



Interior Health
Every person matters

INCLUSION SELF CARE
PEERS LOVE RESPECTFUL JUSTICE
EDUCATION DIGNITY
NON-JUDGEMENTAL EVIDENCE-BASED
LIFE SAVING OPENNESS WELCOMING KIND
HARM REDUCTION
ACCESSIBLE FEELING HEARD EMPOWERMENT
FEELING VALUED RESPECTING EXPERTISE
COMPASSION COMMUNITY PRAGMATISM

Guide to Harm Reduction

For Frontline Staff Who Provide Service Delivery and
Management of Harm Reduction Services

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Introduction

The purpose of this manual is to provide you, the health care worker, with the tools and knowledge to successfully engage and support clients and family members who may be either directly or indirectly impacted by substance use.

You will learn how to:

- integrate harm reduction principals into practice;
- maximize the distribution of products to reduce harms associated with substance use and behaviours impacting sexual health, and;
- support fellow care providers to effectively educate, support and provide services.

This manual is based on, and encourages the use of, best practices in harm reduction and is guided by trauma informed practice. It is intended to provide background and cultural considerations around issues specifically faced by people who use drugs (PWUD) and/or at risk of Sexually Transmitted and Blood Borne Infections (STBBI).

You will be able to use this manual as a guide and reference to:

- familiarize yourself with aspects of drug use and drug culture;
- understand and promote harm reduction strategies, including overdose prevention;
- engage with people who use substances, including special populations such as Aboriginal peoples, youth, LGBTQ2S¹, and people who participate in sex work;
- implement harm reduction services from a trauma informed perspective;
- support the distribution and return of harm reduction supplies;
- provide education on safer drug use and sexual practices.

Substance Use

Lots of people use drugs for a variety of reasons and many people will never become dependent on them or deal with an addiction. Drug use can be spiritual, experimental, or recreational. Dependence on substances refers to a persons need for frequent, repeated doses of a substance to make them feel normal. Some drugs, such as opioids, alcohol, or benzodiazepines are tolerance building and require medical support and supervision to assist with withdrawal. No matter the reason behind the substance use, harm reduction services exist to support the individual in staying as safe as possible.

¹ Lesbian, Gay, Bisexual, Transgender, Queer, Two-Spirited

Section 1: Harm Reduction & Trauma Informed Practice

Harm Reduction

Harm Reduction is an umbrella term used to describe programs, policies and practices that aim to reduce the negative consequences associated with behaviours that are typically considered high risk. In this context those behaviours include drug use and some sexual activities.

Harm Reduction includes a range of health interventions to reduce harms associated with substance use and sexual health for both individuals and communities. It aims to improve health outcomes related to substance use, addiction, overdose, Sexually Transmitted and Blood Borne Infections (STBBIs), other illness and injuries, social isolation, violence, oppression, trauma, and criminal justice system involvement. Harm Reduction programs are proven not only to reduce infections¹, injuries², and death³ related to substance use and sexual health⁴, but also increase social and vocational functioning⁵, and to reduce public disorder.⁶

Principles of Harm Reduction²

The values associated with harm reduction are consistent with the values and ethics of many professions, such as nursing⁷, and social work.⁸ This includes providing compassionate and non-judgemental care, treating people with respect and dignity, promoting and advocating for informed-decision making, and the promotion of justice.^{7,8} Harm Reduction is built on a foundation of six key principles that are meant to guide ones practice.

Pragmatism: Harm reduction recognizes that drug use is a complex and multi-faceted phenomenon that encompasses a continuum of behaviors from abstinence to chronic dependence and produces varying degrees of social harm. Harm reduction accepts that the non-medical use of psychoactive or mood altering substances is a universal phenomenon. It acknowledges that, while carrying risks, drug use also provides the individual and society with benefits that must be taken into account.

Focus on Harms: The fact or extent of an individual's drug use is secondary to the harms from drug use. The priority is to decrease the negative consequences of drug use to the person and others, rather than decrease drug use itself. While harm reduction emphasizes a change to safer practices and patterns of drug use, it recognizes the need for strategies at all stages along the continuum.



Human Rights: Harm reduction respects the basic human dignity and rights of PWUD. It accepts the individual's decision to use drugs and no judgment is made either to condemn or support the use of drugs. Harm reduction acknowledges an individual's right to self-determination and supports informed decision making in the context of active drug use. Emphasis is placed on personal choice, responsibility and management.

² Adapted with permission from the [BC Harm Reduction Strategies and Services, Harm Reduction Training Manual](#)

Involvement of PWUD: Harm reduction acknowledges that PWUD are the best source for information about their own drug use, and need to be empowered to join the service providers to determine the best interventions to reduce harms from drug use. Harm reduction recognizes the competency of PWUD to make choices and change their lives. The active participation of PWUD is at the heart of harm reduction

Maximizing Options: Harm reduction recognizes that PWUD benefit from a variety of different approaches. There is no one prevention or treatment approach that works reliably for everyone. It is providing options and prompt access to a broad range of interventions that helps keep people alive and safe. Individuals and communities affected by drug use need to be involved in the creation of effective harm reduction strategies.

Priority of Immediate Goal(s): Harm reduction starts with “where the person is” in their drug use, with the immediate focus on the most pressing needs. It establishes a hierarchy of achievable interventions that taken one at a time can lead to a fuller, healthier life for PWUD and a safer, healthier community. Harm reduction is based on the importance of incremental gains that can be built on over time.

Social Determinants of Health

It is important to understand that harms associated with substance use are more than just a health issue. Substance use must also be understood in the context of social determinants of health. The social, cultural and economic aspects which contribute to one’s health are very diverse and are often out of the direct control of the individual themselves. There are several social determinants of health that can contribute, both negatively or positively, to substance use⁹:

- Income, housing and food security
- Early childhood development; education and literacy
- Healthcare services
- Employment and working conditions
- Social support networks and social environments
- Physical environments
- Health behaviours such as smoking or consuming alcohol
- Genetics
- Gender
- Culture

The Canadian Centre of Substance Abuse notes that a “*comprehensive, holistic and integrated approach is needed to address risks and harms. The continuum of services and supports includes not only ‘treatment’ but also a much broader spectrum, both upstream and downstream, provided collaboratively by multiple sectors*”.⁹

When substance use and mental health problems arise they can quickly prevent people from responding to different challenges in their lives. This underlines the importance of providing safe and supportive environments in order to prevent and reduce the severity of both mental health and substance use problems.⁹

History of Harm Reduction

The concept of harm reduction originated in England in the mid-1980s to respond to increasing rates of Human Immunodeficiency Virus (HIV) amongst people who injected drugs. There was a strong connection amongst the rising rates of HIV and Hepatitis C virus in Canada in the late 1980s that led to the adoption of needle exchanges and other harm reduction initiatives in order to address these concerns¹⁰. By the late 1990s harm reduction was recognized and included in the 4-pillar approach to substance use: Harm Reduction, Treatment, Prevention and Enforcement.¹¹

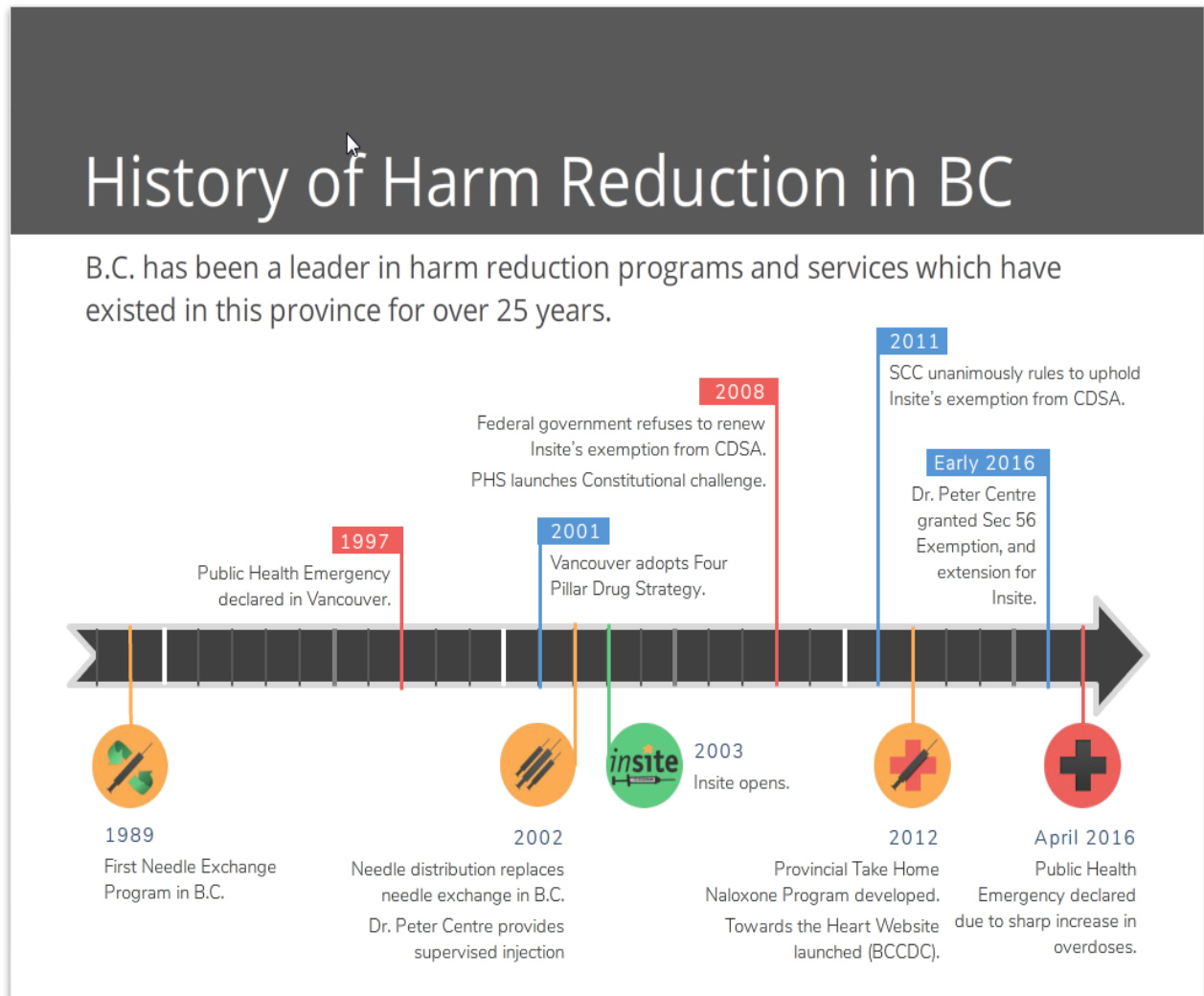


Figure 1. Brief Timeline of Harm Reduction Milestones in BC, Shane Van de Sype

Harm Reduction in British Columbia

Harm reduction services are provided across the province in a variety of settings. Services are based on the understanding that there are people in our communities that use substances. Harm reduction addresses the need for health care staff to meet people where they are at in their substance use journey, or in other words to provide service based on what an individual expresses they need. This also includes ensuring a change in behaviour is not required in order to provide service.

“Harm reduction has the potential to address many of the social, cultural and structural factors that contribute to overdose, improve the health status of People Who [Use] Drugs (PWUD), and support the civil rights of participants living with addiction and poverty. When non-judgmental harm reduction is practiced, it profoundly changes the living environment to one that values and includes [PWUD] alongside everyone in the community.”¹²

The goal is to reduce the risks associated with drug and alcohol use and to help people be as healthy as possible in mind and body, while they are using. This also includes the promotion of safer sex activities and to support people to be better equipped to make safer decisions.

Trauma Informed Practices

Trauma Informed Practice (TIP) demonstrates an understanding of the role that violence and trauma play in the lives of most PWUD. By incorporating the knowledge of trauma and its varying effects into all aspects of service delivery, spaces are created that place importance on the individual’s safety, choice and control.¹³

TIP is very similar to the core principles of harm reduction; it is about an overall approach, or way of being with a client rather than a specific course of treatment.

A quote commonly referenced is, *“if the frogs in a pond started behaving strangely, our first reaction would not be to punish them or even to treat them. Instinctively, we would wonder what has happened to the pond”¹⁴*. TIP, like harm reduction, is a curious approach that asks “What has happened in this person’s life to create this current situation?” instead of asking “What is wrong with this person?” This approach can be particularly helpful when a service provider feels stuck and struggles to understand.¹³

“Trauma-informed approaches are similar to harm-reduction-oriented approaches, in that they both focus on safety and engagement. A key aspect of trauma-informed services is to create an environment where service users do not experience further traumatization or re-traumatization (events that reflect earlier experiences of powerlessness and loss of control) and where they can make decisions about their treatment needs at a pace that feels safe to them.”¹³

What is Trauma?

Trauma can be defined as experiences that overwhelm an individual's capacity to cope.¹⁵ There are different types of traumatic experiences that occur in a person's lifetime. These include¹³:

- **Single Incident Trauma** – an unexpected and overwhelming event (accident, natural disaster, single episode of assault, sudden loss, witnessing violence);
- **Complex trauma** – ongoing abuse, domestic violence, war, ongoing betrayal;
- **Developmental trauma** – results from early exposure to ongoing or repetitive trauma incidents (as infants, children, youth) involving neglect, abandonment, abuse (emotional or physical). Often occurs within a child's care giving system and disrupts healthy attachment and development;
- **Historical Trauma** – the cumulative emotional and psychological wounding over the lifespan and across generations emanating from massive group trauma. (genocide, residential schools, slavery);
- **Intergenerational Trauma** – an aspect of historical trauma that describes the psychological or emotional effects that can be experienced by people who live with trauma survivors.

As illustrated, trauma is not only caused by single events such as big catastrophes, it can be caused by repeated everyday occurrences such as bullying or sexual harassment. In addition, there are a number of dimensions influencing the impact of traumatic experiences; these include: magnitude, complexity, frequency, duration, and whether the event occurs from an interpersonal or external source.¹³

Effects of Trauma

Trauma can impact every aspect of an individual's life and may show up in different ways. Trauma responses are unique to each individual, and can be experienced differently by specific populations, such as women, men, children, Aboriginal peoples or refugees.¹⁵ People who have experienced trauma may also experience:

- Physical Issues: chronic pain or fatigue, headaches, or digestive problems;
- Emotional/Cognitive Issues: depression, anxiety, anger management, dissociation, fearfulness, and suicidal thoughts;
- Spiritual: loss of connection to family, self, and community, feelings of guilt, shame, and self-hate, and loss of meaning;
- Interpersonal: inability to trust, difficulty establishing and maintaining relationships, frequent conflict in relationships, and difficulty with boundaries;
- Behavioural: substance use, self-harm, high-risk sexual behaviours, isolation, and criminal justice involvement.

Why Use Trauma Informed Practice?

The strong link that exists between trauma and substance use means that clients accessing services will have improved outcomes with a trauma informed approach.¹⁵ Adopting TIP principles prevents further victimization of people accessing services.

In order to provide a trauma informed approach, self-reflection and a general understanding of our own perceptions are needed¹³. When engaging in client interactions understand:

- there is a common connection between substance use and trauma;
- people may exhibit a range of responses to certain situations;
- people who have experienced trauma experience difficulty forming trusting relations– it takes time;
- disclosure of trauma is not required – treat all individuals in a way that creates safety and understanding, regardless of whether or not they disclose trauma as part of their history;
- recognize when someone might be responding to the effects of their trauma.

Practicing in a trauma-informed way requires a shift in thinking and language. Unfortunately, the behaviours and responses of those who have experienced trauma are often misunderstood and labelled in stigmatizing and deficit-based ways (e.g. something is missing or wrong with the individual; that the individual deserves the consequences). All staff can play an important role in understanding responses as normal attempts to cope and adapt to the overwhelming impact of trauma. By reframing how we look at and individual’s responses we can empower individuals and de-stigmatize their experience.

Moving from...	To...
What is wrong?	What has happened?
Controlling	The individual is trying to make choices to have their needs met.
Manipulative	The client has difficulty asking for what they need or want.
Symptoms (often defined as deficits)	Adaptations (how the individual has come to manage).
Borderline	The individual is doing the best they know how given their past experiences.
Malingering³	The individual is seeking help in a way that feels safer to them.

Foundations of TIP

A trauma informed approach is different than providing Trauma specific services. Trauma specific services are focused therapeutic interventions that target specific traumatic experiences with the goal of healing and recovery. These services are provided in ways that recognize the need for physical and emotional safety, as well as choice and control in decisions affecting one’s treatment.

A TIP approach ensures that how we deliver service, or interact with clients, comes from a place of nonviolence, learning and collaboration.¹⁵ It does not mean that you are working through an individual’s trauma with them, but it does ensure that services do not unintentionally re-traumatize people.

³Malingering: Exaggerate or feign illness in order to continue receive support or services

TIP is more about the overall essence of the approach, or way of being in relationship, than a specific treatment strategy or method.

Key Principles of Trauma Informed Practice

Like harm reduction, the foundation of TIP is based on key principles.¹³ These are highlighted below, along with strategies for engaging with clients.

Trauma Awareness

Understand the prevalence of trauma experiences amongst PWUD, the impact on development, the wide range of adaptations people use to cope with trauma, and the relationship to physical health, mental health and substance use.

Strategies to Implementation: Communicate a sensitivity to trauma issues, screen (when appropriate) for trauma experiences.

Emphasis on Safety and Trustworthiness

An emphasis on physical, emotional, and cultural safety is fundamental because trauma survivors often feel unsafe and have likely experienced, or are still experiencing, unsafe relationships and living situations.^{13, 15}

Strategies to Implementation: Ensure welcoming intake procedures; creating an open, welcoming space that is non-threatening is important to foster in TIP practice; Respect informed consent, be consistent and accountable.

Opportunity for choice, collaboration and connection

Creating safe environments that foster a sense of efficacy, self-determination, dignity, and personal control for those receiving care.

Strategies to Implementation: Communicate openly, equalize power imbalances, allow the expression of feelings without judgment, provide choices to treatment preferences, and work collaboratively with clients.

Strength based and skill building

Assist clients to identify their strengths and (further) develop resiliency and coping skills for managing the effects of trauma.

Strategies to Implementation: Staff can teach and model skills in recognizing triggers, and grounding or calming techniques.

Suggested Resources:

[Trauma Informed Practice Guide](#)

[Trauma Informed Approaches to Addictions Treatment](#)

[Trauma Informed Care Toolkit](#)

[Bridging Responses: A Frontline Worker's Guide to Supporting Women who have Post-Traumatic Stress.](#)

Section 2: Service Delivery & Engagement Strategies

Service Delivery Models

A range of services and service delivery models are required in order to maximize the options for those accessing services. Best practice recommendations suggest that a variety of delivery models, especially for distribution of harm reduction supplies, work in complement to one another and are not mutually exclusive. Implementation of a wide spectrum of delivery models can contribute to minimizing drug-related harms^{16, 17} as well as meet a number of the core principals of harm reduction and trauma informed practice.

Supply Distribution and Recovery Programs

Goals: To decrease the spread of blood-borne pathogens by providing sterile drug use equipment, recovering used equipment, and increasing connection to the health system. Including access to treatment, supports, education and information.



Supervised Consumption Services (SCS)/Overdose Prevention Services (OPS)

Goals: Prevent morbidity and mortality from overdose, prevent transmission of HIV/HCV, increase access to detox, treatment, health and social services, and educate around safer substance use.

Outreach Strategies

Goals: Meet individuals who are hard to reach where they are at. Services can include education around safer use and new injecting material, where to access testing, treatment, or other health and social services.

Overdose Prevention Strategies – Take Home Naloxone

Goals: To prevent overdoses by providing education on how to recognize and respond to an overdose, including the administration of naloxone. Provision of low-barrier access to naloxone kits for responding to opioid overdoses. Education is often focused on opioid overdoses.



Drug Replacement Therapy

Goals: Often focused on providing best practice treatment options for management of opioid misuse disorder. This includes Opioid Agonist Treatment (OAT) such as Methadone or Suboxone®; Injectable Opioid Assisted Treatment (iOAT). OAT can help individuals to remain in treatment, reduce criminal activity, increase access to health and social supports. Other replacement therapy programs include treatment for alcohol addiction through Monitored Alcohol Programs (MAP).

Housing First

Goals: To provide low-barrier housing options to individuals who experience chronic homelessness and who may also be dealing with mental health and addiction challenges. A housing first approach does not treatment or abstinence to take place in order to maintain their housing.

Engagement Strategies

Harm reduction providers work to build relationships with people to deliver the best possible service to individuals and the community. Effective client engagement recognizes the diversity of consumers of harm reduction supplies and services. Services should understand why individuals are accessing harm reduction supplies and how best to support each person. This means knowing how and why supplies are being used, being aware of the specific issues different individuals may face, and by providing education, referrals and support to each person on an individual basis. It can also mean providing services in a variety of formats, such as fixed site locations, outreach, peer based distribution and vending machines.¹⁸

A number of suggested strategies are listed below, along with how they align to the core principles of Harm Reduction.

Ensure Individuals Come First

Core Principle – Priority of Immediate Goals / Human Rights

- Always greet the person regardless of what else you are doing – make eye contact, smile, etc.
- Be friendly
- Thank people for coming in
- Understand if the client is in a rush
- Remember to use people first language

Meet an Individual's Needs: Reducing the Spread of Infection

Core Principles – Priority of Immediate Goals / Human Rights / Involvement of PWUD / Maximize Intervention Options / Focus on Harms

- Always give out what is asked for without judgment or limitations
- Support secondary distribution or peer distribution
- Ask people if they know how to use harm reduction supplies and offer education; be open to learning from clients about the supplies and how they use them as well

Care For Our Communities

Core Principles – Involvement of PWUD / Pragmatism / Human Rights

- Encourage return of used supplies whenever possible
- Support peers to organize and participate in community clean ups. Harm reduction consumers are part of the community-returning used needles re-enforces that feeling
- Involve peers in community development work relating to improperly discarded paraphernalia

- Thank people for returning used supplies
- Ask if they have information to share about their community

Place importance on the Health of PUWD

Core Principles – Involvement of PWUD / Maximize Intervention Options / Priority of Immediate Goals

- Having access to health care services is the goal of all harm reduction programs
- Important for people to know what resources are available
- Be familiar with what illness looks like – specific cues, illnesses and symptoms related to substance use and sexual practices
- Incorporate a TIP at all times
- Always try to follow up with client, be consistent and trustworthy

Respect is a Two Way Street

Core Principles – Human Rights / Pragmatism

- Clients and service providers must be respectful to each other
- Ensure anonymity is an option for clients accessing harm reduction services or supplies
- Both staff and clients should respect each other's privacy. Staff should not share confidential information with outside services unless given permission to do so by the client.

Section 3: Special Populations

Aboriginal Communities and Cultural Safety

In working with Aboriginal (First Nations, Metis, Inuit) individuals, families, and communities within Interior Health it is imperative to become familiar with where the mandate to provide culturally safe care originates.

In 2015, the **Truth and Reconciliation Commission** of Canada: Calls to Action #23 outlined the need to “provide cultural competency training for all healthcare professionals.”¹⁸ Also in 2015, all of British Columbia's Health Authority Chief Executive Officers signed the **Declaration of Commitment on Cultural Safety and Humility** in Health Services which further places “a high priority on cultural safety and humility as essential dimensions of quality and safety within the health services.”¹⁹

In BC, Aboriginal people comprise approximately 5% of the population. In the Interior, there are approximately 54,000 Aboriginal people across the region²⁰, which represents about 7.7% of the population. Of that population, 58% live out of community and 42% in community within one of the 7 nations of Dākelh Dené, Ktunaxa, Nlaka'pamux, Secwepemc, St'át'imc, Syilx and Tsilhqot'in.²¹

For those who have not worked in or with First Nation communities it is imperative to understand that there are 203 bands within BC, and each band belongs to a Nation, with languages, traditions, processes and attitudes that are individual and distinct. Since each Nation has their own protocols to be followed, time spent on building relationships as well as researching the local Nations is important. Also, when presenting information in Aboriginal settings, it is imperative to give verbal thanks to the traditional stewards of the land (the local First Nation) where the presentation is taking place.²²

There are Aboriginal people living in urban communities within BC. Urban Aboriginal people may be local First Nations, or Metis, or Inuit, and/or from other communities across Canada and the United States. It is good practice to become familiar with the urban Aboriginal organizations in your region, such as the 25 Friendship Centres, and the 35 Metis Chartered communities.

The burden of disease for HIV/AIDS has been greater for Aboriginal people in the province of British Columbia (BC)^{23, 24} with injection drug use being the most common mode of HIV transmission. Although Aboriginal people comprise approximately 5% of the population of BC, in 2014 Aboriginal people made up 13% of new HIV infections. This over representation is even more pronounced for Aboriginal women who accounted for 34% of new HIV cases in women in BC.^{23, 24} Hepatitis C is also affecting Aboriginal peoples at a greater rate compared to the population at large, with the prevalence of HCV infection quite high amongst Aboriginal people.²⁵

The history of colonization of Aboriginal peoples in Canada, including the multigenerational trauma of the residential school system has significantly impacted and shaped a number of factors facing Aboriginal communities such as poverty, inadequate housing and homelessness, early childhood development, physical environments, access to health services, support networks and social environments, gender, violence, and trauma.²⁶ These factors contribute to increased disease rates and risk of transmission of blood borne infections, specifically HIV^{23, 24} and HCV.²⁵ Additionally, culturally unsafe medical services and structures make it difficult to access appropriate and timely healthcare.^{26, 27}

There are also many protective factors or health determinants for Aboriginal communities including use of Elders, traditional ceremonies, individual counseling, self-determination, and western healing strategies used in conjunction with Aboriginal cultural practices.²⁷ The Aboriginal Health Foundation (AHF) has conducted evaluations on the efficacy of these protective factors, and the outcomes have indicated that “culture is good medicine” and that community healing supports individual healing.²⁷

Suggested Resources:

[Harm Reduction](#) - Indigenous Wellness Team, First Nations Health Authority

[Indigenizing Harm Reduction, Here to Help](#) – Here to Help

["Walk With Me: Pathways to Health; Harm Reduction Service Delivery Model"](#) Canadian Aboriginal AIDS Network (CAAN)

[Community Readiness Model](#) - TriEthnic Centre, University of Colorado

Youth

Harm reduction measures do not only apply to adult but youth as well. On many occasions youth can present a challenging dynamic and are often placed into categories such as difficult, unmotivated, and unreliable which hinder their involvement in their own care. The attitude of “we know best” frequently denies youth from the same care provided to adults. The Canadian Pediatric Society makes 5 key recommendations for the inclusion of a harm reduction approach to working with youth who may be using substances²⁸:

- Screen all preadolescent and adolescent patients for potentially risky behaviours at regular health care visits.
- Provide messages that encourage delay in initiation of potentially risky behaviours, and at the same time, promote risk-reduction strategies if adolescents choose to engage or are already engaging in the behaviour.
- Use principles of motivational interviewing in the assessment and discussion of risky health behaviours with adolescent patients
- Become familiar with the resources in their communities that provide harm reduction programs for substance abuse, pregnancy prevention and injury prevention.
- Advocate for the introduction, further development and evaluation of evidence-based prevention and treatment programs that use a harm reduction philosophy in schools and communities.

Confidentiality

Confidentiality is a core expectation of service but often comes into consideration and concern when providing care for youth. Understanding the limitations to confidentiality, for many, is a challenge due to parents feeling they have the right to request information and/or withhold information from them and youth wanting to withhold information such as sexual activity or substance abuse from their parents.

“Confidentiality is a right for all competent persons; therefore, all competent teens have the right to keep their health status private from family members, including parents”²⁹

The challenges at times are both ethical and legal. Many times we are inclined to tell the parents without taking into context the potential harms, such physical or mental abuse that may result in disclosing information. In such a case the obligation is to promote client safety and advocating for the client right to privacy. If a harm reduction service provider has concerns they should connect with a regulatory body or another available resource. Please connect with your local [Health Authority Harm Reduction Coordinators](#) if you need further support.

Age of consent

Decision-making in these situations should be in accordance with the [Infants Act](#) which clearly states that consent to medical treatment depends on the mental capacity, not the chronological age of the patient³⁰. In BC, the capacity to accept or refuse treatment is dependent on the teen’s ability to understand his or her condition and the options available to him or her. To be capable, the teen must understand and appreciate the risks and benefits of accepting or refusing treatment.

Included in the BCCDC Harm Reduction Services and Strategies Policy³¹ document there are [Guidelines for Providing HR Services to Mature Minors in BC](#) to understand the processes for working with minors in harm reduction.

Suggested Resources:

[Street youth in Canada: findings from enhanced surveillance of Canadian street youth](#)
[Sexually transmitted infections in Canadian street youth: findings from enhanced surveillance of Canadian Street youth](#)
[Addressing determinants of sexually transmitted and blood borne infections among street-involved youth: access to health services](#)
[Sexting: considerations for Canadian Youth](#)
[Harm Reduction Policies and Programs for Youth](#)

Lesbian, Gay, Bisexual, Transgender, Queer, 2-spirit (LGBTQ2)

As with many marginalized populations, many LGBTQ2 people experience substance use, mental health issues, trauma, discrimination and violence. Substance use within the LGBTQ2 community is 2-4 times higher than the general population.³² Higher rates of substance use could be due to many factors, including criminalization history (homosexuality was illegal until 1969 in Canada), coping with stigma and trauma, altering mood, reducing sexual inhibitions, and recreation.³² Harm reduction service providers must be educated on how to create safe spaces and how to support LGBTQ2 clients, which can include avoiding using heteronormative* and ciscentric* language and instead using inclusive language. This means understanding LGBTQ2 experiences and identities, identifying community resources and ensuring clients feel safe and supported in accessing your services.

*For unfamiliar terms, please use the Queer Terminology suggested resource listed below

Suggested Resources:

[Queer Terminology](#)
[Sex and Drugs Series, CARBC at UVIC](#)
[LGBTQ People, Drug Use & Harm Reduction](#)
[Gender-Informed Prevention & Harm Reduction Programs](#)
[Health Initiative for Men \(HIM\)](#)
[CATIE LGBTQ Brochures](#)
[Qmunity](#)
[The Genderbread Person A Providers Guide to Substance Use Treatment for Lesbian, Gay, Bi Sexual, Transgender Individuals](#)
[Being Safe Being Me: Results of the Canadian Trans Youth Health Survey](#)

Sex Workers

Sex work is defined by the World Health Organization as “the provision of sexual services for money or goods.”³³ There are many different types of work people may engage in, from outdoor street level sex work, to escorts, to those providing services out of their homes. The term, sex worker, is preferred over “prostitute” (specific legal implications) or “sex trade worker” (trade of services often not equal), as it recognizes the work relations involved.

Many people find their way into sex work, commonly survival sex work, to support their substance use habits. Survival sex work for others may be due to entrenchment in street/drug culture or may be forced upon them by others. Individuals constantly face the threat of bad dates, stigma, disease, violence, incarceration, and death.³⁴ A lack of understanding and awareness of survival sex work leads to further stigma and discrimination. Stigma impacts the types of interactions sex workers have with the people who can have a profound effect on their general well-being, including police officers, doctors, nurses, outreach workers, welfare agents, landlords, people purchasing sex, family, friends, romantic partners, and managers.³⁴

Suggested Resources:

[PEERS Victoria Resources Society – Sex Work 101](#)
[HUSTLE: Men on the Move](#)
[Sex Work in Canada](#)

Incarcerated, Institutionalized and Deinstitutionalized

Substance use is a common reality in Canadian prisons and with that come a host of other consequences. It is important to recognize that a number of health inequities exist for individuals who are involved in the criminal justice system. Canadian prison populations experience stigma and discrimination,⁷ and significantly higher rates of communicable disease, such as HIV⁷ and HCV, than non-incarcerated populations³⁵, this is particularly driven by injection drug use³⁵. Recommendations and calls for an expansion of harm reduction programs within prison settings, specifically syringe distribution, have been made but as of yet have gone unheard.^{35, 36, 37}

Individuals recently released from institutions like prison are confronted with many challenges. This process of reintegration can be affected by both an individual’s past experiences but may also be a direct consequence of incarceration³⁸.

Individuals may have probation restrictions, parole expectations, difficulty socializing and relating to others, and street debts to settle. Providing a supportive, non-judgmental service assists this group in facing their barriers with support and compassion.

Suggested Resources:

[Focus on Harm Reduction for Injection Drug Use in Canadian Prisons](#)
[Prison Health Now](#)
[On Point: Recommendations for Prison-Based Needle and Syringe Programs in Canada](#)

Recent release from prison is also an extremely heightened time for overdose risk.³⁹ Communication on risk and overdose response should be offered along with a Take Home Naloxone kit whenever possible.

Section 4: Working with Individuals⁴

Personal Values, Attitudes and Misconceptions

To put harm reduction into practice, it is important to convey acceptance and support individuals to become the experts in their own lives. The service provider, regardless of their beliefs should not show disapproval of active drug use as it can destroy the therapeutic relationship and the individual's sense of self-worth. The value of dignity and worth is profoundly important when working with vulnerable clients who have been socially and politically stigmatized.^{40, 41}

Stigma and Discrimination

Stigma can be defined as a mark of disgrace associated with a particular circumstance, quality, or person.^{42, 7} These perceived judgements can affect how we interact with clients and provide service. People who use substances and their families experience stigma more than people with mental illness or other physical disabilities.^{42, 43} The effects of stigma can be profoundly damaging to individuals, families or communities associated with substance use.⁷ An example of the serious nature with which stigma affects others is the Overdose Public Health Emergency in British Columbia⁴⁴ which began in 2016. Many of those who have died from illicit drug overdose deaths were alone and inside their homes. The judgement and fear associated with identifying yourself as someone who uses drugs pushes people to use in isolation, where the risk of death is far greater. Ultimately, stigma kills.

Major barriers in providing effective and accessible harm reduction services include stigma and discrimination⁴⁵. Health care providers have been found to hold negative attitudes towards PWUD, specifically illicit drugs⁷. However, these negative attitudes and experiences are “not isolated problems for individuals but rather they occur in a cultural context in which social norms and policies play a role.”⁷ A focus on systems such as the “war on drugs” “can hinder the introduction of evidence-based measures that can reduce the harms of drug use”⁷ and in turn reduce stigma.

The [Peer Engagement Best Practices Guidelines: A Guide for BC Health Authorities](#) cites stigma and trust as a major barrier to accessing services across all health authorities in British Columbia.⁴⁵ These best practice guidelines, developed by people with lived experience, cite the importance of being committed to the work of harm reduction as service providers as well as taking the time to build credibility and rapport with clients and maintain and reinforce confidentiality.

“The impact on anyone who may have used illicit substances is that you are categorized – you are identified by your drug use or your drug of choice, not as a human being or who you are.”⁴⁶ Charlene

⁴Section has been adapted, with permission, from Section 6 of the [Harm Reduction Services & Strategies \(HRSS\) Training Manual](#)

Language and the Power of Words

Words matter; language and the words chosen to speak about people have significant meaning. Terms often used to describe PWUD, such as addict, junkie, or crack head, dehumanize the person and diminish their self into just behaviour. The language chosen can either contribute to stigma or push back against it. People providing services to PWUD must commit to using person first language, which highlights that an individual is first a person, a human, and not just behaviour. Examples of this include terms such as person who uses drugs, person who injects drugs, or person who participates in sex work.

Suggested Resources:

[Stop Stigma, Save Lives](#)

[Respectful Language and Stigma Regarding People who use Substances](#)

BCCDC released recommendations⁴⁷ for using respectful language when speaking about PWUD. Two key recommendations for healthcare professionals are 1, to use language that promotes recovery and, 2, avoid slang and idioms.

Section 5: Harm Reduction Supplies and Distribution

Supply Distribution

This section will review the supplies distributed for the promotion of both safer substance use and safer sex. There is extensive research and further information outlined in detail in the [Canadian Best Practice Recommendations Part I](#)¹⁷ and [Part II](#).¹⁶ This resource is **strongly recommended** reading for staff regularly working in harm reduction.

One of the goals of harm reduction in the context of drug use and high risk sexual behavior is to reduce the harms, such as transmission of infections, associated with the behaviour. Harm reduction measures originated out of a need to respond to rising rates of HIV amongst People who Inject Drugs (PWID) and are rooted in a population health approach.^{48, 49}






Overall, rates of HIV in BC have been declining over the past decade. Currently, rates of HIV amongst PWID in BC continue to go down as a result of extensive harm reduction services that are available.⁵⁰ While rates are going down slightly amongst men who have sex with men (MSM), this demographic still sees a greater proportion of all new HIV infections in BC.⁵⁰ Hepatitis C continues to be an issue amongst PWID and the majority of new cases are a result of injection drug use.⁵¹ Impacting the rate of infections associated with substance use and sexual behaviour can be achieved through education around safer sex practices, safer substance use, and by providing relevant supplies. There are various routes of transmission of infections therefore harm reduction approaches must be varied and at times used simultaneously.




Staff working in programs that provide harm reduction supplies should familiarize themselves with the supplies, rationale and typical use. Efforts should be made to have supplies as accessible as possible, in a variety of formats (e.g. packed brown bags to go, bulk supply available). No limits should be placed on the number of supplies requested.^{16 17} There are a variety of reasons for requesting large amounts such as type of drug people are using (i.e. cocaine injection can sometimes occur more than 20 times per day), peer distribution, or living in rural/remote locations.

Suggested Resources:
[Safer Injection](#)
[Safer Injection Video](#)

Safer Injection Supplies

Please refer to Appendix B for Summary of Best Practice Recommendations on Needle and Syringe Distribution

Supplies provided by BCCDC Harm Reduction Program	
	<p>Use of individual sterile water packets reduces the risk of sharing water or using unsafe water sources. Used or shared water can carry HIV, Hepatitis C, and other infectious agents.</p>
	<p>Alcohol swabs are particularly important for cleaning the injection site before injecting. When used after injecting the alcohol swabs interfere with the healing of the skin.</p>
	<p>Standard 1cc (barrel) with a 28 ½ (point) gauge needles are most commonly used. ½ cc barrels with a 28 ½ point needle are also provided but less commonly requested. Sites should have both sizes on hand in all distribution locations</p>
	<p>Points are the individual needles, which come in a variety of sizes from 18 gauge (largest) to 27 gauge (smallest). They are screwed onto 3 cc or 5 cc barrels. These larger barrels and needles are used for a variety of reasons, including intravenous (26-27 gauge), and hormones or steroids (18-25 gauge)</p>
	<p>Cookers are used to mix and/or heat drugs and are single use only. They replace the need for using spoons; which unless cleaned properly can be a mode of transmission for HIV, HCV or other infections. Contained in the package are also one, sterile cotton filter, and one absorptive pad for after injection. Cotton filters help filter the drug (removing pieces of wax, chalk from pills, and buffer/additives). One sterile filter is found in each of the cooker containers.</p>

	<p>Vitamin C also known as Citric Acid or Ascorbic Acid is used to dissolve crack or brown/black tar heroin for injection use. The smallest amount of Vitamin C is needed. Any leftover Vitamin C should be disposed of to reduce risk of contamination. Using vinegar or lemon juice can burn the veins and both liquids may carry bacteria that can lead to infections.</p>
	<p>Tourniquets, or ties, help to bring the veins up, making them easier to find. Soaking the injection site veins in warm water or applying a warm compress also helps. It is important to teach that the tie must be removed before the injection, not afterward.</p>
	<p>Sharps containers are the preferred disposal method. Teaching and encouraging clients to use proper containers verses discarding sharps into the garbage or on the ground, helps reduce the risk of needle injuries to others. Sharps containers come in 2 sizes: small (1 litre -which holds approximately 100 needles), and an individual black container, which holds both used and unused supplies.</p>

Encouraging Safer Injecting Practices

Whenever possible talk with and teach clients about safer injecting practices as they may not be aware of the information. Don't forget to ask clients questions about their own practices, you can learn from your clients as well.

Common Harm Reduction Messages: Safer Injection Practices¹⁷

- *Always have all your own supplies, “everything new, every time”.*
- *Give out as many supplies as needed so people don't need to reuse or share. Never place limits on requests for supplies. For example, people who use cocaine may inject every 20-30 minutes versus people who use opioids every 3-6 hours.*
- *When possible, wash your hands before injecting.*
- *Use a tourniquet to make veins more accessible.*
- *Keep bevel side of needle up when injecting.*
- *Flagging ensures that the needle is inserted properly. If the vein is missed it increases the risk of abscesses and other harms.*
- *Always use a filter – it reduces the amount of harmful particulates going into the bloodstream.*

Sharps Disposal

Education to clients on appropriate retrieval and disposal of needles is an important part of harm reduction services. Safe disposal practices include multiple approaches, such as provision of personal sharps containers to clients, partners and community members; public drop boxes in areas frequented by PWID; and in some areas pick up services through needle hot lines or community agency pick-up services. Canada has moved away from an exchange (one-for-one) model to a distribution model with no limits on supplies, which has been shown to achieve high sharps return rates and less equipment reusing^{16, 17, 52, 53, 54}.




Retrieving and disposing of sharps from communities reduces the risk of transmission of BBI and other harms due to accidental needle stick injury or equipment sharing or reusing. Although risk of BBI transmission is low in both community settings and occupational settings, there is greater risk of equipment sharing or reusing^{17, 53, 54}. That being said, needle stick injuries can be very traumatic and emotionally distressing for the person who experiences it and their loved ones.




Please see Appendix C Disposal and Handling of Drug Use Equipment. Please see Appendix D Disposing of Needles Safely.

Safer Smoking Supplies

The addition of inhalation, or smoking supplies, is newer to BC but an important tool in engaging people who smoke their substances into harm reduction services. Much harm can be associated with smoking drugs such as, burns and cuts, pneumonia or tuberculosis, and the breakdown of gums and teeth¹⁶. The most commonly smoked substances are crack cocaine, crystal meth and heroin. Behaviours associated with smoking crack cocaine increase the risk of contracting HIV and HCV and greater distribution of smoking equipment can reduce equipment sharing and increase service access for people who smoke drugs^{16, 55}.


Please see Appendix E Best Practice Summary on Distributing Safer Inhalation Supplies Crack Smoking, Appendix F Best Practice Summary on Distributing Safer Inhalation Supplies Meth Pipe Distribution, and Appendix G Summary on Distributing Safer Inhalation Supplies Foil Distribution.

Supplies provided by BCCDC Harm Reduction Program (exception – glass stems, meth pipes, foil)	
	Glass stem is preferred over metal or plastic. Glass stems are considered ‘core supply’ for safer crack smoking along with mouthpieces, push sticks and screens.
	Mouthpiece or Vinyl Tubing is used to reduce risk of dry, split lips and transmission of heat burns to the lip that can result in germ exposures.
	Wooden push stick preferred over metal or plastic to reduce scratching to the inside of the pipe, this can cause the pipe to weaken and break.

	<p>Alcohol Swabs to clean hands and mouthpiece to keep clean.</p>
	<p>Screens are used in place of Brillo for crack smoking. The screen holds the crack rock at the end of the pipe. Brillo emits toxins and can slip out of place causing it to be inhaled. Screens fit tightly in the pipe and emit fewer toxins.</p>
	<p>Crystal meth pipes reduce the incidence of using homemade implements to smoke crystal meth, which can result in harms like inhalation of toxic fumes, burns and blisters. Sharing homemade implements also carries higher risk of transmission of HIV and HCV⁵⁶.</p>

Common Harm Reduction Messaging: Safer Smoking

- *Use a mouthpiece to prevent burns or cuts on the lips/fingers*
- *Encourage use of brass screens over brillo – brillo can cause infections and burns when inhaled*
- *Protect the lips with balm or lubricant*
- *Chewing gum reduces the wear on teeth and increases presence of protective saliva*

	<p>Foil is used primarily for smoking heroin, but can be used to smoke other drugs as well. Foil provision is often seen as an opportunity to promote a switch from injection (more harmful) to smoking (less harmful).</p>
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Safer Sex Supplies

Distribution of safer sex supplies like condoms and lubricant, and education on how to properly use them has shown to be effective in prevention the transmission of sexually transmitted infections and HIV. Correct and consistent use of condoms increases the efficacy. Providing a variety of different supplies allows for people to use what best suits their needs.





Although internal condoms are not widely used, with adequate education there are many beneficial aspects like allowing an individual to insert the condom themselves, are latex-free, and one size fits all.

Consuming drugs while also having sex is not uncommon. Many drugs can often heighten ones sexual experience and pleasure but it can also lead to unintended harms such as lowered inhibitions. The ability to gauge risk may also be impacted, leading to disruption of basic safety behaviours and increased risky sexual activities.^{56,57}

There are other STI’s that are less common. Practicing safer sex by using condoms, having regular checkups/PAP smears, and talking to healthcare professionals if something doesn’t feel right (i.e. like bumps, discharge, sores, itchiness or any unexplained symptoms) helps prevent and/or identify infections.

Suggested Resources:
[Common STI’s](#)
[Smart Sex Resource](#)

More information on common Sexually Transmitted Infections can be found at:
<http://www.healthlinkbc.ca/healthfiles/httoc.stm>

Provided by BCCDC Harm Reduction Program	
	Lubricated condoms act as an external barrier, providing protection from pregnancy and sexually transmitted infections.
	Flavoured condoms are recommended only for oral use, as there is a risk of yeast infection or irritation when used for penetrative sex.
	Non-lubricated condoms can be used for oral sex, or you can add your own water or silicone based lubricant for penetrative sex.
	Internal condoms (also known as female condom) are inserted into the vagina, with the excess material of the condom providing external coverage. It can also be used for anal sex by removing internal ring and placing it over the penis. It can be worn 6 – 8 hours prior to sex and is made of non-latex material ^{58, 59, 60} . (nitrile). Compatible with all types of lubricant.
	Water based lubricant is compatible with latex and non-latex condoms and silicone sex toys. Lubricant can increase pleasure and reduces friction and condom breakage.

****Note:** Terminology when providing education on safer sex should be gender neutral. For a guide on gender neutral sexual health education, please see [Inclusive Sex Ed Checklist](#) by Jack et Jacques.

Naloxone Distribution and Overdose Prevention

Take Home Naloxone Program

Overdose prevention, recognition and response are an important and lifesaving aspect of harm reduction services. There has been broad expansion and acceptance for the distribution of naloxone along with education on the recognition and response to opioid overdoses. The BCCDC facilitates the provincial Take Home Naloxone program which enables staff working with PWUD to provide overdose education and a kit with all the needed supplies to respond to an opioid overdose. All programs working with PWUD are strongly encouraged to provide overdose prevention programs, such as Take Home Naloxone as a core program and ensure education and supplies are provided alongside harm reduction services and supplies.

The BC Centre for Disease Control's website [Toward the Heart](#) is host to a significant amount of resources on overdose prevention and naloxone. The [Training Manual: Overdose, Prevention, Recognition and Response](#) is the preferred manual for reviewing overdose prevention. Frontline staff is *encouraged* to take the time to review the entire manual for a comprehensive understanding of overdose prevention, recognition and response.

General Education 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*
- *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)*

Suggested Resources:

[Tips for Preventing Overdoses from Uppers](#)
[Tips for Preventing Overdose from Crystal Meth](#)
[Why Gives Breaths?](#)

Section 6: Peer Engagement

Harm reduction places high value on the engagement of peers, or people with lived experiences in substance use. Active participation of peers means that the real ‘experts’ are being included in the development of services, programming and policy. The BC Peer Engagement Principles and Best Practices note that “in principle, peer engagement in harm reduction is similar to the engagement of marginalized community members in other participatory public health processes where there is openness, respect, equity, and fairness at the table”⁶¹ In order to achieve social justice, peers must be represented at the table where decisions are made and meaningfully engaged along the way. The stigma associated with substance use means that individuals are often reluctant to access health and social services, leading to health inequities. This is very true for individuals who access harm reduction services ⁶¹. Those best able to understand what needs to change to reduce these inequities are the people who directly experience them – peers.

For frontline service providers, supporting meaningful engagement involves sharing their power, learning and adopting best practice recommendations, and understanding the needs of peers throughout the process. A review of both the [BC Peer Engagement Principles and Best Practices](#) and the [Peerology: A Guide for and by People who use Drugs on how to get Involved](#) is **required reading** prior to any engagement with peers. This ensures that the safety of the peers is upheld and increases the likelihood of success.

“Eye rose from the dead to say thank you for naloxone training” Kevin



Suggested Resources:

[Nothing About Us Without Us” Greater, Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical, and Human Rights Imperative](#)

Appendix A – Commonly used Drugs and Their Effects

Heroin and other opioids
<ul style="list-style-type: none"> • Heroin can be smoked or injected; other pharmaceutical opioids can be taken orally or injected. • Desired effects include relaxation and pain relief • Adverse effects of heroin use include overdose, stroke and death
Amphetamines and methamphetamines
<ul style="list-style-type: none"> • Cocaine (coke, blow, soft) and crack cocaine (rock, hard) are amphetamines and can be snorted, smoked, injected or swallowed. • Crystal Meth (methamphetamine) also referred to as crystal, side, jib, crank, or tina can be snorted, smoked, injected or swallowed • Pharmaceutical medications such as Dexadrine, Ritalin, and Concerta are also methamphetamines and can be taken orally or injected • Desired effects include increased alertness and confidence, happiness and decreased need for sleep • Adverse effects include violent or irrational behaviour, anxiety, aggression and psychosis and heart problems
Ecstasy
<ul style="list-style-type: none"> • Usually swallowed as a pill but is sometimes snorted or injected • Desired effects include feelings of happiness and increased energy • Adverse effects of ecstasy use include hyperthermia, i.e. the body overheating
Benzodiazepines
<ul style="list-style-type: none"> • Benzodiazepines (benzo's) are widely available through prescription. Brand names include Valium, Ativan, and Xanax • They are usually swallowed or dissolved under the tongue and should never be injected • Desired effects include sleepiness, lowered inhibitions and are used to treat anxiety • Adverse effects include extreme mood swings and overdose, which can be fatal • Benzo's also tolerance building and require supported detox in order to stop or taper down
Cannabis (Marijuana)
<ul style="list-style-type: none"> • Cannabis is smoked or eaten • Desired effects include relaxation, happiness and increased appetite • Adverse effects include increased anxiety, paranoia and psychosis • Cannabis is commonly used recreationally, but it has other uses. <ul style="list-style-type: none"> ▪ In some countries, doctors prescribe it to relieve pain and stimulate the appetite in HIV and cancer patients. ▪ In some cultures, it is used in religious ceremonies to enhance awareness.
Alcohol
<ul style="list-style-type: none"> • Desired effects include decreased inhibitions and feelings of relaxation and well-being • Adverse effects include poor judgment, poor coordination and aggression. At very high doses, alcohol can lead to unconsciousness and death.

Appendix B

Needle and syringe distribution

RECOMMENDED BEST PRACTICE POLICIES to facilitate use of a sterile needle and syringe for each injection and reduce transmission of human immunodeficiency virus (HIV), hepatitis C (HCV), hepatitis B (HBV), and other pathogens:

- Provide sterile needles in the quantities requested by clients without requiring clients to return used needles
- Place no limit on the number of needles provided per client, per visit (one-for-one exchange is not recommended)
- Encourage clients to return and/or properly dispose of used needles and syringes
- Offer a variety of needle and syringe types by gauge, size, and brand that meet the needs of clients and educate clients about the proper use of different syringes
- Educate clients about the risks of using non-sterile needles
- Provide pre-packaged safer injection kits (needles/syringes, cookers, filters, ascorbic acid when required, sterile water for injection, alcohol swabs, tourniquets, condoms and lubricant) and also individual safer injection supplies concurrently

Key messages

Injection with a used needle puts people who inject drugs at risk for infections such as HIV, HCV, and HBV, and can also damage the skin, soft tissue, and veins. HIV, HCV, and HBV can survive in used needles and syringes, and can be transmitted when needles and syringes are shared. Most new HCV infections in Canada are attributed to injection drug use. Needle sharing rates vary across Canada and have declined in some communities in recent years. While this decline is encouraging, continued efforts to reduce needle sharing and reuse are needed to reduce disease transmission and other harmful effects.

NSPs need to distribute enough needles to ensure that clients use a new needle for each injection. One-for-one exchange policies – that is, one new needle for each used needle returned to an NSP – reflects outdated and unsatisfactory practice. Studies of NSP policies show that limiting the number of needles distributed to clients may reduce program effectiveness. For programs, calculating the number of needles necessary is challenging because the number of people who inject drugs is often unknown and the frequency of injection varies from person to person. It has been estimated that approximately 1000 needles are required per person per year.

Access to a variety of types of needles and syringes is recommended. Clients may prefer different types of needle gauge, syringe volume, and brand, and may not use NSP services if they cannot obtain their preferred types. When selecting needles to distribute, NSPs need to consider avoiding needles/syringes with a lot of “dead-space” because this is associated with increased risk of HIV and HCV transmission. Safety-engineered syringes may offer some benefits, but a number of concerns have been raised. More research is needed before a recommendation can be made for or against these types of syringes.

According to evidence, bleach is not an effective way to disinfect needles and does not reduce the transmission of HIV, HCV, and other viruses or bacteria. This reinforces the importance of using a new needle for every injection. Therefore 100% or greater needle coverage is an important goal.

Appendix C

Disposal and handling of used drug use equipment

RECOMMENDED BEST PRACTICE POLICIES to facilitate disposal of all used injection equipment (i.e., needles/syringes, cookers, filters, swabs, tourniquets) and non-injection equipment (i.e., stems, mouthpieces, screens, other smoking and inhalation devices) in accordance with local, provincial/territorial, and federal regulations regarding disposal of biomedical waste and to prevent needlestick and/or sharps-related injuries to staff members, clients and others:

- Regular review and assessment of compliance with local, provincial/territorial and federal regulations regarding collection, storage, transportation, security and disposal of biomedical waste
- Educate clients and staff members on how to properly handle, secure and dispose of used injection and non-injection equipment
- Encourage clients to return and/or properly dispose of used injection and non-injection equipment
- Provide clients with tamper resistant sharps containers in a variety of sizes
- Provide multiple, convenient locations for safe disposal of used equipment in rural and urban settings. Do not penalize or refuse to provide new equipment to clients who fail to return used drug equipment.
- Visually estimate the amount of returned equipment; staff should not touch used equipment and neither staff nor clients should manually count used equipment
- Encourage staff and clients to be vaccinated against hepatitis B (HBV)
- Provide access to safety devices for staff and procedures for first aid and post-exposure prophylaxis (PEP)

Key messages

Needle and syringe programs (NSPs) and other harm reduction programs play a key role in the collection and disposal of used syringes, stems, screens, and other drug use equipment. Removing used equipment from circulation helps to reduce the risk of transmission of human immunodeficiency virus (HIV), hepatitis C (HCV), HBV, and other blood-borne pathogens associated with accidental needlestick or sharps injuries and equipment reuse. Evidence shows that strict exchange policies such as “one-for-one” are not necessary, or desirable, to achieve high return rates; therefore, such policies are discouraged. Lack of knowledge of correct practices or convenient locations can prevent clients from safely disposing of used supplies. Evidence shows that intense police presence and “crackdown” programs can be access barriers for new equipment and disposal services. A variety of options exist to increase access to safe disposal methods including:

- drop boxes
- syringe vending machines
- residential pick-up
- alley and street patrols
- increasing hours of operation of NSPs and harm reduction programs
- community clean-up initiatives
- supervised injection facilities

“Routine Practices” are a thorough approach to handling of used supplies and assume that all body fluids and soiled items present a risk for disease transmission. “Routine practices” also include procedures and standards for immunization, vaccination, training, and first aid to ensure safe management of used materials. Training for such practices and vaccinations should also be offered to clients. Programs are encouraged to use this kind of approach to address handling and disposal of used supplies.

Appendix D



Disposing of Needles Safely

If you find a needle in the community, take these steps to dispose of it safely:

Step 1:

- Find a rigid plastic container (e.g. shampoo or liquid laundry bottle) or sharps container
- Place the bottle or sharps container on the ground near item to be disposed of
- Do not recap the syringe or break off the needle

Step 2:

- Use gloves with tongs or pliers to firmly grasp the plunger end (the non-sharp end)
- Use one hand and keep it in sight
- Always point the sharp end of the needle down and away from you

Step 3:

- Do not hold bottle or sharps container in your hand
- Put the needle in sharp-end first and tightly seal

Step 4:

- Wash hands thoroughly with soap and water afterwards

Step 5:

- Dispose of container by bringing it to your local pharmacy or harm reduction service or contact your local public health unit.

What if you have been poked, scratched, or cut by a needle?

- Do not panic. The risk of infection (HIV, Hepatitis B or C) is low.
- Wash the affected area immediately with soap and warm water, do not squeeze.
- Seek medical attention immediately.

Appendix E

Safer crack cocaine smoking equipment distribution

RECOMMENDED BEST PRACTICE POLICIES to facilitate smoking with a pipe – stem, mouthpiece, and screen – which is made from materials that are non-hazardous to health and have never been shared.

- Provide safer smoking equipment - stems, mouthpieces, screens, and push sticks - in the quantities requested by clients without requiring clients to return used equipment
- Make available both pre-packaged kits and individual pieces of equipment
- Integrate distribution of safer smoking equipment into existing harm reduction programs and services, including within needle and syringe programs (NSPs)
- Provide safe disposal options, including personal sharps containers, and encourage clients to return and/or properly dispose of used or broken pipes
- Provide other harm reduction supplies, such as condoms and lubricant, in the quantities requested by clients with no limit on the number provided
- Educate clients about safer use of equipment, safer smoking practices, the risks of sharing smoking supplies, and safer sex
- Educate clients about the proper disposal of used safer smoking equipment
- Provide multiple, convenient locations for safe disposal of used equipment

Equipment is considered unsafe and needs to be replaced when:

- The pipe and/or the mouthpiece have been used by anyone else
- The pipe is scratched, chipped or cracked
- The mouthpiece is burnt
- The screen shrinks and is loose in the stem

Key messages

Smoking crack cocaine puts people at higher risk for infection by human immunodeficiency virus

(HIV), hepatitis C (HCV), and other viruses and bacteria. Burns and lesions in the mouth (including lips), along with behaviours such as pipe (and mouthpiece) sharing and “shotgunning” can increase the risk of becoming infected or transmitting diseases. Crack cocaine can reduce the body’s ability to fight infections and levamisole, an adulterant sometimes found in crack cocaine, increases this risk. Viruses and bacteria may also survive on pipes and can be transmitted between people if pipes are shared. Using damaged (i.e., hazardous) pipes increases the risk for getting cuts to the lips and hands which can increase the chances of infection.

Studies on Canadian safer smoking equipment programs show that greater distribution of safer smoking supplies can reduce equipment sharing and increase service access for people who smoke crack cocaine. Offering safer smoking supplies beside safer injecting supplies can benefit people who may use multiple drugs in different ways. Distribution of supplies should be sensitive to client needs. For example, the length of mouthpieces should be decided with input from people who smoke crack cocaine. No limits should be placed on the quantities of supplies distributed.

Four items are considered to be “core” supplies for safer crack cocaine smoking:

- a) Heat-resistant glass (Pyrex or Borosilicate) stems
- b) Mouthpieces – Composed of food-grade material
- c) Push sticks – Composed of a non-scratching material
- d) Screens – High heat resistance, pliable, and with no chemical coatings.

Other supplies including condoms and lubricant may also be distributed for clients according to local needs.

Appendix F

Safer crystal methamphetamine smoking equipment distribution



RECOMMENDED ACTIVITIES to evaluate the need to distribute safer crystal methamphetamine smoking equipment:

- Assess the prevalence of crystal methamphetamine smoking and related smoking and sexual harms in the community, especially among youth and men who have sex with men
- Determine how best to engage people who smoke crystal methamphetamine in harm reduction services and how to link directly to safer sex programming
- Assess the level of support among people who use drugs for distribution of safer crystal methamphetamine smoking equipment
- Assess education and other equipment needs within this population
- Obtain a legal opinion regarding distribution of safer crystal methamphetamine smoking equipment
- Evaluate and publish any initiatives undertaken

Key messages

Methamphetamine (also commonly known as “meth,” “crystal,” “ice,” “speed,” “crank,” and other names) is a synthetic central nervous system stimulant that can be ingested via smoking, injecting, intranasally, or orally, depending on its form. There are several ways to smoke the drug, but it is typically heated in a small, glass pipe – often with a bowl or ball on one end of it – and then the resulting vapours are inhaled. At the time of writing, there were a few Canadian harm reduction programs informally distributing equipment designed specifically for smoking crystal methamphetamine. Canadian estimates of smoking methamphetamine are lacking in the literature, while American and some international data have shown increases in methamphetamine use and smoking. Methamphetamine use can have acute negative side effects and prolonged use can lead to a number of health harms, including dependence.

There is no biological evidence linking crystal methamphetamine smoking and transmission of HIV, hepatitis C (HCV), and other blood-borne pathogens. However, multi-person use of crystal methamphetamine smoking equipment is a similar behaviour to multi-person use of crack cocaine smoking equipment, which is believed to elevate the risk of blood-borne pathogen transmission. This similarity suggests the need to more fully assess the potential risk of transmission among those who smoke crystal methamphetamine. Research shows that people who use methamphetamine are at increased risk of HIV due to the relationship between the drug and sexual risk behaviours, and a population that has been well studied in relation to this finding are men who have sex with men. Methamphetamine is sometimes used along with sildenafil (commonly known as Viagra), a combination associated with higher risk sexual behaviour.

Given limited evidence, it is difficult to determine whether distributing ball pipes for smoking methamphetamine would be taken up by Canadian harm reduction program clients and would reduce pipe sharing. Distributing this equipment might reduce instances of homemade pipes that are likely to break and/or cause injury or burns. Targeting locations where methamphetamine smoking may take place (e.g., late-night clubs, bathhouses) with provision of safer smoking equipment, plus safer sex and educational materials, may reach populations that are currently underserved but that would benefit from harm reduction services.

To see the full version of the Best Practice Recommendations, go to:

<http://www.catie.ca/sites/default/files/bestpractice-harmreduction-part2.pdf>

Appendix G

Foil distribution



RECOMMENDED ACTIVITIES to evaluate the need to distribute foil sheets for safer smoking of heroin and other drugs:

- Assess the prevalence of heroin smoking and related smoking harms in the community
- Determine how best to engage people who smoke heroin in harm reduction services
- Assess the level of support among people who use drugs for distribution of foil sheets for safer smoking
- Assess education and other equipment needs within this population
- Obtain a legal opinion regarding distribution of foil sheets for safer smoking
- Evaluate and publish any initiatives undertaken

Key messages

Aluminum foil is used to smoke some drugs that produce inhalable vapours when heated (e.g., brown heroin, other illicit drugs such as methamphetamine, and pharmaceuticals). Smoking heroin in this way is commonly referred to as “chasing the dragon” and is a common route of administering the drug in some regions of the world. Drugs are placed on the foil and heated from underneath while a tube or cylindrical tool (e.g., a straw) is used to direct and inhale the vapours. The tube or “pipe” can also be made out of pieces of foil. At the time of writing, Canadian harm reduction programs were not distributing foil sheets for safer smoking of heroin or other drugs. Some programs in other jurisdictions, notably the United Kingdom, distribute foil sheet packs.

Lung and breathing problems are some of the risks associated with smoking drugs, although we still have much to learn about the risks of smoking heroin. There is little research that documents the potential health risks associated with using aluminum foil to smoke drugs. Although there is no available literature about people sharing the foil tubes or pipes they make for “chasing”, in theory these items can be shared like other types of pipes. If such sharing occurs, it might present risk of pathogen transmission.

In some places like the UK, social marketing campaigns have tried to promote smoking instead of injecting heroin. Foil has been considered a route or reverse transition intervention (RTI), a strategy to either prevent or divert people from injecting. Given limited evidence, we are cautious about specific best practice recommendations regarding foil distribution, especially where it might be used as an RTI tool. Encouraging transitions from injecting to smoking might reduce injection-related risks, but may potentially lead to new smoking-related risks.

There is a need for research in all of the above-mentioned areas and outcome evaluations on foil distribution by harm reduction programs, particularly in Canadian contexts. Preliminary evaluations suggest that some people who use drugs are open to trying foil offered by programs. Programs should maintain close relationships with their clients and local communities to stay up to date on emerging drug use trends and community/cultural acceptance of changes in practices, and any user-led initiatives or campaigns led in an effort to address emerging risks.

Appendix H – Common Infections Related to Substance Use

Common Infections Related to Substance Use	
Abscess or Boil	<p>Germs get pushed under the skin and cause a boil like growth that can be very painful and difficult to treat. This can lead to skin infections like MRSA or infections of the blood like a Septic Infection. Using new supplies for every injection will help prevent against this type of infection</p> <p><i>“Everything New, Every Time”</i></p>
Endocarditis	<p>An infection of the heart that can be very serious and possibly fatal. Symptoms include fever, night sweats or chills, coughing, shortness of breath, chest pain, swollen ankles, and fatigue, weak or lose weight. Commonly associated with injection drug use</p>
Hepatitis B	<p>Hep B (HBV) can lead to serious liver disease and cancer. It is spread by contact with infected body fluids, (i.e. blood and sexual fluids while by having unprotected sex), sharing needles, and to a newborn through its infected mother. The Hep B Vaccine gives a high rate of protection against the virus and is now given to babies to provide immunization from the virus.</p>
HEP C	<p>Hep C is a disease of the liver caused by the Hepatitis C virus. Hep C is spread by blood to blood contact. High risk activities include sharing drug use equipment, sharing tattoo or body piercing equipment, blood transfusions in a country where the blood supply is not routinely screened for Hep C, unsterilized medical equipment, and blood or cutting rituals. Activities that have some risk include sharing personal hygiene and grooming supplies, unprotected sexual intercourse, transmission from a woman to a baby during pregnancy or childbirth, and needlestick injuries.</p>
HIV/AIDS	<p>HIV (Human Immunodeficiency Virus) weakens the immune system. Without HIV treatment, the immune system can become too weak to fight off serious illnesses and eventually, a person becomes sick with life-threatening infections. This is the most serious stage of HIV infection, called AIDS (acquired immunodeficiency syndrome). The two most frequent ways that HIV is transmitted is through sex or by sharing needles or equipment used to inject drugs. HIV is transmitted through 5 body fluids: blood, semen, vaginal fluids, rectal fluids and breastmilk.</p>
MRSA	<p>Methicillin Resistant Staphylococcus Aureus is a bacterial infection, usually on the skin. It is more difficult to treat because it is resistant to many antibiotics. Protect yourself by cleaning your hands.</p>

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