcohol pads for cleaning wounds
- Clean gauze and tissue
- Ascorbic acid for breaking down crack cocaine
- Tourniquets

Safer Smoking Supplies

- Shatterproof Pyrex pipes for smoking meth or crack cocaine
- Re-useable mouthpiece
- Wire Screens
- Wooden pushsticks
- Lighters or matches
- Alcohol swabs for cleaning hands, pipes and the mouthpieces of pipes

3) OPS Site staff may also want to assess need for and offer:

- Teaching and counseling about safer injection practices.
- Information related to resources available for the provision of drug and alcohol (internal and external) counseling, detox and treatment programs
- Teaching, counselling and assessment re: vein care and infection control
- Referrals to primary or other health care

4) While the OPS site is open, staff should:

- Clean up any spills or mess as they occur
- Regularly monitor the area outside of the site
- Clear litter as needed throughout the day
- Clean consumption booths as per protocol after each client
- Attend to blood or bodily fluid spills as per protocol
- Ensure surfaces, handrails and doorknobs are cleaned regularly

5) When the OPS site is closed, staff should:

- Ensure adequate clean-up is done (washrooms checked, coffee urns cleaned, garbage taken to the dumpster) and that all supplies are restocked.
- Search all cupboards and hiding spots for belongings left by clients.
- Ensure debriefing is done.
    - If possible, include the entire staff team on shift.

Remember! Signs and symptoms of overdose or drug toxicity include:

- Being awake, but unable to talk
- Passing out
- Body very limp
- Face pale or blue, or face that is flushed

- Breathing is slow and/or is shallow, erratic or has stopped
- Complaint of pressure or tightness to chest
- Foaming at the mouth
- Shaking or seizures
- Choking sounds or gurgling noise
- Throwing up
- Skin that is sweaty and hot or cold and clammy
- Complaint of hallucinations or confusion

In the event of an overdose, OPS Site staff will:

- Remain calm
- Attempt to wake up client
- Provide verbal and tactile stimulation
- Get client to open eyes
- Get client to talk
- If responsive, assist to walk around
- If above steps are unsuccessful, initiate Overdose Protocol

B – Safer Self-Injection Pop-Up OPS Site

I - Background

The following are example protocol that can apply to an injection pop-up OPS Site.

II - Protocol

Due to legal repercussions it's advisable that staff should **NOT** be permitted to perform venipuncture or administer the drug to a service user.

At all times staff should promote service user empowerment.

III - Potential Activities

The following are a list of potential activities OPS Site staff may want to engage in:

- Verbally explain all steps in safer injection process.
- Palpate service user's arm for veins.
- Point out potential injection sites, including physically guiding service user's hand to the appropriate injection area.
- Encourage hand washing as a measure to prevent infection.
- Swab service user's arm with alcohol swab to reduce infection from unclean injection practices
- Tie off service user's arm and remove tourniquet before service user injects to prevent vein damage and blood leakage from the injection site
- Physically demonstrate all steps in safer injection process using separate set of clean equipment and own body (mock injection)

IV - Hazardous Activities

The following should be undertaken with additional caution and only when other options have been exhausted. Before engaging in any potentially hazardous activity, staff member should assess if the person accessing the OPS Site is lucid/coherent enough to comply with instructions and if the service user is currently prone to sudden or erratic movements.

Staff should engage in the following potentially hazardous activities with extreme caution:

- Stabilizing syringe or vein while syringe is in body (risk of needle stick injury to staff). Priority is to educate service users to self-anchor their veins.
- Removing syringe from body in emergency situations (risk of needle stick injury).

If service user is lucid and stable please make a verbal agreement with them: ask service user to give verbal notice if, in the process of receiving injection support, they are going to move their syringe/rig (i.e., re-landmark). While the service user adjusts the syringe, staff will remove themselves from booth.

V – When Directly Supervising Injections

OPS Site Staff may want to be mindful of the following when directly supervising injections:

- Self-injection should take place only in the assigned booth with service user seated in a chair (whenever possible), so as to minimize risk of needle-stick injury related to service user and/or staff positioning, and minimize unpredictability of service user movements
- OPS Site staff should stand/sit on the side of the service user that is furthest from the hand holding the syringe
- For anchoring, staff should place their hands behind and below the syringe and on the opposite side of the limb, away from the syringe
    - Note: the best way to anchor a vein it to educate service user to self-anchor.

VI – Potentially Unauthorized Activities:

The following activities may carry potential legal consequences including charges up to manslaughter should the OPS user overdose:

- Inserting the syringe into the body or vein
- Flagging (pulling the plunger back to ensure the needle is in the vein)
- Depressing the plunger

NOTE: These are assisted injection practices and are not part of the SCS staff role

C – Safer Inhalation Pop-Up OPS Site

The following are example protocol that can apply to an inhalation pop-up OPS Site.

I – Background

Due to legal repercussions it's advisable that staff should **NOT** be permitted to administer the drug to a service user.

At all times staff should promote service user empowerment.

II – Protocol

There are extreme complications with running an inhalation pop-up OPS Site due to Worksafe BC regulations related to smoking-related toxins. Please reference Worksafe OHS Regulations Part 4.70 – Indoor Air Quality, which is available here: https://www.worksafebc.com/en/law-policy/occupational-health-safety/searchable-ohs-regulation/ohs-regulation/part-04-general-conditions#SectionNumber:4.70

***To legally satisfy Worksafe requirements, OPS Sites that allow safer smoking technically require a Mechanical Ventilation Set*-Up that has been inspected and approved by the Building Inspection Services at City Hall and the Fire Prevention Bureau.** This may include the following:

- Fresh, filtered air circulation and intake
- Alarm system that has been inspected and approved by the appropriate bodies
- Sprinkler system that has been inspected and approved by the appropriate bodies
- Access to oxygen cylinder with a bag valve mask
- Automated External Defibrillator (AED)
- Burn Blanket – in the event of a fire a burn blanket must be accessible

With this being said, it is important to recognize that unsanctioned OPS Sites will have a difficult time securing the proper ventilation equipment to overcome the barriers set by Worksafe BC. If you are choosing to run a pop-up OPS Site that allows for safer smoking, try to ensure that the environment is as well ventilated as possible or outside.

It is important to remember that folks whose route of administration is via smoking are still at risk of fentanyl overdose. This is especially the case with those choosing to smoke heroin.

III – Potential Activities

The following are a list of potential activities OPS Site staff may want to engage in:

- Verbally explain all steps in safer inhalation process
- Encourage hand washing as a measure to prevent infection
- Physically demonstrate all steps in safer inhalation process using separate set of clean equipment and own body (mock inhalation)

IV – Hazardous Activities

It is important for OPS Staff to remember that the inhalation of any type of smoke can be hazardous to your health.

V – When directly supervising inhalation

OPS Site Staff may want to be mindful of the following when directly supervising inhalations:

- Self-inhalation shall take place only in the assigned room with service users seated in a chair (whenever possible).
- Staff will be positioned outside the room at a station that allows a complete view of the Inhalation Room.

VI – Potentially Unauthorized Activities:

The following activities may carry potential legal consequences including charges up to manslaughter should the OPS user overdose:

- Directly assisting with smoking procedure.

D – Post-Consumption

I – Overview

After consuming drugs, folks accessing the OPS Site should be allowed stay at their booth (for up to 20 minutes); afterword staff can offer folks additional seating in the OPS as needed. Post consumption observation may or may not be sought be folks using the OPS Site's services.

If possible, offer folks coffee and other snacks!

II – Leaving the Site

Prior to leaving the SCS, staff should attempt to discuss with the client harm reduction strategies for the rest of the day, and to encourage the client to return to the SCS for future supervised drug use as needed.

Staff should attempt to ensure that high-risk clients such as youth and women feel safe when leaving the OPS Site.

E – Service Bars

It is important for OPS Site staff to recognize the oppressive effects of the criminal justice system, and to engage in restorative justice, harm reduction, and community building in order to prevent alienation in their communities. Alienation as a key ingredient in the successful functioning of capitalism and colonialism, and it is advisable that OPS Site staff be mindful of the importance of mending communities rather than dividing them whenever possible.

OPS Site staff should be open to and want to engage in conflict resolution processes that repair and don't dehumanize. However, ongoing malicious and/or oppressive behaviour should be treated as an attack on an OPS Site and the following protocol may be necessary to ensure the autonomy and functioning of a space.

Pop-Up OPS Site Staff May want to think about the following rule for their site.

- **OPS Site users can be prohibited from using the site for the day by any staff, including peers, due to uttering threats of violence or carrying out violence against anyone on the premises.**

Periods of prohibition of more than one day will be set by the OPS Site staff if they determine that the circumstances are severe enough to warrant it.

It is advisable that barred OPS Site users must meet with the OPS Site Staff. They will be readmitted after OPS Site staff is assured that the behaviour will not continue.

Three Steps for Staff/Client Safety:

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

It is advisable that there is documentation of prohibition from using the site. This may include the following protocol

- Staff must communicate with the OPS Site manager as soon as a prohibition occurs.
- The OPS Site Staff are responsible for making the decision to place a person on OPS Site prohibition after a review of the documented events.

APPENDIX A: User Agreement

User Agreement, Release and Consent Form: Overdose Prevention Service Site

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

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

I understand the above and am able to give consent.

Name: _____ (must include first & last initials)

Date of Birth: _____ (D/M/Y)

Completed by: _____

Date: _____ (D/M/Y)

Handle or Identifier:
(Name, nickname, or #,
Ideally same as at Insite)

APPENDIX B: Stat Form with Handle

Date	***User Handle***	***Substance Used***	***Overdose?***

APPENDIX C: Anonymous Stats Form Kept By Tally

SHIFT STATS **OPS SITE!**	
Name of staff on shift: **Date:**	
Safer use conversation/peer counselling?	
In person witnessed use?	
OD response?	
After-OD monitoring (phone, text, or in person)?	
Rig Sweep?	
Naloxone Training Done?	
# of Kits Dispenced?	
Fentanyl Testing?	
Number of Turnaways (Folks who asked for your services when you were unavailable)?	

OCCUPATIONAL HEALTH & SAFETY (OH&S) GUIDELINES/PROTOCOLS

I – Purpose

The purpose of this guideline is to stop the spread of germs to others by ensuring that peer staff understand how to protect themselves and folks they are engaging with from contact with the blood or body fluids of other people.

The term "standard precautions" has replaced the term "universal precautions".

II – Directives

It is advisable that any peer staff follow standard precautions and treat all blood and body fluids of every person as potentially infectious. Potentially infectious body fluids include the following:

- Blood.
- All body fluids, secretions, and excretions (except sweat and tears), regardless of whether they contain visible blood.
- Non-intact skin and mucous membranes.

There are also risks for infection associated with airborne or large droplets transmission. All staff should follow specific precautions related to pathogen transmission.

III – Guidelines

A – Hand Washing

Hand washing is the best single way to prevent the spread of germs from one person to another. Wash hands thoroughly with soap and water for at least 10 to 15 seconds or use a 60% alcohol-based waterless antiseptic agent if hands are not visibly soiled or if no sink is available.

Always wash hands:

- Before and after wearing gloves to provide client care
- Before and after providing first aid
- After handling blood or body fluids

B – Gloves

1. Non-Latex or Rubber Disposable Gloves
    - Use for short-term only.
    - Wear when handling blood, body fluids, or when cleaning cuts, scrapes or wounds.
    - Wash hands after removing gloves.
    - Dispose of gloves into a plastic bag and then into the regular garbage when finished care.
    - Do not wear gloves when in contact only with client's intact skin.

2. Heavy Duty Household Type Gloves
    - Use for cleaning.
    - Wash with cleaner after use and turn inside out to dry in between uses.

- Discard gloves after every shift.

C – Aprons/Gowns

Wear a moisture-resistant disposable apron or gown when there is potential for splash or spray of blood or body fluids (e.g., wound irrigation or profusely draining wounds).

- Wear the apron with the fluid-resistant side facing the client.
- Dispose of soiled aprons or gowns into a plastic bag and then into the regular garbage.

D – Masks

Wear masks only when there is potential for splash or spray of blood or body fluids to the face.

- For certain infectious conditions, spread by droplets or through the air (e.g., infectious tuberculosis), masks are recommended until the client is deemed non-infectious. See Health Canada guidelines that are specific to type of infection.
- Specific types of masks that filter particles of one micron in size may be required.
- Wear a mask only once then discard them into a plastic bag and then into the regular garbage.

E – Eye Goggles

Wear eye goggles when there is a potential for splash or spray of chemicals, blood or body fluids to the eyes (e.g., wound irrigation).

- Goggles may be cleaned with soap and water while wearing rubber household gloves, and may be used indefinitely.

F – Sharp Objects

Place needles and syringes into a puncture-proof metal or plastic container with a lid.

- Do not use a glass container.
- Never re-cap, bend or break off used needles.
- Once the container is 75% full: Place in large sharps bin.

Sharps containers should be:

- Located as close as practical to the work area.
- Available in different sizes as required for different purposes and worksites.
- Replaced when they are 75% full.
- Maintained upright throughout use.

G – Personal Articles

Never share toothbrushes or razors as they can transmit small amounts of blood from one user to the next.

- Dispose of razors carefully.

H –Cleaning Spills of Blood or other Body Fluids

1. Wear disposable non-latex or rubber gloves, and use protective eyewear if there is a risk of splashing.

2. Remove most of the spill by using disposable absorbent material such as paper towels.
3. Place used paper towels in a plastic bag and deposit in the regular garbage.
4. Wipe the floor, or any contaminated surface, with a disinfectant solution such as Pinesol or Mr. Clean.
5. Alternatively, prepare a disinfectant solution by mixing one part household bleach to nine parts of water; use a fresh bleach solution every time as it may lose its strength.
    a. **Consider toxicity concerns when mixing bleach solutions!**
    b. Use other household germicides or disinfectant agents for carpets or upholstery that may be damaged by bleach.
    c. Soak mops or brushes that have been used for cleaning in a disinfectant for 20 minutes.
    d. Wash your hands thoroughly with soap and water when you are finished.

I – Immunizations

Whenever possible, staff immunizations should be up-to-date.

IV - Injuries/Exposure to Blood and Body Fluids For All

First, cleanse the area/puncture site thoroughly with warm water and soap. In the event of an eye splash, flush the eye with tap water for 10-15 minutes. Then, go directly to the emergency of the nearest hospital. You should be assessed for risk of exposure to blood-borne pathogens at the emergency department as soon as possible, preferably within two hours of the incident.

A – For Staff

Report to your supervisor immediately, or leave a message if unable to speak directly. Ask your supervisor or designate to call Occupational Health & Safety.

V – Needle Stick Injuries/Safe Disposal of Sharps

A – In the Case of Needle Stick Injury or Exposure to Blood and Body Fluids While at Work

1. Cleanse the area/puncture site thoroughly with warm water and soap, or a suitable antiseptic soap such as Hibitane or Salvodil. In the event of an eye splash, flush the eye with tap water for 10-15 minutes.
2. Report to your supervisor immediately, or leave a message if unable to speak directly.
3. Go directly to the emergency of the nearest hospital. You should be assessed for risk of exposure to blood-borne pathogens at the emergency department as soon as possible, preferably within two hours of the incident.
4. If you know the source/person of the blood or body fluid, ask the person, (or parent/guardian) if he/she consents to have blood testing as well. They can go to emergency with you.
5. Ask your supervisor or designate to call Occupational Health & Safety at 1-866-415-8690

B – Safe Disposal of Sharps

The main cause of HIV infection in occupational settings is via percutaneous (e.g., needle-stick) injury resulting in exposure from infected blood. Research suggests that HIV infection is rare after a needle-

stick injury; however infection of hepatitis B & C is much more easily transmitted through a needle. Whether the risk of infection after a needle-stick injury is common or uncommon, this is still understandably an area of considerable concern.

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

Picking up sharps:

- Use tongs to pick up needles.
- If no tongs are available, use a gloved hand to carefully pick up the needle(s) and dispose of gloves and WASH HANDS after needle contact.
- Hold needle tip away from you.
- Put needle(s) in a puncture resistant can or jar.

VI – How to Handle Garbage Safely

- Physical handling of garbage should be kept to a minimum.
- Use waterproof garbage bags.
- Be Alert! If possible look for sharps protruding from garbage bag, and listen for broken glass when moving the bag.
- Don't compress garbage or reach into garbage containers with your hands or feet.
- Don't use bare hands when handling garbage. Wear puncture resistant and liquid resistant gloves or use other tools designed for picking up garbage.
- Don't let garbage get too full. Leave enough free space at the top of the bag, so that when you grab it, you grab the top of the bag only.
- You may have to change bags more often to prevent them from getting too full. This will also make them lighter - and thus easier to hold away from your body.
- Hold the garbage bag by the top of the bag, away from your body. Don't hold garbage against your body.
- Don't place one hand under the bag to support it.

VII – Infection Control Routine Practices

A – Protocol

The following measures should be implemented in an OPS Site:

- Upon entry, folks using the services will be encouraged to wash their hands
- Service users will be offered a variety of drug use supplies tailored to their individual preferences for safe injection/inhalation
- Service users will be provided with sterile or clean safe injection/inhalation equipment
- Service users will be directed to a disinfected station for safe injection/inhalation
- Following injection, each service user will be instructed to dispose of their used equipment in the biohazard container accessible at each injecting station or in the main biohazard container available near the injection room exit
- Service users will be encouraged not to bend or break off needles prior to disposal

- Staff are responsible for supervising the disposal process
- Service users will be directed to wash their hands post-injection/inhalation
- Service users will be asked to wipe down their injection booth/inhalation table after use with Cavicide wipes provided.
- Staff will be required to clean each station following injection/inhalation, using protective gloves and approved disinfectants
- OPS Site staff are responsible for removing filled biohazard containers, placing filled biohazard containers into the larger biohazard storage containers and replacing filled biohazard containers for each station

The OPS Site will be equipped with the following:

1. Cavicide wipes
2. Gloves in a variety of sizes (small, medium, large)
3. A mounted biohazard container at each injection booth/inhalation booth
4. At least one large biohazard storage container (i.e., for storing filled booth containers)
5. Ideally, a hand-washing station containing soap, paper towel, and a sink
6. Clean or sterile injection drug use equipment

Safer Injecting Education and Drug Use Education Guidelines

It is important for OPS Site staff to seek out opportunities to educate folks accessing the sites services, including about venous access and safer consumption practices.

Safer drug use education consists of counselling service users on proper techniques for drug preparation, insertion and high-risk practices. This may include but are not limited to the following:

A – Needle/Syringe Distribution

It is recommended that the thickness of the needle corresponds to the thickness of the vein that is being injected as using an inappropriate needle size can cause vein damage, bleeding and/or infection. Allow service users to select a needle based on their personal preference.

B – Preparation for Injection

It important for folks accessing an OPS Services to be instructed on the following:

1. Inject in a place that is dry, clean, well-lit and has running water available for hand washing to minimize the risk of infection. If running water is unavailable, alcohol swabs can be used as an alternative. Also, a piece of paper can be used in situations where a clean injection surface is unavailable.
2. When injecting in a group setting to prevent the sharing of drug use equipment, service users can mark their equipment to distinguish theirs from others.
    a. Possible ideas for marking items include: use of nail polish, attaching a piece of tape to the barrel of the syringe, scraping a number off of the barrel of the syringe, cutting off half of the plunger top and/or half of the cooker.
3. When intravenously injecting a drug in pill form, the drug is to be crushed as finely as possible with a sterile tool in order to reduce the likelihood of injecting undissolved particles. Coating is not dissolvable and should be removed with sterile water to reduce vein damage. Air bubbles should be removed from the syringe prior to injection as this will prevent an air embolism, a medical condition that occurs when air enters into the bloodstream. Use wheel filters to minimize this risk.
4. An acidifier should be used to help break down and dissolve solid particles and to reduce burning sensation and vein damage.
5. Use an alcohol swab to clean the injection site.

C – Insertion and Flagging

The following techniques can be administered to assist someone in locating a vein: use of a flexible tourniquet with easy release, running warm water over the injection site, tightening of a shirt sleeve, producing a pumping action with the fist and swinging the arm in a circle, ensuring service user is hydrated.

Upon injection into a vein the needle is to be positioned at a 35 degree angle, ensuring that the bevel is facing up. The needle can then be slowly inserted into the vein in the direction of the blood flow to reduce vein damage

Flagging is a method of ensuring that the needle is in the vein. Flagging is done by pulling the plunger back slowly until a trickle of blood flows into the syringe

Possible signs of injection into an artery include: blood that is frothy or brighter red than usual or if the plunger is pushed back by pressure from intense blood flow, intense pain and blood sprays

Once the syringe is inserted into the vein, the tourniquet can be released and the plunger can be slowly pushed to inject the drug. It is important to release the tourniquet either before injecting or as quickly as possible after injection as injecting into a tied-off vein can cause pressure in the vein and can lead to vein ruptures

The needle should be removed at the same angle as it was inserted and the site of injection should be raised (if possible to reduce pressure and less blood spray). This helps reduce vein damage. In order to stop bleeding, pressure should be applied to the injection site for a few minutes with clean, dry, gauze, tissue or cotton ball

Dead-space syringes

All syringes contain some fluid otherwise referred to as "dead space" that occurs when the plunger is depressed. However, the amount of fluid is dependent on if a needle is permanently attached or is detachable as well as its length and gauge

An individual's risk of transmission increases when reusing a needle that contains fluid contaminated with HIV, HCV and Hepatitis B (HBV) in the dead air space. In fact, even a small percentage of syringe-sharing with high dead space syringes can still increase the risk of transmission

D – Use of Bleach to Disinfect Injection Equipment

Evidence suggests that the use of bleach as a disinfectant for injection equipment is ineffective in preventing HCV or HIV transmission among people who inject drugs. Service users should be encouraged to use new equipment each time they inject.

E – Cooker Distribution

Cookers are used in order to mix drugs in powder or solid form into a solution that can be injected for drug use. Cookers are also used for cooking or heating the drug to further break it down. Heat can also reduce the complications associated with injecting undissolved particles. Service users should take caution to avoid touching the cooker with the flame as this may cause soot to get into the solution and can lead to health problems when injected. Other drugs such as cocaine do not need to be heated. Some individuals may also use other items such as spoons and/or bottle caps to mix or heat drugs.

A new cooker should be used upon every injection in order to reduce the risk of transmission of HIV, HCV, HBV and other pathogens within contaminated cookers. If there is any chance of the cooker being reused, service users should be encouraged to clean it after use, using an alcohol swab to remove residue.

Educate service users regarding adequate heating of drug solution in order to effectively kill off germs. For instance, encourage service users to bring drug and water solution to a boil.

F – Education Regarding Consumption into the Jugular Vein

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

1 The anatomical location of the jugular is very close to large blood vessels (including arteries), nerves, the trachea and the esophagus
2 An abscess in close proximity to these structures could cause the compression of nerves and vessels supplying blood to the brain
3 A large abscess on the path of the jugular vein could potentially cause compression or narrowing of the airway
4 Jugular infection could travel easily to the brain or heart

Air embolus can easily enter the blood stream from jugular injection and travel into the heart and coronary arteries (heart attack) or the brain (stroke) or to the lungs (pulmonary embolism). Air is more likely to enter through injection into the jugular vein because it lacks valves and because of the negative pressure in the jugular vein, associated with aspiration.

Safer Smoking Supplies Cost Recovery Model – Background Information

I – Background

The Best Practice Recommendations for Canadian Harm Reduction Programs recommends freely distributing heat-resistant pipes for the safer inhalation of crack, as well as evaluating the distribution of foils for smoking heroin, and of heat-resistant pipes for the safer inhalation of meth.

Currently, most Health Authorities purchase and distribute small quantities of safer smoking equipment to supplement the supplies provided by the provincial harm reduction program. While they are not able to provide consistent unlimited access to supplies, they provide the following:

- Heat-resistant pipes smoking crack (often called 'stems').
- Heat-resistant pipes for smoking crystal meth (often called 'bowls').
- Foil for smoking substances.

Currently, available supplies for the full range of harm reduction supplies for safer crack cocaine, safer heroin, and safer methamphetamine smoking do not meet demand for these supplies in BC. Specifically, they are unable to provide consistent supplies of heat-resistant lead-free borosilicate (sometimes branded as Pirex or Simax) pipes and foil used for smoking.

Lack of access to foils and pipes may put people who use substances at risk for harms including from:

- Injecting, rather than smoking, substances. If individuals are forced to inject drugs due to a shortage of supplies, they are at an increased risk of overdose due to the rapid onset of the effects of drugs associated with injection. Moreover, injection of drugs leads to a greater potential for the transmission of blood-borne infections including HIV and hepatitis C and other injection-related infections.
- Using non-recommended materials for smoking substances, such as conventional glass tubes or lightbulbs. These materials are not heat resistant, shatter easily, and can cause injuries which may increase risk for hepatitis C transmission.
- Sharing of supplies due to shortage, which increases the risk of infections including pneumococcal disease.

Although, safer smoking supplies should be provided for free as a necessary component of existing distribution models, the BCCDC recognizes that existing service gap may impact the ability to adequately supply communities with what they need to use drugs safely. Peers and researchers have observed that lack of access to safer smoking supplies leads to people using unsafe supplies such as broken glass, pop cans and other supplies to create makeshift pipes.

II – Cost Recovery of Meth and Crack Pipes

Canadian Best Practices in harm reduction indicate that harm reduction supplies should be made available in the quantities requested by clients. Due to current budgetary restraints of regional and provincial health authorities, availability of safer smoking supplies does not currently meet demand in BC. Health Authorities may not be able to directly operate cost-recovery programs in part because exchange of money for health services is not a generally accepted practice; however, the door is still open for drug user groups and community-based organizations to sell supplies in order to bridge the

service gap.

Drug user and community-based organizations could run a simple cost recovery model on safer smoking supplies to continue to keep them stocked. This would mean selling supplies at cost to guarantee enough of a return on supplies to allow for a group to re-purchase them.

The former Drug Users Resource Centre ran an effective cost recovery model for both meth and crack pipes for many years. More information can be found here:

https://bc.ctvnews.ca/canada-s-first-crack-pipe-vending-machines-come-to-vancouver-1.1676803

https://www.cbc.ca/news/canada/british-columbia/drug-users-resource-centre-open-house-fix-1.3652315

Safer Smoking Supplies Cost Recovery Model – Ordering Process

I – Ordering Process

To bridge current gaps in availability of safer smoking supplies, the BCCDC has struck an agreement with the harm reduction supply distributor Stevens to provide access to supplies for drug user organizations. Unfortunately, pipes and foils can only be bought in large volumes, by the case; this may mean that smaller organizations may still have difficulty procuring them. For organizations that wish to place an order, fill out the attached Safer Smoking Supply Order Form and email it to BCCS@stevens.ca. Or call your order in by:

1. Calling Stevens at # 604-634-3088
2. Quote the account #4310620
3. Provide the "ship to" address with contact name and telephone number.
4. Stevens requires the orders to be paid before shipping via credit card or a mailed cheque.
5. Shipping on orders over $250 is free!

Prices for safer smoking supplies are as follows:

Product Name and Number	Amount	Price (per Unit)
Tube Glass 100mm 8mm OD (415-8MMX1MMX100MM)	2540 crack pipes per case	$545 per Case + $65.40 Tax = **$610.40 (0.24 per Unit)**
Tube Glass 100mm 10mm OD (415-10MMX1.5MMX100MM)	1600 Crack Pipes per Case	$545 per Case + $65.40 Tax = **$610.40 (0.38 per Unit)**
Tube Glass 130mm 10mm Bowl Foam Wrapped (415-10X1.5X130FOAM)	432 meth pipes per case	$575 per Case + $69.00 Tax = **$644.40 (1.49 per unit)**
Foil Sheets Precut to 5x7 Inches (813-BES57HUCC)	12 boxes of 500 sheets = 6000 foil sheets per case	$139.75 per Case + $16.77 Tax = **$156.62 (0.03 per Unit)**

Please note: safer smoking glassware can also be ordered directly from *Pegasus Glass* – the manufacturer of the glass stems. Please reference Appendix A.

II – Cost Recovery

If groups require more pipes than the health authority can provide, pipes can be procured via this process. The pipes can be sold at cost to recoup the funds spent.

For example:

Supply	Resale Value	Total Return
Crack Pipe (8mm)	$0.25	$635
Crack Pipe (10mm)	$0.40	$640
Meth Pipe*	$1.50	$648
Meth Pipe†	$2.00	$864
Box of Foil (500 Sheets)	$14.00	$168
25 Sheets of Foil	$0.75	$180

*Note – This is the price for a bare bones cost recovery model on Meth pipes
†Note – This price for meth pipes includes money for operational costs (staffing, administration, etc.)

Appendix A – Ordering Directly from Pegasus Glass

Please note, glassware can also be purchased directly from Pegasus but the prices will vary depending on location.

The pre-tax and pre-shipping price of glassware bought directly from Pegasus is as follows:

Product (Number of pipes)	Price per Box (No Shipping/No Tax)
Tube Glass 100mm 10mm OD (1600)	$448.00
Tube Glass 130mm 10mm Bowl (432)	$388.00

Please note that shipping costs vary drastically and can be shockingly high! It is recommended that sites get a shipping quote from Pegasus Glass before purchasing. Orders also carry a 12% tax.

To contact Pegasus and get a quote please send an email to Laurie Dillon (ldillon@pegasus-glass.com) or Roxanne Sellick (rsellick@pegasus-glass.com).

SAFER SMOKING SUPPLY ORDER FORM

E-MAIL this order to BCCS@stevens.ca

If you don't have e-mail, call 604-634-3088

Receiving Site: _____ **Date Submitted:** _____

Contact Name: _____ **Delivery Days:** _____

Account #: 4310620 **Delivery Times:** _____

Shipping Address: _____

_____ **Email:** _____

Postal Code: _____ **Fax Number:** _____

Phone Number: _____

Stevens requires the orders to be paid before shipping via credit card or a mailed cheque.

Please allow up to 2 weeks delivery.

PRODUCT NUMBER	DESCRIPTION	UNITS ISSUED	PRICE	QUANTITY ORDERED
SAFER INHALATION SUPPLIES				
415-8MMX1MMX100MM	Tube Glass 100mm 8mm	1 CASE = 6 BOXES = 2540 PIPES	$545/CASE + $65.40/TAX = **$610.40**	_____CASES
415-10MMX1.5MMX100MM	Tube Glass 100mm 10mm	1 CASE = 6 BOXES = 1600 PIPES	$545/CASE + $65.40/TAX = **$610.40**	_____CASES
415-10X1.5X130FOAM	Tube Glass 130mm 10mm Bowl Foam Wrapped	1 CASE = 6 BOXES = 432 PIPES	$575/CASE + $69.00/TAX = **$644.00**	_____CASES
813-BES57HUCC	Foil Sheets (Precut to 5x7 Inches)	1 CASE = 12 BOXES = 6000 SHEETS	$139.75/CASE + $16.77/TAX = **$156.62**	_____CASES

How to Create a Budget for Your Peer Group

I - Budget Support

In general, if you receive funding for your group, it's important to consider spending funds on the operations of your peer organization, including but not limited to, honoraria, food, meeting space costs, travel (e.g. transit stipends or mileage), and potential legal fees.

Option 1 – Identify a Lead Financial Agency/Community Partner to Administer Funds

If you do not yet have a society formed, it is important to identify a lead financial agency (health authority or community partner) that can hold the funds you receive in their account and track spending for you. Typically, you will require signatures from two signers from your peer group in order to withdraw funds. Community partners will usually take 10% of the total funds awarded to pay for administrators to track your budget for evaluation purposes. It is important to account for the administrative expense in your budget.

Option 2 – Open a Business Bank Account to Administer Funds

If you are registered as a non-profit society, two of members of your society's board can open a business bank account at a local bank. This option generally gives peers more freedom and autonomy over how to spend their funds.

II – Questions to Ask Your Peer Group when Budgeting

1. When does our peer group meet?
2. How often (e.g. weekly, every two weeks, monthly, etc.)?
3. How long are our meetings?
4. Where will our meetings be held?
5. How will people get to and from the meetings?
6. What activities would our group like to do?

III – Making a Budget

The following is a non-exhaustive list of some things you may want to consider when making a budget for your peer group!

Item	Description	Cost
Peer Honoraria	Compensating peers for their time. This is a sliding scale depending on the level of engagement. This could include setting up the room, taking minutes, and attending the meeting. The BCCDC best practice guidelines suggest paying peers a living wage for their expertise. Although this is not always an option for all groups it is important to consider.	$15 – $30 per hour.
Food	Providing food/snacks can improve meeting attendance.	Cost varies: *$30-40 per meeting (8-10 people) or more.*
Meeting space	Varies depending on the venue. Where possible, work with the regional health authority and community partners who can provide "in-kind" (free) space. Otherwise, some other low-cost or free options include libraries, community centres, and coffee shops.	Cost varies: *Free or $20-50 per hour*.
Travel	In urban areas, this could mean transit tickets. In more rural and remote areas, this could mean mileage (paying people per km travelled to attend a meeting) and/or carpooling.	Cost varies: *Mileage can be ~$0.50 per km*
Elder Honorarium	Compensating Indigenous Elders for their time and respecting the sacred cultural teachings Elders share with participants. Work with your local Aboriginal Friendship Centre or First Nation. Sometimes, an Indigenous member of the group may be able to acknowledge the territory and open the meeting.	Cost varies: *sometimes provided in-kind.*
Grant writing	Paying for professional grant writers to apply for grant funds to sustain and expand your peer group.	Cost varies: *Anywhere from in-kind/volunteer to ~$50/hr*
Training	Peer capacity building training can also be part of the budget. Look to local, regional, and provincial resources that are free or low-cost (e.g. PeerNet BC, PHSA Mobile Response Team, Homelessness Services Association of BC). You can also bring in a facilitator or trainer. Some training could include: first aid, conflict resolution, communication skills, etc.	Cost varies: *Free to ~$50 per hour*
Legal Fees	Consider having a budget for legal consultation if possible, as theoretical legal challenges frequently crop up due to the gray area that peer groups operate in.	Cost varies: *Anywhere from in-kind/volunteer to ~$200/hr*

IV – Example Budget

Item	Description	Cost
Peer honoraria	8 peers x 1 monthly meeting x 2 hours @$20.00 per hour x 12 meetings per year	$3840.00
Food	Snacks $20.00 x 12 meetings per year	$240.00
Meeting space	Provided in-kind (free) by community partner	$0.00
Travel	Bus tickets $2.95 x 8 peers x 2 trips per meeting x 12 meetings per year	$566.40
Administrative Costs	10% of subtotal (all costs up until this point)	$464.04
		Total: $5104.44

V – Resources

BCCDC Peer Engagement Best Practices
http://towardtheheart.com/assets/uploads/1516141269o4KkCMkq2ytmhxVyGjcQ9DSWtUoI1d8FLnzYdIv.pdf

BCCDC Peer Payment Standards
http://towardtheheart.com/assets/uploads/1519946965Qvm0rdCCJYLBRdPdbJF3cSb8aSHjXBpcSOL59Ue.pdf

How to Become and Run a Non-Profit Society in BC

Step 1 – Before you Begin

It's important to have a least one person on your team with some computer literacy skills. In general, the process of operating and running a society requires at least a basic ability to use an email, manage a bank account, and take meeting minutes digitally.

If no one is available, this skill set can be acquired quite with some diligent work! Frequently, libraries and other community centres will offer computer literacy courses and help you learn the necessary skills in Microsoft Word, Excel, and certain web based applications (examples include Gmail and Google Drive).

Step 2 – Register a Name

The first step to register a non-profit society requires the registration of a name. The name of your non-profit society should generally indicate the purpose of the society. For example, if your group regularly does needle sweeps in Abbottsford you may want to consider a name like "The Abbotsford Rig Diggers Society".

You **must** submit a name approval request if you intend to incorpoarte, register a business, or register an extraprovincial company.

In order to submit a society name approval request, visit the following website:
https://www.bcregistry.ca/societies/

There is a $30 + ($1.50 service fee + tax) charge for each name request that is searched in BC. This fee is applicable whether you submit 1, 2, or 3 choices. The fee is not refundable once your request is processed. However, if you cancel your request before it is processed, a refund may apply.

You cannot register a business or incorporate a company unless you have the name approved first.

The approval of a name in British Columbia is intended solely to protect the public interest by:

- preventing names of corporate entities (only) from being so similar that they are likely to confuse or mislead the public; and
- providing a record which allows the public to determine which individuals are associated with a corporation or business name. Also, a business name is prohibited from being the same or similar to a corporate name.

Step 3 – Incorporating a Society

By filing the necessary paperwork and paying the filing fees, one or more persons can incorporate a society. Just make sure you have all the information you need before you start the online application. This includes a name, information about the applicant, a constitution, bylaws, and director's information. There is also a fee of $50 required to incorporate a society.

If you require assistance or have questions about whether or not to incorporate, seek legal advice.

Under the Societies Act there are two kinds of societies: ordinary societies and member-funded societies.

When incorporating, a society will need to indicate if it wants to be a member-funded society.

I – Constitution

The constitution of your society must specify your organizations name.

The constitution of your society must specify the purpose of the society.

The constitution of your society should address what happens to the remaining funds in an organizations possession if the organization ceases to exist.

The purposes of a society state why the society exists. A society may have one or more lawful purposes including the following:

- Agricultural
- Artistic
- Benevolent
- Charitable
- Educational
- Environmental
- Patriotic
- Philanthropic
- Political
- Professional
- Recreational
- Religious
- Scientific
- Social
- Sporting

A purpose cannot include operating a business for profit or gain.

A society may be ordered to alter its purpose if it is contrary to the Societies Act of BC.

If your society chooses to be a member-funded society, the following statement will be automatically included as part of the society's constitution:

> *This society is a member-funded society. It is funded primarily by its members to carry on activities for the benefit of its members. On its liquidation or dissolution, this society may distribute its money and other property to its members.*

II – Bylaws

Option 1: Adopt the Model Bylaws

The easiest way to set up your bylaws is to adopt the model bylaws as a set, without any changes. The model bylaws are intended to provide a sample framework of basic procedural rules for the convenience of new societies when they incorporate.

Make sure all the provisions are suitable for your society as you will be adopting the entire set of bylaws as is. (For example, Bylaw 3.7 provides that proxy voting is not permitted so this bylaw would not be suitable for a society that intends to allow its voting members to appoint proxy holders.)

Read the model bylaws here:
http://www.bclaws.ca/civix/document/id/complete/statreg/216_2015/search/search?84#Schedule1

Option 2: Create Your Own Bylaws

If you wish to create bylaws to suit your specific organization you can use the model bylaws as a guide or start from scratch. Whatever you choose, make sure the bylaws for your society contain the matters (provisions) required by Section 11 of the Societies Act

1. Are in English
2. Are in a text format that can be uploaded, copied and compared (.doc, .docx, .wps, .txt, .rtf, or .pdf)
3. Societies are responsible for ensuring their bylaws comply with the Societies Act. Please seek legal advice if you require assistance in drafting or changing bylaws.

A society's bylaws contain rules for governing the society, including provisions for membership, directors and general meetings.

Please see Appendix A for an example of bylaws created by a drug user organization.

III –Director's and Society's Information

Societies need to provide the names and addresses of all the directors of the society.

A director is an individual (not an organization or corporation) who meets specific qualifications and is responsible for the management of a society. An individual who applies to incorporate a society may become a director but this is not a requirement.

1. How Many?
   - An ordinary society must have at least three directors and at least one of the directors must be resident in B.C.
   - A member-funded society needs only one director, and the director does not need to be a B.C. resident.
2. Qualifications
   - A director must be qualified under the Societies Act and the bylaws of the society.
   - Generally this is an individual (not an organization or a corporation) who:

I. Is at least 18 years of age (younger directors may be permitted under certain conditions)
II. Is capable of managing their own affairs
III. Is not undergoing bankruptcy
IV. Has not been convicted of fraud or corporate offence within the last five years
V. Meets any additional qualifications noted in the society's bylaws

A director's address may either be the director's residential address or an address at which the director is available to receive deliveries during normal business hours: 9 am to 4 pm local time, Monday to Friday.

The Societies Act requires all incorporated societies to maintain a registered office in British Columbia. Societies need to provide a mailing address and a delivery address (if different from the mailing address) for the registered office. An email for the society is also requested.

A delivery address is a location at which a record could be physically left with a representative or agent of the society, or in a mail slot at that address. The email address will be used to send notifications such as the Annual Report reminder and information regarding any upcoming Corporate Registry changes.

IV – The Incorporation Process

Once all of the above steps are completed you will be using an application called **Societies Online** to send the government your information.

Use the name request reservation number to open the rest of the incorporation application: Applicants, Constitution, Bylaws, Directors and Registered Office Address.

> **Note:** If you are using Societies Online for the first time, you will be asked to create a BCeID account.

You can log in to **Societies Online** here: https://www.bcregistry.ca/societies/

V – Certificate and Notification

Once the filing is complete, the society will receive certified copies of the incorporation documents, including the certificate of incorporation, the constitution and bylaws of the society and a statement of directors and registered office.

Notification of the incorporation will be published by the registrar

Step 4 – Opening a Business Bank Account

Once you have received notification of incorporation as a society it is possible for two of your society directors to open a business bank account.

A bank account enables drug user groups to be their own financial administrator should they receive funding.

Generally, speaking, once a society is registered, two directors with photo ID can open a joint account that requires two or more signatures for withdrawals at a local bank.

Step 5 – Filing an Annual Report

Incorporated societies must hold an annual general meeting (AGM) each calendar year and file an annual report.
File your society's annual report each year within 30 days after the annual general meeting. Societies are not required to hold an annual general meeting or file an annual report the year they incorporate.

Set up an annual report reminder for next year when you file your annual report. The reminder is sent to the primary and alternate (if given) email address we have on file for your society.

File annual reports for your society through Societies Online and pay by

- Credit card
- Pre-authorized debit or
- BC OnLine account

Before logging in, make sure you know the annual general meeting date.

Don't have internet access?

- You may also complete your filing at a Service BC location by using a community access terminal.

Financial Statements and Minutes

- Financial statements and meeting minutes do not need to be filed with the society's annual report. Keep these documents at your society's registered office.

Changing Society Information

- If there has been a change to the delivery or mailing address of the registered office, or a change in director information as a result of an annual general meeting, you will have the opportunity to change the information at the same time you file the annual report.

Request an Extension

If your society is unable to hold an annual general meeting within the calendar year, you may request an extension through Societies Online. You have until December 31st to do this. Before you request an extension, make sure your society is up to date on holding its annual general meetings and has filed all its annual reports for previous calendar years.

If the request for an extension is granted, your society must hold an annual general meeting between January 1 and March 31 of the following calendar year. A meeting held in this extended period is deemed to have taken place the previous calendar year. An annual general meeting must still be held (and an annual report filed) for the current calendar year.

What to Do If No Meeting is Held

If your society does not hold an annual general meeting, file an annual report noting that no annual general meeting was held in the calendar year. You have until January 31 to do this.

If you have missed the annual general meeting extension date given to you by the registrar, file an annual report noting that no meeting was held. Do this within 30 days of the date the meeting should have been held (given to you by the registrar).

Dissolution

If a society fails to file an annual report or hold an annual general meeting for two consecutive years, the registrar may send notice of the registrar's power to dissolve the society.

To avoid dissolution, the society must hold an annual general meeting in the same year the notice is sent and file an annual report for that annual general meeting, along with any outstanding annual reports from previous years.

Appendix A – Coalition of Peers Dismantling the Drug War Bylaws and Constitution

I – Bylaws

Bylaws of Coalition of Peers Dismantling the Drug War (the "Society")

Part 1 — Definitions and Interpretation

Definitions

1.1 In these Bylaws:

"Act" means the *Societies Act* of British Columbia as amended from time to time;
"Board" means the directors of the Society;
"Bylaws" means these Bylaws as altered from time to time.

Definitions in Act apply

1.2 The definitions in the Act apply to these Bylaws.

Conflict with Act or regulations

1.3 If there is a conflict between these Bylaws and the Act or the regulations under the Act, the Act or the regulations, as the case may be, prevail.

Part 2 — Members

Application for membership

2.1 A person may apply to the Board for membership in the Society, and the person becomes a member on the Board's acceptance of the application.

Duties of members

2.2 Every member must uphold the constitution of the Society and must comply with these Bylaws.

Part 3 — General Meetings of Members

Time and place of general meeting

3.1 A general meeting must be held at the time and place the Board determines.

Ordinary business at general meeting

3.2 At a general meeting, the following business is ordinary business:

(a) adoption of rules of order;
(b) consideration of any financial statements of the Society presented to the meeting;
(c) consideration of the reports, if any, of the directors or auditor;
(d) election or appointment of directors;
(e) appointment of an auditor, if any;
(f) business arising out of a report of the directors not requiring the passing of a special resolution.

Notice of special business

3.3 A notice of a general meeting must state the nature of any business, other than ordinary business, to be transacted at the meeting in sufficient detail to permit a member receiving the notice to form a reasoned judgment concerning that business.

Chair of general meeting
3.4 Any director or member may chair meetings; rotating chair responsibility as per agreeance of the quorum.

Alternate chair of general meeting
3.5 If there is no individual entitled under these Bylaws who is able to preside as the chair of a general meeting within 15 minutes from the time set for holding the meeting, the voting members who are present must elect, by consensus, an individual present at the meeting to preside as the chair.

Quorum required
3.6 Business, other than the election of the chair of the meeting and the adjournment or termination of the meeting, must not be transacted at a general meeting unless a quorum of voting members is present.

Quorum for general meetings
3.7 The quorum for the transaction of business at a general meeting is 3 voting members or 10% of the voting members, whichever is greater.

Lack of quorum at commencement of meeting
3.8 If, within 30 minutes from the time set for holding a general meeting, a quorum of voting members is not present,

(a) in the case of a meeting convened on the requisition of members, the meeting is terminated, and

(b) in any other case, the meeting stands adjourned to the same day in the next week, at the same time and place, and if, at the continuation of the adjourned meeting, a quorum is not present within 30 minutes from the time set for holding the continuation of the adjourned meeting, the voting members who are present constitute a quorum for that meeting.

If quorum ceases to be present
3.9 If, at any time during a general meeting, there ceases to be a quorum of voting members present, business then in progress must be suspended until there is a quorum present or until the meeting is adjourned or terminated.

Adjournments by chair
3.10 The chair of a general meeting may, or, if so directed by the voting members at the meeting, must, adjourn the meeting from time to time and from place to place, but no business may be transacted at the continuation of the adjourned meeting other than business left unfinished at the adjourned meeting.

Notice of continuation of adjourned general meeting
3.11 It is not necessary to give notice of a continuation of an adjourned general meeting or of the business to be transacted at a continuation of an adjourned general meeting except that, when a general meeting is adjourned for 30 days or more, notice of the continuation of the adjourned meeting must be given.

Order of business at general meeting

3.12 The order of business at a general meeting is as follows:

(a) elect an individual to chair the meeting, if necessary;

(b) determine that there is a quorum;

(c) approve the agenda;

(d) approve the minutes from the last general meeting;

(e) deal with unfinished business from the last general meeting;

(f) if the meeting is an annual general meeting,

(i) receive the directors' report on the financial statements of the Society for the previous financial year, and the auditor's report, if any, on those statements,

(ii) receive any other reports of directors' activities and decisions since the previous annual general meeting,

(iii) elect or appoint directors, and

(iv) appoint an auditor, if any;

(g) deal with new business, including any matters about which notice has been given to the members in the notice of meeting;

(h) terminate the meeting.

Methods of voting

3.13 At a general meeting, voting is by a show of hands, and one hundred percent consensus of voting members must be reached before a decision is made.

Announcement of result

3.14 The chair of a general meeting must announce the outcome of each vote and that outcome must be recorded in the minutes of the meeting.

Proxy voting not permitted

3.15 Voting by proxy is not permitted.

Matters decided at general meeting by ordinary resolution

3.16 A matter to be decided at a general meeting must be decided by ordinary resolution unless the matter is required by the Act or these Bylaws to be decided by special resolution or by another resolution having a higher voting threshold than the threshold for an ordinary resolution.

Part 4 — Directors

Number of directors on Board

4.1 The Society must have no fewer than 3 and no more than 11 directors.

Election or appointment of directors

4.2 At each annual general meeting, the voting members entitled to vote for the election or appointment of directors must elect or appoint the Board.

Directors may fill casual vacancy on Board

4.3 The Board may, at any time, appoint a member as a director to fill a vacancy that arises on the Board as a result of the resignation, death or incapacity of a director during the director's term of office.

Term of appointment of director filling casual vacancy
4.4 A director appointed by the Board to fill a vacancy ceases to be a director at the end of the unexpired portion of the term of office of the individual whose departure from office created the vacancy.

Part 5 — Directors' Meetings

Calling directors' meeting
5.1 A directors' meeting may be called by any 2 directors.

Notice of directors' meeting
5.2 At least 2 days' notice of a directors' meeting must be given unless all the directors agree to a shorter notice period.

Proceedings valid despite omission to give notice
5.3 The accidental omission to give notice of a directors' meeting to a director, or the non-receipt of a notice by a director, does not invalidate proceedings at the meeting.

Conduct of directors' meetings
5.4 The directors may regulate their meetings and proceedings as they think fit.

Quorum of directors
5.5 The quorum for the transaction of business at a directors' meeting is a majority of the directors.

Part 6 — Board Positions

Election or appointment to Board positions
6.1 Directors must be elected or appointed to the following Board positions, and a director, may hold more than one position:

(a) secretary;
(b) treasurer.

Directors at large
6.2 Directors who are elected or appointed to positions on the Board in addition to the positions described in these Bylaws are elected or appointed as directors at large.

Role of secretary
6.3 The secretary is responsible for doing, or making the necessary arrangements for, the following:

(a) issuing notices of general meetings and directors' meetings;
(b) taking minutes of general meetings and directors' meetings;
(c) keeping the records of the Society in accordance with the Act;
(d) conducting the correspondence of the Board;
(e) filing the annual report of the Society and making any other filings with the registrar under the Act.

Absence of secretary from meeting
6.4 In the absence of the secretary from a meeting, the Board must appoint another individual to act as secretary at the meeting.

Role of treasurer
6.5 The treasurer is responsible for doing, or making the necessary arrangements for, the following:

(a) receiving and banking monies collected from the members or other sources;
(b) keeping accounting records in respect of the Society's financial transactions;
(c) preparing the Society's financial statements;
(d) making the Society's filings respecting taxes.

Part 7 — Remuneration of Directors and Signing Authority

Remuneration of directors
7.1 These Bylaws do not permit the Society to pay to a director remuneration for being a director, but the Society may, subject to the Act, pay remuneration to a director for services provided by the director to the Society in another capacity.

Signing authority
7.2 A contract or other record to be signed by the Society must be signed on behalf of the Society

(a) by the secretary, together with one other director,
(b) if the secretary is unable to provide a signature, by the treasurer together with one other director,
(c) if the secretary and treasurer are both unable to provide signatures, by any 2 other directors, or
(d) in any case, by one or more individuals authorized by the Board to sign the record on behalf of the Society.
(e) after meeting minutes are circulated, directors and members who were not present at the meeting will have two (2) days to veto any decisions that were made; in the event of a veto, item to be discussed for consensus at the next meeting.

II – Constitution

Constitution of the Coalition of Peers Dismantling the Drug War

1 – Preamble

After 3 years of crisis, the Coalition of Peers Dismantling the Drug war has come together out of the collective pain of the damage caused by institutional inaction against the tainted drug supply that exists in “British Columbia” and elsewhere. Despite all of government’s so called "best efforts", we have not seen a reduction in the rate of death from overdose in our communities, which, at the time of writing, is nearly 5 times that of the murder rate in this country. The blood is on our societies’ collective hands, and we are a community that has suffered immensely under the Kafkaesque mismanagement of public health policy and state repression.

Problematic drug use is largely the by-product of a trauma, and the war on drugs is the result of nothing more than racism and colonialization. The racist nature of prohibition and the war on drugs in

Canada began with prohibitive laws targeting indigenous folks who were drinking in the 1860s, and continued through the opium act at the turn of century which targeted Chinese immigrants. There are evidence based solutions to the existing illicit drug poisoning crisis, but they are largely ignored at the expense of those that the war on drugs is designed to punish.

The health industry works under the guise that it wants to help the people, it consults with people who use drugs, but this remains largely tokenistic window-dressing when it ignores what they say. If this industry truly wants to help the people - who have spoken over and over - there must be a safe supply of drugs and there must be safe spaces for drug users to go, free from repression, threats to their health and further stigmatization.

The CPDDW believes that a safe supply of drugs doesn't mean an inaccessible high barrier supply of drugs; it means the provision of a clean and safe supply of ALL scheduled drugs for ALL people, a supply that is readily available and does not follow a medicalized model. Alcohol prohibition failed in the exact same way as our current prohibition on drugs, and existed for similar reasons. Drug users don't want to be outsiders, of course they'd like to come in from the cold, but how does society expect them to do so when it telling them that their fundamental existence is criminal.

When society spend every increasing funds on police, while the police bully the poor and destroy the little possessions they have, but refuses to address ongoing concerns about the war on drugs, our coalition asks where priorities lie. Drug users need safe places to use their drugs regardless of preference or root of administration. Drug users want community safety. They need real housing and spaces to exist within.

We have an obligation, as citizens of a democracy, to care for our fellow human beings. We must stop ignoring the evidence, provide a safe supply of drugs in a real way, provide outreach to folks most in need, and provide folks with places to go. This is not a game. These are people's lives at stake and we will protect them.

"By breaking the rules of the game, one has disrupted the game as such. One has exposed it as a mere game. One has shattered the world of appearances, the fundamental pillar of the system. One has upset the power structure by tearing apart what holds it together. One has demonstrated that living a lie is living a lie. One has broken through the exalted facade of the system and exposed the real, base foundations of power. One has said that the emperor is naked. And because the emperor is in fact naked, something extremely dangerous has happened: by one's action, one has addressed the world. One has enabled everyone to peer behind the curtain. One has shown everyone that it is possible to live within the truth. Living within the lie can constitute the system only if it is universal. The principle must embrace and permeate everything. There are no terms whatsoever on which it can co-exist with living within the truth, and therefore everyone who steps out of line denies it in principle and threatens it in its entirety." -Vaclav Havel

2 – The Name of the Society

The name of this society is the Coalition of Peers Dismantling the Drug War.

3 – Purpose of this Society

The CPPDW advocates for the following:

1. The end of the drug war and total dismantling of the CDSA and rescheduling of all drugs.
2. A safe demedicalized supply of all drugs, accessible to all people.
3. The release of all prisoners of drug war and total dismantling of the prison-industrial complex.
4. Employment of people who use drugs as stakeholders in all systems of biopower management.
5. Permanent, stable, and tenant controlled low barrier housing for low income individuals.

The CPPDW seeks direct and immediate solutions to the lack of a safe supply of drugs by any means necessary.

4 – Winding up or Dissolution

In the event of winding up and dissolution of the society, the funds of the society remaining after the satisfaction of its debts and liabilities shall be distributed among other organizations promoting the same purpose and which are duly qualified as charitable organizations by Revenue Canada according to a motion adopted by the majority of the society's members at the time of winding up and dissolution. This provision is unalterable.

How to Take Minutes at a Meeting

Taking good meeting minutes at a board meeting is an important and fulfilling role. Meeting minutes are more than a general accounting of discussions; they serve as an official and legal record of the meeting of your society. Minutes are used in a variety of ways including tracking progress, detailing future plans, and serving as a reference point. Among other things, your meeting minutes should reflect a record of motions, votes, and abstentions.

Taking Meeting Minutes Step by Step

Generally speaking, the note taker at a meeting has the role of secretary; this person will essentially have four steps involved with recording effective meeting minutes. They may need to spend a little time planning before the meeting, take notes during the meeting, and writing a formal report after the meeting. They will also be responsible for filing and sharing the minutes of each meeting.

Step 1: Preparation for Meeting

Every organization records their minutes a little bit differently. Have a discussion with the members of your group about any current or expected formats that you are expected to use. Review past meeting minutes to use as a template.

Generally speaking the secretary will prepare a meeting agenda before the meeting which includes the names of all attendees, guests or speakers.

Please see ***Appendix A*** for an example agenda format.

Step 2: Taking Record of the Meeting

Unless your organization requires you to type notes at the meeting, you can either type them out or write them longhand. The two most important things to know when taking the record of the meeting is what information to record and how to present it.

Meeting minutes should generally include:

1. Date of the meeting
2. Names of the meeting participants and absentees
3. Corrections and amendments to previous meeting minutes
4. Additions to the current agenda
5. Motions taken or rejected
6. Voting
    a. That there was a motion and second, and the outcome of the vote
7. Actions taken or agreed to be taken
8. Next steps
9. Items to be held over or tabled
10. New business
11. Next meeting date and time

Meeting minutes sometimes include the following:

1. Time the meeting was called to order
2. Whether a quorum is present
3. Open discussion or public participation
4. Time of adjournment

How you detail the discussions during a meeting is as important as making sure to include as much of the information in the bullets shown above as possible.

For each agenda item, you may want to write a short statement of each action taken by the group, along with a brief explanation of the rationale for their decision. If there are extensive arguments, write a succinct summary of the major arguments.

It is important to record discussions as descriptively as possible, but also to avoid inflammatory remarks and personal observations. A good way to do this is by avoiding adjectives and adverbs whenever possible. Check your language to be sure that it is clear, unambiguous, and complete.

As noted earlier, minutes are an official and legal record of the board meeting. In a legal arena, meeting minutes are presumed to be correct and can be used as legal evidence of the facts they report. Hence it is important to document discussions to accurately reflect the actions and intentions of the group. Societies and boards generally have legal liability, so try keeping information basic and language simple to avoid any legal complications that place the organization at a disadvantage in any legal proceedings. Use names only when recording motions and seconds.

After the meeting, you will want to write the formal record when everything is still fresh in your mind, so prepare the record as soon after the meeting as you possibly can.

Step 3: Writing the Official Record of the Meeting Minutes

Review the agenda to gain the full scope of the meeting. Add notes for clarification. Review actions, motions, votes, and decisions for clarity. Edit the record so that the minutes are succinct, clear, and easy to read.

It's better to attach meeting handouts and documents that were referred to during the meeting to the final copy, rather than summarizing the contents in the minutes.

Step 4: Signing, Filing and Sharing Minutes

Follow your organization's by-laws and protocols for singing and storing minutes. It's a good idea to have back-up copies either in print, a hard drive, or (best case) a unique internet portal.

Generally, the secretary also has the responsibility for sharing minutes, but ensure you are following your group's rules surrounding the sharing of minutes.

Helpful Tips for Taking Meeting Minutes

1. Use a template
2. Check off attendees as they arrive
3. Do introductions or circulate an attendance list

4. Record motions, actions, and decisions as they occur
5. Ask for clarification as necessary
6. Write clear, brief notes-not full sentences or verbatim wording
7. Maintain the same verb tense

Common Mistakes in Taking Board Meeting Minutes

1. Ambiguous description of board actions
2. Including information that could harm the group in a legal sense
3. Lengthy delays in providing minutes after a meeting
4. Delays in approving minutes from past meetings-missing mistakes
5. Failing to file and manage documents
6. Failing to get documents signed if necessary so they serve as an official and legal record

Always be mindful that the purpose of taking meeting minutes is to reflect the true intentions of the group and that they are an official and legal record. Given the breadth of detail and complexity of process associated with proper documentation of meeting minutes, many organizations find using a tool, such as a board portal software, helps make this work easier and more efficient, and can ultimately elevates organizational performance. As serious as the job is, the task of taking and preparing minutes is a rewarding and edifying experience.

APPENDIX A – Example Meeting Minutes

Coalition of Peers Sweeping Up the Streets
Meeting Minutes

Meeting Date: Wednesday January 55, 2999
Meeting Location: The Box Factory

In attendance: Davide, Michelle, Samantha
Regrets: Jeff Jefferson
Absent: Lum Lum

Check In

Review of Action Items:

-*Lum Lum will ensure we have clean needles to give out*

-*Davide will draft a statement to the press about our success as a project*

Financial Report:

-We have approximately have $20 in the bank, and $200 cash.

Other Agenda Items:

-Needle sweep update *(Davide)*
-We're grabbing those needles quick as the dickens!

-Society Stuff *(Davide)*
- Has our improperly spelt society name been corrected?
  - Yes, done by Davide last week
- Have we opened a bank account?
  - Yes, Lum Lum did it last week.

-Legal stuff *(Michelle)*
-We need help from a lawyer to get Jeff Jefferson out of jail for our political action last week.
-*Tabled until next meeting*

-Meth pipe vending machine *(Samantha)*
-Can we use some of our funding to run a meth pipe vending machine?
-Motion put forward by Davide, seconded by Michelle – all in favour

-Communications *(Davide)*
-Davide to go to the media with an update on our success story.

-Next meeting?
-Next Wednesday at 5pm

Things to consider when Hiring or Organizing with People who Use Drugs

I – Acknowledgement

This document takes direction from a contract designed by the RainCity Peer Witness Pilot; a group of non-unionized peers was formed in January 21st 2017 in response to the drug poisonings in Vancouver BC.

The BCCDC acknowledges that initiatives addressing the harms associated with illicit drug use must always include the meaningful involvement of people who use drugs to be effective and just, and that people of lived experience on the front lines play a crucial role in saving vulnerable people's lives.

II – Role Summary

The first piece of information you will want to give s perspective hire is a summary of their role within your organization.

Information you may want to include is as follows:

- Who does this person report to and how?
- What is the goal of their job?
    - *Examples include*:
        - Promoting the safety and comfort of people accessing an OPS Site by providing non-judgmental, experience-based drug use witnessing;
        - Support and counseling;
        - Provide safer use info (including instruction on the use of Naloxone);
        - Providing other peer-based supports including informal relational support;
        - OD response;
        - Keeping the community free from needles.
- Who else will the peer be interacting with?
    - What other service providers or institutional staff will the peer have to engage with?
    - Will the peer be engaging with the police?
- Is disclosure of past substance use precondition for the job?
- What other skillsets are required?
    - Examples include:
        - Computer literacy;
        - Ability to take notes or record stats;
        - Ability to write about their experiences;

- Promotion of the safety, comfort and well-being of the folks they are engaging with

III – Expectations

It is important that folks you are working with understand what is expected of them while they are at work. The next important piece of information to share with a perspective hire are their workplace expectations. Workplace expectations may include the following:

a) *Adherence to expectations and follow up:*
   - How are expectations formed? More importantly, are they developed with the group of peers that you are working with?
   - Is your group's leadership committed to supporting staff and helping them to negotiate and adhere to expectations with a strengths-based and harm-reductive approach?
   - Is it expected and encouraged that staff will be in regular contact with leadership in order to ensure they are well-supported and able to meet expectations, especially in situations of ethical complexity and ambiguity?
   - If an inability to meet expectations results in a decision by leadership to remove a peer from their role, can a peer request an appeal of this decision and/or a review by the rest of the team?

b) *Governance:*
   - Are peers made aware of governing decisions made by the group's leadership or decisions made by the team as a whole?
   - What happens if a peer dissents from a decision made by group's leadership?

c) *Attendance:*
   - What is the flexibility surrounding a peer missing work?
   - Will failure to communicate about reasons for absence result in removal from scheduled shifts?
     - *Example: Without explanation 3 missed shifts will result in removal from the schedule.*

d) *Dual Relationships/Professional Boundaries:*
   - Peer work is relational in nature and a peer's familiarity with and connection to communities is an essential area of expertise and qualification for their role. As such, it should be expected that peers will frequently encounter overlap of their personal relationships and relationships with folks accessing their services.
   - To mitigate the potential for harm caused to peers and those they know outside of work, because of these dual relationships and the inherent imbalance of power created by a service provider/service recipient relationship, you may want to ask that:

    - Peers exercise transparency by reporting dual relationships to leadership, and the team whenever possible.
- If a peer is unsure of how to balance their job expectations and the immediate requirements of a personal relationship while on shift, peers may want to request support from leadership to decide on the best approach.

e) Inappropriate/Violent Behaviour:

- What is the tolerance policy towards any behaviour that could be considering harmful to folks accessing the peer's services?
- These behaviours include but are not limited to things like:
    1. Use of violent and discriminatory language, including racism, sexism, homophobia, transphobia, ableism, poor bashing, body shaming, drug use shaming, or any other language which a service recipient or co-worker has identified as making them feel unsafe.
    2. Sexualized language and un-solicited comments about service recipients' physical appearance.
    3. Verbal threats, intimidation and baiting/escalation.
    4. Non-consensual touching of any kind.

f) *Fitness for Duty:*

- Peer work should not be purely abstinence based or oriented solely to those in recovery. This means that peers may use or be under the influence while at work; the BCCDC advocates for a policy for peer workers to be "well not high". This means that a peer may use or be under the influence of drugs while on shift, but must also be able to perform their shift duties.
- What is your group's expectation in regards to peers performing their professional duties in a coherent, competent, and respectful manner while representing the organization, regardless of whether they are using drugs?
- Some things you should consider are what to do if a peer is:
    1. Feeling they are inebriated in any way which impairs their ability to keep service users safe.
    2. Are exhibiting sleepy behaviors related to fatigue or substance use which may cause them to lack awareness of their surroundings ("nodding", napping, etc.).
    3. Are exhibiting signs of agitation or irritability which cause those around them to feel unsafe.
    4. Are exhibiting signs of disorientation.
    5. Are exhibiting impaired ability to communicate (i.e. heavily slurred/incomprehensible speech, delayed or absent response)
    6. Are exhibiting uncontrolled/erratic movements or other signs of impaired motor control which may put themselves or others at risk.

g) *Non-discrimination in the Workplace:*
    - Are peers expected to uphold antidiscrimination policies and if so what are they?
    - Are peers obligated to serve everyone with the same quality of service and in the same nonjudgmental manner? If not, why?

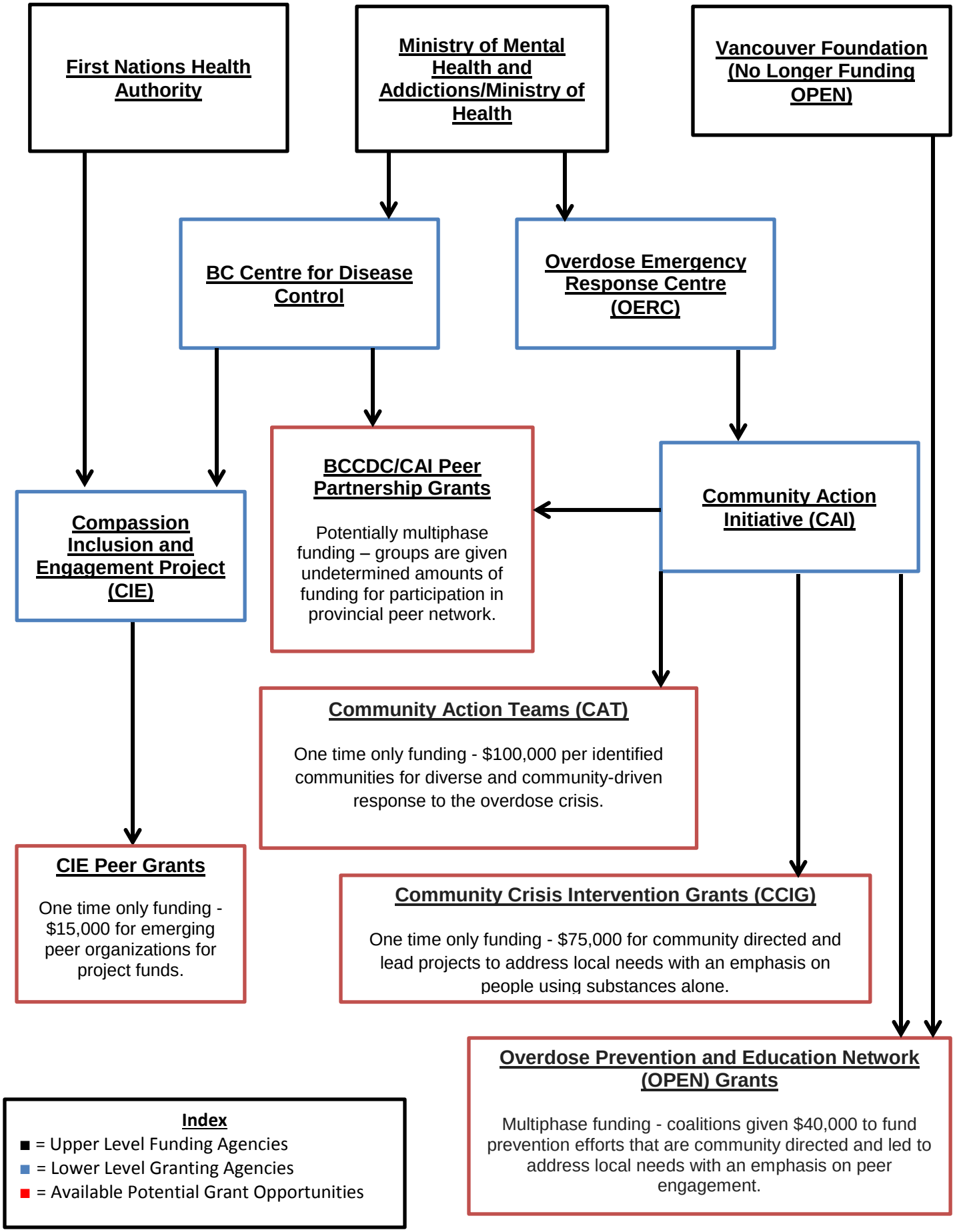
IV – Qualifications

The final pieces of information to include for perspective hires are the qualifications necessary for a peer to work for your organizations.

Some things to consider are whether or not the peer has:

- Direct lived experience with drug use
- Direct lived experience of related health and social conditions such as poverty, sex work, homelessness and/or other physical or mental health issues,
- Current knowledge of the local street scene, community resources, and cultural norms related to street life.

Eris' Overdose Emergency Response Funding Flowchart



How to Receive an Income Exemption for your Peer Group under Current British Columbia Ministry of Health Policy

Last updated January 28, 2019.

I - Background

Drug users are often the first responders to overdose events and should be paid fairly for their contributions to research, service delivery and overdose prevention activities. Unfortunately, peers are frequently paid cash stipends below the minimum wage, meaning that drug users' knowledge and labour becomes vastly undervalued. Current Ministry of Social Development policy relating to income claw-back prevents peers from making over certain levels of income per month if they receive welfare or disability assistance. Unlike professional workers such as paramedics and firefighters, many peer support volunteers are dealing with the loss of their friends, with no formalized supports in place. To combat the existing wage gap between peer workers and other service providers, the BCCDC, with the assistance of the OERC, Raincity Housing, and partners at the Ministry of Social Development, have worked out a way to prevent peer income claw-back due to individual's income surpassing set monthly earning exemptions (see below). Although we recognize this exemption contains many problematic elements, it is of utmost importance that individuals are compensated fairly for their contributions to current overdose prevention services. As such, we hope this exemption helps to further secure a living wage for peers on the frontline of the overdose crisis.

Any questions about this document can be directed to Eris Nyx at the BCCDC – eris.nyx@bccdc.ca

II - Essential Elements Required for a Program to fit into Policy

For a program's peer payments to be considered exempt, and therefore not subject to claw-back from a person's PWD (Persons with a Disability) or IA (Income Assistance) payments, the peer support program must:

1) Be run in accordance with Ministry of Health/Health Authority peer support manual.

- Examples can be found here: https://towardtheheart.com/assets/uploads/1502392095pS7Cr8pMMC3xed4576edy2mHGOyNxJnLFCmcbzU.pdf https://www.health.gov.bc.ca/library/publications/year/2001/MHA_Peer_Support_Manual.pdf
- Note: Health authority endorsement is important!

2) Make payments to peer workers who have a 'mental disorder'.

- Note: 'Mental disorder' can include a *person with addictions.*

3) Receive funding, in some part, from the Ministry of Health or affiliated provincial healthcare organizations (e.g. BC Centre for Disease Control).

If confirmation of above can be provided and endorsed by the organization running the program, the Ministry of Social Development will consider the payments to peers as exempt from claw back.

In order to qualify for the exemption of peer payments, please send a description of your program, preferably using the attached form, as well as an endorsement from the Health Authority the program resides in, to Dave Jagpal at the Ministry of Social Development and Poverty Reduction

(dave.jagpal@gov.bc.ca). If one requires help with their application, they can contact Eris Nyx at the BCCDC with questions (eris.nyx@bccdc.ca)

III - Example Program Description

This pilot is a volunteer/honorarium-based program funded by [*insert health authority*] until [*insert funding date*] to operate in [*insert program location*] as a complement to the existing overdose prevention services in the province. Its intention is to provide peer-based support in order to increase safety and comfort for those most directly affected by overdose. Please be advised that self-disclosure of recent or active lived experience is a pre-requisite condition for participation in this program.

Note: Further program-specific details must be included in your program description including an outline of specific case by case achievements or statistics.

IV - Ministry of Health /Health Authority Therapeutic Volunteer Program and Other Volunteer Payments

- Peer payments qualify for income exemptions under the following stipulations: https://www2.gov.bc.ca/gov/content/governments/policies-for-government/bcea-policy-and-procedure-manual/eligibility/income-treatment-and-exemptions
- MOH refers to the Ministry of Health.
- A designated agency refers to an agency that has been approved by a health authority to provide services on its behalf, in accordance with regulations and policies the health authority is subject to.
- A client with a mental disorder refers to a person with a mental health and/or substance abuse disorder using the services of a health authority or a designated agency of a health authority.

Description	Income Status	Treatment	Income Type
Therapeutic Volunteer Supplement (TVS)			
Payments by a *health authority,* or a designated agency, to a client with a mental disorder participating in the Therapeutic Volunteer Program	Not considered income	Exempt	4B – Therapeutic Volunteer Supp
Other Payments by a health authority or a designated agency			
Payments to a person with a mental disorder and/or to a volunteer who has a mental disorder, for the cost of fees for participating in recreation or leisure activities.	Not considered income	Exempt	4C – Other MOH Volunteer Pmnts
Payments to a person with a mental disorder to cover the cost of participation as a presenter or participant in training and education	Not considered income	Exempt	4C – Other MOH Volunteer Pmnts

seminars and conferences, public lectures on mental health/addictions treatment and management, and other related topics.			
Payments to a person with a mental disorder who provides formal or informal peer support, in accordance with the Ministry of Health Peer Support Manual.	Not considered income.	Exempt	4C – Other MOH Volunteer Pmnts
Payments to a person with a mental disorder to cover the costs of travel, meals and honoraria for clients who are invited to participate in discussions with health authorities, or who present information regarding the planning, delivery or evaluation of mental health and addictions services.	Not considered income	Exempt	4C – Other MOH Volunteer Pmnts

Note: Proof of an official diagnosis is not a requirement (nor should organizations ask for proof as they are at risk of violating privacy laws) for participation in peer support, however self-disclosure of recent or active lived experience of problematic substance use is.

V - What to do if Payments Received by Peers don't fall within the Scope of the MoH Peer Support Manual?

- If peer payments do **NOT** fall within the above categories, they may still be exempt due to earnings exemption clauses within the Ministry of Social Development and Poverty Reduction (MSDPR) legislation.

- Please note that the MSDPR legislation defines earned income as "any money or value received in exchange for work or the provision of a service".

- For people receiving payment through a peer support program that doesn't fall with the MoH Peer Support Manual, the payment would likely be subject to earnings exemptions at the amounts described below.

Monthly Earnings Exemptions – Income Assistance and Disability Assistance

- Income assistance and disability assistance clients are eligible for a monthly earnings exemption. The level of exemption is based on family unit size and composition – see tables below.

Income Assistance	
Eligible Clients	**Earnings Exemption Amount (per month)**
All family units, including individuals eligible for income assistance who are not listed below.	$400

All family units with a *dependent child* or caring for a *supported child.*	$600
A family unit where at least one individual is a **Person with Persistent Multiple Barriers (PPMB).**	$700
All family units with a dependent child with a severe disability or who care for a supported child with a severe disability where the disability of the child precludes a parent from working outside the home for more than 30 hours per week.	$700

Disability Assistance		
Eligible Clients	**Base amount (multiplied by the # of qualifying months in the calendar year).**	**Maximum Annual Earnings Exemption (full calendar year).**
A family unit with one adult recipient who has the PWD designation.	$1,000	$12,000
A family unit with two adult recipients where **only one** recipient has the PWD designation.	$1,200	$14,400
A family unit where **both** individuals have the PWD designation.	$2,000	$24,000

Application for Income Exemption under the Ministry of Health /Health Authority Therapeutic Volunteer Program and Other Volunteer Payments

Organization Name:

Peer Engagement and Evaluation Project

Organization Funder:

PHSABC via the BC Centre for Disease Control

Organization Description:

Previously the Peer Engagement and Evaluation Project, the PEEP Consultation and Advisory Board work as provincial consultants to inform and advise on harm reduction services and peer initiatives including, but not limited to, harm reduction policies and documentation. The goal of the PEEP Consultation and Advisory Board is to use folks with lived experience to inform and enhance peer engagement with best practice recommendations so service providers BC wide can work with peers in their communities to better meet local needs. This board builds on existing peer relationships and explores new ways for more meaningful, ongoing dialogue with service providers and community partners. PEEP works to establish peer engagement as the norm in BC and expand the opportunities for voices of peers who have been missing from our table (e.g. those from remote/rural regions), and to empower and inspire peer leaders who bring a broader representation of the voices of people in their communities and become part of BC Harm Reduction Strategies and Services. PEEP is a consultation board that contains peers in every health region, and aims to develop guidelines that can be implemented and evaluated to establish best practice recommendations. The PEEP Consultation and Advisory Board requires self-disclosure of recent or active lived experience of substance use as a pre-requisite condition for participation.

Organizations Key Projects:

- Helped to produce *PEER Engagement Principles & Best Practices: A Guide for BC Health Authorities and Other Providers*
    - Available here: http://www.bccdc.ca/resource-gallery/Documents/PEEP%20Best%20Practice%20Guidelines.pdf
- Helped to produce *A Guide for Paying Peer Research Assistants: Challenges and Opportunities*
    - Available here: https://towardtheheart.com/assets/uploads/1502392095pS7Cr8pMMC3xed4576edy2mHGOyNxJnLFCmcbzU.pdf
- Helped to produce How to Involve People Who Use Drugs in Decision-Making Meetings
    - https://towardstheheart.com/assets/uploads/15161442266vojisI05U2QPZPuPU4p56pnp6FOSjcoMnObC2L.pdf
- Further consulting and recommendations for the BCCDC.

What Document Underpins the Organizations Ethics?

PEER Engagement Principles & Best Practices: A Guide for BC Health Authorities and Other Providers

How are peers payed?

Peers at PEEP are paid an honorarium for their time, normally via direct deposit due to the diffuse nature of the project.

Exemption Type:

Description	Income Status	Treatment	Income Type
Payments to a person with a mental disorder to cover the costs of travel, meals and honoraria for clients who are invited to participate in discussions with health authorities, or who present information regarding the planning, delivery or evaluation of mental health and addictions services.	Not considered income	Exempt	4C – Other MOH Volunteer Pmnts

Qualification Check List		
	Yes?	**No?**
Is the organization run in accordance with the Ministry of Health/Health Authority Peer Support Manual?	**X**	
Does the organization make payments to peer workers who have a mental disorder or addictions issues?	**X**	

THE MENTAL HEALTH ACT AND YOU

When you are admitted to the psychiatric ward of the hospital, you may be admitted either voluntarily or involuntarily. Depending on your status of admission, you have different rights under the law (Mental Health Act of BC). The following outlines your rights and responsibilities.

Voluntary Admission to Hospital

If you choose to be admitted to the hospital for a mental illness, it means that you are fully aware of your situation and voluntarily enter treatment in the hospital. Even though you choose to do this, it can be a time when you are unsure of your rights as a citizen and as a person using mental health services.

In Canada, all citizens are governed by the Canadian Charter of Rights and Freedoms. These broad rights guide the way our society treats all individuals in Canada. The Charter may be viewed on the web at http://laws.justice.gc.ca/en/charter.

If you want to leave the hospital and were voluntarily admitted, the director must be told immediately of any patient who is voluntarily admitted who wants to be discharged and any patient over 16 years admitted voluntarily must be discharged if s/he wants to leave.

Involuntary Admission to Hospital – "Committed"

Under Section 28 of the mental health act a member of the police may pick up a person they believe has a mental disorder and take them to a doctor or hospital Emergency ward for an examination. Note that substance use disorders can be considered "mental disorders". Upon arrival at the hospital, the person must be let go if a doctor does not complete the necessary medical certificate.

With this being said, a judge or justice may issue a warrant to have a person picked up for examination if they believe there are sufficient reasons to believe that the individual meets the requirements, and the usual methods of involuntary committal would take too long. The written authorization of a warrant is enough to pick up a person, take them to a designated facility, and admit them for treatment for a period of up to 48 hours. After 48 hours, if the director has not received 2 completed medical certificates stating how the person meets the criteria for involuntary admission, the patient must be discharged."

When you are involuntarily admitted or "committed" to a hospital for a mental illness or disorder, you come under the Mental Health Act of British Columbia. This means that you do not have a choice about staying in hospital. Under the Mental Health Act, the staff will see that you receive medication or treatment for your disorder even if you are against taking it.

The Mental Health Act is intended to help people with mental disorders to obtain treatment and care that medical doctors believe is needed when a person does not recognize they are ill. The Act also is intended to provide safeguards for the rights of people who are involuntarily admitted to a psychiatric facility. A plain language version of the Act may be found at www.cmha-bc.org/content/resources/cmhapubs/cmhapubs.htm or the official government version at www.healthservices.gov.bc.ca/mhd/publications.html

Criteria for Involuntary Admission Section 22/Mental Health Act of BC

If you are admitted involuntarily to the hospital for care and treatment it is because two doctors have separately examined you and it is their opinion that:

1. You are suffering from a mental disorder that seriously impairs your ability to react appropriately to your environment or to associate with others; and,
2. You require treatment from this hospital so that you do not become more ill; and,
3. You should be in hospital to prevent your substantial mental or physical deterioration or to protect yourself or other people; and,
4. You probably would not seek help on your own.

You may be admitted for just a few days or for up to one month, depending upon how well you respond to treatment. However, the law requires the doctor to automatically review your situation at the end of one month.

Rights of People Involuntarily Admitted under the Mental Health Act of BC 1998

According to the law (Mental Health Act), each person who is involuntarily admitted to hospital must be made aware of their rights and sign **Form 13** indicating that they have been notified of their rights under the Act. A copy of the 1998 Mental Health Act must be available for people in the hospital to review. Rights of people involuntarily admitted must be posted on a nearby bulletin board.

1. You have the right to know the name and location of the hospital and ward to which you have been involuntarily admitted.
2. You have the right to know why you have been involuntarily admitted to this hospital.
3. You have the right to get advice from a lawyer about this admission at any time.
4. You have the right to a Review Panel Hearing if you or a person on your behalf thinks you are ready to leave the hospital.
5. You have the right to a second medical opinion about your psychiatric treatment if you or someone on your behalf questions it.
6. You have the right to look at the documents authorizing your involuntary admission to ensure that you have been treated according to the law.
7. You have the right to appeal to the Supreme Court if you want a judge to decide whether or not you should stay in hospital.

A copy of Form 13 and the “Rights Under the Mental Health Act” are available at**:**
www.healthservices.gov.bc.ca/mhdforms/mhdforms.html

Need help?

If you believe your rights have been breached, then it may be helpful to talk or write directly to the person or organization giving you the services. Sometimes they will welcome the complaint or concern as it helps them to improve their standard of service or uncover a problem.

If you feel uncomfortable or unable to do this, you can take a friend, relative or advocate with you as support. You also have the support of the Hospital Patient Representative who is trained to help people resolve health care concerns. This service is for free.

Be sure to address your concern fairly and respectfully. Some communities may have access to mental health advocates who will help you work through your concerns. There are provincial

organizations like the BC Coalition for People with Disabilities or the office of the Ombudsman or the Minister of State for Mental Health who are also available to help you address your concerns if you cannot get them resolved locally.

For More Information:

• Office of the Ombudsman
1-800-567-3247 or www.ombudsman.bc.ca

• Freedom of Information and Privacy Commissioner
1-800-663-7867 or www.oicbc.org

• BC Human Rights Tribunal
1-888-440-8844 or www.bchrt.bc.ca

SAFE SUPPLY

CONCEPT DOCUMENT

February 2019

Canadian Association of People who Use Drugs©

#SAFESUPPLY CONCEPT DOCUMENT

16 PAGES | TAKE AS NEEDED | USE TO PREVENT OVERDOSE DEATH | MADE IN CANADA

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Contents

The Concept of Safe Supply

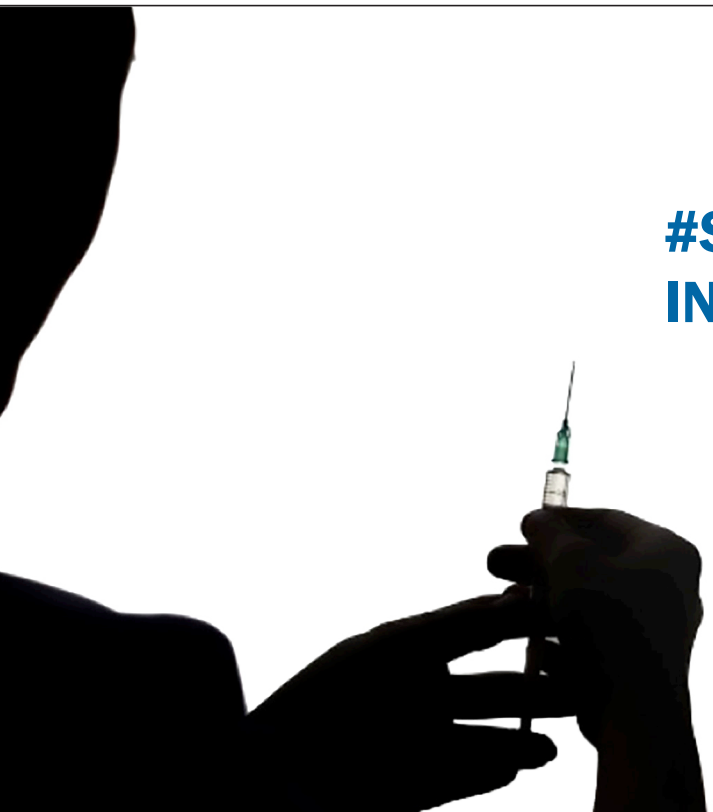
This report is a general outline of the "safe supply" concept, of what safe supply is, and the role of safe supply in drug policy. The purpose of this document is to provide clarity to what is meant by the term "safe supply" with a mind to keeping conversations on point when safe supply and drug policy are being discussed.

The safe supply ideas set out in this report are meant to be examples of how they could be provided and are not meant to form a comprehensive guideline for designing a safe supply system. Safe supply program designers should be creative and thoughtful to the needs/wants of the drug using population being served. The thoughtful approach to safe supply requires thinking as economists to imagine policies and programs that will truly appeal to those who would otherwise prefer to consume drugs purchased on the illicit market.

HOW "SAFE SUPPLY" IS DEFINED

Safe supply refers to a legal and regulated supply of drugs with mind/body altering properties that traditionally have been accessible only through the illicit drug market.

Drugs included are opioids such as heroin, stimulants such as cocaine and crystal methamphetamine, hallucinogens such as MDMA and LSD, and marijuana.



#SAFESUPPLY INCLUDES INJECTABLE DRUGS

The Need for Safe Supply

SAFETY: In the midst of the worst overdose epidemic in Canada's history, 11 people are dying every day. Most of the deaths are related to the rise of fentanyl and its analogues adulterating the illicit drug market, a reality that is likely to stay for the long term.[1] Yet, the need for safe supply has existed long before the current overdose epidemic. For many decades the drug using community has had to risk overdose, poisoning, infection, disease transmission, and death because it has been forced to rely on the illicit drug market.[2] Meaningful and purposeful expansion of the provision of safe and regulated drugs to compete with the black market will significantly curtail these harms, and is a necessary step to stop the ongoing overdose crisis.

HUMAN RIGHTS: Prohibition based drug policy is by nature dehumanizing and degrading to individuals, our society, and humanity, as the suffering it causes affects the least fortunate among us the most. Historically, prohibition has been a tool to stigmatize the poor as morally deficient by their choice to consume drugs, and therefore not deserving of even their basic needs. Safe supply changes that narrative by respecting the agency of individuals who choose to use drugs, removing the labels of "wrong" and "bad" in respect to drug using behaviour. The provision of a regulated drug supply is a necessary step to end the stigmatization of drug use and drug users.

The purpose of this document is to provide clarity to what is meant by the term "safe supply" with a mind to keeping conversations on point when safe supply and drug policy are being discussed.

JUSTICE: Abuse by the criminal justice system under the War on Drugs has disproportionately affected people of colour and the poor, especially relative to the amount of drugs consumed by society as a whole.[3] Those with more resources have better means to navigate the legal pitfalls of engaging in illicit drug use and, especially if they are white, tend to be less likely targets by law enforcement in the first place. Safe supply is a means to limit this source of stratification, allowing all drug users to feel dignified regardless of who they are in the social hierarchy and the substance they choose to consume.

EFFECTIVENESS: While different interventions work best for different individuals, the evidence is consistent in showing that people who use drugs are more likely to benefit from safe supply treatment options in comparison to more traditional treatments in terms of keeping clients on treatment, lowering their amount of illicit drug use, creating stability and improving their quality of life. For example, recent heroin maintenance trials in Vancouver involving over 200 participants had retention rates over 80 per cent after a year on treatment, and those remaining on treatment had drastic reductions in illicit opioid use.[4] In comparison, in British Columbia retention rates of new clients on methadone is under 35 per cent after a year,[5] and suboxone[6] and slow release oral morphine are similar in effectiveness.[7]

Safe Supply and the Harm Reduction Concept

"Safe supply" is an element of harm reduction, as it is a strategy designed to reduce the risks associated with drug use in a criminalized context. Like harm reduction, safe supply is based on a moral foundation that the individual choosing to use drugs has the right to do so and people who use drugs should not be treated as morally deficient, be criminalized, or deemed mentally ill for their drug use. However, there are some conceptual dilemmas that exist with the harm reduction concept creating a need for safe supply to exist as its own category. Harm reduction has essentially been a strategy for reducing the harm and risks of drug use that arise from drug prohibition. Needle exchanges, supervised injection sites, and drug checking machines all require the existence of the current morally-based punitive drug policy framework in order to have their meaning and/or utility as harm reduction.

If a morally neutral drug policy framework were in place, there would not be a need for a special philosophy to justify providing services that are essentially basic health care to people who use drugs. For example, sterile needle distribution would simply be considered standard practice in health care if not for the backdrop of the War on Drugs. The practical need for drug-checking machines, naloxone, and supervised consumption sites would be greatly diminished if drug consumers simply had access to a legal and regulated supply of drugs. In short, the conceptual dilemma of harm reduction is that its supporters often advocate for interventions (e.g., supervised consumption, drug checking, naloxone) that a fully realized harm reduction model would have much less need for if people had access to a safe and regulated supply of their preferred drugs. So in this way harm reduction gets in its own way.

#SAFESUPPLY MEANS FREEDOM.

The idea of safe supply addresses this conceptual difficulty by sorting the contradictory role of harm reduction. Harm reduction has the important role of mitigating the harms and risks that arise from drug use continuing to be criminalized, while safe supply strategies work toward new framework solutions that remove, or greatly reduce, the criminalized context of drug use altogether, preventing the harms and risks associated with it in the first place. Safe supply is the next step in the construction of a human rights based drug policy framework, whereas harm reduction is a humane response to deal with the outcomes of inhumane policy.

Safe supply is a drug policy category that ought to fit alongside other "pillars" of drug policy such as treatment, harm reduction, education, and prevention. *For humane drug policy to be comprehensive, policy makers must consider and implement safe supply measures in order to meet the needs of the significant portion of the drug using population that, for whatever reason, choose to consume drugs.*

For humane drug policy to be comprehensive, policy makers must consider and implement Safe supply measures in order to meet the needs of the significant portion of the drug using population that, for whatever reason, choose to consume drugs.

Unlike other categories, safe supply has been neglected because it does not fit well within the prohibition-based frameworks that guide drug policy in most parts of the world. As harm reduction has gained acceptance and legitimacy in some parts of the world, it has created more political space for safe supply measures to be seriously considered. If we are serious about ending prohibition then is imperative that collectively, we pursue the new political and sociological policy landscape that allows us to create drug policy based on a new framework that respects the human rights of those who choose to use drugs.

#SAFESUPPLY MEANS FREEDOM FROM INCARCERATION.

How Safe Supply Can Be Provided

The purpose of safe supply is to provide a safer way for people to access what they are seeking in street drugs. Safe supply strategies must balance the need to minimize the risks of the drug itself while ensuring dispensing models are accessible enough to "undercut" the illicit market. If the model overburdens the clients with surveillance, punitive measures, safety controls, and/or other requirements that are either too time consuming or invasive, the program runs the risk of turning clients off altogether, failing in its primary mission. Models should be designed based on the drugs being substituted, the people it is serving, and feasibility considerations.

Further considerations include:

- The drug being offered should be a safe version of the drug sought by the client, or a close approximation of that drug being sought.
- Safe supply programs should be developed in partnership with people who use drugs. Every effort should be taken to ensure an environment that resembles one that people would use drugs in. Providing an environment that is overly medicalized or clinical will turn off many people who would otherwise participate in safe supply programming.
- Respect that people use drugs to provide euphoria, not just maintenance. If safe supply doses are too low, people will continue using street fentanyl.
- Withholding drugs from someone in a program as punishment without a process that addresses the dynamics of the power imbalance between staff and patient is unethical.
- Multiple daily visits to a clinic or health care facility can be a hindrance for some people to stay in safe supply programming. Models that allow for take homes doses would increase retention and should be considered if the opportunity permits.
- Safe opioid programs typically use diacetylmorphine, the active ingredient of heroin, to substitute for heroin. Some clients of injectable programs have complained that pharmaceutical grade opioids, such as diacetylmorphine and hydromorphone, are too intense and lack the warmth of opioids found in the illicit market. Future programs may want to consider using more artisanal versions of opioids if possible.
- Since fentanyl and its analogues are being commonly used across Canada, care must be taken to understand how tolerance to a substance like fentanyl may impact an individual's dosage on a safe supply program. However, concerns about fentanyl tolerance should not dissuade decision makers from utilizing opioids like heroin and hydromorphone in their programming. Tolerance to a drug can increase quickly, but it also falls just as quickly.

- While options of dexedrine, ritalin, adderall, etc. as replacements for illicit stimulants are helpful, policy makers need to consider ways to provide regulated access to cocaine for people who seek cocaine. This drug is already used in Canada as a topical anaesthetic for some surgical procedures in a liquid hydrochloride preparation.

- The same logic applies to people using methamphetamine, which is on Health Canada's special access program in a pharmaceutical preparation (desoxyn).

DISPENSING MODELS

Moving from more controlled dispensing models to less, the following are some of the ways that can be considered for dispensing drugs to clients accessing safe supply:

1. Drugs are prescribed and administered in a supervised setting under the care of health professionals and/or peer workers.

2. Drugs are prescribed and dispensed by a health care worker or pharmacist, but have the option to administer it on their own terms outside of a supervised setting, such as their own home, in take home doses.

3. Drugs are dispensed without prescription, but are administered in a supervised setting under the care of health professionals and/or peer workers.

4. Drugs could be dispensed at entertainment venues or social settings that are licensed to do so (e.g., MDMA, alcohol, powdered cocaine).

5. Drugs can be made available without prescription in dispensaries and shops (e.g., cannabis, hallucinogenic mushrooms, poppy seed tea, opium bulbs).

STIMULANT USERS NEED #SAFESUPPLY TOO.

Some Examples of Safe Supply

ALCOHOL

The commonly used example of safe supply is alcohol, available legally and regulated in various ways throughout much of the world. In contrast to the era of alcohol prohibition early last century, when thousands of Americans perished from the effects of consuming alcohol from the black market that was either tainted or distilled very poorly, the benefits of a legal and regulated supply of alcohol is obvious.[8] During prohibition it was possible to acquire safe alcohol through prescription, but being able to dispense it in stores, bars, and restaurants with conditions has proven to be more effective in meeting the needs of alcohol consumers.

CANNABIS

Only recently has the political climate allowed for consideration of a safe supply of cannabis, even though the health risks with cannabis are generally not as severe as they are for alcohol. Traditionally one had to rely on the cannabis cafes in the Netherlands for safe supplies of marijuana, but recent developments in the Americas in the last decade and some have changed all that. Beginning in the 1990s with cannabis becoming available by prescription and administered through dispensaries in California, cannabis policy has relaxed to the point where regulated supplies of cannabis are available without prescription in a number of states in the US, as well as Canada and Uruguay.

OPIOIDS (HEROIN/FENTANYL)

Under the War on Drugs it has not been as practical or feasible politically to consider safe supply options for certain drugs such as heroin, but there are examples. Perhaps the most well known are the Heroin Assisted Treatment (HAT) clinics first set up across Switzerland, and then spread to Germany, Denmark, Spain, the Netherlands and Vancouver, Canada. In these clinics, heroin is prescribed and administered to clients on site under the supervision of health care workers. The amount of the drug prescribed is tailored to the tolerance level of the user and the aim is to give enough so there is no incentive for the client to get more from the black market. (Clinics somewhat similar to these used to operate with success in North America in the early part of last century.)[9]

In the United Kingdom, heroin has been available as a take home prescription off and on, depending on the region, for almost a century. However, the practice of take home supply has diminished greatly as the War on Drugs took its toll on UK drug policy. An interesting example was a clinic run by Dr. John Marks in Liverpool, England in the late 1980s that prescribed and administered heroin

(and cocaine) to his patients in tea-leaf cigarettes. Dr. Marks' program had a significant effect on reducing involvement in crime and lowering HIV transmission rates among the drug using population surrounding the clinic. After running for 15 years, Dr. Marks program came to an end after receiving exposure in the US media, forcing the ideologically opposed Thatcher government to take notice and intervene.[10]

In Canada as of late, injectable opioid programs are expanding beyond the Crosstown Clinic in Vancouver, although far slower than many would like considering the severity of the present overdose crisis. Regulatory barriers around diacetylmorphine have required the expanding injectable programs to rely on liquid hydromorphone, an opioid similar to diacetylmorphine (heroin) used in the SALOME clinical trial. However, the high cost of the liquid hydromorphone in Canada has led to a push to pursue administering (much cheaper) hydromorphone tablets to clients who will crush, filter, and inject them.

STIMULANTS

There is an ongoing search in the research community to find a replacement for cocaine that will retain participants in cocaine replacement trials, but the level of success has been limited. A 2016 Cochrane review of 26 studies and nine potential replacement stimulant medications concluded that although the evidence is unclear, the treatments looked promising and that the concept should be investigated further.[11] In 2007, Vancouver City Council was seriously considering implementing a large-scale stimulant replacement program testing a number of these options, but was unable to follow through with the idea.[12]

What seems clear is that stimulant replacement treatment needs to include options that resemble what people are seeking in the illicit market. We must find ways to provide regulated cocaine, to those who seek cocaine. One successful program of this sort was again by Dr. John Marks, who administered limited amounts of cocaine in tea-leaf cigarettes from his clinic in Liverpool. Vancouver's own drug research legend, Dr. Bruce Alexander, in his work on safe supply suggested that cocaine could potentially be administered as maintenance in oral form as pills, chewing gum, tea, or wine.[13] Allowing our minds to wander, perhaps a smart machine placed in a controlled setting could be designed to dispense cocaine to clients in increments agreed upon with a physician.

PARTY DRUGS

Party drugs like MDMA (ecstasy) and LSD (acid) have a reduced risk of negative physical or mental health side effects and could be sold at nightlife venues and/or music clubs. The drugs could be dispensed by specialized staff and sold behind the counter in limited amounts to people who meet certain criteria such as age and are exhibiting signs of self-control.

What Safe Supply is Not

Substitution treatments, such as methadone, buprenorphine/suboxone, and slow release oral morphine do not meet the criteria as safe supply because they do not contain the mind/body altering properties that people seek in recreational drugs. Substitution treatments have benefited many people and absolutely must be made available to anyone who is ready to make it work, but this is not what we are talking about when referring to safe supply. It should be mentioned that many people would benefit from access to both substitution treatment and safe supply options, and these options can be used in conjunction with each other.

Implementing Safe Supply

In light of the current overdose crisis and the changing realities of the illicit drug market, the benefits of expanding safe supply measures cannot be understated. Although there is not a wealth of real world models, and relatively little research for guiding the expansion of safe supply options, the following two resources do an excellent job of introducing ideas for regulating the drug industry:

- The Transform Drug Policy Foundation based out of the United Kingdom (www.tdpf.org.uk), in particular its 2009 guide *After the War on Drugs: Blueprint for Regulation*, was a helpful resource for this document and would be a great starting point for those looking for safe supply possibilities.[14]
- The 2018 report *Regulation/The Responsible Control of Drugs* by the Global Commission on Drug Policy provides a strong, balanced, and comprehensive perspective on the regulation of drugs.[15]

ASK YOUR DOCTOR ABOUT PRESCRIPTION HYDROMORPHONE.

CONSIDERING THE SYSTEM

In Canada today, and especially in British Columbia, the legal and regulatory conditions are no longer a factor preventing the expansion of decent safe supply options. And the challenge for implementing safe supply strategies is not coming up with good ideas for safe supply, but in being able to normalize those ideas and make them palatable to decision makers who ultimately answer to the public. Using a "low-hanging fruit" strategy, policy makers should first look to identify those most at risk of harm from the illicit market and provide them access to proven safe supply interventions, such as injectable treatment using heroin or hydromorphone. As these programs are implemented and improved to suit the needs of those clients, new programs can be developed and refined to suit the preferences of drug consumers who are more difficult to identify and whose needs vary more broadly. It is important that the research community be quick on its feet to collect good data from new programs in order to better inform what is working and what is not as we look to expand the safe supply system quickly.

Thankfully today, rather than criminalizing drug use, there is increasing momentum to treat drug policy as a public health issue. However, the move toward a public health approach is not complete when the legitimacy of the choice to use drugs is still not recognized and users must continue to depend on the illicit market for their supply. Solutions to the overdose crisis that centre on getting people to stop taking drugs (even if it is by putting them in treatment as opposed to jail) continues the entrenchment prohibition and the harms associated with it. Treatment options for those who want treatment are extremely important, but treatment must be made available on a policy framework based on legal and regulated supply.

CONSIDERING THE PERSONAL

As is typical of movements for social change, protectors of the current standard will first take steps to block progressive ideas altogether, and when that fails, resort to contesting and redefining progressive concepts to be less of a challenge to the way things are done. For example, the more conservative minded may look to frame safe supply options as fringe interventions that are meant to be applied only as a last resort and on a temporary basis until clients can be transitioned to the traditional treatment options. Logistical challenges (e.g., cost, space, location, staff, training), of which there will be many, will be welcomed by some to provide further reasons for not pursuing safe supply strategies at all.

Those looking to implement safe supply programs should be cognisant and emotionally prepared for the barriers and setbacks that are typical with challenging the status quo. Even though the current drug policy framework has been a disaster for our society, there are many people working within it that may see their own particular role as effective and will point to cases where they see success as reasons to avoid making significant change. It is fair to encounter resistance from people emotionally invested in the work they do that they feel works and is being threatened. It is important to engage these perspectives with a mind to being respectful and constructive.

Appropriateness of the Term "Safe Supply"

There are some who argue that "safe" in the term safe supply is inappropriate and misleading because even legal drugs have risks associated with their use. It is true the word "safe" could be misconstrued, but most should recognize its meaning by the way it is being used and in comparison to unsafe drugs. Using an analogy, we can say that thrusting a hammer toward a nail in your hand is not inherently safe, but because hammering nails is legal we can easily access hammers and nails that are "safe" and learn how to use them in safe ways. It is in this sense that legal and regulated drugs are "safe" even though there is still risk of harm. With the quality of the substance assured, people who use drugs are in a far better position to confront the risks associated with drug use.

Expectations of Safe Supply

Just as a safe supply of alcohol was not meant to solve all of the problems of alcoholism, it did provide the starting point eliminating the need to correct the many problems created from it being illegal. Safe supply works toward ending the criminalizing of the vulnerable through drug policy. Safe supply brings back the possibility of hope, stability, and dignity for people who use drugs. It will not be a "cure all," or a magic bullet, but it is a necessary component of ending the War on Drugs that has done so much to divide and harm our society. Those who are truly invested in ending prohibition will make expanding safe supply a top priority.

#SAFESUPPLY IS PRESCRIPTION HEROIN.

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“NOTHING ABOUT US WITHOUT US” IS OUR GUIDING PRINCIPLE.

The Canadian Association of People Who Use Drugs (CAPUD) is raising the voice of people who use(d) drugs throughout the policy making process at every level of government.

We strive to reduce oppressive societal conditions that people who currently or formerly use drugs face and emphasize the need for their direct involvement in public policy decision making. We focus on the strengths, talents, and merits of our membership as we build a better future for people who use drugs.

We currently have membership in nine Canadian provinces. Our board is composed entirely of people with lived experience.

Read our Safe Supply fact sheet: capud.ca/safesupply

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