SCHOOL DISTRICT NO. 60 (PEACE RIVER NORTH)

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Board of Education

A G E N D A B O O K

FOR THE

REGULAR BOARD MEETING

BOARD ROOM

MONDAY, APRIL 24, 2023 @ 5:30 p.m.

OUR MISSION
All our students will graduate, crossing the stage with dignity and grace.

OUR VALUES
The core values that guide the work of the school division are *RESPECT, COMPASSION, HONESTY, RESPONSIBILITY, and RELATIONSHIPS*.

OUR STRATEGIES
As a district, we are committed to FOUR OVER-ARCHING STRATEGIES:

- DELIVERY OF EXCELLENT EDUCATIONAL PROGRAMMING FOCUSSED ON STUDENT OUTCOMES
- PROVISION OF ETHICAL LEADERSHIP FOCUSSED ON RELATIONSHIPS AND CONTINUOUS IMPROVEMENT
- EXEMPLARY MANAGEMENT PRACTISES FOCUSSED ON ALIGNING RESOURCES FOR OPTIMAL RESULTS
- ENGAGED GOVERNANCE FOCUSSED ON ADVOCACY, ACCOUNTABILITY, AND COMMUNITY PARTNERSHIPS

THE BOARD OF EDUCATION OF SCHOOL DISTRICT NO. 60

REGULAR BOARD MEETING

MONDAY, APRIL 24, 2023

5:30 P.M.

AGENDA

1.0 **Call to Order**

Acknowledgement that today's Board Meeting is being held within the traditional territory of the Dane Zaa and Treaty 8.

2.0 **Additions to the Agenda/Acceptance of the Agenda**

3.0 **Presentations/Delegations**

4.0 **Trustee Input (Celebrations)**

5.0 **Minutes of the Regular Board Meeting, March 13, 2023** (pages 6-16)

5.1 Approval of the Minutes

5.2 Business Arising from the Minutes
(See attached Action Item List for completed and ongoing items)

a) Standing Finance Committee Presentation
Chair Gilbert

b) SD 60 Overdose Response Awareness Follow up *(Attachments)*
Chair Gilbert

6.0 **Approval of Excerpts of the In Camera Board Meeting, February 21, 2023** (page 17)

7.0 **Announcements and Reminders**

April 25	SUP-PAC Meetings *(Gilbert/Lehmann)*	12:00 p.m.	Board Room
April 27-30	BCSTA AGM		
April 27-28	Elementary Badminton Tournament		MMMCS/NPSS
May 1	Framework Presentations	3:30 p.m.	Board Room
May 5	NID Day (Indigenous Learning)		
May 15	NPAA Dinner	5:00 p.m.	Board Room
May 8	Audit Committee (Trustees)	12:30 – 1:30 p.m.	Board Room
May 8	COTW Regular Meeting	1:30 p.m.	Board Room
May 9	Budget Public Meeting	5:30 p.m.	Board Room
May 18	District Public Speaking Competition		ARYES
May 22	Victoria Day		
May 23 (Tues)	Board Regular Meeting		Board Room
May 25	Doig Days		DRFN

May 30	SUP-PAC Meetings *(Gilbert/TBD)*	12:00 p.m.	Board Room
June 2	Elementary Track Meet	8:30 a.m.	
June 5	COTW Regular Meeting	1:30 p.m.	Board Room
June 9	Clearview Slo-Pitch Tournament		Clearview
June 19	Board Regular Meeting	5:30 p.m.	Board Room
June 23	NPSS Graduation	1:30 p.m.	NPSS
June 29	Last Day for Students		
June 30	Hudson's Hope Graduation		Hudson's Hope
June 30	Administrative Day – Schools Close		
July 3-5	CSBA Congress		Banff

8.0 **Senior Staff Reports**

8.1 Superintendent's Report (page 18)

8.2 Secretary-Treasurer's Report (page 19)

9.0 **Reports of Regular Committee of the Whole Meeting, April 22, 2023** (pages 20-21)

9.1 Approval of Minutes

9.2 Business Arising
(See attached Action Item List for completed and ongoing items)

9.3 Policy Committee *(Attachment)*
- Next meeting date: Monday, June 5, 2023 @ 11:00 a.m.

10.0 **Other Reports**

10.1 BCSTA – *Trustee Gilliss*

10.2 BCPSEA – *Vice-Chair Lehmann*
BCPSEA Regional Meeting *(Attachment)*

10.3 Board Pro-D Committee – *Chair Gilbert*

11.0 **Correspondence**

11.1 Kindergarten Vision Screening – Letter from Margaret Little *(Attachment)*
Chair Gilbert

11.2 Indigenous Education Carry-Forward – Ministry Letter *(Attachment)*
Chair Gilbert

12.0 **Unfinished Business**

12.1 NE Roundtable Update *(Attachment)*
Chair Gilbert

13.0 **New Business**

13.1 50/30 Challenge Meeting Report *(Attachment)*
Chair Gilbert

14.0 **PRNTA Update** – Michele Wiebe, President

15.0 **CUPE Local #4653 Update** – Jennie Copeland, President

16.0 **District Parent Advisory Council (DPAC) Report** – Corrie Bennie, President

17.0 **Questions from the Press and Public Related to Agenda Items**

18.0 **Suspend Regular Meeting & Move into In-Camera Meeting**

19.0 **In Camera Motions brought forward for implementation**

20.0 **Adjournment**

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Please Note:
Where an individual/group knows in advance they wish to address the Board, a request in writing should be made to the Secretary-Treasurer one week in advance of the Board Meeting in accordance with Board Policy #1003.1.

The request must indicate the subject of the presentation, any technology requirements (ie. screen, projector, laptop use) and the estimated time required for the presentation. Presentations will be limited to a maximum of 10 minutes, unless approved otherwise.

If approval is granted, an electronic/written copy of the presentation must be provided no later than Thursday of the week before the date of presentation.

"PROVISIONAL" MINUTES
SCHOOL DISTRICT NO. 60 (Peace River North)

REGULAR MEETING **Monday, March 13, 2023**
5:30 p.m.

Present: Helen Gilbert, Chair – Board of Education (Area 5)
Madeleine Lehmann, Vice-Chair (Area 1)
Ida Campbell, Trustee (Area 4)
Nicole Gilliss, Trustee (Area 3) *(via Zoom)*
David Scott-Moncrieff, Trustee (Area 2)
Tom Whitton, Trustee (Area 5)

Stephen Petrucci, Superintendent of Schools
Angela Telford, Secretary-Treasurer
Leah Reimer, Recording Secretary

Guests/Media
Matt Preprost, Alaska Highway News
Jeff Mayer, SD 60 – Project Heavy Duty
Dan Bourdon
Mrs. Dan Bourdon
Nigel Wray
D. Johnson
Wayne Bell
Cindy Bartsch
Mavis Sutherland
Rhonda Lupul
Shawn Allan
Karen White
Marc White
Jaret Thompson

Regrets: Bill Snow, Trustee (Area 5)

This Regular Board Meeting will be recorded and uploaded to our district website

Disclaimer: The definitive documentation and decisions are documented in the meeting minutes

Call to Order Chair Gilbert called the meeting to order at 5:30 p.m.

Acknowledgement that today's Board Meeting is being held within the traditional territory of the Dane Zaa and Treaty 8.

Agenda

Approval of the Agenda
Motion #35-23 Scott-Moncrieff/Campbell
THAT the agenda be accepted as presented.

CARRIED.

Presentations/Delegations

None

Trustee Input At this time, opportunity was given for Trustees to report on activities undertaken and/or information of interest:

Trustee Campbell
- Attended liaison schools
- Attended some PAC meetings
- Attended Board Advance
- Shout out to District of Taylor – Wednesday, March 15 and Thursday, March 16 they are providing activities for early dismissal days for the students
- Attended band fundraiser – they have a lot of support and it was well attended

Trustee Gilliss
- Not present

Vice-Chair Lehmann
- Was away for a family emergency
- Attended Board Advance

Trustee Scott-Moncrieff
- In regular contact with Administrators, things are going well
- Going out to the Blueberry River First Nation this Thursday
- Attended Board Advance

Trustee Snow
- Not present

Trustee Whitton
- Went skiing with one of the schools…great to see the kids grow in a different way
- Attended the Central School play Aristocats at the North Peace Cultural Centre. It was amazing to see the skill level and vocal range
- Attended Board Advance and the data walk

Chair Gilbert
- Attended DPAC and SUPAC meeting
- Attended BCSTA virtual training session on “governance”
- Attended Board Advance
- Participated in preschool reading sessions…the joy 5 year olds have is uplifting
- Observed the CM Finch science fair projects
- Attended a staff appreciation lunch in Hudson’s Hope to thank them for their efforts during the fire evacuation
- Attended Central School’s Aristocats play

Minutes of the Regular Board Meeting

Approval of the Minutes

Motion #36-23 Whitton/Campbell
THAT the Regular Meeting Minutes of February 21, 2023 be adopted.
CARRIED.

Business Arising from the Minutes

The following business arose from the above noted Minutes:

Superintendent's Report – French Immersion Week

- Chair Gilbert has the draft letter done and will meet with Trustee Whitton after the meeting to discuss further

Approval of Excerpts

Motion #37-23 Campbell/Whitton
THAT the excerpts from the January 23, 2023 In Camera Meeting Minutes be approved and appended to these Regular Meeting Minutes.
CARRIED.

Announcements & Reminders

March 15/16	Early Dismissal Days		
March 20 to March 31	Spring Break		
March 30	BCSTA Virtual Orientation Session (Working with People)	5:00 p.m.	Virtual
April 7	Good Friday		
April 10	Easter Monday		
April 11	Policy Committee Meeting (Trustees)	12:30 p.m.	Board Room
April 11 (Tues)	COTW Regular Meeting	1:30 p.m.	Board Room
April 12	Regional Science Fair		NPSS
April 13	BCSTA Virtual Orientation Session (Relations with First Nations)	5:00 p.m.	Virtual
April 17	BCPSEA Regional Meeting	1:00 – 4:00 p.m.	Prince George
April 21	NID Day (Pro-D)		
April 24	Board Regular Meeting	5:30 p.m.	Board Room
April 25	SUP-PAC Meetings *(Campbell/Lehmann)*	12:00 p.m.	Board Room
April 27-30	BCSTA AGM		
May 1	Framework Presentations	3:30 p.m.	Board Board
May 5	NID Day (Indigenous Learning)		
May 8	Audit Committee (Trustees)	12:30 – 1:30 p.m.	Board Room
May 8	COTW Regular Meeting	1:30 p.m.	Board Room
May 9	Budget Public Meeting	5:30 p.m.	Board Room
May 22	Victoria Day		
May 23 (Tues)	Board Regular Meeting		Board Room
May 30	SUP-PAC Meetings *(Gilbert/TBD)*	12:00 p.m.	Board Room

ACTION: Chair Gilbert is in the process of confirming the Science Fair details and will send out information to trustees once finalized

Senior Staff Reports

Superintendent's Report
A written and electronic report was presented. Topics discussed and reported included:

Human Resources Summary for Teachers & AO's
- For information purposes

Superintendent's Report
- For information purposes

Out of District Field Trips *(Attachment)*
- Additional field trip was added
- See motion below

Community Coaches
- See motion below

Posts of Responsibility *(Attachment)*
- Additional Post of Responsibility was added
- See motion below

Motion #38-23 Scott-Moncrieff/Lehmann
THAT the Board accept the Superintendent's Report with the exception of Out of District Field Trips, Community Coaches and Posts of Responsibility.
CARRIED.

Trustee Gilliss joined the meeting @ 5:50 p.m.

Motion #39-23 Campbell/Whitton
That the Board of Education adopt the Out of District Field Trips as presented, including the new addition.
CARRIED.

Motion #40-23 Campbell/Lehmann
That the Board of Education adopt the following Community Coach as presented
CARRIED.

Motion #41-23 Whitton/Scott-Moncrieff
That the Board of Education adopt the following Post of Responsibility as presented, including the new addition.
CARRIED.

Secretary-Treasurer's Report
A written report was presented. Topics discussed and reported included:

Finance Update to February 28, 2023
- For information purposes
- The Amended Annual Budget is now represented
- When support staff increase funding comes from Ministry, we will be on track
- Examples of Miscellaneous Revenue…donations, vehicle disposals, etc.

Project Heavy Duty *(Attachment)*
Jeff Mayer, Teacher & Coordinator

- May 29 – June 2 is the target day
- Program was promoted at the Petroleum Club dinner
- Have compiled a list of donors and have been connecting with them
- Have a potential long-term site…Parkwood Estates (across the bypass road from Margaret Ma Murray Community School)
- Students are not just pushing dirt around, but will be doing actual work on projects
- Shared about vision regarding the logging component of the program
- Have been doing interviews with various media
- Spent a lot of time with colleagues to get a balanced and fair application process
- Applicants chosen: 12 (7 males, 5 females); 5 Indigenous; 4 – grade 11's and 1 grade 12 form the Dual Credit Program
- Hudson's Hope (1 male, 2 females – includes a brother and sister)
- Prespatou – missed grade 12 students but spoke with Grade 11's…there is not a lot of interest this time
- Mid-April will be promoting on the radio with two students participating in the program
- Will be donating draw prizes (ie. camp chair, cooler & fire pokers designed by Project Heavy Duty students) for the Oilman's Dinner in April
- All trustees are welcome to attend and see what is happening during Project Heavy Duty week

Human Resources Summary Report

- For information purposes

Standing Finance Committee – Budget 2024 Consultation

- Chair Gilbert - looking to the Board for a consensus on the importance of presenting to this committee
- Options: written or an oral presentation or not doing anything at all, which has not been the history of this Board
- Consensus of trustees was that these presentations have had an impact in presenting the needs of our district, particularly the oral presentation that has been done in Dawson Creek or via Zoom in the past

ACTION: Register to do an oral presentation and bring back to the Board at the April 24, 2023 meeting for input on presentation topics

Motion #42-23 Whitton/Lehmann
THAT the Board accept the Secretary-Treasurer's Report.
CARRIED.

Reports of Regular Committee of the Whole Meeting

Business Arising from the Minutes
The following business arose from the above noted Minutes:
None

Policy Committee
- Next meeting – April 11, 2023

Other Reports

BCSTA

Budget Analysis, *Chair Gilbert*
- Attended a call with Board Chairs and Superintendents. One of the topics covered was Ministry is coming out with a food program and the details on how districts are going to implement that
- Secretary-Treasurer - there may be an announcement for funding on March 15, 2023

Provincial Council Update
- For information purposes

BCSTA AGM Registration
- Information has been sent to Trustees, please let District Staff know if you're attending
- Five motions will come forward from the NIB as well as our motion regarding Assessment Wait Times
- Trustee Gilliss - Provincial Council Rep will stay until the Sunday to attend meetings

BCSTA Advocacy for Boards of Education
- For information purposes

BCPSEA
- For information purposes
- Exempt Compensation Working Group – still working on the process and who is involved in the working group

Board Pro-D Committee

Trustee Advance Follow Up
- Participated in a data walk looking at district's results in preparation for Frameworks
- Spoke about the Strategic Plan going forward and forming a committee comprising two trustees, the Superintendent and the Secretary-Treasurer to discuss options and timelines. This information will then be brought back to the Board for review

ACTION: Board to form a working committee to review the Strategic Plan

Motion #43-23 Campbell/Whitton
THAT a working committee be formed in regards to the review of the Strategic Plan.

CARRIED.

Proposed Three Year Calendar 2023-2024, 2024-2025, 2025-2026
- Thank you to the public for feedback
- Based on feedback, moved the "in-lieu" day for November 11 from the Friday before to the Monday after
- Other feedback was not able to be done due to contractual obligations for Christmas Break, Spring Break and the last day of school being the last Friday in June
- Has District Staff responded to those who provided feedback?

ACTION: Superintendent will look into whether feedback has been provided and respond back to the Board

Motion #44-23 Scott-Moncrieff/Campbell
That the Board adopt the proposed 2023-2024, 2024-2025, 2025-2026 Three Year Calendar as presented.
CARRIED.

Capital Plan Bylaw No. 2023/24-CPSD60-01

Approved Projects
- Hudson's Hope – HVAC Upgrade
- Central School & Robert Ogilvie – upgrade electrical controls for HVAC system
- Two new bus replacements

Motion #45-22 Whitton/Lehmann
THAT in accordance with Section 68(4) of the *School Act*, all three readings of the Capital Bylaw No. 2023/24-CPSD60-01 be given at this meeting
CARRIED.

Motion #46-22 Campbell/Scott-Moncrieff
THAT the Board adopt the First Reading of Capital Bylaw No. 2023/24-CPSD60-01
CARRIED.

Motion #47-22 Scott-Moncrieff/Whitton
THAT the Second and Third Reading be read in short form
CARRIED.

Motion #48-22 Lehmann/Whitton
THAT the Board adopt the Second Reading of Capital Bylaw No. 2023/24-CPSD60-01
CARRIED.

Motion #49-22 Campbell/Scott-Moncrieff
THAT the Board adopt the Third and Final Reading of Capital Bylaw No. 2023/24-CPSD60-01
CARRIED.

Correspondence

None

Unfinished Business

The following unfinished business arose from the previous meeting minutes:

Board Chair Update – Partner Liaison Meeting
- For information purposes

New Business

SD 60 Overdose Response Questions
Trustee Whitton

- Three areas of concern:
  - Student safety and the proposed safe injection site
  - Current drug prevention policies in schools and education on drug overdose crisis and prevention…we've had great programs in the past but they have gone to the wayside. There is a concern for our children
  - State of communications between the School District and Northern Health. Feel there was a breakdown in communication somewhere.
- Would like to propose drafting a letter containing consideration of feedback from our governing body when choosing a site and the risk to our children

- Superintendent – we are not privy to those processes. When there is a change to a bylaw or zoning that may affect the schools, the City informs the Secretary-Treasurer who then brings it to the Board.

- Trustee Campbell – in the past we've been notified when there have been bylaw and process changes, but we were not in this case

- Trustee Whitton – are there examples of other schools and what happened in these cases? Could Ministry provide that? Maybe we could extend an invitation to Northern Health to discuss further

ACTION: Superintendent to look into current policies, processes, practices in regards to drug prevention and education in our district and bring back to the Board

ACTION: Chair Gilbert to communicate with colleagues through the BCSTA HUB to see if there are other districts dealing with safe injections sites near their schools

ACTION: Chair Gilbert to connect with schools/daycares in the areas to see if there has been an increase in problems since the injection site has opened

ACTION: Chair Gilbert to draft a letter to Northern Health inquiring around their processes in regards to communication and how these decisions are made in regards to choosing a location for a safe injection site

PRNTA Update – Michele Wiebe, President

Not present

CUPE Local #4653 Update – Jennie Copeland, President

Not present

District Parent Advisory Council (DPAC) Report – President

Not present

Questions from Press/Public

At this time, opportunity was given for questions from the press and public:

Public member - whose responsibility is it to hire teachers?

Superintendent – it is a shared relationship between the Human Resources department and school principals. We get applicants and then principals conduct the interviews and make a preliminary decision. HR then makes checks around seniority, etc. before final decision is made.

Public member - when drafting a letter to Northern Health, can you ask if they are aware of the two daycares and the NPCC that children use in close proximity to the site…it seems like a massive oversight.

Chair Gilbert – yes, I can include concerns about demographics and functions in the areas surrounding the site

Public member - why is Northern Health dictating what happens in our city, school district and our schools? Look at the incident in Fort Nelson. Why are we letting them do that? We want to save our children.

Chair Gilbert – Ministry of Health has their mandate and their portfolio and we have ours. To my knowledge there was no government to government contact. We're hearing your concern and we will go through the process of raising the concerns of the Board and the public here

Nigel – I have children going to a daycare and school in the area of the safe injection site. I'm inexperienced regarding city bylaws, but was under the impression that businesses dealing with drugs had to be a certain distance away from schools. Was that taken into consideration when they forced a safe injection site into our community? Maybe touch on that in your letter?

Chair Gilbert – I'm hearing what you're saying

Trustee Gilliss left the meeting @ 6:55 p.m.

Mavis – In regards to the safe injection site, thank you Trustee Whitton for bringing that up. One of the things to be asked is what the expected volume of clients would be to the site and how much traffic there would be. It is important to know what we're getting into. I like the idea of consulting other districts on it.

Mavis – Worked at Pregnancy Care Centre for 8 years. You've heard in the news about the Fort Nelson card deck issue presented by a Northern Health nurse to students in grades 8/9. I counselled a lot of girls and boys regarding sexual activity and the mental and physical fallout of that.

Chair Gilbert – we're aware of those cards…they have not been used in our district. We have processes in place around our personal health curriculum and to the best of my knowledge, it is not a problem here. This is not a topic on our agenda and I can't speak to Fort Nelson.

Mavis – perhaps you could add it to your next board agenda?

Chair Gilbert – at any point, you can reach out to District Staff to request to present as a delegation or address questions to our Senior Staff…that way you don't need to wait for a board meeting to come forward.

Superintendent – generally speaking, we respond to parents of students in our schools as we can give more detailed information on the curriculum and matters specific to the student.

Public member - how much does provincial health work with education in regards to the injection site here in FSJ and sex education in the schools. How much can they override?

Chair Gilbert – a teacher may choose to invite someone into their classroom for a presentation. They can follow up in regards to health matters, but don't have a right to make a demands for curriculum presentations

Public member – in regards to the immunization letters that were sent out through the schools by Northern Health, why were all of the letters addressed to the students, completely bypassing the parents?

Superintendent – from time to time we are directed to pass on information to schools. You would have to address Northern Health on that.

Chair Gilbert – we have protocols of only accepting questions in regards to agenda items because then we are better prepared to answer them

Public Member - could we add the city bylaw information regarding distance of cannabis stores (ie. 200 meters from a school/100 meter from a park) as well as have protocols in place in order to advert a situation like Fort Nelson?

Also, curious about three readings in one meeting, is that a normal process you go through?

Chair Gilbert – some we would stagger over two meetings. The capital bylaw and the projects are pretty set and there wouldn't be a need for public feedback at this point. Public feedback would have been when we put the plan together in the fall.

Trustee Campbell – if there's something that can be changed, we do one reading and then two readings at the next board meeting. Sometimes there is a deadline that requires us to do all three readings

Public member - attended the City Council meeting – they had zero input into the decision of Northern Health's decision as to the location of the safe injection site

ACTION: Chair Gilbert will draft a letter and bring back to the trustees for review. Will also check process on making the letter publicly available

Suspension & Move into In-Camera Meeting

Motion #50-23 Campbell/Whitton
THAT the Board suspend the Regular Meeting and move into the In-Camera Meeting.

CARRIED.

Motion #51-23 Campbell/Whitton
THAT the Board resume the Regular Meeting and those Motions made In Camera be brought forward for implementation.
CARRIED.

Adjournment

Motion #52-23 Whitton/Campbell
THAT the meeting be adjourned. (7:58 p.m.)

_____
HELEN GILBERT, CHAIR,
BOARD OF EDUCATION

_____
ANGELA TELFORD,
SECRETARY-TREASURER

EXCERPTS
FROM THE FEBRUARY 21, 2023
"IN CAMERA" MEETING MINUTES

The meeting was called to order and the In-camera Meeting Minutes, January 23, 2023 were read and adopted.

Business Arising
- Hudson's Hope School Lunch

Superintendent's Report
Items discussed and reported included:
- North Peace Secondary School Enrollment Audit
- Admin Shuffle

Secretary-Treasurer's Report
Items discussed and reported included:
- Labour Management Meeting Minutes – January 25, 2023
- Pension
- Job Evaluation Increases
- NEW – Custodial Premiums Update

Other Reports
- BCSTA
  - Provincial Council Motions Review
  - BCSTA Director Criteria
  - SD 60 Proposed Motion
  - NIB Motions
- BCPSEA
- COTW Discussion Topics

Correspondence
None

Unfinished Business
None

New Business
None

REGULAR MEETING

REPORT TO THE

BOARD OF SCHOOL TRUSTEES

FROM THE SUPERINTENDENT OF SCHOOLS

Monday, April 24, 2023

Human Resources

1. Human Resources Summary Report for Teachers

Human Resources Summary Report for Teachers & AO's
for period of March 10th to April 20th, 2023

	Personnel Assignments	Leaves of Absence	Admin Appointments	Resignations /Retirements	Reports on Teachers
New assignments	17	5		6	3
Changes to existing	10	9			
Return from leave					
Payout prep					

RETIREES only:

- FRANKHAM, Lisa
- YOUNG, Marie

Education

1. Superintendent's Report

https://togetherwelearn.prn.bc.ca/2023/04/20/superintendents-report-april-2023/

2. Substance Abuse Prevention & Education *(Attachment)*

3. Out of District Field Trips *(Attachment)*

Recommended Motion: That the Board of Education adopt the Out of District Field Trips as presented.

4. Community Coaches *(Attachment)*

Recommended Motion: That the Board of Education adopt the Community Coaches as presented.

Respectfully submitted,
Stephen Petrucci, EdD, Superintendent of Schools

REPORT TO THE

BOARD OF EDUCATION

FROM THE SECRETARY-TREASURER

Monday, April 24, 2023

REGULAR MEETING

Operations

1. **Finance Update to March 31, 2023** *(Attachment)*

2. **Food Security Grant** *(Attachment)*

3. **Board Office Closure – Summer Shutdown** *(Attachment)*

Human Resources

1. **Human Resources Support Staff Summary**

Human Resources Summary Report for Support Staff
For period of March 10th, 2023 to April 20th, 2023

	Personnel Assignments	Leaves of Absence	Resignations
New assignments	14		6
Changes to existing	6		
Return from leave	1		
Layoff			
Retirements			
Termination			

Angela Telford,
Secretary-Treasurer

SCHOOL DISTRICT #60 (PEACE RIVER NORTH)
COMMITTEE OF THE WHOLE
"REGULAR" MEETING MINUTES
TUESDAY, APRIL 11, 2023
1:30 P.M.

Present: Helen Gilbert, Chair, Board of Education
Madeleine Lehmann, Vice-Chair
Ida Campbell, Trustee
Bill Snow, Trustee
Thomas Whitton, Trustee

Stephen Petrucci, Superintendent
Angela Telford, Secretary Treasurer
Leah Reimer, Executive Assistant

Guests/Media:
Michele Wiebe, PRNTA President
Wayne Bell, Public
Public (3)

Regrets: Nicole Gilliss, Trustee
David Scott-Moncrieff, Trustee

Education

Education Update
Stephen Petrucci, Superintendent

Framework Presentations & Departmental Reports *(Attachments)*

Baldonnel Elementary School *(2:00 – 2:30 p.m.)*
Christine Todd, Administrator
- Report was presented and questions fielded from Trustees

Inclusive Education *(2:30 – 3:00 p.m.)*
Keith MacGillivray, District Principal
- Report was presented and questions fielded from Trustees

Alwin Holland Elementary School *(3:15 – 3:45 p.m.)*
Melody Braun, Administrator
- Report was presented and questions fielded from Trustees

Operations

Operations Report
Angela Telford, Secretary-Treasurer

- Report was presented and questions fielded from Trustees
- Water well drilling at Baldonnel and Upper Pine – we were assured from the testing there was good quality water but didn't produce good results (ie. Baldonnel – dry; Upper Pine – not drinkable). Looking into next steps
- Upper Halfway Gymnasium – how are we doing in regards to the budget and inflation? Angela - there is a substantial inflationary contingency built in. Ministry meetings taking place are in regards to the construction. We are hitting our targets up to this point
- Facilities secure space – built not because of any issues but moving forward, we want to be able to control the inventory that we have. Purchasing will take place in house. Large tools need to be checked in and out to keep better track of where they are and to help prevent potential damage
- Bus drivers – great to see. We also have the capacity to fill additional field trips (ie. 3-4 per day)
- Workflow of work orders and completion surveys – surveys are out and not all have been received back. Work orders – went back to paper for the interim because electronically, they were not being completed (ie. we closed thousands of work orders that were incomplete). Paper copy seems to work until we can figure it out electronically
- Safety Emergency Response meeting - custodial supervisor should read safety supervisor
- Safety/Custodial supervisor is doing a great job working with compliance expectations around asbestos, WHMIS, and WorkSafe BC
- Margaret Ma Murray phone system – why do we need a new system as that one is fairly new? Current system is same as Facilities and Ecole Central and they are often "down" and there is not good connection at times. We will eventually be switching over district wide and moving from iTel to Telus VOIP systems

REGULAR - April 24, 2023					Unfinished	
Meeting Date	**Meeting**	**Topic**	**Action Item/Recommendation**	**Assigned to:**	**Business**	**Completed**
May 7/21	COTW	Finance Consultation - Standing Comm	Research where our funding percentage expenditures are in comparison to "like" districts	Angela	x	
Oct 4/21	COTW	Facilities Review - FCI Update	Provide more detailed information in regards to the FCI report	Angela	x	
Sept 12/22	Board	ST Report - Surplus Appropriation	Provide board with a more detailed summary	Angela	x	
Feb 21/23	Board	Policy Committee	Send out Policy 5005 for Notice of Motion & bring to May 23 Board Meeting for adoption	Leah	May 23/23	
Mar 13/23	Board	Other Report - Board Pro-D	Form a working committee to review the Strategic Plan	Helen	x	
Mar 13/23	Board	New Business - SD 60 Overdose Respons	Communicate with colleagues through the BCSTA HUB to see if there are other districts	Helen	x	
			dealing with safe injections sites near their schools			
Mar 13/23	Board	New Business - SD 60 Overdose Respons	Connect with colleagues to of any injections sites in their districts have had any	Helen	x	
			problems since the injection site has opened			
Mar 13/23	Board	New Business - SD 60 Overdose Respons	Draft a letter inquiring around their processes in regards to communication and how	Helen	x	
			these decisions are made in regards to choosing a location for a safe injection site			
Mar 13/23	Board	Questions from Public & Press	Draft a letter & bring back to trustees for review; check process for sharing publicly	Helen	x	
Completed						
Dec 12/22	Board	Business Arising - Audit Committee	Bring back Policy 1011 & ToR to a future meeting	Angela		Feb 6/23
Feb 6/23	COTW	NEW - Special Regular Board Mtg	Reschedule to February 13, 2023 @ 1:00 w/ Zoom option to ratify CUPE MoA	Leah		x
Dec 12/22	Board	Business Arising - Trustee Crim Checks	Look into other policies around the province & bring back for further discussion	Angela		Feb 6/23
Feb 6/23	COTW	Operations Report	Helen to draft a letter to Dawson Road Maintenance/MoT re: road conditions	Helen		x
Jan 23/23	Board	Superintendent's Report	Proposed Three Year Calendar on March 13 Regular Agenda	Leah		Mar 13/23
Feb 21/23	Board	Business Arising - K-12 Reporting	Provide trustees with support document referenced by Jarrod Bell	Stephen		x
Feb 21/23	Board	Supt Report - Comm Coaches/PoR	Provide more detailed info regarding Community Coaches and PoR	Leah		x
Feb 21/23	Board	New Business - Recording Reg Mtgs	Include disclaimer in minutes and Board Chair script	Leah		x
Feb 21/23	Board	Supt Report - French Immersion Week	Draft a letter and organize a picture to be presented by Trustee Whitton	Helen		x
Mar 13/23	Board	Announcements & Reminders	Science Fair details will be sent out to Trustees once finalized	Helen		x
Mar 13/23	Board	Proposed Three Year Calendar	Look into whether those whose provided feedback have been responded to	Stephen		x
Feb 6/23	COTW	Framework Presentations	Sup't & ST to discuss communication options between schools and trustees	Stephen/Leah		x
Feb 21/23	Board	Business Arising - K-12 Reporting	Summarize key speaking points as it comes out and bring draft to the Board Chair	Stephen		Apr 24/23
Mar 13/23	Board	Announcements & Reminders	Confirm Science Fair details & send out to trustees	Helen		x
Mar 13/23	Board	New Business - SD60 Overdose Respons	Look into current policies, processes, practices in regards to drug prevention and	Stephen		Apr 24/23
			education in our district and bring back to the Board			
Mar 13/23	Board	ST Report - Standing Finance Committee	Register to do an oral presentation & bring back to April 24 Board mtg for topic discussion	Helen		Apr 24/23

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BC Overdose Prevention Services Guide

2019

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TABLE OF CONTENTS

1.0 ACKNOWLEDGMENTS

This document was developed by the BC Centre for Disease Control (BCCDC) Guidelines Committee on behalf of the Joint Task Force on Overdose Response in British Columbia in 2017. The guideline is based upon the Vancouver Coastal Health Overdose Prevention Site Manual (Dec. 7, 2016). The Committee reviewed the available scientific literature, policies and procedures, as well as engaging in ongoing discussion with the Regional Health Authorities, Emergency Health Services, law enforcement and community service providers to address issues as they arose. The guideline should be seen as a living document. As the social, legal, scientific and health services contexts of Overdose Prevention Services evolve in BC and in Canada, this document will be updated.

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2.0 INTRODUCTION

2.1 Overview of OPS Protocol and Resources

This guideline is intended for service providers and Public Health practitioners offering overdose prevention services (OPS) in the community. OPS were initiated by the BC Minister of Health in Dec. 2016 due to increasing mortality from illicit drug overdoses. While this document provides guidance for the majority of circumstances service providers and practitioners may encounter, knowledge and practice are always evolving and you are encouraged to connect regularly with your local Harm Reduction Program leads and Medical Health Officers. Although there may be overlap between OPS and Supervised Injection/Consumption Services (SIS/SCS), a separate provincial guideline has been produced and should be referred to by SIS/SCS sites approved by Health Canada.

The guidance in this document primarily concerns and references injection drug use, however the authors recognize that clients may prefer to use drugs in other ways. Consequently, the guideline may also be applied to clients who ingest their drugs orally (i.e. swallow) or nasally (i.e. snort).

The guideline does not cover opioid smoking. Although law enforcement follows trends in the chemical composition of illicit drugs and their cutting agents, very little is known about what chemical by-products are produced when these drugs are burned, or their effects on health. Also, unlike injecting, swallowing or snorting, smoking illicit drugs will release these unknown chemicals into the air. In non-emergency situations where clients are smoking drugs inside, it is recommended to do so with open windows and staff to allow the room to clear of smoke before entering.

OPS provide designated spaces for the purpose of monitoring people who use drugs for signs of an overdose. This permits rapid intervention if an overdose occurs to prevent brain injury and death. For an overview of OPS protocols and service recommendations, see Appendix A: Overdose Prevention & Response Protocol Recommendations for Service Providers (Vancouver Coastal Health and Fraser Health, 2016). For guidelines and resources for OPS within supportive housing and homeless shelters, see Appendix B: Guidelines and Resources for Supportive Housing Providers, Homeless Shelter Providers and Regional Health Authorities on Overdose Prevention and Response.

2.2 Key Elements in Overdose Prevention

Key elements in preventing deaths from overdose are:

(1) using drugs with other people;
(2) calling for assistance in the event of an overdose;
(3) ensuring that naloxone and other life-saving first aid (e.g. breaths) are available quickly.

Key elements in preventing deaths from overdose may be achieved by:

- encouraging people residing in shelters and housing to ask staff or peers to periodically check in on them;
- training staff, and possibly interested peers (persons with past or present experience with injection drug use) and/or volunteers, to monitor a designated space and respond to an overdose;
- providing harm reduction and first aid supplies, including naloxone, in designated spaces and anywhere else there may need to be access to them;
- providing residents with a designated space within the shelter or housing facility where they can be monitored while using drugs
- providing education, upon request, to residents and clients about overdose risk and how to reduce it;
- arranging for visits by health care providers to provide supplies and support to staff and residents.
- providing referrals to health and social supports, including treatment options and primary care.

3.0 PURPOSE

This document outlines principles, protocols, training and related supplies to enable harm reduction workers to provide a space designated for overdose (OD) prevention. Such a designated space may be integrated into an already existing social service or health care setting or may be in a newly established location.

4.0 BACKGROUND

4.1 Epidemiology

British Columbia is in the midst of a drug overdose crisis due to illicit opioids. According to the BC Coroners Service, there were more than 930 apparent illicit drug overdose deaths in BC from Jan. 1 to Dec. 31, 2016. This compares to 518 in 2015, an increase of 79.2%. In December 2016, there were 142 illicit drug overdose deaths: the highest monthly mortality number in provincial history and more than double the average monthly number since 2015 (59).

89.9% of illicit drug overdoses in 2016 occurred inside (61.3% private residences, 28.7% other inside locations), 9.2% occurred outside in vehicles, sidewalks, streets, parks, etc., and 0.9% had an unknown injury location (BC Coroners Service – Illicit Drug Overdose Deaths in BC, January 1, 2007 - December 31, 2016).

4.2 Legislation and Regulation

On April 14, 2016, the BC Provincial Health Officer declared a Public Health emergency under the *Public Health Act* in response to increasing overdoses and overdose deaths.

Health Canada revised the Federal Prescription Drug List on March 22, 2016 to make naloxone more accessible to Canadians in support of efforts to address the growing number of opioid overdoses. In September 2016, the College of Pharmacists of British Columbia changed the scheduling of emergency use naloxone from Schedule ll to unscheduled to increase accessibility. Consequently, naloxone can be made available for sale/purchase anywhere. Consequently, the *Health Professions General Regulation* under the *Health Professions Act* was amended to enable any person in a community or acute care setting to administer naloxone and first aid to another person if they suspect that person is suffering from an opioid overdose.

On December 8, 2016 Overdose Prevention Services (OPS) opened as part of the provincial response to the opioid overdose (OD) emergency as ordered by the BC Minister of Health. The Health Minister of British Columbia enacted the ministerial order under the *Health Emergency Services Act* and *Health Authorities Act* to support the development of overdose prevention services. The minister has the authority to take such measures in the face of a public health emergency. The order was enacted on the advice of provincial health officer and will last for the duration of the Public Health emergency. The order gives BC Emergency Health Services and regional health authorities the ability to provide overdose prevention services as necessary on an emergency basis. It is the responsibility of each individual health authority to assess the need in their region and provide such emergency services in a manner consistent with federal legislation.

4.3 Health and Social Issues

This guideline supports low barrier service for people who inject drugs (PWID) who often have experienced significant and intersecting discrimination, oppression, marginalization and stigma due to drug use and structural violence. Stigmatizing and/or criminalizing PWID contributes to the crisis by pushing people into more isolated situations where they are more likely to experience overdose.

High rates of overdose, disease, and death in PWID are critical and concerning indicators of drug-related harms in society. Providing services to help deal with the underlying traumas and challenges facing PWID is an important part of the provincial response.

5.0 GOALS, OBJECTIVES AND PRINCIPLES

5.1 Goals and Objectives

Aside from drug overdose, harms associated with injection drug use may include skin abscesses, transmission of HIV and hepatitis C, blood-borne infections (BBI), excess morbidity and mortality for PWID, stigmatization of PWID and exacerbated mental wellness.

Goal. The primary goal of OPS is to provide a space for people to use previously obtained drugs with sterile equipment (in the case of injection drug use), in a setting where trained staff are present and able to respond to overdoses as needed.

Objectives. The following objectives support OPS in attaining the overall goal of reducing harms associated with injection drug use:

- Provide space for PWID under the supervision of trained staff to intervene in overdose
- Reduce health, social, legal, and incarceration harms associated with drug use
- Support networks of people with lived experience, and peer workforce as integral to crisis intervention
- Create opportunities to work with PWID to build trusting relationships
- Optimize on the use of health and social services by PWID

5.2 Principles

5.2.1 Harm Reduction

Harm reduction is based on a strong commitment to public health and human rights with a primary aim of reducing the adverse health, social, economic and cultural consequences of using illicit drugs. OPS aim to reduce harms associated with injection drug use and promote health for PWID through:

- Increased opportunity for peer support networks and peer participation
- Reducing the number of overdose deaths
- Provision of Harm Reduction supplies to reduce transmission of blood-borne infections, endocarditis, and sepsis
- Increased access to low barrier services for PWID
- Increased referral pathways to local services

5.2.2 Improved Population Health

OPS improves overall population health through increased community capacity to adequately respond to the current overdose crisis in BC and through providing a point of access to harm reduction services, primary care and/or referral to treatment options based services for PWID, as determined by those accessing OPS services.

5.2.3 Integrated Services

OPS are uniquely positioned as a low barrier point of entry into health and or social services for drug users.

6.0 CORE SERVICES

Overdose prevention services (OPS) are generally seen as an intensive intervention along the continuum of harm reduction services for marginalized populations. OPS should be low barrier, person-centered and offer a trauma-and-violence informed, culturally safe and supportive environment. Abstinence may or may not be a goal for participants accessing the service. Aside from overdose prevention, OPS can also provide referral pathways for participants who wish to access services related to opioid use and/or other health or related social issues.

Core services of OPS Include:

- Provision of a designated monitored space for injection drug use
- Intervention for drug overdoses
- Provision of Harm Reduction supplies (e.g. sterile needles, filters, cookers, condoms, etc.)
- Harm reduction teaching, training and referral services as requested by participants

7.0 SERVICE PROVIDERS

7.1 Guiding Principles for Service Providers

OPS models will vary across BC depending on the environment and context. An institutionalized, 'one size fits all' approach is not appropriate for participant-centered, trauma-and-violence informed and culturally responsive services, and a tailored approach is required to enable a wide variety of people who may experience overdose and other harms to access services.

In some regions, service providers have found that minimizing signage and rules typically found within established supervised injection sites has improved access to overdose prevention. Providers have also found that by allowing people who use drugs to contribute to rules and culture of the OPS, they experience better relationships than in more formal health care settings.

7.1.1 Relationship Building

Relationship building and connection has been the centre of harm reduction work for many years. The following qualities in OPS staff can significantly contribute to building trust with clients:

- Capacity to accept and respect people
- Self-awareness, an open mind an heart, and willingness to reflect on one's responses and boundaries
- Sensitivity and a working knowledge and understanding of the local community context
- Accept that all people are on their own journeys, and do it in their own way at their own pace
- Pro-Choice and ability to step back as an action; respecting choice even if it’s not what was recommended
- A willingness to work as a team, and try different approaches when current ones are not working
- A sense of humor and humility
- Support networks and ways to care for yourself that help to sustain longevity in the work

7.1.2 Confidentiality

It is recommended that people working in harm reduction receive basic training in confidentiality and sign a confidentiality agreement (See Appendix C: *Service Provider Confidentiality Agreement Template*). The following are fundamental aspects of maintaining confidentiality when providing OPS:

- All participant information obtained by while working at the OPS is confidential.
- Because many OPS are often set up as a "one room" model, there may not be a separate area to have sensitive discussions. Take extra precaution to maintain participant confidentiality.
- Any information discussed on site, in staff meetings, during debriefing or in communication systems must remain confidential.

7.1.3 Responsibility/Accountability

Harm reduction workers and employers are responsible for ensuring appropriate training and/or professional designation, in relation to the duties they may be carrying out (e.g. proper training for rescue breathing supported by bag/valve masks and oxygen, if available, vs. general rescue breathing with face masks, Assisted injection, etc.). See Appendix D: Key Responsibilities for OPS Service Providers.

7.2 Documentation/Data Collection

Documentation is a crucial component for all OPS in BC in order to: 1) evaluate the impact and effectiveness of these programs; and 2) to meet regulatory standards for documentation and professional accountability. See Appendix E: *Required Documentation and OPS Intake Templates:*

- User Agreement/Release Form (1st visit only)
- OPS: Release of Responsibility Waiver (1st visit only)
- Visit and Overdose Log
- Youth Registration and Assessment
- Overdose Prevention Sites Core Data Elements for Overdose Incident

7.3 Support for OPS Service Providers

Provision of OPS requires particular attention to the wellness of staff. Attendance to repeated overdoses, sometimes several during the same shift, can be traumatic. This is especially true for people with lived experience as they are often working within their own community, and often witnessing high overdose and mortality rates among friends and family. See Appendix F: Support for Peers Providing Overdose Prevention and Response Services

8.0 SERVICE DELIVERY

The recommended service provider to participant ratio is 1:2. The maximum number of participants in the OPS at one time is determined by the number of tables for injection and service providers onsite. Staffing should take into consideration allowances for service providers' time to debrief and take breaks during their shift if required or when indicated. Ideally participants can be monitored post injection in a nearby location.

For an overview of the recommended training, protocols, prevention and follow up for OPS, See Appendix A: *Overdose Prevention & Response Protocol Recommendations for Service Providers* ([VCH] &{FHA], 2016).

Local Law Enforcement

Criminalization of drug use is inconsistent with the goals of OPS since OPS focuses on drug use as a health issue. The key is to ensure that people feel safe to access OPS and are not targeted or subjected to increased criminalization by police or security because of using services. This creates distrust and increases mortality by forcing people to use in hidden spaces and alone. Public order outside of OPS sites can be maintained without use of enforcement or increased security measures. Staff, particularly peer staff, should be seen as a priority in hiring as a means to provide optimal services delivery. See Appendix Q for additional information.

8.1 Participant Profile

In order to maintain low-barrier service provision, personal information including contact information is not required for access to OPS. OPS participants may choose or be given a unique identifier and confidentiality will be maintained at all times.

8.1.1 Participant Codes of Conduct

Statements of participant rights, responsibilities and codes of conduct should be clearly outlined and posted so they are visible to everyone accessing the site (See Appendix G: *Participant Rights and Codes of Conduct*).

8.1.2 Management of Specific Behaviors

- An appropriate service provider response requires de-escalation skills in a caring and respectful manner, and access to a quiet space when possible.
- Appropriate decision making around temporarily or permanently barring someone. Access to services can be lifesaving for people.
- Participant perception of judgemental behavior or strict rule enforcement may incite aggressive behavior.
- Service providers who have lived experience (Peers), the availability of food, drink and a warm dry place to relax post injection offers extra comfort which can minimize the potential for aggression.
- Participant rights, responsibilities and codes of conduct should be made available/visible to everyone accessing the site (See Appendix G: *Participant Rights and Codes of Conduct* [INSITE, 2016]).
- Aggressive behavior can result from agitation, frustration, or anxiety related to the physical and mental side effects of illicit drug use, and/or experiences of homelessness, poverty, criminalization, and marginalization.

For further recommendations see Appendix H *Management of Specific Participant Behaviors*)

8.1.3 Eligibility for OPS Access

To ensure the safety of everyone in the OPS, service providers must retain the authority to refuse entry and request ineligible participants to leave. It is recommended that staff consult with participant first, then management before

initiating a longer-term participant ban. Any use of bans should be appropriate to the behavior and employed beginning with least restrictive means. Service providers should be particularly sensitive that bans which restrict use of OPS should be avoided to prevent deaths. For example, use of substances in other agency locations such as washrooms should not result in ban from agency but rather redirecting people to appropriate sites for use. A goal of the OPS should always be to protect access for all people (See Appendix I: *Prohibition from Accessing OPS*).

Eligible: The following criteria indicate participants *as eligible* to access OPS when they are:

- Willing to sign the User Agreements and Waiver Release (site specific)
- Willing to adhere to the OPS Code of Conduct
- Not exhibiting overly aggressive behavior
- Not previously prohibited from entering the site
- Aged at least 16 years or over, or a mature minor capable of providing informed consent to their own health care as per the *Infants Act*
- Not using injection drugs for the first time and between the ages of 16-19 years

Ineligible: The following criteria indicate participants *as ineligible* to access OPS when they are:

- Mature minor unable to consent to their own health care (*Infants Act*)
- Under the age of 19 and no previous history of injection drug use (IDU). Overdose prevention services are generally seen as an intensive intervention along the continuum of harm reduction services for extremely marginalized populations. Youth who do not have a history of IDU should access resources that can more appropriately address their level of need.

Participants assessed as *ineligible* to use the OPS will be asked respectfully to leave the OPS.

Reasons for Service Refusal to Eligible Participants.

People may be politely denied admittance even when eligible if they have no intention of using drugs on the premises or the site is full

8.2 Reasons for Service Refusal from OPS

Service refusal occurs when participants are declined access for an identified amount of time and should occur as a last resort. Service providers should be aware that service refusal from OPS may cause more harm to the person, and should be considered in the decision-making process. The decision to deny a participant from accessing OPS lies with the site supervisor and is often specific and temporary. (See Appendix I: *Prohibition from Accessing OPS*).

8.3 OPS Access for Participants with Special Circumstances

The following individuals are considered as requiring specific considerations when seeking access to OPS.

- Youth
- Overly intoxicated
- First time using injection drugs
- Pregnant
- Non-Self Injectors

See Appendix J: Participants with Special Circumstances: Access to OPS.

8.4 Injection Services

8.4.1 Key Concepts

This section outlines key concepts to minimize the risk of needle stick injury, to safely prepare and then self-inject.

1. **Participants should self-inject where possible.**
2. **Service providers who are under a regulatory body are not permitted to perform the venipuncture or administer the drug to the participant; however, peer to peer inection may be permissible under certain circumstances (see 8.4.4.4).**
3. **Injection of illicit substances is associated with:**
    a. Blood-borne infections such as HIV and hepatitis C
    b. Injection related infections
    c. Death due to overdose
4. **Potential harms can be reduced through:**
    a. Application of harm reduction philosophy and core principles of health promotion
    b. Promoting participant agency and autonomy, especially in their wellness and injection practices
    c. Health teaching and care as determined by participants by trained staff
5. **Safe disposal of sharps including sharps containers is critical because:**
    a. The main cause of HIV infection in occupational settings is via percutaneous (e.g. needle-stick) injury resulting in exposure to blood with higher viral loads of HIV.
    b. 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. It is recommended that people working in OPS settigs have Hepatitis B vaccinations.
    c. Use procedures laid out in this section to minimize chances of an accident related to needle-stick injury.

8.4.2 Physical Space

The space for drug consumption may vary depending on the size of the population being served and the resources of the organization. The following are recommended space attributes and equipment:

- The space should be warm and well-lit
- Ventilation for OPS sites should meet the Canadian standard for air changes, which is dependent on occupancy. In most cases, one window or open door is sufficient for ventilation purposes. Please see Appendix K for further details on the standard.
- Mirrors may be strategically placed to facilitate monitoring and self-injection; or the site should provide portable mirrors for clients on request
- Sharps disposals should be easily accessible for each client and in washrooms
- Table and chairs should have non-permeable, non-flammable surfaces, which can be easily cleaned with hospital grade cleaning supplies.
- Chairs may be positioned facing a wall to optimize privacy but is still accessible and able to be periodically monitored.
- There should be adequate space for staff or volunteers to perform naloxone administration and artificial respiration if necessary.
- The area should have a clear and open pathway to the entrance/exit should medical transport by emergency health services be required.

8.4.3 Equipment

Provide disposable trays for participants to collect equipment prior to proceeding to an injection booth. The following equipment should be available:

- Tourniquet
- 1cc and 0.5cc syringes/rigs. Choice in size varies and is a matter of personal preference.
- Sterile water for cooking
- Sterile cookers and filters (such as cotton) to filter the substance and reduce the amounts of harmful contaminants
- Alcohol swabs
- Gauze
- Band-Aids
- Ascorbic Acid (for breaking down crack cocaine)
- Sharps containers
- Cleaning supplies
- Fire extinguisher if available

Disposal systems for both bio hazardous waste and sharps should be easily accessible. Encourage participants to dispose of their own equipment.

8.4.4 Safer Injection

The following practices significantly reduce the risk of needle stick injury to staff, participants or visitors to the OPS.

- Participants dispose of needles in appropriate containers supplied by OPS
- Participant knowledge re: safe handling of injection equipment.
- Participants who use sharps outside of the OPS environment are instructed to put sharps in a heavy plastic or metal container with a secure lid.

OPS staff trained in safer injection techniques may offer education/guidance for participants upon request. These activities are undertaken with extreme caution and carried out by trained staff. (See Appendix L: *Activities that Require Extreme Caution: Supporting Safer Injection*).

8.4.4.1 Pre-Injection Assessment

Before the participant accesses the injection area:

- assess for participant safety
- assess the participant's ability to follow simple directions
- consider the participant's current state of mind
- assess whether the participant is currently prone to sudden or erratic movements
- request that the participant dispose of all used needles (reduce risk of needle stick injury)
- request that the participant places the rig to be used on the table
- offer the participant hand sanitizer or the option to wash their hands
- consider location of sharps container in booth in relation to your location in booth (you may be in the path to the sharps container post injection)

*If there is concern regarding safety based on the above assessment staff can inform supervisor and may choose to not engage in booth assistance, especially for activities listed in Appendix L: *Activities that Require Extreme Caution: Supporting Safer Injection*.

8.4.4.2 Authorized Activities

Authorized Activities - Booth assistance by *trained* staff **if requested**:

- Encourage hand washing as a measure to prevent infection;
- explain steps in safer injection process (Harm Reduction Education);
- Palpate and locate veins – land marking is an important part of vein care;
- Identify potential injection sites, including physically guiding participant's hand to appropriate injection area;
- Swab injection site with alcohol swab to reduce infection;
- Tie off participant's arm;
- Physically demonstrate all steps in safer injection process using separate set of sterile equipment and own body (mock injection only).

Participants with substantive history of injection drug-use may not require booth assistance and often serve as a valuable resource for safer injection practices for other OPS users, these folks may also be able to assist non-self-injectors if necessary.

8.4.4.3 Jugular Self Injection (Jugging)

Jugular veins pose high risk of medical complications. If a participant insists on using this site to inject support the participant with the harm reduction education outlined in the protocol. (See Appendix M: *Injection into the Jugular Vein [Jugging]*).

8.4.4.4 Assisted Injection

While self-injection is preferred, non-self-injectors (people who are unable to self-inject) may seek peer to peer assisted injection if neither education of the person to self-inject, nor the provision of physical supports, will address the person's immediate need to be protected from harm. (See Appendix J, part D: *Non-Self-Injectors*.)

The public health rationale for permitting assisted injection by peers is to reduce the risks of injection for highly vulnerable persons who are unable to self-inject. Like those who do self-inject, they are at risk of overdose death, but in addition they are highly vulnerable to the transmission of HIV and HCV infection.

It is important to note that under the current legal framework it remains possible that providing assisted injections could result in serious criminal liability for those who assist; thus the person assisting should make an informed choice when providing assisted injections.

8.5 Disposal of Injection Equipment

- After injecting, each participant disposes of their used injection supplies in the sharps container, which is readily accessible at each injecting station. Participants are asked to not bend or break off needles before disposal.
- OPS staff will supervise the disposal process.
- If needle pick-up is required – use tongs if available; if using hands wear industrial gloves (black rubber)
- The disposal containers should be puncture resistant plastic and not filled to more than three-quarter capacity.
- When three quarters full, the sharps disposal container should be sealed.
- The filled containers should be removed and placed in a large cardboard bin provided by a hazardous waste company (where available)
- All full sharps containers should be stored in a locked, non-service area.
- Needle disposal/pick-up should be arranged by the site supervisor
- Agencies are responsible for hazardous waste pick up: consult with the regional health authority.

8.6 Needle Distribution

Service providers should encourage all participants to stay and inject at the OPS; however, if participants intend to inject elsewhere, needle distribution should be provided. Needle distribution services include:

- Distribution of all supplies (e.g. cookers, sterile water) including syringes
- Education on safe disposal of injection equipment
- Extending access to whoever needs them, regardless of the person's age, substance-using status or choice of substance used. (see Appendix J*: Participants with Special Circumstances; Access to OPS* [re: Youth])
- Individuals should receive enough supplies (injection equipment) to enable a clean needle for each injection.

8.7 Secondary Health Harms Associated with Injection Drug Use

For information on common secondary health harms associated with injection drug use See Appendix N: *Secondary Health Problems Associated with Injection Drug Use.*

8.7.1 Referral for Substance Use Treatment Including Opioid Agonist Therapy

- Long term opioid agonist therapy including iOAT, methadone, buprenorphine and other alternatives are an evidence based overdose prevention strategy for people with opioid use disorder.
- OPS staff should familiarize themselves with local addiction treatment services and be able to refer clients to primary care and treatment supports as requested.

9.0 OVERDOSE

This section outlines information for recognition and response to drug overdose for both stimulants and opioids. All OPS staff should be trained to respond to an overdose.

9.1 Opioids: Background and stages of Intoxication

Background Information

Opioid drug class includes:

- Substances directly derived from the opium poppy (such as opium, morphine, and codeine),
- The semi-synthetic opioids (such as heroin), and
- The purely synthetic opioids (such as methadone and fentanyl).

Opioids affect central nervous system receptors. The pharmacological effects include sedation, respiratory depression and analgesia as well as intoxication and withdrawal. The time to peak blood concentration and half-life depends on the specific opioid in question and will affect the length of time to intoxication.

Commonly used opioids:

- Codeine
- Heroin
- Morphine
- Demerol
- Amileridine (Leritine)
- Methadone
- Hydromorphone (Dilaudid)
- Fentanyl
- Opium
- Pentayocine (Talwin)
- Percocet (Percodan)

Opioid intoxication symptoms:

- Depressed level of consciousness (LOC)
- Constricted pupils
- Decreased respiration,
- Gurgling, snoring
- Body is limp
- No response to noise or knuckles being rubbed firmly on the sternum
- Skin looks pale or blue, and feels cold
- Slow or no pulse
- Person cannot stay awake
- Pinpoint pupils
- Cannot talk or walk

Opioid withdrawal symptoms:

- Anxiety, irritability
- Dilated pupils
- Sweating
- Nausea/vomiting

Atypical Opioid Overdose Symptoms

- Muscle rigidity
- Unusual movements of the arms and legs
- Seizures
- Delirium
- Staring gaze
- Walking or awake
- Decorticate posturing
- Slowed or irregular heartrate
- Vomiting

Stages of Opioid intoxication:

Stage	Services Provider Response
One: Drowsy	• Monitor Closely
Two: Nodding (intermittently falling asleep)	• Remain calm, monitor – paying attention to respiratory rate/minute • May verbally check in with the participant – being mindful not to disrupt their experience
Three: Nodding with respiratory rate less than ten breaths per minute	• Remain calm, attempt to wake participant • Gently shake and talk to participant • Get participant to open eyes • Get participant to talk • If responsive, assist to walk around • If available, may require oxygen
Four: Unresponsive	**Initiate Opioid Overdose Protocol**

9.1.1 Opioid Overdose Protocol (BCCDC, 2016)

Note: If oxygen or bag valve masks are available in your facility see Appendix O: *Protocol for providing Oxygen Therapy and Use of Bag Valve Masks.*

1 Identify

- Before approaching MAKE SURE AREA IS SAFE- clear away any needles and put on gloves
- UNRESPONSIVE (doesn't respond to verbal stimulation [shouting their name] or pain. Tell them what you are going to do: nudge/touch them, then do sternal rub/pinch ear lobe/finger webbing)
- SLOW BREATHING (less than 1 breath every 5 seconds), may be snoring/gurgling
- Skin (may be pale or blue, especially lips and nail beds; may be cool or sweaty)
- Eyes (pinpoint (i.e. very small) pupils)

2 Take Charge

DELEGATE the following Tasks (examples below, some can be done by 1 person, some may not be needed):

(1) Phone 911
(2) Rescue breathing
(3) Meet emergency responders and direct them to the OD
(4) Get overdose response supplies
(5) Give naloxone
(6) Crowd control

3 Call 911

PHONE 911

- Say it is a medical emergency (not responsive not breathing) make sure ambulance is dispatched
- Give the address to the dispatchers
- Send someone to meet emergency responders at main entrance or street and direct them to the site of the overdose

4 Rescue Breathing

- Head tilt, chin lift - Clear mouth/airway & tilt head back
- You can use a breathing mask as a barrier – ensure the barrier is sealed around the mouth to maximize breaths
- PINCH NOSE and give 2 breaths
- Continue to give 1 BREATH EVERY 5 SECONDS (even after giving naloxone, until the person regains consciousness or paramedics arrive)

5 Give Naloxone: If the person has not regained consciousness with rescue breathing.

- Swirl the ampoule, then snap the top off the ampoule (away from your body)
- Draw up all the naloxone in the ampoule (1 mL) into the VanishPoint syringe
- Inject entire dose at 90° STRAIGHT INTO A MUSCLE (THIGH, upper arm, butt) - can inject through clothes

6 Evaluate

- WAIT 3-5 MINUTES to see if the person regains consciousness
- Don't forget to CONTINUE RESCUE BREATHING 1 breath every 5 seconds until the person is breathing on their own
- Give 40-50 breaths before deciding to give an additional dose of naloxone

7 More Naloxone

- If there is no response after 3-5 minutes, GIVE A 2ND DOSE OF NALOXONE (as described above)
- WAIT 3-5 MINUTES - about 40 breaths (CONTINUE TO GIVE RESCUE BREATHS)
- Continue to give naloxone as described above every 3-5 minutes (while rescue breathing) until the person responds OR paramedics arrive

8 Document and Debrief

- Tell paramedics about all emergency care provided (including # naloxone injections given)
- Fill out your organization's Critical Incident form and any other required paperwork
- Talk to your coworkers and/or site coordinator and/or site manager and/or access support through your employer (BCCDC, 2016)

9.1.2 Rescue breathing

The greatest harm from opioid overdose is brain damage due to lack of oxygen. Rescue breathing is a critical component of an opioid overdoes response.

In a witnessed overdose, it is very likely that the client's heart is still beating. **Prioritizing giving breaths**: the person is lacking oxygen due to depressed activity of the central nervous system. Breaths should be given every 3-5 seconds while preparing to administer naloxone AND approximately 30-40 breaths should be given between each injection of naloxone.

9.1.3 Oxygen Therapy and Bag Valve Masks (BVM)

Some OPS programs may have access to oxygen tanks or BVM supplies. For sites that do wish to provide oxygen the following guidance is offered. See Appendix O: *Protocol for providing Oxygen Therapy and Use of Bag Valve Masks.*

Background

- There is minimal published literature on oxygen use by laypeople in the outpatient setting and no known published studies on its utility in opioid overdoses in the community.
- Expert opinion, as outlined in the 2016 *Canadian Consensus Guidelines on First Aid and CPR*, allows for oxygen (O2) administration by trained first responders.
- There is expert agreement that provision of O2 by lay people within the OPS context is appropriate. Some OPS have portable tanks of oxygen available for use in an emergency.
- Oxygen should only be used on people who are unconscious and whose oxygen saturation is less than 90%. This is to prevent the potential harm that oxygen can cause when given to someone who has an underlying respiratory illness.
- A person who is unconscious and showing a depressed respiration rate would benefit more from BVM with or without additional O2 (e.g. room air) if used by someone trained and competent in its use.
- Sites that plan to have O2 should also procure oxygen saturation machines and BVM. Staff must have received training on the safe use of the equipment as well as safe storage and maintenance of oxygen tanks and ensure supplies are maintained.

Definitions

- Oxygen therapy is the administration of oxygen as a medical intervention, which can be for a variety of purposes in both chronic and acute patient care. Oxygen is essential for cell metabolism, and in turn, tissue oxygenation is essential for all normal physiological functions.
- Bag Valve Masks (BVM) is an airway apparatus used to cover the patient's nose and mouth and begin ventilating the lungs mechanically by squeezing a reservoir of oxygen or air.
- Oxygen saturation refers to the extent to which hemoglobin is saturated with oxygen. Hemoglobin is an element in the blood that binds with oxygen to carry it through the bloodstream to the organs, tissues and cells of the body. Normal oxygen saturation is usually between 96% and 98%.
- Pulse oximeter: a device, usually attached to the earlobe or fingertip that measures the oxygen saturation of arterial blood by sensing and recording capillary pulsations.

9.1.4 Naloxone

Naloxone is a safe and *highly effective* antidote to opioid overdose. Naloxone is an opioid antagonist and has a much higher affinity (attraction) for the same receptors in the brain as heroin and other opioids.

Naloxone displaces and prevents opioids from working at receptor sites in the brain. It has no effect on non-opioid drugs and no potential for abuse. If there are two first-responders, one can administer naloxone while the other manages airway, breathing, and circulation.

Once naloxone is administered, responders continue to perform airway, breathing, and circulation interventions. Naloxone has a short half-life: 15 to 30 minutes. This is much shorter than most opioids, so it is important to monitor a person after an overdose for 30 minutes or more. This is best done at the hospital.

9.2 Stimulants: Background and Stages of Intoxication

Background Information

Stimulants can cause increased heart rate, blood pressure, and body temperature. A stimulant overdose can cause cardiac or respiratory arrest as well as seizure. Patients may report chest pain, shortness of breath, disorientation, or panic. These symptoms require medical attention, and the person should be supported to attend hospital via ambulance.

Commonly used stimulants include:

- Cocaine
- Crack cocaine
- Amphetamines
- Ritalin
- Adderall

Stimulant overdoes symptoms may include:

- agitation, shaking
- chest pain
- high level of anxiety
- seizure

9.2.1 Stimulant Overdose Protocol

Stimulant overdose has a variety of presentations and can be precipitated by lack of sleep. The person should be monitored, kept safe and encouraged to attend hospital.

A stimulant overdose can lead to seizure, heart attack, or stroke as a result of elevated body temperature, heart rate, blood pressure, as well as dehydration.

Additional steps in the event of a stimulant overdose:

- Apply cool cloth to back of person's neck or to forehead
- Limit stimulation by moving the person to a quiet location with low light
- Encourage person to take slow, deep breathes
- If person becomes unconscious or has chest pain call 911.
- Perform assessment/intervention to maintain airway, breathing, and circulation (PHS, 2016)

If the person is having a seizure:

- Don't restrict their movement
- Don't put anything in their mouth
- Protect their head (place a pillow underneath their head)
- Place the person in the recovery position.
- Call 911

10.0 OPERATIONAL PROTOCOLS

10.1 Cleaning the facility and Disposal of Equipment

To guard against infection and contamination, the OPS sites should be kept as clean and tidy as possible at all times. Keeping the site tidy also shows respect for the participants. When service providers' clean booths, take out garbage or tidy up the OPS space - the main focus is to avoid needlestick injuries through:

- Paying close attention – do not get distracted when cleaning debris off the booth or floor
- Never using hands to take garbage off a booth – use a small dustpan and brush.
- Ensure good lighting in the workspace

See Appendix P: *Cleaning Checklist Template for OPS Space* as an example template for cleaning recommendations at OPS.

Cleaning Booths/Floors – Reminders:

- Don't get distracted
- Never use hands to remove garbage from an injection booth or the floor
- Wear gloves whenever cleaning
- Use a dustpan and small brush to remove debris from the booth.
- Use a dustpan and large broom to remove debris from the floor
- Encourage participants to clean debris off their own booths
- Wearing gloves, wipe down booths/mirrors with industrial disinfectant wipes such as CaviWipes or other hospital grade cleaners.

Refer to Section 7.0: *Service Delivery*

- *Safer Injection*
- *Disposal of Injection Equipment*
- *Equipment Disposal*

10.2 OPS Flow

10.2.1 Admission into OPS/Reception

- Reception staff greet each participant
- Reception staff assesses each participant for eligibility to access the service (See Section 7.0 *Service Delivery: Eligibility to Access OPS*)
- Participants sign the following forms as per site policies (See Appendix E – *Required Documentation and OPS Intake Templates):*
    - Adults:
        - *User Agreement, Release and Consent Form: Overdose Prevention Services (OPS)* – (Signed on the 1st visit only).
        - *Overdose Prevention Services (OPS): Release of Responsibility Waiver* – (Signed on the 1st visit only).
    - Youth:
        - *Youth Registration and Assessment* - (To be completed for each visit)
- All participants are registered in the *Overdose Prevention Services (OPS): Visit and Overdose Log* (Appendix E) before each visit.
- Participants will only need to provide their alias for subsequent visits.

10.2.2 Leaving the OPS to Provide Overdose Assistance (site specific).

OPS Staff may, on occasion, see a person outside the facility who requires immediate assistance.

Guidelines:

- Depending on agency/regional health authority protocols, service providers may or may not be required staff to leave the facility to provide care.
- For some OPS, there may be an associated chill out area located outside or adjacent to the OPS area. If overdose occurs in this area, staff may be required to respond.
- Staff may respond to an overdose outside of the designated OPS space to provide care only if the safety of participants and other staff inside the OPS is ensured.
- The primary responsibility is to provide service within the OPS and to ensure the safety of participants and staff on-site.

Staff may choose to leave the facility to respond to an overdose when:

- The situation is life threatening and cannot wait until Emergency Health Services or police arrive.
- The situation does not present a risk to staff safety or health.
- Emergency services (911) have been called.
- A second person accompanies them or can observe them from inside the OPS.
- It is the individual staff member's decision to leave the facility to provide service/support.

10.2.3 Washroom Monitoring (Site Specific)

Staff may be required to access the washroom in case of emergency, even if locked from the inside. Monitoring participant washroom use and initiating an appropriate response to any occurrence should be part of OPS protocol.

It may be beneficial to alert participants that staff will “check in” if the washroom is occupied for longer than usual (e.g. approx. 5 minutes). Indoor overdoses often occur in facility washrooms.

10.3 Death Protocol (site specific)

- Clear away any crowds that have gathered.
- As with all medical emergencies, contact Emergency Health Services ambulance (911) to request immediate assistance.
- Secure the immediate area around the individual, providing privacy and prohibiting access to area by other participants.
- Place all the individual's belongings in a plastic bag with their name on it and secure them in an office or space separate from the OPS space.
- Call the supervisor immediately and/or the regional health authority or agency Administrator on call.
- Check in with team members to see if they need to debrief the incident.

11.0 OCCUPATIONAL HEALTH AND SAFETY (OCHS)

11.1 OPS Space Requirements

For OPS space requirements please refer to the following sections:

- Appendix K: *Physical Space and Ventilation Requirements*
- Section 7.0: Service Delivery*:*
    - *Physical Space*
    - *Equipment*

11.2 Equipment

The following equipment is recommended for cleaning purposes:

- Industrial black gloves
- Cavi-Wipes (Industrial cleaning product for wiping down booths– wear gloves)
- Dust pan and brooms:
    - Large for floors
    - Small for removing debris from tables
- Sharps Containers
    - Sharps containers should be located as close as practical to the work area.
    - Different sharps containers are required for different purposes and worksites.
    - Replace containers when they are 75% full.
    - Sharps container should be maintained upright throughout use.

11.3 Personal Protective Equipment (PPE)

- The risk of unintended fentanyl exposures to staff treating overdose victims is extremely low. Fentanyl citrate and fentanyl HCl crystals in powders intended for street use are too large to become airborne or easily inhaled.
- In BC, there have been no reported cases of secondary exposures of fentanyl to first responders, health care workers or private citizens administering naloxone, despite thousands of overdose reversals in the field and in health care facilities.
- No additional Personal Protective Equipment is required when attending patients with drug exposures unless there is a risk of respiratory and/or bodily fluid exposure.
- Routine practices such as gloves and additional precautions should continue to be used when there is a risk of respiratory and/or bodily fluid exposure. The additional practices and/or elevated levels of PPE used in other professions are not required at this time.

11.4 Equipment Disposal and Transportation of Sharps

Equipment Disposal

Service providers must be familiar with safety and handling guidelines: post these guidelines in disposal areas and janitorial closets.

Transportation of Sharps

- 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.

How to Handle Garbage Safely

- Consider removing garbage just outside of the OPS regularly to avoid sharps being disposed here.
- Physical handling of garbage in the OPS 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. If available wear puncture resistant and liquid resistant gloves, polyurethane 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 the top of the bag is easily handled.
- Change bags often to prevent over-filling. This allows for a lighter, less full back and makes it easier to hold away from the body when transporting.
- Hold the garbage bag by the top of the bag, away from the body – never hold the bag against the body.
- Do not place one hand under the bag to support it.
- Use tongs to pick up sharps.
- If tongs are not available, use a gloved hand to carefully pick up the needle. Dispose of gloves and WASH HANDS after needle contact.
- Hold needle tip away from the body.
- Put needle/s in a puncture resistant can or jar.

11.5 Needle Stick Injuries/Exposure to Blood and Body Fluids (Insite, 2016)

In the event of a needle stick injury:

- 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.
- Report to the supervisor immediately.
- Go directly to the local emergency department to be assessed for risk of exposure to blood-borne infection as soon as possible: preferably within two hours of the incident.
- If the source/person of the blood or body fluid is known, request (or parent/guardian) their consent to have blood testing as well. They can go to emergency as well – preferably at the same time.
- Request or designate the site supervisor to complete Worker's Compensation Board form -Employers Report of Injury or Industrial Disease (WorkSafe BC).

11.6 Unknown Substance Left Behind

For any controlled or unknown substances left on site:

- Immediately bring to the attention of the site supervisor
- The site supervisor will place the substance in an envelope, which is then sealed, dated and initialed by the supervisor.
- The envelope should be placed in a locked safe in the staff-only area.
- The envelope will be logged into a record-keeping book, by supervisor.
- Contact the local police department
- A member of the local police department will log out the envelop

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13.0 APPENDICES

Appendix A: Overdose Prevention & Response Protocol Recommendations for Service Providers (VCH & FHA, 2016)

OVERDOSE PREVENTION & RESPONSE PROTOCOL RECOMMENDATIONS FOR SERVICE PROVIDERS

Vancouver Coastal Health fraserhealth

PURPOSE

Provide guidance for service providers to develop overdose (OD) prevention and response policies and protocols.

OD PREVENTION & RESPONSE: FIRST AID & HARM REDUCTION TRAINING

Does your staff have:

- ☐ **OD prevention and response training?** Provincial training resources and a Training Manual can be found at TowardTheHeart.com. Contact your local health authority for training support.
- ☐ **First Aid Training** that includes responding to overdoses? This is essential for unregulated care providers working where overdose risk is high.
- ☐ **Harm Reduction Training?** Knowledge of harm reduction practices is fundamental for staff who work with people who use substances. Harm reduction addresses: safer use of drugs and alcohol; appropriate use of harm reduction equipment; access to health care; personal and cultural safety practices; and mechanisms for dealing with critical incidents. Contact your local health authority for training opportunities. Access the online Harm Reduction Training from the Course Catalogue Registration System (CCRS).

SUBSTANCE USE PROTOCOL

Does your agency:

- ☐ **Have a substance use protocol** (examples found here)? Policies that force drug use off site (or to be hidden) increase risk of undetected ODs, and greatly diminish your staff's ability to intervene effectively.
- ☐ **Have punitive sanctions or a Residential Tenancy Agreement that states that "any drug-related criminal activity" is a reason for end of tenancy?** This will likely inhibit communication about drug use and overdoses.
- ☐ **Have a substance use protocol known by all clients?** Share it with clients in casual conversations or posters.

OVERDOSE PREVENTION

Does your agency:

- ☐ **Recommend that all staff who have contact with clients receive the training referenced above?**
- ☐ **Have a protocol addressing both onsite and offsite ODs?**
- ☐ **Track staff training?** Does training happen yearly?
- ☐ **Have an agency staff trainer** (or an external resource)? This will help with timely new staff and client trainings.
- ☐ **Have OD response drills at regular intervals at each facility in your agency?**
- ☐ **Identify quiet corners where clients and their guests might use substances and be at risk for OD?** e.g. bathrooms, stairwells and develop a system for regularly checking these spaces.
- ☐ **Have a public bathroom?** If so, does this space have its own protocol to prevent ODs that includes:
  - ☐ Regular safety checks?
  - ☐ Secured, tamper resistant sharps containers?
  - ☐ Locks that can be opened from the outside?
  - ☐ Posted bathroom protocol for clients to see?
- ☐ **Have regular site assessments?** This will ensure a review of all OD prevention and response measures.

Does your agency have signage that includes:

- ☐ **List of staff who are trained in OD response** (particularly if not all staff are trained)?
- ☐ **List of clients who are trained in OD response** (voluntary)?

*All underlined text is connected to a hyperlink

Version 2, 2016

☐ SAVE ME signs? Cue people on OD response steps (including those with low literacy).
☐ Door signs for clients who have naloxone and are trained in opioid OD interventions (voluntary)?
☐ A naloxone sign at the front desk? To inform clients and guests that staff are trained to respond with naloxone.

Does your agency have client-focused OD prevention such as:

☐ **How to determine which clients are at risk of OD?** OD risk should be assessed at intake and on an ongoing basis. Clients can be at higher OD risk at different times. A resource for this is: Housing Opioid OD Risk Assessment Tool.
☐ **Developing care plans in collaboration with clients during known times of OD risk.** Can include but not limited to:
  ☐ How to facilitate supporting clients to use alone more safely in their rooms:
    ☐ Encourage clients to inform staff when using substances (with OD potential) in their room to facilitate a follow-up room check (may be via: in-person, phone call, intercom, baby monitor).
    ☐ Timing for room checks should be based on route of administration, time of use, and ease of use.
  ☐ Support client to be trained in opioid OD prevention and response.
  ☐ Discuss with client when to call 911.
☐ **Addressing stigma in your agency?** Is stigma about substance use preventing clients from accessing services?
  ☐ **Vertical stigma** – staff to peer. ☐ **Lateral stigma** – peer to peer. ☐ **Self-stigma** – self-judgment.
☐ **OD prevention as a standing item on all client advisory groups and staff meetings?** This will ensure continued evaluation, input and feedback from both groups.

OVERDOSE RESPONSE

Does your agency:

☐ **Allow trained staff to administer naloxone to clients in the event of an overdose?** Is there a protocol describing this intervention? Is staff trained yearly? Does your agency have naloxone onsite?
☐ **Have a shift change checklist that:**
  ☐ Details overdose responses that occurred on that shift.
  ☐ Requires a communication log review.
  ☐ Establishes roles and responsibilities of each person on shift in case of an OD (including volunteers/students).
  ☐ Identifies clients with new or increased OD risk.
  ☐ Include inventory checks of naloxone kit and emergency supplies.
☐ **Have a means of emergency communication?** e.g. cell phones, walkie-talkies, panic buttons.
☐ **Provide clients with access to phone, 24/7?**
☐ **Have a system to ensure staff is always reachable?** e.g. posted phone number and/or staff location.

POST OVERDOSE INCIDENT FOLLOW-UP

Does your agency:

☐ **Debrief with staff and clients following an OD?**
☐ **Have post-OD intervention duties?** e.g. restocking supplies, reporting: critical incident form, naloxone usage log, naloxone administration, OD response information form?
☐ **Make alert posters to notify clients?** After how many ODs? Is a template used? When are posters removed?
☐ **Alert extended community after OD incidents?** After how many ODs? Who is information shared with (managers, health authority, other non-profit organizations)?
☐ **Have a guide to promote staff resiliency and prevent distress after an OD reversal?**

CLIENT INVOLVEMENT

Does your agency:

☐ **Encourage clients to get training including acquiring their own naloxone kit?**
☐ **Have accessible venues to solicit client feedback?** A variety of options can be used together such as: monthly client peer meetings, annual anonymous surveys, a suggestion/complaint box.
☐ **Have paid client peer trainers?** Peer trainers are an asset to both client and staff trainings.

*All underlined text is connected to a hyperlink

Version 2, 2016

Appendix B: Guidelines and Resources for Supportive Housing Providers, Homeless Shelter Providers and Regional Health Authorities on Overdose Prevention and Response

Guidelines and Resources for Supportive Housing Providers, Homeless Shelter Providers and Regional Health Authorities on Overdose Prevention and Response

February 15, 2017

Purpose

The purposes of these guidelines are to provide management and staff of supportive housing and homeless shelters with best practice advice and resources on prevention, recognition and response to overdoses.

Background

Overdoses are unpredictable, can happen in any setting, and a quick response can prevent significant disability or death. People who use drugs may reside in any setting, and due to the illegality of drug possession their drug use may not be apparent to staff and tenants/clients at supportive housing and homeless shelters. As such, staff and management may need to take steps to prevent, recognize and be prepared to respond to overdoses should they occur.

Key elements in preventing deaths from overdose are (1) educating and encouraging people not to use drugs alone, (2) utilizing the actions below to reduce the stigma that encourages isolation and (3) ensuring that naloxone and other life-saving first aid is available quickly in the event of an overdose. These goals may be achieved by:

- providing education to tenants/clients about overdose risk and how to reduce it;
- ensuring that tenants/residents will not be evicted for disclosing drug use;
- allocating space within the shelter or housing facility where those who use drugs may do so in the company of others;
- provision of harm reduction and first aid supplies, including naloxone kits and sharps disposal containers, in allocated spaces and anywhere else there may need to be access to them;
- training of staff, and interested tenants/clients, peers and/or volunteers, to monitor allocated spaces and respond to an overdose;
- managing access to the space so that tenants/clients use is not impeded by guests, but also ensuring that guests do not use drugs unsupervised such as in bathrooms and stairwells.
- discouraging drug use alone; and for tenants/clients who choose to use alone, encouraging them to work with staff to establish a plan for room checking to reduce risk based on when a tenant/client is likely to be using drugs;
- arranging for visits by health authority community health nurses, or by community paramedics, to provide advice, advise on supplies, and provide support to staff and tenants/clients.

Guidelines

Given the diversity of supportive housing and homeless shelters in BC the following may or may not apply to specific circumstances, and should be adapted accordingly.

1. Develop an overdose prevention, recognition and response protocol for your organization. This may include information on:
    a. First aid and harm reduction training
    b. A substance use protocol
    c. Overdose prevention, recognition and response
    d. Post overdose incident follow-up
    e. Tenant/client involvement
    f. Incident debriefing and psychosocial support for staff
    g. Evaluation, with tenants/clients, of the effectiveness of the protocol.

    Details on what should be considered under these headings may be found in the *Overdose Prevention & Response Protocol Recommendations for Service Providers* by Fraser Health and Vancouver Coastal Health (Resource # 1).

    For non-profit community organizations which serve a population in a facility at risk of overdose, the BC Centre for Disease Control (BCCDC) may be able to provide supplies at no cost containing naloxone and other emergency overdose response supplies through the BC Facility Overdose Response Box Program (http://towardtheheart.com/naloxone/forb/). An expectation of this program is that information about overdose responses will be provided to BCCDC.

    In addition information on planning tools i.e. sample protocols, policies and check sheets are available to any organization at http://towardtheheart.com/naloxone/forb/program-modules.

    For more information about the Take Home Naloxone Program, which provides overdose prevention and response training, as well as naloxone kits to eligible individuals, visit http://towardtheheart.com/naloxone/.

2. Involve staff, volunteers, and tenants/clients in developing an overdose plan. People with lived experience can provide a rich perspective on what may and may not work in your facility. To learn more about how to involve people who use drugs in developing a plan see resource #2.

3. Determine who is at risk of overdose and level of risk (see resource #3)

4. Develop step-by-step instructions on how to recognize and respond to overdoses, including the importance of call 911 for all overdoses (see resource #4).

5. Review and practice your overdose response protocol regularly.

6. Ensure that facility policies are not a barrier for people who are prescribed opioid-assisted treatment medications such as buprenorphine/naloxone (e.g. Suboxone) or methadone to treat their opioid use disorder, as these medications are internationally recognized as a best practice in treating opioid use disorder.

7. Anticipate the psychological impacts of overdose events and the need for providing or referring staff and tenants/clients to psychosocial support services (see resource #6).

Resources

1. *Overdose Prevention & Response Protocol Recommendations For Service Providers* (http://www.fraserhealth.ca/media/Overdose_Prevention_Response_Protocol_Recommendations_Service_Providers.pdf)


Overdose Prevention Checklist V3.pdf

2. *How to Involve People Who Use Drugs* (http://towardtheheart.com/assets/resources/how-to-involve-people-who-use-drugs-20140227posted_7.pdf)


how-to-involve-people-who-use-drugs.pdf

3. *How to determine who is at risk of overdose, and the level of risk* (http://www.drugsandhousing.co.uk/hoorat4colour.pdf)


hoorat4colour.pdf

4. *How to recognize and respond to overdoses*

   http://www.fraserhealth.ca/health-info/health-topics/harm-reduction/overdose-prevention-and-response/recognizing-an-overdose/

   http://www.fraserhealth.ca/health-info/health-topics/harm-reduction/overdose-prevention-and-response/responding-to-overdose/

   
   RECOGNIZING AN OVERDOSE.pdf

   
   RESPONDING TO AN OVERDOSE.pdf

5. See additional resources compiled by Fraser Health at:
   http://www.fraserhealth.ca/health-info/health-topics/harm-reduction/overdose-prevention-and-response/overdose-planning-organization/overdose-planning-for-your-organization.
   or contact the Portland Hotel Society for their "Harm Reduction and Overdose Management Policy and Procedures" (604 683 0073) .

6. *Incident debriefing and psycho-social support resources*
   - Take Home Naloxone: A Guide to Promote Staff Resiliency & Prevent Distress After an Overdose Reversal

     http://towardtheheart.com/assets/naloxone/naloxone-staff-resiliency-final_185.pdf

     
     Naloxone-staff-resilie ncy-BCCDC Dec 23 20:

   - Healthcare Resiliency During Prolonged Response by Health Emergency Management BC

     
     HEMBC Staff Resiliency.pdf

- In addition see resources available from the Public Health Agency of Canada at http://www.phac-aspc.gc.ca/publicat/oes-bsu-02/index-eng.php and listed below:
  Taking Care of Ourselves, Our Families and Our Communities

  Helping Children Cope

  Helping Teens Cope

  Self-Care for Caregivers

- Additional information may be found in *"Opioid Overdose in Supportive Housing, How to Keep People Safe."* by Shannon Riley RN, BSN, MPP, Project Manager, Illicit Drug Overdose Response, Prevention, Vancouver Coastal Health Authority (http://summit.sfu.ca/item/16417)

  Appendix – Ministerial Order with respect to Overdose Prevention Services

Appendix C: Service Provider Confidentiality Agreement Template

CONFIDENTIALITY UNDERTAKING FOR OVERDOSE PREVENTION SERVICES SERVICE PROVIDERS

In consideration of my contract placement at _(*indicate regional health authority [RHA]/agency*)__; I acknowledge and agree to the following:

1. I will adhere to the Information Privacy and Confidentiality Policy and related policies and subsequent amendments, concerning the collection, use and disclosure of information obtained in the course of my service with (*indicate RHA/agency*);
2. I understand that all personal information concerning staff and the people who receive services (including medical records) is confidential and may not be communicated to anyone in any manner, except as authorized by (*indicate RHA/agency*) or applicable policies;
3. I understand and acknowledge that all information regarding the affairs of (*indicate RHA/agency*), including corporate, financial and administrative records is confidential and may not be communicated or released to anyone in any manner except as authorized by (*indicate RHA/agency*) or applicable policies;
4. I will not copy, alter, interfere with, destroy or remove any confidential information or records except as authorized by (*indicate RHA/agency*) and in accordance with established policies; and
5. I understand that compliance with confidentiality is a condition of my placement with (*indicate RHA/agency*) and that failure to comply may result in immediate termination of my placement, in addition to legal action by (*indicate RHA/agency*) and others.

Print Name _____

Signature _____ Dated (mm/dd/yr) _____

Appendix D: Key Responsibilities for OPS Service Providers

- Check the overdose response and harm reduction supplies inventory.
- Review overdoses from last shift – ensure proper paperwork has been submitted
- Initiate communication with OPS participants
- Role model respectful behavior
- Be responsive to participants requesting further information/ support (e.g. social, mental health or addiction services)
- Provide overdose response and life support
- Offer education on safer injection techniques
- Control the flow and numbers of participants into and out of each area in accordance with established staff to participant ratios
- Ensure the safety of resting participants; checking in for a response at least every 20 minutes, more often if they are at risk
- Monitor participant activity - enforce the OPS Code of Conduct as necessary.
- Apply guidelines for verbal de-escalation and consequences for aggressive behavior, as outlined in the Occupational Health and Safety Section of this manual
- Build a sense of ownership/shared responsibility among participants of the OPS
- Debrief work-related issues at the end of each shift *and* following any critical incident
- Work collaboratively with other team members and help to orient new staff and participants
- Maintain documentation and data collection as required
- Address concerns regarding breaches of the OPS policy/protocols to the responsible person in charge or alternate.
- Maintain a structured, healthy and clean worksite
- Dispose of used equipment in accordance with established protocols
- Clean OPS tables after each use in accordance with established protocols
- Regularly monitor the area outside of the site.
- Refer all media inquiries or public presentation opportunities to the supervisor or RHA/agency Communications Department

Appendix E: Required Documentation and OPS Intake Templates

Form 1: *User Agreement, Release and Consent Form: Overdose Prevention Services (OPS)* – (Signed on the 1st visit only).

Prior to using the OPS, 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 staff and Codes of Conduct.
- I will remain in possession of my own drugs for injection at all times.
- I authorize OPS 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 Overdose Prevention Site, (*Indicate Regional Health Authority/Agency*) 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 #,) | |

Revised February 4th, 2017

Form 2: Overdose Prevention Services (OPS): Release of Responsibility Waiver – (Signed on the 1st visit only).

Purpose: To waive responsibility of OD Prevention Services staff and volunteers upon a participant leaving the site against medical advice (AMA).

Participant Name/Handle: _____

I _____ have had the risks of leaving the OD prevention service AMA explained to me and I release all staff from all responsibility if my safety/life is compromised because of leaving this facility AMA. I am solely responsible for my own life/safety once I leave the OD Prevention Site.

Participant Signature: _____ Date/Time: _____

Staff Witness: _____ Date/Time: _____

OR

Participant left OD Prevention Service AMA, with knowledge of the risks involved, but without signing waiver.

Staff signature: _____ Date/Time: _____

Witness: _____ Date/Time: _____

Revised February 4th 2017

Form 3: ***Overdose Prevention Services (OPS): Visit and Overdose Log***

Please fill out one row in the table for **each visit** and use a new sheet at the start of each day.

Identifier/Handle (if given)	Time of visit (include time of day and circle am or pm)	Did the person overdose? (Yes/No)	**If the client overdosed, answer these questions as well:**	
			Was naloxone given?	Was the person taken by ambulance to an emergency department?
1.	am / pm	□ yes □ no	□ yes □ no □ unknown	□ yes □ no □ unknown
2.	am / pm	□ yes □ no	□ yes □ no □ unknown	□ yes □ no □ unknown
3.	am / pm	□ yes □ no	□ yes □ no □ unknown	□ yes □ no □ unknown
4.	am / pm	□ yes □ no	□ yes □ no □ unknown	□ yes □ no □ unknown
5.	am / pm	□ yes □ no	□ yes □ no □ unknown	□ yes □ no □ unknown
6.	am / pm	□ yes □ no	□ yes □ no □ unknown	□ yes □ no □ unknown
7.	am / pm	□ yes □ no	□ yes □ no □ unknown	□ yes □ no □ unknown
8.	am / pm	□ yes □ no	□ yes □ no □ unknown	□ yes □ no □ unknown
9.	am / pm	□ yes □ no	□ yes □ no □ unknown	□ yes □ no □ unknown
10.	am / pm	□ yes □ no	□ yes □ no □ unknown	□ yes □ no □ unknown
11.	am / pm	□ yes □ no	□ yes □ no □ unknown	□ yes □ no □ unknown
12.	am / pm	□ yes □ no	□ yes □ no □ unknown	□ yes □ no □ unknown
13.	am / pm	□ yes □ no	□ yes □ no □ unknown	□ yes □ no □ unknown
14.	am / pm	□ yes □ no	□ yes □ no □ unknown	□ yes □ no □ unknown
15.	am / pm	□ yes □ no	□ yes □ no □ unknown	□ yes □ no □ unknown

Form 4: *Youth Registration and Assessment* - (To be completed for each visit by Senior Staff Member)

Background

Youth represent the highest risk group for acquiring HCV and HIV through IVDU. Research indicates that they engage in high-risk behaviours to a greater extent than adults with established intravenous drug use. Youth who do not have a history of IVDU should access substance use resources that can more appropriately address their level of need and prevent initiation to IVDU. Prompt referrals to treatment options is an evidence-based strategy at preventing initiation to IVDU.

Name: _____ **Date:** _____

Handle:_____

DOB:_____

Verified with ID? ☐Y ☐N **ID Type:** _____

Reasons for wanting to access OPS:

Drug History: *Substances, routes, duration, frequency*

_____
_____
_____

Injection sites visualized? ☐Y ☐N ☐N/A Congruence between history and presentation? ☐Y ☐N

Notes: _____

Understanding of risks related to IVDU:

☐*OD* ☐*Tolerance* ☐ *Addiction* ☐*Infectious Disease* ☐*Emboli*
☐ *Vasc/Nerv Damage* ☐*Injecting Unknown Substances* ☐*Scarring/tracks* ☐*Access to HR Supplies*

Notes: _____

Does youth present with need for immediate OPS access? ☐Y ☐N **OPS Access Granted?** ☐Y ☐N
Notes:

Are there any adult contacts identified by the youth: ☐Y ☐N

If yes, please complete the following:

Contact's Name: Relationship to youth:
Phone/Cell#

Harm Reduction Education

†*OD Prevention* †*Not Using Alone* †*Hand Washing* †*ETOH Swab* †*VC/location*
†*Flagging* †*Disease Prevention* †*Drug preparation* †*Equipment* †*Alt routes of ingestion*
†*Take Home Naloxone (if opiate use in drug hx)*

Notes: _____

Referrals Provided? ☐Y ☐N *If yes – where and was transport offered?*:
_____

Form 5: Overdose Prevention Sites Core Data Elements for Overdose Incident (Complete for every OD incident)

Contact: margot.kuo@bccdc.ca

Last Revised: January 3rd, 2017

Background: On Dec. 8th, BC enacted a ministerial order to create overdose prevention sites. To support the decision making of the BC Health System Steering Committee on Overdose Response some basic metrics on the sites at a provincial level are needed.

Objectives of Surveillance: 1) To capture overdose events that may not otherwise be captured by existing surveillance 2) To monitor overdose events related to Overdose Prevention Sites.

Focus of Data Collection: Overdose Prevention Sites in BC operate on different models in a variety of settings. The focus is to provide no barrier venues for persons who use drugs to be in a safer environment with a person with naloxone available nearby in case of overdose. In keeping with this, data collection must not pose barriers while collecting minimum core elements from all sites with a focus on information that is readily available to any person, with or without medical training responding to an event.

This core data tool was developed collaboratively with Northern, Island, Vancouver Coastal, Fraser, BCCDC, and Interior Health Epidemiologists. Implementation will depend on settings and models.

CORE DATA ELEMENTS	
Person	
Core Data Element (as it would ideally appear on a data collection tool)	**Definition and Other Information**
Gender (if known): ❑ Male ❑ Female ❑ Transgender ❑ Unknown	The gender of the person experiencing the overdose. Data collection tools to include at minimum male, female, unknown.
Age Group: ❑ under 19 ❑ 19-39 ❑ 40 or older ❑ Unknown	The estimated age group of the person experiencing the overdose. Broad age categories are used to allow estimation by first responders.
Place	
Overdose Prevention Site or Response Group Name/Code:	Name or Code of the Overdose Site (e.g. Powell St. Getaway). A list of overdose prevention sites by name and code with an address and Response Groups/Names with an affiliated site or area is required to interpret this field.
Overdose Occurred: ❑ Inside ❑ Outside	Indoors or Outdoors as best describes where the person experiencing the overdose was seen to overdose or was found.

Time	
Date: DD/MM/YYYY	The date of the overdose event
Time of Overdose: _____:_____ ❑ A.M. ❑ P.M **HH MM**	The time that most closely approximates when the person showed observable signs of overdose or was found unresponsive.
Event/Intervention	
Was 911 Called: ❑ Yes ❑ No ❑ Unknown	Whether or not 911 was phoned.
Was Naloxone Given: ❑ Yes ❑ No ❑ Unknown	Whether or not Naloxone was given (any form but injectable is assumed for most settings)
How many injections of Naloxone were given: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ more than 5	The number of naloxone injections given as a part of this overdose response. The underlying assumption is that the 0.4 mg vials are standard in community kits and Overdose Prevention Sites. Only count injections prior to a paramedic taking over.
Was rescue breathing performed? ❑ Yes ❑ No	Whether or not breaths were given or observed to be given by anyone as a part of the overdose response.
What was the outcome? ❑ Client Left ❑ Client Transported to the ED ❑ Client Died	The outcome of the event as best described by one of the three options. May also include unknown but this has been excluded from example format to encourage a usable answer.

Additional Summary Statistics Required Weekly:

1. **Estimated number of visits/interactions per site per week**
2. **Estimated number of ODs per site per week (should equal report numbers)**

Appendix F: Support for Peers Providing Overdose Prevention and Response Services

The experience of witnessing and/or responding to an overdose is often stressful and overwhelming. The impact on health care providers responding in emergency situations is well recognized and acknowledged in the health care system; with resources such as critical incident debriefing and counseling available through employers. As part of the overdose response, it is important to have resources available for all of those providing overdose prevention and response services. Experiences such as these, if unresolved, may interfere with performing one's daily life and work commitments, and trigger further trauma, grief and loss.

Unlike most health care professionals, Peers (a person who has both lived experience with drug use (either past or present), and uses that lived experience to inform their professional work) may be in a position where they lack the institutional support systems for immediate and ongoing emotional/mental health and well-being, thus often left to cope with the psychological impact of overdoses on their own.

A critical step in mitigating some of these impacts lies in the support and provision of regular and standardized services for Peers. These initiatives can be implemented at three levels: Peer-to-Peer, organization/agency for Peer, and community initiatives. They should all provide relevant, appropriate, and timely Peer supports.

Peer-to-Peer

Peers themselves are best positioned to empathize and intimately understand the lived experiences of other Peers. Peer-to-Peer support cultivates a setting whereby Peers can both look to other individuals who may have lived similar experiences for support, whilst other Peers can share their knowledge and expertise.

One potential Peer-to-Peer initiative whereby this may occur includes the formation of a Peer support team specifically oriented to people with lived experience, who are working as Peer workers at Overdose Prevention Sites.

This team could:

- work with Peers to develop active Peer support practices within teams through training and education;
- offer support and debriefing to all Peer workers at Overdose Prevention Sites;
- nurture self-care and self-assessment among Peer workers; and,
- triage to other services if needed and available.

Peers can encourage self-care for themselves and each other by:

- being patient and understanding with themselves;
- taking time to relax and take breaks (ex. go for a 15-minute walk during a lunch or coffee break. Do something enjoyable);
- taking timeout from media reports (including social media) and breaks from thinking and talking about overdose events;
- taking breaks from work and/or limiting the number of hours worked in a day or week;
- negotiating or asking to do other types of work or trading off with work;
- ensuring a good night's sleep;
- taking time to practice self-care and reflection;
- encouraging communicating or stating needs with others they trust;
- normalizing expectations – talking about what does stress, anxiety, being overwhelmed look and feel like
- recognizing that the work you do is saving lives.

Know and respect your limits. Commit to regularly scheduled time off. If you feel exhausted and need extra time-take it. If, at any time, you feel overwhelmed and unable to cope, consider who is a safe person for you to talk with and

debrief. Identify someone you trust and feel safe talking to, it could be: another Peer worker, harm reduction worker, or community worker for example.

Organization/Agency for Peer

Organizations can enhance Peer staff resiliency by creating a supportive work environment and promoting self-care as a regular and worthwhile practice.

Actions to achieve this may include:

- openly acknowledge and value Peers and Peer work that is saving lives daily. Respect, and acknowledge the expertise and work being done by Peers in unusually stressful situations;
- Peers have important experiential knowledge about how best to provide services. Recognize and utilize that expertise in the development and operation of services;
- designate time and resources for Peer-to-Peer support including education and training for Peers to support each other;
- provide relief on short notice and on an as-needed basis to Peer workers;
- ensure that Peer workers have scheduled breaks and are encouraged to take them;
- prioritize and allow Peer staff to debrief following critical incidents - if they feel it would be helpful. If they prefer not to debrief, give staff a few moments (or whatever time they need) to recover from the adrenaline rush of reversing an overdose – they may need to take a walk, buy a coffee or make a phone call to a friend or family member;
- normalize the need to debrief and encourage taking time for oneself to manage stress, grief, loss and vicarious trauma;
- provide opportunities for regular debriefing with and among Peer workers including discussing how overdoses were managed ("what went well and what could be improved");
- provide a safe physical space where people can gather to discuss their experiences or seek respite;
- allow and encourage individuals to communicate when they feel stressed or overwhelmed. Further support this by encouraging and demonstrating non-judgemental responses or behaviour.
- obtain or secure support from community or leisure centres for streamlined access to passes.

In addition, the following resources outline suggestions as to how better to include Peers at a decision-making table or engagement process:

- Peer Engagement Principles and Best Practices;
- Peerology.
- A Guide to Promote Staff Resiliency & Prevent Distress after and Overdose Reversal further outlines management strategies to address the risk factors that may lead to staff distress.

Community Initiatives for Peer Support Services

Community initiatives that bring people together to give them the power or opportunity to act may include:

- information meetings about overdose events going on in your neighbourhood;
- memorials, candlelight vigils;
- regular acknowledgement of those who have died. For example, practice a moment of silence to recognize lives that have been lost next time you have a group gathering (ex. VANDU includes this practice at their meetings);
- Grief and Loss Support Groups - look for one in your neighbourhood, or consider starting one through existing Agencies.

Finally, a Provincial initiative (approved by the Ministry of Health and under the auspices of the Provincial Health Authority), not noted above, involves a current project that is underway for the rapid development and implementation of a Mobile Response Team (MRT). The MRT is a provisional team created in response to the recognition of the psychosocial impact that the opioid overdose public health emergency has on frontline workers.

The purpose of the MRT is to offer psychosocial supports to staff and volunteers of community-based organizations working within the opioid overdose public health emergency. This includes individuals who have been impacted by the effects of critical incidents such as multiple overdoses and/or deaths.

The activities and services the MRT are to provide include to:

- provide education and crisis response services;
- mobilize to designated sites across the province as a health resource for front line workers;
- provide psychoeducational materials;
- introduce Peer support tools to individuals and groups;
- assess and respond to province-wide critical incidents.

Team members will be deployed to areas experiencing high rates of overdoses and overdose deaths (i.e. the Lower Mainland, Surrey, and Downtown Eastside) before expanding to Vancouver Island, the Interior, and Northern BC.

More information can be obtained from: mrt@phsa.ca

Appendix G: Participant Rights/Responsibilities and Code of Conduct (Insite, 2016)

Rights and Responsibilities of Overdose Prevention Site Participants

The rights and responsibilities offered below are are not exhaustive. Ideally, OPS rights and responsibilities are developed to reflect the local context and in collaborative with PWID.

Rights

To feel safe, respected and treated with dignity.
To be in a place of respite.
To be unharmed physically, emotionally, or psychologically by staff.
To be in a clean environment.
To receive appropriate support and attention.
To access services even while under the influence of drugs or alcohol.
To have a voice in the operations and functioning of the site, in conflict resolution processes and in regards to complaints or concerns.

Responsibilities

To respect others while on site.
To help create and maintain a safe place.
To not cause physical harm to other participants or staff.
To use the site for self-administration
To not deal, exchange, share or pass drugs to anyone else on-site.
To reduce harm by not sharing rigs or equipment, disposing of used supplies in the sharps container, and not walking around with uncapped rigs.
To not display weapons or money on-site.
To not bring outside conflicts into the site.
To not engage in solicitation of any kind on site.
To respect the property and privacy of others in the site.
To follow the reasonable directions of OPS staff.
To bring concerns or complaints to the attention of RPICs.

Appendix H: Responding toSpecific Participant Behaviors

A) Management of Observable Behaviors

Anxiety
Anxiety is an observable change in behavior and can increase through stimulant use. Mild anxiety can be beneficial for motivation and heightened awareness for problem solving. Moderate to severe anxiety can cripple the ability to perceive, think and conceptualize and the ability to cope with a situation.

Table 1: Management of Behaviors that Indicate Anxiety

Behaviours	Service Provider Response	Interventions

• Eye contact: loss of eye contact/avoidance, blank stare, rolling eyes, excessive blinking, eyebrow movement, smiling, frowning.
• Verbal contact: talkative, quiet, laughing, crying, joking, talking faster.
• Physical Signs e.g.:
  o rocking, restless, pacing,
  o sitting very still,
  o a need for more personal space,
  o holding their breath.
  o wringing hands, drumming fingers, opening and closing hands.
• Other signs:
  o asking lots of information seeking questions in an attempt to regain a sense of control (and a general dissatisfaction with answers to these questions)
  o very poor short term memory
  o procrastination.
	• A caring, respectful response to anxiety behaviour generally provides adequate support to lower the anxiety level and prevent escalation to anger and other aggressive behaviours **in 95% of the population.**	• Be respectful of the participant's belongings/ personal space (do not touch the participant without their permission).
		• Actively listen to gain understanding from their point of view and what may be driving the behaviour.
		• Answer questions to give the participant back a sense of control and reassurance.
		• If you cannot answer their question, find out the answer, direct them to who may be able to answer their question, or explain there may not be an answer (do not ignore the question or need).
		• Focus on what you **can** do for the participant not what you **cannot** do (e.g. "How can I help?").
		• Assist the participant to verbalize feelings in their own words, avoid using leading questions.
		• Re-direct participant's energy into safe activities.

B) Management of Aggressive Behavior

Depending on the stage of escalation, not all behavior perceived as aggressive requires participant eviction from the site. there are several techniques that can effectively dissipate aggression and restore a calmer environment. Service providers should understand how to assess for potential aggression and experiences or circumstances that can increase the likelihood of aggressive behaviors. It is important for service providers to present a consistent approach to participants. The key to the successful use of behavior modification techniques is a consistent approach by all staff.

Assessment for Potential Aggression:

- Assess the participant's potential for aggression on admission considering the indicators outlined below.
- Self-awareness; e.g. understand personal thoughts/attitudes, and actions towards people who are aggressive or have potential to become aggressive.
- Assess the environment for overall activity, e.g. a highly active, crowded or loud environment may stimulate or exacerbate behaviour.

Experiences/Circumstances that may contribute to a greater likelihood of participant demonstration of aggression:

- Previous history of aggression (this is the #1 predictor of aggressive behaviour)
- Chemical dependency (either in an intoxication or withdrawal state)
- Psychological factors, poor mental health
- Poor problem solving skills
- Inability to cope with stress on a day to day basis
- Cognitive impairment, lack of inhibition, labile moods
- Psychosis/Delirium/dementia
- Suicide intent, plan, thoughts or history
- Poor physical health
- Hypoxia
- Electrolyte imbalance
- Head injury
- Sensory impairment
- Sepsis
- Loss/grief (e.g. loss of central love interest, family member, housing, income, health)
- Feelings of powerlessness, anger, fear and failure
- Socio-economic indicators (e.g. poverty, low-income households)
- High residential mobility
- Demographic indicators (e.g. aggression is more likely within the age range of 20-24 years and in males)

Verbal Aggression

Verbal aggression can range from challenging (lowest form of verbal aggression) to threatening (highest form of verbal aggression). Lower stages of verbal aggression can often be managed through specific techniques and approaches. Threatening in the form of verbal aggression is intolerable and requires the participant to be directed to leave the OPS.

Table 2: Management of Lower Stages of Verbal Aggression

Stages of Verbal Aggression	Service Provider Response	Intervention
Stage One: Challenging Behaviors • Relentless questions, with no satisfaction - do not care what the answer is • Garden variety questions, which are questions that have nothing to do with the issue at hand but used as a distraction • Rhetorical questions - a form of distraction • Demanding/instant gratification • No respect for rules or regulations - challenge and test staff.	• If this line of questioning continues, it could become very personal and the service provider's credibility, skill or knowledge. • Acknowledge that the person has escalated from the information seeking questions of anxiety to the challenging questioning of the first level of verbal aggression	• Remain calm. • Do not argue; focus on a common goal. • Redirect them back to the issue at hand. • Ask them a question to distract them (e.g. "Can I ask you something?"). • Give a positive directive to assist them in getting their needs met. • Give the individual reasonable choices or consequences - positive first, and a specified time to decide. • Use time and space.
Stage Two: Refusing Behaviors • Disagreeable • Refusing • Silence • Walk away • Verbally (calm or aggressive manner) • Distracting behaviours (refusal in disguise) • Repeated complaints, requests and demands • Blaming others • Exaggerated response of annoyance	• Remember people in most situations have the right to refuse care. Our role is to give them a clear understanding of the choices they have and the consequences of the choices they make.	• Remain calm. • Verify that they are refusing. • Verify the reason for the refusal. • Give a positive directive. • Give the individual reasonable choices or consequences- positive first, and a specified time to decide.
Stage Three: Loud Behaviors • Button pushing • Yelling, shouting	• At this level of verbal aggression, loud behaviours are driven by emotions and not rational thought. The participant may be feeling powerless and frightened, and escalate their behaviour in an attempt to create a sense of control for him or herself.	• FIRST PRIORITY: SAFETY FOR STAFF AND PARTICIPANT. • Remain calm - isolate the person if safe to do so, and either move them or clear the area of on-lookers • Give a directive to the participant that puts your safety first (e.g. "Please leave the building"). • Provide time and space and assess the need for additional staff to be present, or call police.
Stage four: Threatening Behaviors	• **See Table 3: Physical/Verbal Aggression, Behavior that Challenges OPS Rules: Intolerable Behaviors Requiring Direction for Participant to Leave the OPS**	• **See Table 3: Physical/Verbal Aggression, Behavior that Challenges OPS Rules: Intolerable Behaviors Requiring Direction for Participant to Leave the OPS**

Table 3: Physical/Verbal Aggression and/or Behavior that Challenges OPS Rules Requiring Direction for Participants to Leave the OPS*

Behavior	Service Provider Response	Interventions
Verbal aggression (stage four) • Verbal threats are intolerable behaviour and will be managed as intolerable behaviour. **Physical aggression** • Sexual touching. • Physical touching with the intent to harm a person • Throwing objects with the intent to harm a person or damage the facility. • Punching or slapping a staff member or another participant. • Kicking with the intent to harm a person or damage the facility. • Spitting that is directed at a staff member or another participant. • Fighting in the facility. • Defacing the facility. • Damaging equipment Setting fire to the facility. • Walking around with an uncapped needle. **Challenge of Facility Rules** • Stealing. • Refusing to stop any behaviour that facility staff have requested the participant to stop.	• Staff Safety always comes first • Consider past history with the participant, and whether or not a specific service provider has rapport with them. • Be aware of your own limitations and the volatility of the situation. • When asking the participant to leave the facility, assess the need for more staff to be present and/or whether it is necessary to contact the police. • If the situation is volatile, remove yourself from until appropriate support arrives • Be familiar with the course of action you need to take -know what you can and cannot do ahead of time • Prepare for the unexpected: • Be aware at all times re: who is available to assist you? • Request the participant to return to the OPS for follow-up with the supervisor to negotiate when they may be able to return? • Know your exits	**For all Behaviours:** In a calm, clear, matter-of-fact manner • State the reason for asking the participant to leave • Direct the participant to leave the facility. • State when the participant may return **1. Intervention: Physical Aggression/Assault:** • Quickly assess the situation o Call 911 o Assess if weapons present o Clear exits for staff o Remove bystanders from the area • Immediately have two staff members attend the incident while waiting for police: o One to give direction to the person being assaulted re: protecting themselves/removing themselves from the attacker. The victim should have only one voice to concentrate on, so as not to cause further confusion. o A second staff member directs the participant to stop the attack and leave the facility. Attempts to distract the attacker can offer the victim a window of opportunity to escape. • Clear bystanders from the area. • Remove any potential weapons from the area. **2. Staff Experience of Physical Assault:** • Call for help. • Trigger an emergency call if available. • Protect the vulnerable areas of the body (e.g. face, neck, • Move to an area occupied by other staff • Ensure that help is on the way.

*The above behaviors have been identified as intolerable to the OPS. When a staff member asks a participant to leave and restricts access to the service, all staff must respect that staff member's decision in order to enforce limits behaviors.

Evacuation

Should the building need to be evacuated because of violence in a room, staff will ensure that all people not involved in the incident vacate the building. Staff not taking charge of evacuating their areas should attend the incident and provide any assistance they can without putting their safety at risk. The closest staff member not directly involved with the incident will call 911. Advise the dispatcher that there may be sharps and bio-hazardous material in the site. When evacuating the building, staff will close and lock all doors if possible.

Evacuation of staff and participants from the OPS could be necessary in the following situations:

- Fire
- Violent/potentially violent incident which staff cannot contain
- Earthquake
- Bio-chemical hazard

In the above situations, safety of staff and participants is the primary concern. Should an exit be blocked for any reason (e.g. fire, violence or threat of violence, etc.) the staff person in charge of their area is responsible for leading everyone in their area to the next closest safe exit. The site supervisor checks that 911 has been called, coordinates the evacuation and ensures that all staff and participants have left the building.

Appendix I: Prohibition from Accessing OPS

Participants can be prohibited from using the site for the day by any staff, due to:

- Uttering threats of violence or carrying out violence against anyone on the premises.
- Attempting to deal, purchase or share drugs on the premises.
- Periods of prohibition of more than one day will be set by the RPIC if they determine that the circumstances are severe enough to warrant it.

The following are recommended time frames for prohibition according to the circumstance:

1. Prohibited from using the site for the rest of the shift/day when a participant's behavior that is extremely difficult to control or there is refusal to follow staff direction
2. Prohibited from using the site for up to 24 hours. Access is reinstated only after speaking with the site supervisor. 24-hour prohibition is appropriate for circumstances where the participant has threatened violence directed toward a service provide or other participants, and/or a participant is dealing drugs on site
3. Prohibited from using the site for a period over 24 hours. Access is reinstated once consensus is reached with all services providers, including a supervisor and a manager. This may be reasonable for participants demonstrating:
    - Repeated or serious threats or violence
    - More than one prohibition has already been requested by service providers

Readmission after Being Prohibited from Using the Site

Barred participants must meet with the site supervisor/manager. They will be readmitted after assurances are made that the behavior will not continue.

The Steps for Service Provider/Participant Safety if Prohibition is Assigned to a Participant

1. The first step is to avoid triggering conflict (e.g. communicate openly, respectfully and calmly; do not demonstrate aggression or become demanding).
2. The second step is de-escalating the conflict. This includes backing up co-workers by appropriately intervening in conflict in ways that do not make the participants 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 participants feel unsafe, the police should be called.

Documentation of Prohibition from Using the Site

- Service providers must communicate with supervisors as soon as a prohibition occurs.
- The supervisor is responsible for making the decision to place a person on further prohibition after a review of the documented events.
- The prohibition list will be kept current at the sign-in. Reason for refusal will be clearly documented.

Appendix J: Participants with Special Circumstances: Access to OPS

For sites entirely operated by peers or unregulated heath care providers it is recommended to develop a link with your local health authority for clinical support and supervision from a regulated health care provider such as an RN, NP, paramedic or MD. Staff should have access to a regulated health care provider or primary care team to discuss challenging ethical issues and to provide additional support to link clients to local support services and health care.

A) First Time Injection Drug Use

It is unlikely that a participant would present to the OPS as a first-time user. People who may be transitioning into injection drug use present an opportunity to offer appropriate harm reduction information, while at the same, an opportunity to deter them from initiating.

In most circumstances these participants are alienated, vulnerable youth who may be at a crossroads between substance use behaviors.

Protocol

Access is granted to the OPS after staff member assessment.

Potential first-time PWID may be deterred from transitioning to injection drug use.

Participants who present with first-time injection drug use may have already made the decision to begin injection drug use; therefore, would not be denied the benefits of OPS harm reduction services.

A concerted attempt to refer the individual to a supervised injection site, if available, should be made.

In the event that first-time participants are determined to begin injecting drugs in the OPS, they will be granted access and then encouraged to have their next injection at a supervised injection site (if available) where they can access nursing support.

B) Pregnancy

Background

There are inherent risks to both the parent and fetus associated with injection drug use. Pregnant PWID are stigmatized both by their substance use and traumatized by the harm that they may be causing to their fetus, making them less likely to access health care services.

Protocol

Pregnant participants may be amenable to interventions to reduce harm, or even access treatment options if low-threshold services are provided.

Engaging pregnant participants in the OPS activities to make it possible to assist them in moving towards safer drug-using behaviors and prenatal care services.

Denying access to pregnant participants is unlikely to result in abstinence from drug use, rather increase possibility of overdose death due to limitations in service delivery.

C) Youth

Background

Youth represent the highest risk group for acquiring hepatitis C and HIV through injection drug use.

Research has shown that younger PWID engage in higher-risk behaviours to a greater extent than established PWID, including sharing needles and other drug equipment. This speaks to the lack of services offered to youth, and the lack of inclusion of youth in service programming and delivery.

There is real potential to reduce the harm associated with ongoing injection drug use in this group, given the rapid acquisition of hepatitis C and HIV infection following initiation into use of intravenous drugs and their increased risk of drug overdose due to their relative inexperience with injection drugs.

The Infants Act explains the legal position of children under 19 years of age and states that children may consent to care on their own as long as the health care provider is sure that the treatment is in the child's best interest, and that the child understands the details of the treatment, including risks and benefits. It is up to the health care provider to assess and ensure the child's understanding of the treatment. For more information on the Infants Act, visit www.bclaws.ca/civix/document/id/complete/statreg/96223_01.

A person under the age of 19 is called a "minor". "Mature minor consent" refers to consent to health care given by a child who is assessed by a health care provider as having the necessary understanding to give consent. A mature minor who is assessed by a health care provider as being capable to give consent is called a "mature minor". A mature minor may make their own health care decisions independent of their parents' or guardians' wishes. In B.C., there is no set age when a child is considered capable to give consent.

A health care provider can accept consent from the mature minor and provide the treatment without getting consent from the parent or guardian if the health care provider is sure that they understand: the need for the treatment; what the treatment involves; and the benefits and risks of having the treatment.

Protocol: OPS Assessment Procedure for Youth Between 16 and 19 years

Youth under the age of 19 will access the OPS only when the youth shows obvious signs of physical addiction to injectable narcotics. When a youth presents at the OPS the supervisor performs the following assessment:

Determination whether the youth has a history of injection drug use and has previously bought injectable narcotics with the intention of self-use, and

The service provider understands that youth/mature minor presenting to an OPS as an opportune point of contact and connecting with youth to ensure they are have access to the services they need based on individual circumstances is of highest priority. Turning youth away from an OPS has the potential to create more harm than building relationships and connection.

Determination that the youth understands: the need for supervised consumption, what supervised consumption involves; and the benefits and risks of supervised consumption.

D) Non-Self-Injectors

Background

For a variety of reasons, some people are unable to self-inject and rely on others to assist with this challenging procedure. This is an important population to engage as research has demonstrated a significantly heightened risk for HIV infection. Issues of power are often linked to this practice and most often, it is women that rely on a man to inject them.

Ideally only self-injection occurs in the OPS; however, sites should consider the local context and aim not to turn away clients who are requesting support from another participant for injection purposes. The public health rationale for permitting assisted injection by peers is to reduce the risks for highly vulnerable persons who are unable to self-inject. Like those who do self-inject they are at risk of overdose death, but in addition they are highly vulnerable to the transmission of HIV and HCV infection. In recognition of the particular vulnerability of the members of this population, OPS staff should make all possible efforts to connect them with support services appropriate to their circumstances, including allowing peer-assisted injection in the OPS in cases where there is no realistic safer alternative.

It is important to note that under the current legal framework it remains possible that providing assisted injections could result in serious criminal liability for those who assist; thus the person assisting should make an informed choice when providing assisted injections.

Protocol

Non-self-injectors will be identified and assessed whether the barrier to self-injection is education or a physical disability.

If the barrier is education, then trained OPS staff may provide education to support the participant to self-inject in a safer manner.

If the barrier is physical disability, the OPS staff will determine whether any physical supports, not directly related to the provision of the injection, might assist in self-injection.

If self-injection is not possible, or cannot be performed safely, participants may choose to have another participant (a peer assistant) perform the injection; if both participants agree to this and are making informed decisions with knowledge of the legalities that exist both within and outside of the OPS setting. In the case of assisted injection, OPS service providers should offer safer injection education to the peer assistant, if needed, just as for self-injectors.

All efforts will be made to connect non-self-injectors with safer support services.

E) Overly Intoxicated Participants

Background

Intoxicated persons present unique problems due to the likelihood of even higher risk of needle-sharing, fatal overdose, assault or otherwise unsafely injecting.

Consideration

If overly intoxicated individuals are denied access to clean equipment and a safe location with on-site supervision this likelihood of harmful outcome is compounded. However, allowing intoxicated individuals to inject when they are clearly at greater risk for overdose also presents certain problems. It is left to the discretion of OPS staff to determine the harm versus benefit (for the individual and other participants using the OPS) in allowing access to a person who is overly intoxicated.

Appendix K: Physical Space for Injecting and Ventilation Requirements

Ventilation for OPS sites should meet the Canadian standard for air changes, which is dependent on occupancy (see below).

Ventilation
9.41 (1) Each personal service room and food preparation area shall be ventilated to provide at least two changes of air per hour
(a) by mechanical means, where the room is normally used by 10 or more employees at any one time; or
(b) by mechanical means or natural ventilation through a window or similar opening, where the room is used by fewer than 10 employees if
(i) the window or similar opening is located on an outside wall of the room, and
(ii) not less than 0.2 m2 of unobstructed ventilation is provided for each of the employees who normally use the room at any one time.
(2) Where an employer provides ventilation by mechanical means in accordance with paragraph (1)(a), the amount of air provided for a type of room set out in Column I of an item of the schedule to this Part shall be not less than that set out in Column II of that item.
(3) Where an employer provides for the ventilation of a food preparation area or a lunch room by mechanical means in accordance with paragraph (1)(a), the rate of change of air shall be not less than nine litres per second for each employee who is normally employed in the food preparation area at any one time or for each employee who uses the lunch room at any one time.
SOR/88-632, s. 38(F).

Appendix L: Activities that Require Extreme Caution: Supporting Safer Injection

Undertake with caution, by trained staff only and when other options have been exhausted

The following are considered activities that require extreme caution:

- Removing tourniquet after participant injects to prevent vein damage and blood leakage from the injection site (risk of needle stick injury to staff).
- Supporting the participant to stabilize the syringe or vein while injecting (risk of needle stick injury to staff)
- Directing the participant to adjust the angle of the syringe while the syringe in body (risk of needle stick injury to staff).
- Supporting the participant to cook/prep drugs (risk of spillage)
- This includes changing syringes
- Supporting removal of the syringe from the body in emergency situations (risk of needle stick injury)

When participating in these activities staff should:

- Always keep their hands behind the syringe, never in front of the syringe tip/needle
- For support in anchoring the vein:
    - Place hands behind and below the syringe, on the opposite side of the limb, away from the syringe
    - Use a tongue depressor to gain further distance between staff hands and the syringe
    - *The best way to anchor a vein is to educate the participant in vein anchoring techniques

If participant is able to, request that they:

- give verbal notice if, in the process of receiving injection support, they are going to move their rig (i.e.: re-landmark)
- While the participant adjusts the syringe, staff will remove themselves from booth

When directly supervising injections:

- Self-injection should take place in the participant's assigned booth with participant seated in chair
- This minimizes risk of needle-stick injury related to:
    - Participant and/or staff positioning
    - Unpredictability of participant movements
    - Stand/sit on the side of the participant that is furthest from the hand holding the syringe.

Authorized Activities – By Trained Staff only:

- Verbally explain all steps in safer injection process (Harm Reduction Education)
- Educate participants to self-anchor their veins and syringes.
- Palpate participant's arm for veins to assist land marking. This is an important part of vein care
- Identify potential injection sites, including physically guiding participant's hand to the appropriate injection area

- Encourage hand washing as a measure to prevent infection
- Swab participant's arm with alcohol swab to reduce infection from unclean injection practices
- Demonstrate how to tie off the participant’s arm
- Physically demonstrate all steps in safer injection process using separate set of clean equipment and own body (mock injection only)

Appendix M: Injecting into the Jugular Vein (Jugging)

BACKGROUND: Those 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 at into any vein. The jugular veins pose higher risk for the following reasons.

- The anatomical location of the jugular is very close to large blood vessels (including arteries), nerves, the trachea and the esophagus
- An abscess in close proximity to these structures could cause compression of nerves, and vessels supplying blood to the brain
- A large abscess on the jugular line could potentially cause compression or narrowing of the airway
- 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 of the lack of valves and because of the negative pressure in the jugular, associated with inspiration

Trained OPS staff can provide injection education in the context of harm reduction, with regards to injecting into the jugular vein.

- Constantly monitoring the OPS space for both overdose **and** opportunities for education, while performing daily tasks
- OPS staff may offer participants who are noted to be injecting into the jugular education. If the participant indicates they require support - determine the following:
  - i) Participant's rationale for using the jugular, and participant's knowledge of risks of injecting into the jugular
  - ii) Whether the participant has any visible or palpable venous access other than the jugular
  - iii) Whether the participant can inject their drugs intramuscularly

Based on the above assessment, in priority sequence:

1. Explore with the participant, the possibility of self-injecting into a different vein
2. Educate the participant regarding other alternatives, e.g. "muscling" (self-inject intramuscularly)
3. Educate the participant on the risks involved with injecting into the jugular
4. Educate the participant to safely self-inject into their Jugular vein, IF and only IF participant determined to do so
5. Document appropriately and accurately on the database.

OPS RN Staff: Nurses are ethically obligated to provide proper and adequate education as outlined in the CNA Code of Ethics “Promoting and Respecting Informed Decision-Making” and the CRNBC Practice Standard “duty to Provide Care” This includes:

- Education on the risks involved (clot or obstruction, embolus, infection, overdose, heart attack/stroke, embolus, compression of vital structures in the neck
- How to minimize these risks (Harm Reduction Education)
- How to landmark the vein for injection and other safer-injection education

Appendix N: Management of abscesses and cellulitis related to injection drug use (PHS, 2016)

This section is for information purposes only. If participants express or present with any of the following health concerns refer to a primary care or emergency room for evaluation.

Abscesses and Cellulitis

- An **abscess** is an enclosed collection of purulent liquid, known as “pus”. It can form in skin, muscle, or other soft tissue in the body.
- **Cellulitis** is an infection of skin or soft tissue.
- Bacteria cause abscesses and cellulitis. Bacteria are often introduced because the skin is not cleaned properly prior to the injection of drugs.
- There are four signs of inflammation / infection:
    - Heat
    - Swelling
    - Redness
    - Pain
- Participants with an abscess should be encouraged to seek medical attention as soon as possible. Their infection may need antibiotics and/or need to be drained. Abscesses may also benefit from frequent application of clean hot compresses, hot tap water in a nitrile glove is a simple and cost effective intervention.

Appendix O: Protocol for providing Oxygen Therapy and Use of Bag Valve Masks

Use of Oxygen: Principles

- Oxygen is only to be used in response to an overdose.
- Do not give oxygen unless the person is unconscious.
- Oxygen saturation should be checked before administration of oxygen, if possible. If the layperson is not familiar with pulse oximeters or one is not available, the person should receive assisted ventilation or O2 until a higher level of care arrives.
- In an emergency in which a person is unconscious and experiencing respiratory collapse (not breathing, low oxygen saturation, blue skin) use a bag-valve mask (ambu bag) with high-flow oxygen at 15 litres/min which will deliver approximately 75-100% oxygen.
- The mask should be held firmly over their face using a C-hold to ensure a good seal.
- Continuously monitor the person's oxygen saturation level with a pulse oximeter.
- In cases of suspected cardiac arrest that CPR with rescue breathing should be commenced. There is reasonable consensus it will cause no harm even if the patient has intrinsic low flow cardiac output.
- When 911 is activated the rescuer will be given instructions over the phone by the 911 call taker to ventilate and if appropriate perform CPR in suspected cardiac arrest.

For patients with chronic conditions such as COPD, a high concentration of oxygen is usually contraindicated. However, if the person is unconscious from an opioid overdose, oxygen is indicated to keep their saturation above 90% until paramedics arrive. In an acute respiratory arrest or OD situation there is no harm in applying O2 to patients with COPD while they are assisted and until they are breathing on their own. Once the paramedics arrive a reassessment can then be done to determine the need for continued supplemental oxygen.

Overdose Response Procedure if Oxygen Therapy Available:

1. Call 911
2. Insert the oral airway or head tilt and chin lift
3. Set the O2 at 15L/min and provide ventilation at 1 breath every 5 seconds
4. If available, follow BVM procedure outlined below
5. Administer naloxone (as described above)
6. Evaluate, (continue to provide breaths, 1 every 5 seconds) while waiting 3-5 minutes before giving another dose of naloxone.
7. Provide continuous oxygen.
8. If there is no response after 3-5 minutes, GIVE A 2ND DOSE OF NALOXONE (as described above)
9. Wait 3-5 min, continue to give oxygen and breaths
10. Continue to give naloxone as described above every 3-5 minutes (while rescue breathing) until the person responds OR paramedics arrive
11. Document and Debrief
12. Restock crash kit and oxygen supplies

BVM Procedure:

Use of a bag valve mask is recommended when two people are available to respond to an overdose. Using a bag valve mask takes practice. It is important to learn to skillfully seal the mask to the face of the patient without crushing it onto the face. The patient's face should be pulled up.

1. Gather your equipment (if available): a pulse oximeter, oxygen source, bag-valve mask device, cushioned rim mask, airways (if available and trained)
2. Head tilt-chin lift is done by using one hand to apply downward pressure on the forehead, while the other hand lifts the chin.
3. If oxygen is available, the bag-valve mask unit should be attached to high-flow oxygen at 15 liters per minute, at which a typical device delivers about 75% oxygen.
4. If trained and available, insert airway
5. Obtain an adequate seal using the 'EC' hand position using the thumb and index finger holding the mask and the upper and lower mask borders, respectively. The other three fingers hold the jaw while performing the jaw thrust. If using the two-provider technique, one person should hold the mask with both hands, while the other provider bags the patient. A common location of air leak is located around the nasal bridge, which should be detected when attempting ventilation.
6. Once the position and seal are obtained, "bagging" can commence. The rate of ventilation for an adult is 10-12 breaths per minute or, approximately 1 bag squeeze every 5-6 seconds.
7. The bag should be depressed for a full 1-2 seconds and then released. Chest rise should be seen. Appropriate oxygenation and ventilation should be reflected by pulse oximetry readings.

Common pitfalls of BVM ventilation include inadequate positioning, improper mask holding, and failure to use an oral or nasal airway. Providers tend to hyperventilate patients. The emergency medicine literature has demonstrated that hyperventilation can be harmful by increasing intra-thoracic pressure, which decreases venous blood to the heart and subsequently decreases cerebral and coronary perfusion.

Appendix P: Law Enforcement and OPS Sites

Adapted from Harm Reduction: a British Columbia community guide. British Columbia Ministry of Health. www.health.gov.bc.ca/prevent/pdf/hrcommunityguide.pdf

Public Health and law enforcement are both concerned with reducing drug-related harms. While the contexts and mandates may differ, both sectors are responsible for public safety and there is considerable overlap and mutual benefit in working together. Both Public Health and law enforcement should recognize the possible positive and negative ramifications of their operations may have on a community: Police enforcement activities may influence health harms such as overdoses and the spread of blood-borne diseases; and Public Health programs may influence crime and public nuisance complaints. Mutual understanding of each other's mandates, jurisdictions, operations and legal and organizational limitations is essential to optimizing access and outcomes for OPS clients and ensuring support from local communities and governments.

Policing practices in many jurisdictions have changed over the past few decades. They have become less reactive and more proactive, intelligence driven, and concerned with implementing best practice. This has required a greater understanding and use of crime prevention strategies, which is a similar approach to health promotion and protection. Harm reduction based approaches to law enforcement complement public health efforts by seeking to reduce the net harm experienced by drug users and the community. Examples of these enforcement practices include greater use of discretion by police, provision of harm reduction training for police and partnerships between police and health agencies. The use of discretion in attending overdoses (e.g. police not attending non-fatal overdoses) is well established and has reduced the reluctance of drug users to call ambulances, resulting in fewer deaths. Other accepted discretionary practices are the use of warnings or cautioning and the use of referrals to appropriate health and social services as alternatives to arrest and confiscation of injection equipment.

Health care providers should recognize that laws change and evolve to reflect societal values. The royal assent of the Good Samaritan Drug Overdose Act in May 2017 provides an exemption from charges of drug possession for people who call 911 for themselves or another person suffering an overdose, as well as anyone who is at the scene. While this act codified an existing discretionary police practice to reduce barriers to emergency care, others legal barriers may be slower to change or may persist indefinitely, and law enforcement may have less discretionary power in some cases.

While police as first responders may frequently be involved with overdose resuscitation efforts, there is evidence that police can reduce harm by maintaining adequate distance from health services used by drug users, so as not to deter access, and by not interacting with drug users during the injection process. According to a report by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), supervised consumption site staff and neighbourhood committees are working in partnership with local police to minimize public nuisance and increase the efficacy of overdose prevention strategies. The Vancouver Police Department was a partner in establishing Insite and supports the facility as part of the four-pillar integrated approach to substance use in Vancouver. Police have reported public order benefits in the wake of the opening Insite.

The Canadian Centre on Substance Use and Addictions (CCSA)'s guideline on the role of police in harm reduction suggests:

- Police should avoid unnecessary visits and enter only with permission from operators unless they are in active pursuit of a suspect
- Police Services should be actively involved with the planning and development of overdose prevention sites and be supportive of the role it plays as a public health initiative.
- Police services should actively refer drug users who are injecting in public to local overdose prevention sites and supervised consumption services along with treatment and support.

OPS staff should recognize that police officers may need to enter facilities to perform law enforcement duties and should make every effort to cooperate. Health care workers and Public Health officials involved in OPS activities are encouraged to proactively engage local law enforcement in all stages of planning and operations and to maintain ongoing dialogue with local detachments to address client and community issues.

Appendix Q: Cleaning Check List Template for OPS Space

Overdose Prevention Site														
Doors														
Floor mopped														
Counters														
Sinks														
Phones														
Garbage out														
Restock towel														
Cupboard doors														
Clean mirrors														
Phones														
Walls														

Appendix R:

Recommendations for Outdoor Inhalation Overdose Prevention Services (OPS)

From the BCCDC 2018 Harm Reduction Client Survey, more than half of participants identified smoking or inhalation as their preferred method of drug use compared to injection and other methods of consumption. [1] Outdoor inhalation OPS promote safer use of opioids through direct observation and reduce the risks associated with using alone. In addition, people who use stimulants are more likely to smoke or inhale rather than inject and may be opioid naïve, meaning these populations are not supported at OPS/SCS that do not provide inhalation services.

This document is intended to provide some guidance and best practice recommendations for outdoor inhalation OPS and has been reviewed by WorkSafe BC.

Checklist

Workplace Health and Safety

- □ Inhalation OPS sites have a responsibility under the Workers Compensation Act and Occupational Health and Safety Regulation for ensuring health and safety of workers.
    - In most situations, a peer support worker being paid a regular wage for time worked is considered a worker under the Workers Compensation Act. If there are questions about whether a peer worker qualifies as a worker, contact the WorkSafeBC Employer Service at 1-888-922-2768 for assistance.
    - Inhalation OPS sites are expected to follow general employer OHS policies and regulations that may need to be adapted for inhalation OPS sites.
    - Assess the risks associated with the outdoor inhalation site with consideration of:
        - Layout of the facility – degree of confinement, proximity to other public areas, businesses, etc.
        - Identify work activities that require entry into the facility (i.e., type of work, duration, frequency) and those that can be done from the outside.
        - Information about the type of products that will be smoked including current information about contamination.
        - Duration of time that clients are smoking inside.
        - Available PPE and training.
        - Consideration of routes of exposure – inhalation, skin, inadvertent ingestion, etc.
    - Employers are expected to identify, assess, and ensure adequate procedures are in place to eliminate or minimize risks, including:
        - Workplace violence

- Working alone or in isolation
- Ergonomics
- Indoor air quality - tobacco and e-cigarettes
- Chemical and biological agents
- Personal protective equipment

- Refer to the WorkSafeBC Feedback on Inhalation OPS Checklist document and the hierarchy of controls for more information
- WorkSafeBC Claims Call Centre (for reporting a workplace injury or disease):
  - Phone: 1-888-967-5377
  - Hours of Operation: Monday to Friday, 8 a.m. to 6 p.m.
- WorkSafeBC Prevention Information Line for health and safety assistance:
  - Phone: 1-888-621-7233
  - Hours of Operation: Monday to Friday, 8:05 a.m. to 4:30 p.m.

Ventilation

- ☐ The inhalation OPS must allow for natural ventilation as much as possible – if using a tent ensure three ends/flaps of the tent are open.
- ☐ A fan can be used to exhaust air out of the tent away from clients, workers, and the public.
- ☐ Other options that require further assessment – a possible option might be the use of portable extractors similar to those used in nail salons and for small scale hot work (i.e., soldering).
- ☐ The inhalation space must remain 6 meters from any air intake, door, or window as per the Safe Tobacco Act.

Heating

- ☐ If heating equipment is used to warm the tent, ensure proper fire safety practices are followed:
  - ☐ Do not use open flame or gas/propane to heat tents. Use electric heaters instead.
  - ☐ When using electric heating equipment, ensure compliance with manufacturer's instructions for placement away from combustible material, such as furnishings and tent fabric.
  - ☐ Ensure tent fabric is rated as flame resistant as required by the BC Building Code (contact local building official).
  - ☐ Ensure fire extinguishers are accessible and workers are trained in their use.
  - ☐ Keep furniture and other combustible material in or near tent away from open flame devices (e.g. lighters or butane torches) and electric heaters.
  - ☐ Provide an adequate number of non-combustible ash trays.

Layout

- Layout should maximize natural ventilation and minimize stagnant spaces
- It is strongly recommended to set up the inhalation spaces in a booth style and in a circular arrangement when possible to build community. Have somewhere for people to sit, put their drugs down, prepare, and use.
    - Having a booth style service considers the importance of privacy and may help to reduce sharing of materials, forced/coerced sharing of substances and considers the vulnerability of some clients in these settings (e.g. Women).
- Have a 'chill out' area in a separate tent or area to reduce smoke exposure
- Have staff conduct tasks such as paper work, questionnaires, and other outreach activities outside of the inhalation OPS area to reduce smoke exposure

Observation/Sight Lines

- These sites are required to be monitored in a similar way to injection OPS spaces. Agencies must consider sight lines and who will be monitoring this space for overdoses or other related harms. Clear roles and responsibilities need to be defined at the agency level (e.g. peer monitoring, staff, video, etc.).
- Remote observation from outside the tent (via transparent curtains or video cameras) reduces smoke exposure to workers.

Personal Protective Equipment

- For protection from inhalation exposure, a worker should wear an appropriately sized filtering facepiece respirator (such as an N95 respirator) if they need to enter for a short duration when second hand smoke is present. This is not the PPE requirement for first responders as their requirements are different.
- Workers required to wear a filtering facepiece respirator (such as an N95 respirator) need to be fit tested for that respirator to ensure an adequate seal to the face for protection. Workers must be clean-shaven for the seal to be effective.
- When performing tasks where workers may have contact the interior surfaces of the tent, the employer must provide and workers must wear the appropriate skin protection based on the assessment of the risks (e.g. Nitrile gloves).

Overdose/Emergency Response

- If there are instances when the worker/individual must enter the tent to respond to a client emergency (e.g. overdose), they must follow safe work procedures to minimize exposure to second hand smoke as much as possible. These procedures may include enhanced ventilation and the use of personal protective equipment to minimize the inhalation exposure to the

worker. See COVID-19 resource on responding to opioid ODs in OPS/SCS for more information.

- If there are instances when a worker/individual must enter the tent to respond to an employee or staff emergency, the worker must follow OFAA protocols.

Cleaning Surfaces

- Due to the nature of the activity taking place, inhalation tents have the potential for a higher risk of surface contamination than other Overdose Prevention Services/Supervised Consumption Sites (OPS/SCS). As substances are smoked, particles settle on surfaces (e.g. walls, tables, ceiling, and furniture) and need to be safely cleaned to reduce the risk of exposure.
- Fentanyl is not easily absorbed by the skin; however, there are other potential routes of exposure (via inhalation, mucosal contact (via finger in the nose or eyes), accidental ingestion) if surfaces are contaminated
- Employers must ensure that workers follow safe work procedures if there is a risk of exposure from contact with surfaces contaminated with residue from the smoke (e.g., cleaning the tent and interior surfaces).
- Select a tent, table and other furnishings made from non-porous materials to facilitate the necessary cleaning/decontamination of surfaces.
- Gloves (heavy duty nitrile) should be worn for all cleaning activities. Eye protection and additional skin protection, as well as emergency washing facilities, will likely be required if concentrated cleaning chemicals are handled/diluted prior to use. If the substance is on the gloves, there is still a risk for ingesting the substance or mucosal exposure (via finger in the nose or eyes)
- Provide instructions for the client to clean any debris and wipe down surfaces afterwards. Then, a worker will clean and wipe down surfaces again. Where practicable, avoid dry sweeping to minimize the potential for aerosolization of residues.
- Surfaces such as tables and other furnishings should be cleaned regularly. Industrial disinfectant wipes (e.g. CaviWipes) or other hospital grade cleaners may be used to clean surfaces where fentanyl and analogues may be present
- Follow safe work procedures for cleaning surfaces outlined in the BCCDC OPS Guide

Signage

- Consider posting signage that acknowledges the space as an inhalation OPS. It is also recommended to engage service users of the space in developing common ground rules and posting these as well.
    - Suggested language for signage "*This outdoor structure is intended to operate as an inhalation Overdose Prevention Site in accordance with BC's Overdose Public Health Emergency and the Ministerial Order M488. This location is monitored for the safety of people who are using substances within.*"

Supports

- □ Consider providing drug checking services. Talk to your Regional Harm Reduction Coordinator(s) for more information.
- □ Have Take Home Naloxone onsite to provide training and distribution to individuals who need kits.

Supplies

- □ Safer smoking supplies, such as straight glass tubes, meth bowls, mouth pieces, screens, and push sticks can be ordered through the BCCDC Harm Reduction Supply Program. Connect with your Regional Harm Reduction Coordinator(s) for more information on ordering.

Training

- □ All staff in the agency must have received adequate training in overdose recognition and response, including the administration of naloxone. If eligible, the agency must be registered with the BCCDC Facility Overdose Response Box Program.
  - □ Note: community-based non-profits are eligible for FORB, not government or for-profit agencies. Government and for-profit agencies can access staff naloxone through their employer and can access harm reduction supplies and Take Home Naloxone through the BCCDC Harm Reduction And Naloxone Programs.
- □ All staff in the agency must have received training on safe work procedures for working at an outdoor inhalation OPS. Workers who require fit testing for filtering facepiece respirators (such as N95 respirators) must be fit tested and trained in how to put them on, take them off, check the seal, care/maintain respirators, and understand their limitations (e.g what they do and do not provide protection from)

Considerations for Housing Locations

- □ For housing locations – an inhalation OPS **must not be** the only smoking area available to residents (i.e. people who smoke tobacco must be offered a place where there is not illicit drug use also happening).

Policies and Procedures

- □ The operating agency will follow the approved Regional Health Authority Manual where applicable:
  - □ Interior Health: Overdose Prevention Services Site Manual
  - □ Fraser Health: Overdose Prevention Site Manual
  - □ Vancouver Coastal Health: Overdose Prevention Site Manual
- □ The operating agency has reviewed provincial BCCDC Guide to Overdose Prevention Sites or Vancouver Coastal Health Housing Overdose Prevention Site Manual and agrees to utilize as a guiding document in service provision.

- □ The operating agency is aware of the data collection requirements and agreeable to completing reporting to Regional Health Authorities (RHAs) as required.

Appendix S

Template: Medical Health Officer Overdose Prevention Services Designation Letter

Date:

To:
[Designated Person's Name]
[Agency]
[Address of agency]

Re: Designation of Overdose Prevention Services

On behalf of the Minister of Health, and in keeping with the public health emergency declared by the Provincial Health Officer on April 14th 2016 under section 52 (2) of the *Public Health Act* S.B.C. 2008, Chapter 28, AND in keeping with Ministerial Order M488 under section 5.2 of the *Emergency Health Services Act* and section 7.1 of the *Health Authorities Act*, I am satisfied that the terms and conditions set out by the BC Ministry of Health are understood and will be met by [Agency] to provide observed consumption as an overdose prevention service at:

Site Name:
Organization:
Address:
[Date and time if relevant]:

Observed consumption refers to the provision of a space for people to consume pre-obtained substances under the supervision of people trained in overdose recognition and response for the purpose of reducing harms such as overdose and death.

In order to maintain this designation, the [Agency] is required to:

- [Insert Regional Health Authority specific requirements]
- Employ staff with training in overdose prevention, recognition, and response.
- Provide harm reduction supplies including Take Home Naloxone kits and training.
- Carry out services in accordance with the BCCDC Overdose Prevention Services Guide.

This designation is only in place for the duration of the public health emergency and at the location specified above, unless modified, extended, or terminated by a Medical Health Officer.

Yours sincerely,

Dr. [first] [last]
Medical Health Officer
[Health Authority]

[1] http://www.bccdc.ca/health-professionals/data-reports/harm-reduction-and-substance-use

This document is based on the Interior Health Recommendations for Sites Offering Inhalation OPS document

Supervised Consumption Services

Operational Guidance

BRITISH COLUMBIA
Ministry of Health

BRITISH COLUMBIA CENTRE ON SUBSTANCE USE
Networking researchers, educators & care providers

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About the BC Centre on Substance Use

The BC Centre on Substance Use (BCCSU) is a provincially networked resource with a mandate to develop, implement, and evaluate evidence-based approaches to addiction and substance use. Building on the extensive efforts of the BC Centre for Excellence in HIV/AIDS and the Urban Health Research Initiative, the BCCSU's vision is to transform treatment of substance use in BC by translating research into education and evidence-based care guidance. By supporting the collaborative development of evidence-based treatment policy, guidelines, and standards, BCCSU will improve the integration of care across the continuum of substance use programming and policy, thereby serving all British Columbians.

The BCCSU is founded on the values of: advancing, seeking and sharing of knowledge; collaboration at all levels across the continuum of care; empowerment of individuals, families, and communities; excellence and quality through innovation and evidence; advocacy for positive policy change, reduction of stigma and support for patients and families; and mutual respect and equity for all members of the community and their contributions.

In order to provide leadership in treatment system for addiction and substance use and to help reach all British Columbians who need these services, the BCCSU will integrate activities of its three core functions:

1. **Research and Evaluation** – Lead an innovative multidisciplinary program of research and evaluation activities to guide health system improvements in treatment and care for addiction and substance use.
2. **Education and Training** – Strengthen education activities that address addiction and substance use across disciplines, academic institutions, and health authorities, and train the next generation of leaders in the field.
3. **Clinical Care Guidance** – Develop and implement evidence-based clinical practice guidelines and treatment pathways.

About the Process

The Steering Committee for the Supervised Consumption Services Guidelines has developed this document as part of the efforts of the Joint Task Force on Overdose Response to expand the reach of SCSs in British Columbia. The Committee reviewed the available scientific evidence, policies, and procedures in place in British Columbia, and assembled experts in the area, including operators of the two SCS facilities in Vancouver. The expert Committee is represented by the following individuals:

Dr. Thomas Kerr, Professor, Department of Medicine, University of British Columbia; Associate Director, BC Centre on Substance Use

Rosalind Baltzer Turje, Director of Clinical Programs, Research and Evaluation, Dr. Peter AIDS Foundation

Chris Buchner, Director of Clinical Operations, Population and Public Health, Fraser Health Authority

Maxine Davis, Executive Director, Dr. Peter AIDS Foundation

Cheyenne Johnson, Director, Clinical Activities and Development, BC Centre on Substance Use

Dr. Marcus Lem, Senior Medical Advisor, Addiction and Overdose Prevention Policy, British Columbia Centre for Disease Control

Kenneth Tupper, Director, Implementation and Partnerships, BC Centre on Substance Use

The Guidelines were externally reviewed by the following content experts from the British Columbia Ministry of Health and other community organizations:

Dr. Brian P. Emerson, Medical Consultant, Population and Public Health Division, British Columbia Ministry of Health

Kathleen Perkin, Manager, Harm Reduction Policy, British Columbia Ministry of Health

Christy Sutherland, MD, CCFP, Dip. ABAM, Medical Director, PHS Community Services Society

Marshall Smith, Executive Director, Cedars Society

Jordan Westfall, President, Canadian Association of People Who Use Drugs

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Executive Summary

Supervised consumption services (SCSs) provide hygienic environments in which people who inject drugs (PWID) can inject illegal drugs under the supervision of a health care professional, a trained allied service provider, or a peer (i.e., person who formerly used or currently uses illegal drugs), without the risk of arrest for drug possession. There are over 90 SCSs throughout the world, with most operating in Western Europe. Evaluations to date have revealed that SCSs are effective in reducing public disorder, unsafe injecting, infectious disease risk behaviours, and overdose morbidity and mortality, as well as in promoting access to health and social services. SCSs have also been found to be cost-effective and to reduce burden on emergency services.

There are different ways to plan, design, and implement a SCS and, accordingly, many issues to consider with respect to the target client population, existing network of services for PWID, and resources available, including funding, space, and staff. Need should be determined through relevant environmental scans, needs assessments, and feasibility studies. This can involve reviewing local health data and/or conducting survey or qualitative research with local PWID and other relevant stakeholders to assess need, potential uptake, and design preferences. Importantly, such work can be instrumental in determining the size and type of SCS needed (e.g., number of injecting spaces), location, and additional services provided within the SCS (e.g., vaccinations, referral to treatment for substance use). To ensure adequate engagement of the PWID population and assessment of need, local PWID should be involved in the planning and execution of such feasibility work.

SCSs vary considerably in their design and operation. Common models include fixed stand-alone SCSs (primarily focus on SCS), integrated SCSs (also provide ancillary care and services), embedded SCSs (operate within settings where non-medical drug use is traditionally disallowed, such as hospitals and housing environments), and mobile outreach SCSs (modified vans that travel to high traffic areas for PWID). Women-only SCSs have also been implemented in some settings, while some SCSs offer hours for women only. Further, SCSs vary considerably in how they are staffed, although it appears that in the Canadian context, there is evidence for benefits of SCS provision by registered nurses or registered psychiatric nurses. However, these staff may be supported by other allied health care and service professionals, including licensed practical nurses and staff members who are peers. There has been local success with novel peer-run models of SCS, and although current federal rules prohibit the involvement of peers within SCS injecting rooms, efforts are needed to further explore, implement and evaluate this model of SCS.

The successful operation of SCSs is contingent on the establishment of relevant policies and procedures. At minimum, these should include: overdose response protocols; documentation procedures; referral pathways; code of conduct/rights and responsibilities for clients and staff; eligibility criteria and intake procedures; criteria and protocol for refusal of service; and procedures for contacting police in the event of aggression or safety related issues. Special efforts are also needed to ensure that staff are trained to provide trauma-informed and culturally safe care. Further, opportunities to expand the scope of SCS should not be overlooked, including the potential provision of injectable opioids, as is currently done in other settings.

SCSs are evidence-based interventions that, when well placed within a broad continuum of services for PWID, can reduce morbidity, mortality, and public disorder, as well as promote access to health and social services. Undertaking a needs assessment and adhering to best practices can make implementation of SCSs easier for all involved. However, it should be noted that presently, the process of obtaining Health Canada approval for a SCS is cumbersome and slow, and therefore other interventions with high potential to immediately reduce drug-related harm should not be overlooked as efforts to establish an SCS are undertaken.

Summary of Recommendations

Supervised consumption services (SCSs) vary immensely in their operation and design. However, despite differences in populations of people who inject drugs (PWID) and settings where SCSs are implemented, the following minimum set of recommendations are offered as being essential to the establishment of any SCS in British Columbia:

1. **Conduct a needs/feasibility assessment**: This should include at minimum an assessment of local drug-related harms, existing services, willingness to use a SCS among local PWID, and support from key stakeholder groups (e.g., local health care professionals, policy makers, law enforcement officials). Such work should involve local PWID to ensure adequate engagement of the local population.
2. **Determine the ideal type of SCS for the setting**: Fixed stand-alone SCSs are recommended in settings with large populations of PWID that are concentrated in a specific area; integrated models are most appropriate in settings where PWID populations are more dispersed and when there is a desire to promote uptake of other services offered in the same health care environment; embedded services are appropriate in institutional, housing, or program settings frequented by PWID and where drug use occurs onsite, is unsafe, or is prohibited; mobile services are appropriate primarily as a compliment to other SCS programs (e.g., fixed stand-alone SCSs, integrated SCSs) and in settings where some PWID are displaced away from other services and therefore difficult to reach with fixed SCSs; women-only sites are recommended in settings where there are sufficient populations of women who inject, and who are particularly vulnerable to the effects of gendered violence and gendered power relations. Women-only SCSs can serve as an effective compliment to other forms of SCS programming, and should be implemented where feasible. One geographical setting may benefit from multiple types of SCS to reach different populations of PWID in the area. Although the current exemption process under Section 56 of the Controlled Drugs and Substances Act requires that only licensed medical and health professionals be authorized to supervise injections within SCSs, there have been local successes with expanding the role of allied health professionals and peers in such settings. Further, past feasibility work has shown that PWID value the inclusion of peers within SCSs, and feel that their inclusion in the injecting room would be an asset. There is also local evidence indicating a preference for peer-operated SCS, and accordingly efforts should be made to further explore, implement, and evaluate this model of SCS. The federal government of Canada is currently reviewing the Act's restrictions, including those that restrict the involvement of peer staff and other allied health professionals. Finally, opportunities to expand the scope of SCS should not be overlooked, including the potential provision of injectable opioids, as is currently done in other settings.
3. **Establish a staffing structure**: Given the many health challenges experienced by PWID accessing SCSs, and the need for emergency overdose response, it is ideal if staffing models include a supervising registered nurse or psychiatric nurse, who can be supported by other allied health professionals. Non-medical personnel, such as community mental health workers, and individuals identified as peers (i.e., people who formerly used or currently use illegal drugs) also play important roles in the planning and operation of SCSs and should be strongly considered for involvement where possible and compensated appropriately. In settings that are resource-constrained, SCS can be run successfully by non-nursing staff.
4. **Create and implement policies and procedures**: The effective operation of SCSs requires a minimum set of policies and procedures. Those seeking to establish new SCSs should create the following policies: overdose response protocols; documentation procedures; referral pathways; code of conduct/rights and responsibilities for clients and staff; eligibility criteria and intake procedures; criteria and protocol for refusal of service; and procedures for contacting police in the event of aggression or other relevant issues. Efforts to ensure trauma-informed and culturally save care are also needed.

1. Introduction

Supervised consumption services (SCSs) provide hygienic environments in which people who inject drugs (PWID) can inject illegal drugs under the supervision of a health care professional (or a trained allied service provider or peer),[1] without the risk of arrest for drug possession. SCSs are part of a continuum of services that address drug-related harms, such as needle/syringe distribution programs, and complementary drug treatment programs, such as withdrawal management, opioid agonist treatment (OAT), and recovery-focused programs (Potier et al., 2014). There are different ways to plan, design and implement a SCS and many issues to consider with respect to the target client population, existing network of services for PWID, and resources available, including funding, space, and staff. SCSs range considerably in size, structure, and staffing.

These guidelines outline and address a range of questions and issues to consider when planning SCSs, as well as examples of existing facilities world-wide. The guidelines are based on the existing evidence, best practices, and lessons learned from SCSs that already exist in British Columbia and elsewhere. However, each SCS is unique, and each potential service must be modified for the specific context in which the service is provided. The goals of these guidelines are to provide health care professionals, service providers, policy makers, peers, advocates, and other stakeholders with the tools to:

- Articulate a rationale for implementing a SCS in their locality, including determining need and feasibility;
- Define organizational goals and objectives of implementing a SCS;
- Plan an overall model of the facility based on need and feasibility;
- Map the range of services that the facility will offer, based on need and feasibility;
- Articulate the role and linkages of the SCS to the broader network of health and care services available in the locality; and
- Operate a SCS, including recommendations for staffing, clinical protocols, and safety policies.

It is not within the scope of these guidelines to provide instructions on how to apply for an exemption under Section 56 of the Controlled Drugs and Substances Act. For more information about the exemption process and to receive an application form, contact exemption@hc-sc.gc.ca or visit Health Canada's webpage on Controlled Substances and Precursor Chemicals (http://www.hc-sc.gc.ca/hc-ps/substancontrol/index-eng.php). The topics covered in these guidelines may help organizers to engage in higher-level, conceptual discussions about the rationale, goals, and design of a SCS, prior to drafting an exemption application. It should be noted that presently, the process of obtaining Health Canada approval for a SCS is cumbersome and slow, and therefore other interventions with high potential to immediately reduce drug-related harm should not be overlooked as efforts to establish an SCS are undertaken.

1.a. Background and Evidence

Supervised consumption services are also called "safer injection facilities", "supervised drug consumption sites/facilities/centres/services", "drug consumption rooms," and other terms. In these guidelines, we use the

1. Exception under Section 56 of the *Controlled Drugs and Substances Act* currently limits the provision of supervised consumption to licensed health care professionals. However, there have been local successes in training and expanding the role of allied service providers (e.g., mental health workers, social workers) and peers (i.e., people who formerly used or are currently using drugs) at SCSs. The federal government is currently seeking to amend the overly restrictive wording of the *Act* in this regard.

term *supervised consumption services* or *SCSs* to refer to legally sanctioned services that provide supervised consumption of illegal drugs[2] by a health care professional, an allied service provider, or a peer. SCSs are different from "shooting galleries" and other non-medical drug use settings, where drug injections occur without medical supervision or the provision of hygienic equipment.

The first legally sanctioned SCS was established in 1986 in Berne, Switzerland. High rates of HIV transmission, increases in drug-related deaths, growing public drug scenes, and the rise of harm reduction principles as viable alternatives to abstinence-based strategies resulted in the establishment of early SCSs (IDPC, 2014). To date, there are over 90 SCSs operating world-wide, with the majority located in Europe, particularly the Netherlands (31 sites) and Germany (24 sites) (EMCDDA, 2016). On average, SCSs in Europe offer seven spaces (rooms or booths) for supervised injecting (Woods, 2014). Australia became the first English-speaking and non-European country to open a facility when it opened the Sydney Medically Supervised Injecting Centre in 2001.

Currently, there are three SCSs in operation in Canada, all of which are located in British Columbia. In 2003, Vancouver Coastal Health, in partnership with the Portland Hotel Society, opened Insite as a three-year pilot project. This was supported by a Section 56 exemption under the *Controlled Drugs and Substances Act* and Insite was subjected to a rigorous arms-length evaluation. In January 2002, the Dr. Peter Centre had initiated SCS. The decision to initiate the service was made after a consultation with the then Registered Nurses Association of British Columbia (now the College of Registered Nurses of British Columbia). The Association confirmed it was within the scope of registered nursing practice to supervise injections for the purposes of preventing illness and promoting health. In 2011, the Supreme Court of Canada concluded that Insite saved lives and improved the health of people who used the services provided at the facility, without compromising the public health and safety objectives of the *Controlled Drugs and Substances Act*.[3] In the wake of this decision, the Dr. Peter Centre sought and eventually was issued a federal exemption in 2016. BC's third SCS, Safe Point, began operation in Surrey in June 2017. Safe Point is one of multiple SCSs to receive federal approval within the recent months. To date, Health Canada has approved 12 SCSs nationwide, and multiple sites are expected to open in the coming months.

Profiles of PWID who attend SCSs suggest that these facilities attract the most socially marginalized of the PWID community (i.e., homeless or housing insecure, people who inject in public). These individuals are also more likely to engage in high-risk drug-use (e.g., more frequent episodes of overdose and daily drug injection), suggesting that these facilities were successful in attracting and providing service for marginalized and hard-to-reach populations (Potier et al., 2014). The main injection-related issues identified among new SCS users include difficulty finding a vein, infection after injection, and lack of knowledge of safer injection practices (Fast et al., 2008; Salmon et al., 2009).

Numerous studies have demonstrated positive impacts of SCSs on the morbidity and mortality of PWID. A systematic review of 75 peer-reviewed journal articles on SCSs found that no overdose-related death was ever reported within a SCS in the studies (Potier et al., 2014). In Sydney, Australia, there was a 68% decrease in calls for ambulances in the vicinity of the SCS during its operational hours (Salmon et al., 2010). In Germany, the opening of multiple SCSs in major cities was found to decrease drug-related deaths (Poschadel et al., 2003). A

2. Drug consumption can take place via intramuscular, intravenous, or subcutaneous injections with a hypodermic needle, but also via inhalation, which includes smoking, chasing the dragon (consuming heroin by inhaling vapours), free-basing (inhaling crack cocaine via a heated pipe), snorting, and ingestion (e.g., swallowing pills). Cocaine has been associated with high levels of communicable diseases (e.g., HIV, viral hepatitis C, tuberculosis) and sores, burns, and cuts from shared crack pipes (DeBeck et al., 2009; McMahon et al., 2003). A Vancouver study shows that there is a high prevalence of public crack smoking and rushed public crack smoking, but little is known about harms of public crack smoking (Voon et al., 2015). Many SCSs in Europe also offer supervised inhalation services, for which facilities have specific ventilated areas and offer sterile inhaling equipment. In these guidelines, we focus on injection drug use and PWID, as facilities in Canada currently offer supervised consumption services only and are supported by a large amount of scientific evidence that demonstrate public health and public safety efficacy of supervised injection drug use.
3. Various provincial policy documents produced by the British Columbia Ministry of Health support this court conclusion, including: *Harm Reduction: A British Columbia community guide* (2005), *Following the Evidence: Preventing harms from substance use in B.C.* (2006), and *Guidance Document: Supervised Consumption Services* (2012).

study in Vancouver found a 35% decline in overdose deaths in the area around Insite (Marshall et al., 2011). Also in Vancouver, frequent SCS users were found to be 70% less likely to share used syringes (Kerr et al., 2005), and modeling studies have estimated that SCSs reduce HIV transmission (Bayoumi et al., 2008; Pinkerton, 2011). SCSs have been associated with increased condom use among PWID in Vancouver (Marshall et al. 2009). Also in Vancouver, approximately 25% of SCS users surveyed received care for injection-related cutaneous infections (Lloyd-Smith et al., 2009). Regular use of SCSs has been associated with other changes in drug use and related practices among PWID, including a reduction in syringe reuse and drug injection in public spaces (Stoltz et al., 2007). In Vancouver, it was found that there was a reduction in the daily mean numbers of PWID injecting in public, syringes discarded in public, and other injection-related litter (Wood et al., 2004).

Frequent attendance at SCSs has also been associated with changes in the uptake of harm reduction practices and treatment programs for addiction and substance use. Regular SCS use was associated with more frequent requests for education on safer injection practices (Wood et al., 2008) and fostered the use of sterile injection materials and disposal of used materials (Fast et al., 2008; Stoltz et al., 2007). Using SCS was also associated with an increase in referral to treatment centres for addiction and substance use, initiation of withdrawal management programs (Wood et al., 2007), and initiation of methadone therapy (DeBeck et al., 2011; Kimber et al., 2008; Milloy et al., 2009; Wood et al., 2007, 2006a). In Sydney, Australia, 25% of the interested PWID started dependence care programs (i.e., buprenorphine maintenance, withdrawal management, methadone maintenance, drug and alcohol counselling, residential rehabilitation, narcotics anonymous, and other self-help and naltrexone maintenance) (Kimber et al., 2008). In Vancouver, among PWID who attend the SCS, 18% engaged in a withdrawal management program (Wood et al., 2006b), 57% started a drug treatment program, and 23% stopped injecting drugs altogether (DeBeck et al., 2011). Qualitative research conducted at the Dr. Peter Centre found that the integrated supervised consumption program influenced PWID's access to care "by building more open and trusting relationships with staff, facilitating engagement in safer injection education and improving the management of injection-related infections" (Krusi et al., 2009). Another recent study found that Dr. Peter Centre participants were 58% less likely to leave hospital against medical advice, suggesting that the integration of SCS within the Dr. Peter Centre may have helped individuals stay in the hospital located across the street from the Dr. Peter Centre (Ti et al., 2016).

While there have been concerns that SCSs encourage and foster drug use, there has been no increase in the number of people using drugs intravenously in localities where such facilities operate (Potier et al., 2014). Further, evaluation work undertaken in Vancouver revealed that the opening of Insite was not associated with increased crime or rates of initiation into injection drug use (Wood et al., 2006; Kerr et al. 2007). These facilities have also been found to be highly cost-effective (Bayoumi, et al., 2008; Pinkerton, 2011).

1.b. Indications for Implementation

1.b.i.Determining Need

Prior to planning or designing a SCS, organizers should first assess and understand the local context of drug use and services for PWID. As part of this process, organizers should consider the following questions:

- Who is the target client population?
- What are the needs of local PWID?
    - Is there evidence of under-addressed drug-related harms (e.g., overdose, injection-related infections)?
    - Are many local PWID injecting drugs in public or semi-public spaces (e.g., restrooms)?

    - Are there specific (sub) groups of PWID who do not access existing services or referrals? What are the barriers/challenges that these clients face in accessing these services or referrals?
- Are local PWID willing to use a SCS?
- What is the optimal design and distribution of SCSs to meet local need?
- What other key stakeholders need to be consulted to ensure the program's success?

To answer these questions, organizers should conduct SCS feasibility assessments in their local context (please see Appendix A). It is possible to conduct a small-scale assessment on limited budget and time. To ensure adequate engagement of the PWID population, local PWID should be involved in the planning and execution of such feasibility work, as has been done successfully in the past (Kerr et al, 2003). A feasibility assessment can help strengthen organizers' rationale for opening a SCS and past research has shown that expressed willingness to use a SCS predicts future use of a SCS (DeBeck et al., 2012). Such work may also shed light on issues that organizers have not have anticipated. For instance, the organizers may discover that local PWID are not interested in injecting drugs under the supervision of a health care professional, but are open to carrying naloxone (medication used to reverse an opioid overdose). This finding can help organizers better channel their resources into developing and/or expanding take-home naloxone training programs or other services. If there is a local drug users group, it may be an excellent community partner for designing and conducting this feasibility assessment.

Organizers should also engage key stakeholders and the broader community in a consultation process so that the proposed SCS is integrated into existing health and social services and engage business, police, and neighbourhood stakeholders. Please see Appendix B for suggested process for community consultation and engagement for the purpose of establishing a SCS.

1.b.ii. Defining Overall Goals

Once organizers have an understanding of the local context, they should define the overall goals, targets, and outcomes for implementing a SCS. The goals and outcomes should be in line with what organizers have found to be needed in their local context (with the input of PWID in the area and communities affected by drug use), as well as being achievable with the available resources. Undertaking this conceptual work can help organizers clearly establish a rationale for the facility, map the range, scope and scale of services they will offer, and more effectively channel their resources.

In relation to their target client population, organizers may consider any number of the following potential goals:

- To reduce rates of non-fatal overdose and overdose-related deaths, and associated ambulance calls and health care utilization;
- To reduce rates of drug-related transmission of blood-borne infections among PWID (i.e., viral hepatitis and HIV);
- To decrease the rates of acute health complications that are related to injection drug use (i.e., soft tissue infections, infective endocarditis);
- To improve uptake of and access to health and care services among PWID;
- To improve PWID's knowledge and uptake of/access to harm reduction practices and services;

- To improve PWID's knowledge and uptake of/access to drug treatment services, including recovery-oriented programs and a range of opioid agonist treatments, including injectable therapies; and
- To reduce drug use in public or semi-public spaces, including inappropriately discarded injection equipment and related litter.

Organizers should keep in mind that the goals and aims of their facility may change over time, in accordance with funding and staffing, as well as changes in the needs of the client population, local service networks, and local drug scene.

2. Supervised Consumption Service Models

There are many ways to design and implement a SCS. The type, range, and scope of services offered depend on the client population's characteristics and needs, existing local services, and resources available to establish a facility.

The basic components of a SCS include:

1. A reception area, distinct from the area where drugs are injected, where potential users of the SCS can learn about the service and its operation;
2. A dedicated drug injection area, which is well ventilated and equipped with drug injecting equipment, as well as a receptacle for the disposal of used equipment. This area should be closed off from the rest of the facility; and
3. A common area for after care or "chilling out" where clients interact with health/care professionals and peer support workers and receive after-care, referral, education, and counselling.

A SCS may also provide a range of ancillary services (please see Appendix F for a list of ancillary services provided in existing SCSs). The type, scale, scope, and breadth of services offered depend on the observed needs of the client population, existing services available in the area, and overall budget and capacity of the facility. Organizers should also establish referral pathways to other existing services in the local area and avoid duplication of services, unless implementing additional existing services was identified as necessary through the needs assessment.

Broadly speaking, there are five different models of SCS that currently operate world-wide: fixed stand-alone models, integrated models, embedded models, mobile outreach models, and women-only models. There are variations in each model, in terms of the size of the facility, weekly number of visits to the SCS, number of staff and their hours, and the number and types of ancillary services offered. Please see case examples referred to under each model below for additional details.

2.a. Fixed stand-alone model

Also called a "specialized model", the stand-alone model of SCS is a distinct facility that is dedicated to providing SCS. A stand-alone SCS is typically located in a high traffic area for PWID and in close proximity to local drug scenes and other services for PWID. A stand-alone facility's primary goal is to provide SCS. This type of facility may offer other additional services, such as showers, refreshments, meals, primary care services, counselling, and temporary housing (i.e., shelter). Some facilities (e.g., Frankfurt, Germany) offer opioid agonist treatment (OAT). However, the majority of the facility's staff time and resources are dedicated to the operations of the SCS program. Stand-alone facilities tend to be larger than most other models of SCSs. This type of facility may be closely connected to other local service organizations for PWID via established referral pathways.

As a stand-alone SCS facility primarily serve people who inject illegal drugs, the facility's services can be specifically catered to the needs of PWID. Also, it has been suggested that a stand-alone SCS may better reach clients who actively avoid or do not seek health care services, if they perceive the facility as a place to safely inject their drugs, rather than as a health care facility per se (Wolf et al., 2003). Accordingly, this form of SCS is best utilized in settings with large and more concentrated populations of PWID, including settings with established drug scenes.

Please see **Appendix G**, which describes Insite (Vancouver, Canada) as an example of a fixed stand-alone SCS.

2.b. Integrated model

Globally, integrated facilities are the most common type of SCS. In the integrated model, SCSs are part of larger facilities that offer an array of different services, typically to clients who are unstably housed and/or who inject drugs. Integrated facilities aim to provide comprehensive health and medical care, as well as social services, as a "one-stop-shop" for harm reduction and health care services. The SCS functions as one of several different interlinked services that address the needs of the target client population (please see **Appendix F** for a list of interlinked ancillary services offered in existing SCSs worldwide). Often, integrated facilities are staffed by an interdisciplinary team of health and care professionals (please see **Section 3. Staffing Models**). These facilities tend to be smaller in size and are appropriate in settings where PWID tend to be dispersed.

Including a SCS within a network of services offered within the same facility allows clients to access a range of services without having to travel outside of the facility premises, thereby helping to prevent loss to care, to decrease barriers in access to care, and to ensure continuity of care. Thus, integrated SCSs may more easily provide wrap-around care for clients who face complex health and social challenges.

Generally, in an integrated facility, SCS is provided in a dedicated area and access is limited to clients who have undergone a prior assessment and have been appropriately screened for eligibility (please see **Section 5. Screening and Informing Clients**). It is important to clearly demarcate spaces where drug injection can take place within the facility and where it cannot, so that clients who are not using the SCS (i.e., may be trying to reduce or avoid illegal drug use) can easily avoid these areas.

Please see **Appendix H**, which describes the Dr. Peter Centre (Vancouver, Canada) as an example of an integrated facility.

2.c. Embedded model

Some SCSs may also be embedded in other models of service and care that traditionally do not allow non-medical drug use, such as supportive housing environments and acute care settings. These settings are well suited for SCSs because they tend to be frequented by PWID.

Supportive housing environments that offer SCS tend to be similar to integrated facilities, in that they provide a multitude of low-threshold services for marginalized and unstably housed individuals who may or may not use drugs. Housing environments can be overnight shelters or residential care. In the Dr. Peter Centre's 24-hour Licensed Nursing Care Residence, registered nurses and registered psychiatric nurses supervise injections in the resident's private suite. The Dr. Peter Centre's Section 56 exemption issued by Health Canada identifies the whole Dr. Peter Centre building as "the site", with supervision of injections in the Residence restricted to the resident's suite. Similar to integrated SCSs, it is important for organizers to separate the SCS from the other programs and services and establish eligibility and access criteria for SCS (please see **Section 5. Screening and Informing Clients**). Please see Appendix I, which describes Eastside Facility (Frankfurt) and Abrigado (Luxembourg) as examples of embedded SCSs in housing environments.

Most hospitals operate under an abstinence-based policy and do not allow non-medical drug use or drug paraphernalia on their premises. This has resulted in PWID engaging in high-risk drug use on hospital grounds (such as using drugs alone in a locked bathroom), avoiding accessing hospitals, and leaving hospital against medical advice (McNeil et al., 2014). Meanwhile, PWID have shown willingness to access SCS in a hospital (Ti et al., 2015). Taking a harm reduction approach and providing SCS within acute care settings has the potential to reduce the identified risks and harms related to drug use among PWID who require acute care. The first known embedded SCS to operate in a hospital is at the Lariboisière Hospital in Paris, which opened in October 2016.

Please see **Appendix I**, which describes the Paris facility.

The embedded model is most appropriate in institutions/programs (e.g., hospitals, housing environments) frequented by PWID, and where drug use is occurring on site, despite specific institutional policies that do not allow non-medical drug use.

2.d. Mobile outreach model

If the local drug scene is not centralized in a particular location but rather dispersed across a large geographical area, a mobile outreach model of SCS may be considered. Mobile SCSs may also be most desirable and complimentary in settings where fixed SCS programs already exist but are out of reach for some PWID. Mobile SCSs consist of modified vans or buses that contain injection booths and that can be moved to locations where public drug activities occur. In some jurisdictions, mobile facilities have been shown to be more socially acceptable for local stakeholders, such as police, policy makers, and neighbourhood business associations, than a fixed site. Mobile SCSs are uncommon and known to have operated only in Spain (Barcelona), Germany (Berlin), and Denmark (Copenhagen).

Due to their smaller capacity, mobile facilities can typically see fewer clients per day compared to larger fixed-site facilities. However, mobile facilities can require similar levels of staffing as larger fixed-site facilities, resulting in higher cost per client than fixed-site facilities (Dietz et al., 2012). A small-scale mobile facility may be combined with a larger stand-alone, integrated, or embedded facility as an outreach program for hard-to-reach clients.

Please see **Appendix J**, which describes Berlin's mobile facility.

2.e. Women-only model

Women who inject drugs face a unique set of barriers, challenges, and dangers that are based in gendered power relations and violence. In Vancouver's Downtown Eastside, women who inject drugs who are under the age of 30 are 54 times more likely to die prematurely when compared to the Canadian non-drug-injecting population of the same age, most frequently via homicide (Miller et al., 2007; Spittal et al., 2006). Consuming drugs in public can expose women to potential violence, requiring women to be constantly vigilant, thus interfering with their ability to protect their health (Bourgois et al., 2004). Women who inject drugs also report being subject to hassling or "grinding" by men for money and drugs (Fairbairn et al., 2008).

Women are more likely to need assistance when injecting than men, which puts them at an increased risk for HIV, viral hepatitis, overdose, and other drug-related harms (O'Connell et al., 2005; Wood et al., 2003). Research suggests that women are more likely to seek assistance when injecting due to unequal power relationship, a lack of knowledge of how to inject, and gendered dynamics with their drug-injecting male sexual partners, even when the women know how to self-inject (MacRae & Aalto, 2000; Bourgois et al., 2004; Shannon et al., 2008). Reliance on a male sexual partner for drug injection can expose these women to intimate partner violence, emotional and financial abuse, and elevated risk for HIV infection (Bourgois et al., 2004; Fairbairn et al., 2008; O'Connell et al., 2005).

SCSs have been shown to mitigate experiences of violence by women who inject drugs. The facilities provide these women a protected space in which to inject their drugs, free from concerns about physical, sexual, or intimate partner violence. Women who use SCSs have also reported that SCSs offer them a refuge from hassling by men and allow them to develop the competency to inject themselves, thereby gaining greater autonomy in their drug injection practices (Fairbairn et al., 2008).

Only one SCS in Hambourg, Germany exclusively serves women, with a focus on female sex workers, and is operated by a women-only staff. Another SCS in Biel, Switzerland offers women-only service for two hours per

week. Clients who access these facilities report feeling more relaxed, comfortable, and safe than in a mixed-gender environment (IDPC, 2014).

Organizers of SCSs can support women who inject drugs by:

- Offering women-only space/hours at the facility;
- Providing safer injection and other targeted harm reduction education for women who are non-self-injectors (please see also **Appendix O** under "Non-self-injectors") and for women (or transgender men) who are pregnant (please see also **Appendix O** under "Pregnant users");
- Providing women's health services, such as gynecological care, contraception, and referrals to women-specific health and support services in the area;
- Establishing gender equity and gendered violence policies in the facility, including staff training and codes of conduct for clients (please see also **Appendix M**); and
- Providing peer-run harm reduction and support services specifically for women.

2.f. Opportunities to develop novel approaches to SCS

It should be noted that opportunities to expand the operation and scope of SCS exist. For example, there are some SCS collocated with programs where prescribed injectable opioids are provided. Prescribed injectable opioid treatment has been shown to be highly successful in attracting and retaining PWID in treatment, in reducing their consumption of illegal drugs, and in improving their overall health and social functioning. (Oviedo-Joekes et al., 2009; Strang et al., 2010).

Social media and other technologies may also offer novel opportunities the supervision of drug consumption and could be explored further (i.e., consumption is supervised or PWID notify others of intentions to use via such technologies). These may be particularly useful in more rural or remote settings, provided emergency response is available and can be mobilized in the event of an overdose. Given the lack of experience with such approaches, rigorous evaluation should be undertaken to determine the associated impacts.

3. Staffing Models

Organizers will need to consider the number and type of staff who are involved in providing SCSs, in accordance with the services offered, the facility's budget and capacity (i.e., the number of injecting booths and the number of people injecting at one time), and scope of practice and regulations outlined by professional bodies. For all staff, organizers should outline the roles and responsibilities, workplace safety protocols, policies, and procedures regarding the following:

- Minimum staffing levels, skill-sets, competencies, and training required to carry out SCSs;
- Clear guidance for health professionals regarding scope of practice and competence from appropriate professional regulatory bodies/colleges for physicians and nurses (e.g., College of Physicians and Surgeons of BC [CPSBC], College of Registered Nurses of BC [CRNBC], College of Registered Psychiatric Nurses of BC [CRPNBC], College of Licensed Practical Nurses of BC [CLPNBC]);
- Adherence to relevant legislation as applicable (e.g., in British Columbia and Canada, examples include the *Health Professions Act*, the *Hospital Act*, the *Community Care and Assisted Living Act*, and the *Public Health Act*);
- Any scope of practice or regulatory decisions that affect SCS delivery;
- Health and safety for clients and staff (e.g., non-violent crisis intervention, universal precautions for blood-borne pathogens, needle stick injuries);
- Compliance with regional Occupational Health and Safety policies and procedures and emergency and/or disaster (e.g., fire, bomb threat, earthquake) preparedness and response;
- Compliance with other relevant regional, provincial, federal policies and/or legislation; and
- Cultural competency relating to First Nations and Indigenous peoples, including cultural safety, attention to social determinants of health, and reduction of stigma (please see **Appendix K** for overarching principles of the *BC First Nations and Indigenous People's Mental Wellness and Substance Use – 10 Year Plan*).

When designing the staffing model for a SCS, organizers should balance budgetary concerns with patient safety and risk management, particularly in relation to possible scenarios of overdose and other emergencies.

An example of an optimal staffing model is a team of trained health care workers (e.g., licensed practical nurses, respiratory technicians, paramedics) and peers who provide SCSs for individual clients, with one or two registered nurse (RN) or registered psychiatric nurse (RPN) present in the injecting room. The RN/RPN may not provide ongoing supervision of injections but provides emergency care and injection-related skin and wound care, conducts pre- and post-injection assessment, and initiates referrals to other medical and care services where appropriate. At Insite, the injection room has two staff members, at least one of whom must be an RN. For each staff member, a maximum of seven injecting clients are permitted at a time (for a total maximum of 13 clients at a time for the 13 injecting booths). A separate treatment room for basic clinical care, consults, and medical emergency is staffed by one RN on an as-needed basis and can accommodate one client at a time.

Organizers may also consider having staff, who are not part of licensed professions, but who have received training in order to provide emergency overdose response. These staff members can be allied health professionals (such as mental health workers) or peers. Although the current exemption under Section 56 of the *Controlled Drugs and Substances Act* requires that only licensed medical and health professionals be authorized to administer SCS, there have been local successes with expanding the role of allied health professionals and peers in SCSs. Further, past feasibility work has shown that PWID value the inclusion of peers within SCSs, and feel that their inclusion in the injecting room would be an asset (Kerr et al., 2003). There is also local evidence

indicating a preference for peer-operated SCS (McNeil et al.,2014), and accordingly efforts should be made to further explore, implement, and evaluate this model of SCS. The federal government of Canada is currently reviewing the Act's restrictions, including those that restrict the involvement of peer staff and other allied health professionals. Peer staff should be appropriately compensated and provided with opportunities to engage in further skills training and education, as well as provided with support around self-care and stress management.

In addition to medical, nursing and other staff to administer supervised consumption and provide related medical services, organizers should include other allied health and non-health professional staff for ancillary services offered in the facility, such as: counsellors, social workers, health care managers, health educators (e.g., nurse educator, social worker, PWID peer educator), and community mental health workers. Also, where appropriate, organizers should engage First Nations and Indigenous Elders, traditional healers, and liaisons at various levels of service and care delivery, including the design of the SCS.

Most existing SCSs, particularly integrated SCSs, are staffed by an interdisciplinary team of health and allied care professionals. All providers on the SCS site should receive training in basic health and safety for clients and staff. The involvement of peers has been identified as important within SCSs, with past feasibility work indicating that most PWID prefer having peer workers present within SCSs (Kerr et al., 2003). Indeed, peer workers have been a part of Insite since its opening and they continue to work there to this day. While some European SCSs employ social work students, we recommend that organizers avoid this as the high turn-over of staffing when using students is difficult for this vulnerable population who may have difficulty forming relationships of trust and benefits associated with having a nurse present may be lost. If a licensed social worker is not available, consider expanding the role of the registered nurse. It has been shown that nurses are able to provide education around safer injection and support for non-self-injectors (please see **Appendix O** for more details about this group) (Wood et al., 2008).

The specific number of staff, staff hours, and the ratio between medical and allied care staff should reflect the size of the SCS and the organizers goals and desired outcomes.

3.a. Pre- and post-injecting procedures and staffing

Organizers should clearly map out the client's footpath when accessing the SCS. In particular, for each of the steps listed below, organizers should consider where the step will take place in the facility, which (and how many) staff members will be involved, what the staff's responsibilities and roles are, and what the appropriate procedures and protocols (including documentation) are:

- Intake/Assessment;
- Injection room;
- Harm reduction/safer injection education;
- Disposal of injection equipment;
- Treatment room (for basic nursing/medical care and responding to overdose); and
- Post-injection area.

In addition to injection-specific procedures, facility organizers should consider the appropriate staff member who will provide ancillary services, such as counselling, peer support, and referrals, and the number of hours they will be available, based on the needs of clients.

3.b. Alternative staffing models

Although an optimal staffing model would have RNs/RPNs available during all hours of operation of a SCS, it is recognized that this may not be possible in many situations, including rural facilities, limited resource settings, and situations where health care worker availability is limited. Because the latter two constraints may be present even in densely populated urban settings, organizers may consider the use of unregulated care provider employees, provided that adequate job descriptions, consent agreements, emergency protocols, training, and documentation are in place.

In BC, provincial colleges for regulated health professionals (e.g. College of Physicians and Surgeons of BC [CPSBC], College of Registered Nurses of BC [CRNBC], College of Registered Psychiatric Nurses of BC [CRPNBC]) all recognize settings where it is necessary for a physician or nurse to allow an unregulated care provider to perform a task within the professionals' scopes of practice. In British Columbia, detailed guidance policies regarding delegation and assignment of tasks are available for the CRNBC and the CRPNBC. Experience from the Take Home Naloxone (THN) Program, pilot projects with homeless shelters, and the development of overdose protocols for residential facilities has demonstrated that lay providers can be efficiently trained to recognize overdoses, call emergency services, administer naloxone, and perform basic life support, if needed.

In facilities that are owned, operated, or funded by BC Health Authorities, such life-saving tasks would usually fall under the scope of practice of an employee who is a regulated health care professional. However, when it is necessary for an unregulated provider to perform these tasks, delegation or assignment is necessary. An act of delegation is specific from one regulated professional to one unregulated provider for one client. Meanwhile, an act of assignment can be made from one regulated professional to multiple unregulated providers for multiple clients. Consequently, assignment may be the preferred mechanism for using unregulated providers in SCSs. Further details on delegation and assignment can be found at:

https://www.crnbc.ca/Standards/Lists/StandardResources/98AssigningDelegatingUCPs.pdf

http://www.crpnbc.ca/wp-content/uploads/2011/02/unregulated_providers.pdf

4. Clinical Practice

It is important for organizers to establish clear procedural protocols and polices with regard to SCSs, as well as the role of each staff member who is authorized to provide supervision and/or provide clinical support. Typically, clinical protocols and policies address the following:

- Intake, registration, and assessment for toxicity and specific health care needs, such as vein care, abscess management, sepsis from soft tissue injuries, and other symptoms;
- Drug injection room procedures (including provision of equipment);
- Disposal of used drug injection equipment;
- Response to unidentified substances left behind on premises (i.e., methods of containment, storage, and notification of local police department for removal);
- Safer injection/harm reduction education;
- Provision of naloxone and associated training;
- Post-injection care procedures (including assessment for sign/symptoms of soft tissue injury and medical emergencies);
- Treatment/clinical room procedures (for abscesses, cellulitis, vein care, infection, etc.);
- Overdose response (see below); and
- Responding to pregnant, breastfeeding, under-age, overtly aggressive or intoxicated participants, and clients who are on opioid substitution therapy or consuming alcohol concurrent to drug use.

The protocols and policies may involve step-by-step procedures, documentation (e.g., charts), and referral pathways within the facility or outside the facility if the service is in another organization.

4.a. Overdose

Although there has been no reported drug-related overdose death in SCSs, organizers must have clear protocols and policies to deal with potential overdoses. The protocols and policies should address:

- Staff education and training;
- Overdose equipment;
- Overdose intervention procedures;
- Expected patient outcomes;
- Assessment procedures;
- Overdose reversal therapy (i.e., naloxone hydrochloride);
- Manual ventilation;
- Responding to cardiac and/or respiratory arrest; and
- Procedures for transferring care to paramedics and emergency departments.

Organizers should also identify the appropriate medical/health professional staff who is authorized to provide response to overdose. For an example of overdose protocol, please see **Appendix L**.

4.b. Harm reduction principles

It is important for organizers to adopt clinical practices that are in line with the principles of harm reduction as described in provincial harm reduction guidelines, such as *Harm Reduction: A British Columbia Community Guide* (2002) and *Following the Evidence: Preventing Harms from Substance Use in BC* (2006). Specifically:

- **Pragmatism**: Accept that non-medical use of psychoactive or mood altering substances is a near-universal human cultural phenomenon;
- **Human rights**: Respect basic human dignity and rights of PWID, including right to self-determination and informed decision making, in a judgment-free context;
- **Focus on harms**: Prioritize decreasing the negative consequences of drug use to the person and others and recognize incremental changes as success;
- **Maximize intervention options**: Recognize that there are a variety of different prevention or treatment approaches and PWID should be able to choose and access a broad range of interventions;
- **Priority of immediate goals**: Meet the person where they are in their drug use and address immediate needs first; and
- **Drug user involvement**: Involve PWID as an active participant in their own care and in the planning of harm reduction policies and interventions. Recognize PWID's competency to make choices and change their own lives.

Organizers should consider how the SCS's clinical practices are part of a continuum of responses to substance use and its related harms and are consistent with the principles of low-threshold service delivery. This can include integrating drug checking as an ancillary or complementary service to help deter unintended injection of dangerous substances, such as fentanyl,[4] or the provision of injectable opioids.

Organizers should also ensure that clinical practices are culturally, demographically, and gender appropriate. For example, when working with First Nations and Indigenous clients, organizers and clinical staff should ensure that facility staff are respectful of Indigenous cultural knowledge and practices, are aware of inter-generational impacts of colonization (e.g., trauma, poverty, addiction and substance use), and do not inadvertently perpetuate systemic racism and discrimination. Where needed, organizers should ensure that traditional healers and Elders are available for these clients, either within the facility as staff or through referral pathways outside the facility.

4.c. Integrating addiction treatment and recovery services into SCSs

It is important to stress that harm reduction generally and SCSs specifically are not inconsistent with the provision of referrals and expanded access to addiction treatment and recovery-oriented services. Specifically, SCSs have been shown to increase the uptake of entry points into the addiction care continuum, including

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4. In November 2016, the federal Standing Committee on Health Interim Report on the opioid crisis recommended piloting drug checking for fentanyl. Please see http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=e&Mode=1&Parl=42&Ses=1&DocId=8597271
5. The participants of the National Summit on Addiction Recovery, which drafted the National Commitment document used the American Society of Addiction Medicine's definition of recovery, which was established in 2013. For the full document, please see http://www.asam.org/docs/default-source/public-policy-statements/1-terminology-atr-7-135f81099472bc604ca5b7ff00003ob21a.pdf?sfvrsn=0

withdrawal management services and addiction treatment among PWID who access the facilities (Wood et al., 2007; DeBeck et al., 2011). Beyond acute addiction care needs, SCSs must also integrate mechanisms to support entry into recovery services. For the purposes of this guideline, the definition of recovery is derived from the definition used in the Canadian Centre for Substance Abuse's *A National Commitment to Recovery from the Disease of Addiction in Canada* (2015),[5] which defines recovery as:

> A process of sustained action that addresses the biological, psychological, social and spiritual disturbances inherent in addiction. Recovery aims to improve the quality of life by seeking balance and healing in all aspects of health and wellness, while addressing an individual's consistent pursuit of abstinence, impairment in behavioral control, dealing with cravings, recognizing problems in one's behaviors and interpersonal relationships, and dealing more effectively with emotional responses. An individual's recovery actions lead to reversal of negative, self-defeating internal processes and behaviors, allowing healing of relationships with self and others.

To achieve these goals, health care providers at SCSs should actively make clients aware of available addiction treatment services and continuously assess clients for willingness to access treatment programs for addiction and substance use (i.e., ambulatory treatment). Providers should also discuss with willing clients about the type of program that is most suitable to their needs and interests which should include peer support, opioid agonist therapy, addiction medicine specialist consultations where available and recovery-oriented housing and treatment programs. Importantly, service providers at SCSs should establish fully functioning referral pathways to addiction treatment programs for substance use in their local area, including:

- Ambulatory addiction treatment programs;
- Inpatient and residential treatment programs;
- Recovery-oriented services include peer-support programs and other resources;
- Where relevant, medically managed outpatient withdrawal management programs at community health centres that provide linkages to addiction treatment, including opioid agonist treatments;
- Where relevant and available:
    - youth-focused ambulatory and residential addiction services;
    - women-only ambulatory and residential addiction services; and
    - Indigenous ambulatory and residential addiction services;
- Supportive recovery (abstinence-based) housing;
- Opioid agonist treatment; and
- Addiction medicine specialist consultation, where available.

All efforts should be made to link clients to a family physician or integrated care teams whenever possible.

4.d. Code of conduct/rights and responsibilities

In order to ensure safety of clients and staff, a SCS should establish a code of conduct or "house rules" that outline the rights and responsibilities of clients as well as staff. It is recommended that organizers develop the code/rights and responsibilities in consultation with clients to ensure that PWID are active participants in their

own harm reduction practices and to build rapport between the facility and local PWID. Typically, these codes/rules, many of which are imposed by federal exemption guidelines, include parameters that:

- Restrict drug consumption to specifically designated areas;
- Prohibit dealing or sharing drugs on site;
- Prohibit clients from physically assisting other clients in injecting drugs;
- Prohibit staff from physically assisting clients in injecting drugs;
- Prohibit staff from providing illegal drugs to clients;
- Prohibit staff from providing clients information on where or how to obtain illegal drugs;
- Prohibit staff from taking control or possession of illegal drugs at any time (any drug left behind to be stored in a locked cabinet and local police department to be notified and asked to remove the substance)
- Limit the amount of time clients can use drug consumption rooms/booths in one sitting (typically 30-45 minutes);
- Prohibit loud or offensive language and threatening or intimidating staff and other clients;
- Require clients to clean up after using drug consumption space and to dispose of used materials in designated disposal receptacles;
- Encourage clients to help keep the facility clean and to collect drug-related debris in the facility's vicinity;
- Remind clients and staff that clients are entitled to non-judgmental service from staff and a clean, peaceful environment in which to inject their drugs; and
- Remind clients and staff that staff reserve the right to refuse service if the client does not meet the eligibility criteria (see **Section 5. Screening and Informing Clients**) or does not adhere to house code/rules.[6]

Please see **Appendix M** for Insite's Code of Conduct and Rights and Responsibilities of Participants.

6. List adapted from Broadhead et al., 2002.

5. Screening and Informing Clients

It is important for SCSs to be low-threshold and low-barrier, but it is equally important for these facilities to establish eligibility criteria for services and to inform clients about drug use and harm reduction strategies, in order to ensure the safety of clients and staff and to minimize risks, such as overdose.

5.a. Eligibility and user agreement

There should be an intake procedure for first time clients to a SCS that includes:

- Screening for eligibility;
- Informing the client about the risks of non-medical substance use;
- Informing the client about expectations, rules and protocols for using SCS (see **4.c Code of Conduct/ Rights and Responsibilities** for examples);
- Informing the client about their rights and responsibilities when using SCS (see **4.c Code of Conduct/ Rights and Responsibilities** for examples);
- Informing the client about any data collection for monitoring, evaluation or research purposes, as well as appropriate ethical considerations; and
- Assessing client for any need for specific physical care, their knowledge of harm reduction techniques and ability to apply these to drug-use, as well as their knowledge of harm reduction services.

Appropriate forms and written protocols (e.g., user agreements and consent form) should be in place. Please see **Appendix N** for Insite's user agreement form.

Typically, SCSs have specific protocols for the following groups:

- First time users;
- Youth (under 19 years of age);
- Pregnant users;
- Non-self-injectors (i.e., needs the assistance of someone else to inject); and
- Overtly intoxicated clients.

The above groups are generally considered to be high-risk and need special considerations and related procedures (please see **Appendix O**).

5.b. Refusal of service

A SCS reserves the right and obligation to refuse service if the staff deems that drug consumption will potentially put the client in danger to themselves or others, if the client does not adhere to the code of conduct or house rules, if the facility is full, or for other reasons pre-determined by the facility organizers. It is important for a facility to clearly outline and communicate the protocols, policies, and procedures around refusal of service to clients and staff (please see **Appendix P** for Insite's protocols for refusal of service).

6. Security and the Safety of Clients and Workers

Although the vast majority of PWID pose no threat to others, mental health issues, stimulant use, withdrawal, and chaotic situations may occasionally lead to uncontrolled behaviours in some clients. Such behaviours may place staff and other clients at risk. Further, overdose can occur anywhere in a SCS. Therefore, proper visibility and monitoring of clients at all times are also critical to preventing overdose deaths.

While ensuring that services are as accessible as possible, SCS operators should also ensure that the facility layout, staffing, training, and protocols minimize security issues and maximize safety. Consideration of the following features should be included in the planning process of SCS sites:

- Secure entrances and exits that ensure the ability to manage client flow (i.e., it is ideal for all rooms two have two potential exits);
- Open layout for the drug injection area with open sight lines so that all clients and staff are visible at all times;
- Adequate lighting in all areas;
- Use of mirrors in any areas not directly visible, including drug injection booths, to monitor client activity and level of consciousness;
- Video monitoring of entrances, exits, and drug injection area as appropriate and in accordance with local privacy legislation/guidelines;
- Adequate ventilation to prevent secondhand exposure to drugs that are heated prior to injection;
- Personal protective equipment (PPE), such as gloves, aprons, gowns, masks, eye goggles, and sharps containers (please see your regional Occupational Health and Safety policies and procedures);
- Minimum staffing levels appropriate for client load; and
- Ability to access back-up staff or security personnel, as necessary.

Clients should be made aware of the security features during their initial screening intake, in addition to being informed of the codes of conduct. It should be emphasized that these features help to ensure the safety of both client and staff. Demonstration of adequate site security may also help to increase the confidence and buy-in of local stakeholders, such as police, policy makers, and community groups and partners.

6.a. Conflict management

There may be instances where SCS staff are required to respond to a crisis situation and/or aggressive behaviour by a client. Each situation will be unique and all facility staff should be trained in crisis management and de-escalation techniques to ensure the safety of all clients and staff. Please see **Appendix Q** for Insite's protocols for crisis management and **Appendix R** for Insite's protocols for the management of escalating aggressive behaviours.

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Appendices

Appendix A: Feasibility assessment study

SCS feasibility studies have been undertaken in numerous settings and can be completed quickly and at low cost. Such studies typically involve administering a short survey to a representative sample of local PWID. Typically, 100-300 surveys are sufficient, and local harm reduction programs, PWID groups, outreach, recruitment posters, and word of mouth can be used to recruit local PWID to participate in the survey. Please see **Appendix C** for an example of a survey for PWID (which organizers can modify and shorten to fit their needs, goals, and time constraints), and **Appendix D** for examples of consent forms for survey interviews. Domains typically assessed through SCS feasibility surveys include:

- Sociodemographic characteristics;
- Drug use patterns and related behaviours (e.g., syringe sharing, injecting in public and semi-public spaces, overdose);
- Willingness to use a SCS; and
- SCS location and design preferences.

Such feasibility work may also be supplemented with semi-structured qualitative interviews with key stakeholders, including local health care professionals, policy makers, police, and neighbourhood business associations (see **Appendix E** for examples of interview guides).

Appendix B: Community consultation and engagement process

The following is a guide on community engagement and consultation for the purpose of establishing a supervised consumption service (SCS) and successfully integrating the SCS into public health and health care services as well as the broader community. It reflect the Dr. Peter Centre's experience with community consultation and engagement over the years. Organizations and communities are encouraged to adapt, build upon, or incorporate successes from previous community consultation experiences, including integration of culturally-based engagement practices.

Objectives:

To establish a respectful community engagement process that supports SCS organizers to engage the communities in order to improve understandings of:

a) Harm reduction as a necessary part of Public Health and substance use services, including the lifesaving and ongoing health benefits of providing overdose prevention measures, blood-borne pathogen prevention, safer injection practices and supervised consumption service;

b) The implementation of emergency overdose prevention sites into residential and other locations (if applicable); and

c) The planned SCS, as part of a continuum of care at the location, including nursing, social services referrals, etc.

Two processes are outlined: key stakeholder consultation and a broader community consultation. Both contribute to meeting Health Canada's requirement that an application for a Section 56 exemption to the federal *Controlled Drugs and Substances Act*). The Community Advisory Committee (CAC), referenced in the key stakeholder process, is a valuable tool for both the organization and key stakeholders. It provides an opportunity for ongoing communication and collaborative problem-solving on issues or misunderstandings that may arise related to SCS operations. In time, with relationships established and better understanding of SCSs, the frequency of, and need for, the committee can be re-evaluated.

1. Key Stakeholder Consultation and Engagement

a) Develop Terms of Reference for Community Advisory Committee (CAC). This document should include an overall purpose of the CAC, its composition, duties and responsibilities, and process (e.g., frequency of meetings);

b) Develop a key stakeholder list for the CAC, which may include:

- RHA-designated key staff at proposed location,
- Local Business Improvement Association or Chamber of Commerce,
- Police department representative for geographic area,
- Health/social service organizations with links to proposed location,
- Local businesses adjacent to proposed location,
- Housing complexes adjacent to proposed location,
- Local hospital with links to proposed location,
- Local Indigenous nation representative,
- Representative from advocacy group for PWID.

c) Identify lead staff for planning and executing details of key stakeholder consultation and engagement process, including facilitators and recorders for meetings;

d) Hold key stakeholder consultation meetings. Suggested agenda items for the meetings include: Q&A about supervised consumption, feedback on the proposed SCS model, and individual feedback. It is recommended that media not be permitted in these sessions;

e) If the proposed SCS will be located inside an existing agency/service, develop a tour plan for proposed location, including a walkthrough of proposed service locations, such as waiting area, injection areas, and post-injection area;

f) Develop facilitator script and process for meetings, which may include:

- Ground rules around safety, giving everyone a chance to speak, and recognizing differences in experiences, perspectives, and opinions;
- Emphasis on information sharing about SCSs, receiving feedback, and hear concerns, not to engage in a debate;
- Definition of SCS and goals of proposed SCS operations; and
- Verbal feedback during the meeting and written feedback on prepared cards/sheets.

g) Develop a sketch of the location's proposed SCS space (if area bears some additional description);

h) Develop Frequently Asked Questions (FAQ) sheets, which may include:

- What is it you are proposing to do?
- What is a supervised consumption service?
- Why provide SCS? (To develop the answer, please see **1.a. Background and Evidence** for impacts of SCSs.)
- Do SCSs already exist? (To develop the answer, please see **1.a. Background and Evidence** and **Appendices G-J** for examples of existing SCSs in Canada and elsewhere)
- Why a SCS at the proposed location? (To develop the answer, please see **Appendix A** for how to conduct a feasibility assessment study to help answer this question.)
- Why would someone use a SCS? (To develop the answer, please see **1.a. Background and Evidence**.)
- What is the process/timeline for this service at the proposed location?
- How will it work here? What will it look like? (To develop the answer, please see **Appendices G-J** for examples of different models of SCSs.)
- How will it impact our current services and clients?
- Won't this service trigger people who are trying to quit or using drugs? (To develop the answer, please see **1.a. Background and Evidence**.)

i) Develop a take-away packet of information;

j) Develop feedback sheets, which may include open-ended questions about what participants like/don't like/would change about various parts of the SCS, such as the proposed pre-injection waiting area, injection room, post-injection drop-in area, and linkages to service.

k) Initiate personal contact with each identified key stakeholder; invite for a tour and to participate in your CAC; consider more than one key stakeholder per tour, when assessed that the key stakeholders would have similar knowledge base and common interests.

2. Community Consultation and Engagement

a) Identify the geographic area that would be considered the most proximal community identified with your location;

b) If at all possible, hold the tours at the proposed location, using the same tour plan, as used in the key stakeholder consultation; if necessary to hold meetings off site, using photos of current site and sketch of proposed SCS space and adjust script accordingly;

c) Determine the number of meetings of groups of 15 that it would be reasonable to undertake, e.g. Sandy Hill set a target of 200 registrants, limited each group to 15, and held three simultaneous group sessions per evening;

d) Consider most effective methods to promote and attract participants to community consultation sessions;

e) All the tools in **1. Key Stakeholder Consultation and Engagement** above are adjusted for the group sessions.

Appendix C. Sample feasibility survey for PWID

Note: The following document is a comprehensive survey questionnaire that captures various types of information needed to assess the feasibility and potential uptake of SIS among PWID. Organizers of SISs are encouraged to adapt and shorten the questionnaire according to their needs and specificities of the local PWID and drug scene.

SECTION 1. DEMOGRAPHIC INFORMATION

READ: To begin, I'd like to ask you some questions about yourself. We are asking everyone the same questions.

1. Have you injected drugs in the **last 6 months**?
   ❒ Yes ❒ No ***(If no, terminate the interview)***

2. Have you injected drugs in the **last 30 days**?
   ❒ Yes ❒ No

3. In which year were you born?
   Year: _____ ❒ Refused to answer

READ: In this study, we are trying to reach a diversity of people including men, women, and transgender people. We are asking these questions to everyone to ensure we capture accurate information.

4. What sex were you assigned at birth (e.g., on your birth certificate)?
   ❒ Female ❒ Male ❒ Refused to answer

5. What is your current gender identity? ***(Do NOT read out list. Check ONE only.)***
   ❒ Female ❒ Male
   ❒ Trans woman (male-to-female) ❒ Trans man (female-to-male)
   ❒ Other: _____ ❒ Refused to answer

6. How do you identify your sexual orientation? ***(Do NOT read out list. Check ONE only.)***
   ❒ Straight/Heterosexual ❒ Gay/Lesbian
   ❒ Bisexual ❒ Other: _____
   ❒ Refused to answer

7. What is your first language? ***(Do NOT read out list. Check ONE only.)***
   ❒ English ❒ French
   ❒ Ojibwa ❒ Cree
   ❒ Oji-Cree ❒ Other: _____
   ❒ Refused to answer

8. Some people identify with an ethnic group or cultural background. To which ethnic or cultural group do you feel you belong? ***(Read out list. Check ALL that apply.)***

❒ White
❒ First Nations
❒ Inuit
❒ South Asian
❒ Arab/West Asian
❒ Other: _____
❒ Black
❒ Metis
❒ Francophone
❒ Southeast Asian
❒ Latin American/Central American/South American
❒ Refused to answer

9. How long have you been living in **[name of city]**?

❒ Less than 1 year (Specify # of months: _____) ***(Skip to Question 14)***
❒ More than 1 year (Specify # of years: _____) ***(Skip to Question 14)***
❒ Don't live in the city (visiting) ***(Continue to Question 10)***
❒ Refused to answer

10. In which neighbourhood do you usually live? ***(Show NEIGHBOURHOODS prompt card. Check ONLY one.)***
IF PARTICIPANT LIVES IN A [NAME OF CITY] NEIGHBOURHOOD, GO TO QUESTION 14.
IF NOT LIVING IN [NAME OF CITY], PROCEED TO QUESTION 11.

11. Have you **ever** lived in **[name of city]**?

❒ Yes ❒ No ❒ Refused to answer

12. Why do you come to **[name of city]**? ***(Read out list. Check ALL that apply.)***

❒ To visit friends/family
❒ To buy/use drugs
❒ For methadone
❒ To shop
❒ Other: _____
❒ To work
❒ To use a health service
❒ To attend a support group
❒ To visit a needle distribution program
❒ Refused to answer

13. How often do you come to **[name of city]**? ***(Read out list. Check ONE only.)***

❒ Less than once per month
❒ Once per week
❒ Daily
❒ Refused to answer
❒ 1-3 times per month
❒ More than once per week
❒ Never

14. Please list all the places that you have lived in the **last 6 months**.
(Do NOT read out list. Check ALL that apply.)

- ❒ A place where people gather to use drugs (crack house)
- ❒ Hospital
- ❒ Hotel/motel room rented on a daily/weekly basis
- ❒ House/apartment (my own or partner's)
- ❒ House/apartment (someone else's—relative or friend)
- ❒ No fixed address (couch surfing, "here and there")
- ❒ On the street (abandoned buildings, cars, parks)
- ❒ Prison/jail/detention centre
- ❒ Rehab
- ❒ Rooming/boarding house
- ❒ Shelter/welfare residence
- ❒ With my parents
- ❒ Medical hostel (live-in home/rehabilitation centre)
- ❒ Transitional housing
- ❒ Other: _____
- ❒ Refused to answer

15. Of the places you listed, where did you live **most** of the time?
(Do NOT read out list. Check only ONE response from Question 14)

- ❒ A place where people gather to use drugs (crack house)
- ❒ Hospital
- ❒ Hotel/motel room rented on a daily/weekly basis
- ❒ House/apartment (my own or partner's)
- ❒ House/apartment (someone else's—relative or friend)
- ❒ No fixed address (couch surfing, "here and there")
- ❒ On the street (abandoned buildings, cars, parks)
- ❒ Prison/jail/detention centre
- ❒ Rehab
- ❒ Rooming/boarding house
- ❒ Shelter/welfare residence
- ❒ With my parents
- ❒ Medical hostel (live-in home/rehabilitation centre)
- ❒ Transitional housing
- ❒ Other: _____
- ❒ Refused to answer

16. Are you **currently** living with anybody who is a current injection drug user?

❒ Yes
❒ No ***(Skip to Question 18)***
❒ Don't know/Unsure ***(Skip to Question 18)***
❒ Refused to answer ***(Skip to Question 18)***

17. ***(If yes)*** Is that person…? ***(Read out list. Check ALL that apply.)***

❒ Boyfriend/girlfriend/partner ❒ Casual sex partner ❒ Close friend
❒ Casual friend/acquaintance ❒ Family member ❒ Someone I don't know
❒ Other: _____ ❒ Refused to answer

18. What is the highest level of education that you have **completed**? ***(Read out list. Check ONE only.)***

❒ Primary School ❒ High School
❒ Any college/university ❒ Refused to answer

READ: In this section, I am going to ask you some questions about your income, including both formal and informal sources. We ask about informal income because many people in this study report getting at least some money through informal sources in order to make ends meet. Because people's health is greatly affected by the amount of their income, we want to understand how people make enough money to live, and how this may impact their health.

19. About how much money did you get (formally and informally) altogether from all sources **last year**? ***(Do NOT read out list. Check ONE only.)***

❒ Under $10,000 ❒ $10,000 - $19,999 ❒ $20,000 - $29,999
❒ $30,000 - $39,999 ❒ $40,000 - $49,999 ❒ $50,000 or more
❒ Don't know/Unsure ❒ Refused to answer

20. Over the **last 6 months**, what were your sources of income? ***(Do NOT read out list. Check ALL that apply.)***

❒ Regular job ❒ Temporary work
❒ Self-employed ❒ Recycling (binning, buys/sell)
❒ Panhandling ❒ OW (Ontario Works)
❒ Stipend/honoraria ❒ Ontario Disability Support Program (ODSP)
❒ CPP (Canadian Pension Plan) ❒ EI (Employment Insurance)
❒ GST rebate ❒ Parent/friend/relative/partner
❒ Theft/robbing/stealing ❒ Selling needles
❒ Selling cigarettes/tobacco ❒ Selling drugs
❒ Other criminal activity ❒ Sex for money
❒ Other: _____ ❒ Refused to answer

21. In the **last 6 months** have you received any of the following for sex? ***(Read out list. Check ALL that apply.)***

❒ Money
❒ Drugs
❒ Gifts
❒ Shelter
❒ Food
❒ I have not exchanged any items for sex in the past 6 months
❒ Other: _____
❒ Refused to answer

SECTION 2. DRUG USE & INJECTION PRACTICES

READ: Now I am going to ask you some questions about your drug use and injecting practices. Again, we are asking everyone the same questions.

22. How old were you the first time you injected drugs (shot up/fixed) or were injected by someone else?

Age: _____ ❒ Refused to answer

23. In the **last 6 months**, how often did you inject drugs?
(Read out responses. Show FREQUENCY (1) prompt card. Check ONE only.)

❒ Less than once per month ❒ 1-3 times per month
❒ Once per week ❒ More than once per week
❒ Daily ❒ Never
❒ Refused to answer

24. Have you **ever** re-used a needle for more than one injection?

❒ Yes
❒ No ***(Skip to Question 26)***
❒ Refused to answer ***(Skip to Question 26)***

25. ***(If yes)*** On average, what percentage of injections are done with a needle you have already used?
(Read out list. Check ONE only).

❒ Always (100% of the time) ❒ Usually (over 75%)
❒ Sometimes (26-74%) ❒ Occasionally (<25%)
❒ Never ❒ Refused to answer

26. On a day when you do inject, how many times a day do you usually inject on average?

Times: _____ ❒ Don't know/Unsure ❒ Refused to answer

27. In the **last 6 months**, in which **[name of city]** neighbourhoods did you inject?
(Do NOT read out list. Show NEIGHBOURHOODS prompt card. Check ALL that apply.)

28. Of the neighbourhoods which you have mentioned, in which neighbourhood did you inject most often? ***(Do NOT read out list. Check ONLY ONE under 2.4.)***

READ: Now I am going to ask you some more details about the places where you've injected drugs in the **last 6 months**.

29. In the **last 6 months**, have you injected in (places)? ***(Read list out. Check ALL that apply)***

- ❒ A sexual partner's place
- ❒ Your own place (if different from sexual partner's place)
- ❒ A relative or friend's place
- ❒ An acquaintance's place
- ❒ A stranger's place
- ❒ A place which you pay to use/exchange drugs
- ❒ An abandoned building
- ❒ A parking lot
- ❒ An alley/laneway
- ❒ A park
- ❒ In a stairwell/doorway of a store/office/other building
- ❒ A car
- ❒ A public washroom/toilet (e.g. library)
- ❒ A hotel/motel
- ❒ A place where you buy drugs
- ❒ A shelter
- ❒ A community-based organization or service provider
- ❒ Other places I haven't mentioned: _____
- ❒ Refused to answer

30. Where do you inject most often in the **summer** months? ***(Check ONE only)***

- ❒ A sexual partner's place
- ❒ Your own place (if different from sexual partner's place)
- ❒ A relative or friend's place
- ❒ An acquaintance's place
- ❒ A stranger's place
- ❒ A place which you pay to use/exchange drugs
- ❒ An abandoned building
- ❒ A parking lot
- ❒ An alley/laneway
- ❒ A park
- ❒ In a stairwell/doorway of a store/office/other building
- ❒ A car
- ❒ A public washroom/toilet (e.g. library)
- ❒ A hotel/motel
- ❒ A place where you buy drugs
- ❒ A shelter
- ❒ A community-based organization or service provider
- ❒ Other places I haven't mentioned: _____
- ❒ Refused to answer

31. Where do you inject most often in the **winter** months? ***(Check ONE only.)***

- ❒ A sexual partner's place
- ❒ Your own place (if different from sexual partner's place)
- ❒ A relative or friend's place
- ❒ An acquaintance's place
- ❒ A stranger's place
- ❒ A place which you pay to use/exchange drugs
- ❒ An abandoned building
- ❒ A parking lot
- ❒ An alley/laneway
- ❒ A park
- ❒ In a stairwell/doorway of a store/office/other building
- ❒ A car
- ❒ A public washroom/toilet (e.g. library)
- ❒ A hotel/motel
- ❒ A place where you buy drugs
- ❒ A shelter
- ❒ A community-based organization or service provider
- ❒ Other places I haven't mentioned (Specify: _____)
- ❒ Refused to answer

32. In the **last 6 months**, how often did you inject in public or semi-public areas like a park, an alley or a public washroom? ***(Read out list. Show FREQUENCY (2) prompt card. Check ONE only.)***

❒ Always (100% of the time) ❒ Usually (over 75%)
❒ Sometimes (26-74%) ❒ Occasionally (<25%)
❒ Never ❒ Refused to answer

33. What are some of the reasons you inject in public? ***(Read out list. Check ALL that apply.)***

❒ It's convenient to where I hang out
❒ There is nowhere to inject safely where I buy drugs
❒ I'm homeless
❒ I'm involve din sex work and don't have a place to inject
❒ I don't want the person I'm staying with to know I use/am still using
❒ I'm too far from home
❒ I need assistance to fix
❒ I prefer to be outside
❒ Guest fees at friend's place, but I don't want to pay
❒ Dealing/middling (connecting sellers to purchasers)/steering (guiding potential buyers to selling)
❒ Other: _____
❒ Refused to answer

34. In the **last 6 months**, have you used water from a puddle, public fountain or other outside source to prepare your drugs or rinse your needles?

❒ Yes ❒ No ❒ Refused to answer

35. Have you **ever** injected alone?

❒ Yes
❒ No ***(Skip to Question 37)***
❒ Refused to answer ***(Skip to Question 37)***

36. In the **last 6 months**, how often did you inject alone?
(Read out list. Show FREQUENCY (2) prompt card. Check ONE only.)

❒ Always (100% of the time) ❒ Usually (over 75%)
❒ Sometimes (26-74%) ❒ Occasionally (<25%)
❒ Never ❒ Refused to answer

37. Have you **ever** needed help to INJECT drugs?

❒ Yes
❒ No ***(Skip to Question 42)***
❒ Refused to answer ***(Skip to Question 42)***

38. ***(If yes)*** How often in the **last 6 months** did you need help when injecting?
(Read out list. Show FREQUENCY (2) prompt card. Check ONLY one.)

❒ Always (100% of the time)
❒ Usually (over 75%)
❒ Sometimes (26-74%)
❒ Occasionally (<25%)
❒ Never
❒ Refused to answer

39. Why do you need help with injecting? ***(Read out list. Check ALL that apply.)***

❒ I don't know how to inject myself
❒ I don't like injecting myself
❒ I can't find a vein on my own
❒ I need help to prepare my own drugs
❒ I prefer someone else to inject me
❒ My partner prefers to inject me
❒ Unsafe to do jugging alone
❒ Other: _____
❒ Refused to answer

40. Who helps you to inject drugs? ***(Read out list. Check ALL that apply.)***

❒ Boyfriend/girlfriend/partner
❒ Stranger
❒ Casual sex partner
❒ Close friend
❒ Casual friend/acquaintance
❒ Date (sex worker)
❒ Family member
❒ Other: _____
❒ Refused to answer

41. Would you be willing to learn how to inject yourself?

❒ Yes ❒ No ❒ Refused to answer

42. In the past have you **ever**… ***(Read out list. Check YES or NO for each question. N/A – non-applicable is ONLY an option for 'k' and 'l')***

	Ever				Last 6 Months			
	Yes	**No**	**N/A**	**Refused**	**Yes**	**No**	**N/A**	**Refused**
a) Exchanged or obtained needles at the local harm reduction program or another needle distribution program?	❒	❒	--	❒	❒	❒	--	❒
b) Got NEW STERILE needles from a friend?	❒	❒	--	❒	❒	❒	--	❒
c) Got NEW STERILE needles from a dealer or someone on the street?	❒	❒	--	❒	❒	❒	--	❒
d) Injected with needles knowing that had already been used by, or were being used by someone else?	❒	❒	--	❒	❒	❒	--	❒
e) Injected with needles without knowing if they had been used by someone before you?	❒	❒	--	❒	❒	❒	--	❒
f) Used other injecting equipment (e.g., cotton, filter, spoon, cooker) that had already been used by, or was being used by someone else including your sexual partner?	❒	❒	--	❒	❒	❒	--	❒
g) Used other injecting equipment (e.g., cotton, filter, spoon, cooker) without knowing if it had been used by someone before you?	❒	❒	--	❒	❒	❒	--	❒
h) Filled your syringe from another syringe that had already been used or was being used by someone else (backloading or frontloading)?	❒	❒	--	❒	❒	❒	--	❒
i) Had drugs and wanted to inject but didn't know where to get a clean needle?	❒	❒	--	❒	❒	❒	--	❒
j) Reused a cooker with drugs in it for an extra wash?	❒	❒	--	❒	❒	❒	--	❒
k) Had trouble getting enough new needles from the NEP to meet your needs?	❒	❒	❒	❒	❒	❒	❒	❒
l) Had a NEP limit the number of needles they would give you?	❒	❒	❒	❒	❒	❒	❒	❒

43. In the **last 6 months**, how often have you BORROWED syringes that had already been used by someone else to inject? ***(Read out list. Show FREQUENCY (1) prompt card. Check ONLY one.)***

❒ Less than once per month ❒ 1-3 times per month ❒ Once per week
❒ More than once per week ❒ Daily ❒ Never
❒ Refused to answer

44. In the **last 6 months**, how often have you LOANED syringes that had already been used by you or were being used by someone else to inject?
(Read out list. Show FREQUENCY (1) prompt card. Check ONLY one.)

❒ Less than once per month ❒ 1-3 times per month ❒ Once per week
❒ More than once per week ❒ Daily ❒ Never
❒ Refused to answer

READ: Now, I'm going to ask about some of the drugs you inject and how often you use them. For each drug that you have injected, I will ask you if you inject daily, more than once per week, once per week, 1-3 times a month, less than once per month or never.

45. Have you injected [drug] in the **last 6 months**? ***(Read list out. For each drug they have injected, ask the frequency of use. Check response that applies.)***

Injection Drugs	**Less than once per month**	**1-3 times a month**	**Once per week**	**More than once per week**	**Daily**	**Never**
Heroin	❒	❒	❒	❒	❒	❒
Crystal Meth	❒	❒	❒	❒	❒	❒
Cocaine	❒	❒	❒	❒	❒	❒
Crack/rock cocaine	❒	❒	❒	❒	❒	❒
Speedball (stimulant mixed with opioids)	❒	❒	❒	❒	❒	❒
Methadone prescribed to you	❒	❒	❒	❒	❒	❒
Methadone not prescribed to you	❒	❒	❒	❒	❒	❒
Morphine	❒	❒	❒	❒	❒	❒
Hydros (HydroMorph Contin or Dilaudid)	❒	❒	❒	❒	❒	❒
Percocet	❒	❒	❒	❒	❒	❒
Generic Oxycodone	❒	❒	❒	❒	❒	❒
Oxy Neo	❒	❒	❒	❒	❒	❒
Fentanyl	❒	❒	❒	❒	❒	❒
Wellbutrin	❒	❒	❒	❒	❒	❒
Ritalin or Biphentin	❒	❒	❒	❒	❒	❒
Tranquilizers or Benzos	❒	❒	❒	❒	❒	❒
Amphetamines (speed, uppers, dexies, bennies)	❒	❒	❒	❒	❒	❒
Steroids	❒	❒	❒	❒	❒	❒
Valium	❒	❒	❒	❒	❒	❒
Gabapentin	❒	❒	❒	❒	❒	❒
Other: _____	❒	❒	❒	❒	❒	❒

46. What is your drug of choice?

- ❒ Heroin
- ❒ Cocaine
- ❒ Morphine
- ❒ Methadone prescribed to you
- ❒ Hydros
- ❒ Generic Oxycodone
- ❒ Fentanyl
- ❒ Ritalin or Biphentin
- ❒ Steroids
- ❒ Valium
- ❒ Other: _____
- ❒ Crystal Meth
- ❒ Crack/rock cocaine
- ❒ Speedball (stimulant mixed with opioids)
- ❒ Methadone not prescribed to you
- ❒ Percocet
- ❒ Oxy Neo
- ❒ Wellbutrin
- ❒ Tranquilizers or Benzos
- ❒ Amphetamines (speed, uppers, dexies, bennies)
- ❒ Gabapentin
- ❒ Refused to answer

47. In the **last 6 months**, which of these drugs did you inject the MOST?

- ❒ Heroin
- ❒ Cocaine
- ❒ Morphine
- ❒ Methadone prescribed to you
- ❒ Hydros
- ❒ Generic Oxycodone
- ❒ Fentanyl
- ❒ Ritalin or Biphentin
- ❒ Steroids
- ❒ Valium
- ❒ Other: _____
- ❒ Crystal Meth
- ❒ Crack/rock cocaine
- ❒ Speedball (stimulant mixed with opioids)
- ❒ Methadone not prescribed to you
- ❒ Percocet
- ❒ Oxy Neo
- ❒ Wellbutrin
- ❒ Tranquilizers or Benzos
- ❒ Amphetamines (speed, uppers, dexies, bennies)
- ❒ Gabapentin
- ❒ Refused to answer

48. Have you **ever** gotten a drug that you think was cut with another substance?

- ❒ Yes
- ❒ No ***(Skip to Question 52)***
- ❒ Refused to answer ***(Skip to Question 52)***

49. In the **last 6 months**, have you gotten a drug that you think was cut with another substance?

- ❒ Yes
- ❒ No ***(Skip to Question 52)***
- ❒ Don't know/Unsure ***(Skip to Question 52)***
- ❒ Refused to answer ***(Skip to Question 52)***

50. The last time you think you got a drug that was cut with another substance, what were you trying to use at the time? **(Show LIST OF DRUGS prompt card. Select ONE only.)**

❒ Heroin
❒ Cocaine
❒ Morphine
❒ Methadone prescribed to you
❒ Hydros
❒ Generic Oxycodone
❒ Fentanyl
❒ Ritalin or Biphentin
❒ Steroids
❒ Valium
❒ Other: _____
❒ Crystal Meth
❒ Crack/rock cocaine
❒ Speedball (stimulant mixed with opioids)
❒ Methadone not prescribed to you
❒ Percocet
❒ Oxy Neo
❒ Wellbutrin
❒ Tranquilizers or Benzos
❒ Amphetamines (speed, uppers, dexies, bennies)
❒ Gabapentin
❒ Refused to answer

51. What do you think it was cut with?

Specify substance: _____

❒ Don't know/Unsure
❒ Refused to answer

52. Have you **ever** shared a pipe for smoking crack or crystal meth?

❒ Yes
❒ No ***(Skip to Question 54)***
❒ Refused to answer ***(Skip to Question 54)***

53. In the **last 6 months**, how often have you shared pipes (e.g. glass stem, pipe, etc.) that had already been used or were being used by someone else to smoke?
(Read out list. Show FREQUENCY (1) prompt card. Check ONE only.)

❒ Less than once per month
❒ More than once per week
❒ Don't know/Unsure
❒ 1-3 times per month
❒ Daily
❒ Refused to answer
❒ Once per week
❒ Never

54. Have you **ever** smoked crack?

❒ Yes
❒ No ***(Skip to Question 56)***
❒ Refused to answer ***(Skip to Question 56)***

55. In the **last 6 months**, how often have you smoked crack?
(Read out list. Show FREQUENCY (1) prompt card. Check ONE only.)

❒ Less than once per month
❒ More than once per week
❒ Don't know/Unsure
❒ 1-3 times per month
❒ Daily
❒ Refused to answer
❒ Once per week
❒ Never

56. Have you **ever** smoked crystal meth?

❒ Yes

❒ No ***(Skip to Section 3)***

❒ Refused to answer ***(Skip to Section 3)***

57. In the **last 6 months**, how often have you smoked crystal meth?
(Read out list. Show FREQUENCY (1) prompt card. Check ONE only.)

❒ Less than once per month	❒ 1-3 times per month	❒ Once per week
❒ More than once per week	❒ Daily	❒ Never
❒ Don't know/Unsure	❒ Refused to answer	

SECTION 3. SUPERVISED INJECTION SERVICES

READ: I'm going to ask you a number of questions about supervised injection services. I will refer to supervised injection services as 'SISs' throughout the rest of the questionnaire. There will be some general questions about your knowledge of them and your acceptance of SISs if a facility were to be opened in the [name of city] area.

58. Have you heard of supervised injection services (SISs)? ***(Show pictures of facilities.)***

❒ Yes

❒ No ***(Go to box below)***

❒ Refused to answer ***(Go to box below)***

READ: ***(If yes to Q58)*** It's good to know that you are familiar with SISs, ***(continue below) OR***

(If no to Q58) Even if you have not heard about SISs, ***(continue below)***

For this interview, we want to use the same definition of SISs, to make sure that we're talking about the same type of place. A supervised injecting service is a legally operated indoor facility where people come to inject their own drugs under the supervision of medically trained workers. People can inject there under safe and sterile conditions and have access to all sterile injecting equipment (cotton, cooker, water, etc.) and receive basic medical care and/or be referred to appropriate health or social services.

59. If supervised injection services were available in **[name of city]**, would you consider using these services?

❒ Yes ***(Continue with next question - skip questions 62-3)***

❒ Maybe ***(Continue with next question)***

❒ No ***(Skip to Question 62)***

❒ Refused to answer ***(Skip to Question 62)***

60. ***(If yes or maybe)*** For what reasons would you use supervised injection services?
(Do NOT read out list. Check ALL that apply)

- ❒ I would be able to get clean sterile injection equipment
- ❒ I would be safe from crime
- ❒ I would be able to inject indoors and not in a public place
- ❒ I would be safe from being seen by police
- ❒ I would be able to see health professionals
- ❒ I would be able to get a referral for services such as detoxification or treatment
- ❒ Overdoses can be prevented
- ❒ Overdoses can be treated
- ❒ I would be injecting responsibly
- ❒ Other: _____
- ❒ Refused to answer

61. Which **one** of these reasons is the **most important** reason for you?
(Read out CHECKED responses Question 60 and check only ONE under 'MOST IMORTANT")

- ❒ I would be able to get clean sterile injection equipment
- ❒ I would be safe from crime
- ❒ I would be able to inject indoors and not in a public place
- ❒ I would be safe from being seen by police
- ❒ I would be able to see health professionals
- ❒ I would be able to get a referral for services such as detoxification or treatment
- ❒ Overdoses can be prevented
- ❒ Overdoses can be treated
- ❒ I would be injecting responsibly
- ❒ Other: _____
- ❒ Refused to answer

62. ***(If maybe or no)*** For what reasons would you **not** use supervised injection services?
(Do NOT read out list. Check ALL that apply.)

❒ I do not want to be seen
❒ I do not want people to know I am a drug user
❒ I am afraid my name will not remain confidential
❒ I would rather inject with my friends
❒ I always inject alone
❒ I feel it would not be convenient
❒ I fear being caught with drugs by police
❒ I'm concerned about the possibility of police around the service
❒ I do not trust supervised injection services
❒ I can get clean needles elsewhere
❒ I have a place to inject
❒ I feel there are too many rules and restrictions associated with using a supervised injection service
❒ I need to avoid other people that would use the SISs
❒ I'm in too much of a hurry to wait to use the injecting room
❒ I don't know enough about SISs
❒ Other: _____
❒ Refused to answer

63. ***(If maybe or no)*** What reasons would make you change your mind?
(Do NOT read out list. Check ALL that apply)

❒ I would be able to get clean sterile injection equipment
❒ I would be safe from crime
❒ I would be able to inject indoors and not in a public place
❒ I would be safe from being seen by police
❒ I would be able to see health professionals
❒ I would be able to get a referral for services such as detoxification or treatment
❒ Overdoses can be prevented
❒ Overdoses can be treated
❒ I would be injecting responsibly
❒ Other: _____
❒ Refused to answer

64. There are a number of policies being considered for SISs. For each of the next statements, please let me know if these policies would be very acceptable, acceptable, neutral, unacceptable or very unacceptable to you. ***(For each statement, read it out and ask how acceptable this would be to them. Show ACCEPTABILITY prompt card. Check the corresponding answer)***.

Injection Drugs	**Very Acceptable**	**Acceptable**	**Neutral**	**Unacceptable**	**Very unacceptable**	**Refused**
a) Injections are supervised by a trained staff member who can respond to overdoses	❒	❒	❒	❒	❒	❒
b) 30 minute time limit for injections	❒	❒	❒	❒	❒	❒
c) Have to register each time you use it	❒	❒	❒	❒	❒	❒
d) Required to show government ID	❒	❒	❒	❒	❒	❒
e) Required to show client number	❒	❒	❒	❒	❒	❒
f) Have to live in neighbourhood	❒	❒	❒	❒	❒	❒
g) Video surveillance cameras on site to protect users	❒	❒	❒	❒	❒	❒
h) Not allowed to smoke crack/ crystal meth	❒	❒	❒	❒	❒	❒
i) Not allowed to assist in the preparation of injections	❒	❒	❒	❒	❒	❒
j) Not allowed to assist each other with injections	❒	❒	❒	❒	❒	❒
k) Not allowed to share drugs	❒	❒	❒	❒	❒	❒
l) May have to sit and wait until space is available for you to inject	❒	❒	❒	❒	❒	❒
m) Have to hang around for 10 to 15 minutes after injecting so that your health can be monitored	❒	❒	❒	❒	❒	❒

65. There are various services being considered to provide with the proposed SIS. I'm going to read out a number of services. I will ask you if they are very important, important, moderately important, slightly important, or not that important to you. ***(Read out each service and for each ask how important the service would be to them. Show IMPORTANCE prompt card. Check response for each question.)***

Injection Drugs	**Very Important**	**Important**	**Moderately Important**	**Slightly Important**	**Not that Important**	**Refused**
a) Nursing staff for medical care and supervised injecting teaching	❒	❒	❒	❒	❒	❒
b) Washrooms	❒	❒	❒	❒	❒	❒
c) Showers	❒	❒	❒	❒	❒	❒
d) Social workers or counsellors	❒	❒	❒	❒	❒	❒
e) Drug counsellors	❒	❒	❒	❒	❒	❒
f) Aboriginal counsellors	❒	❒	❒	❒	❒	❒
g) Food (including take away)	❒	❒	❒	❒	❒	❒
h) Peer support from other injection drug user	❒	❒	❒	❒	❒	❒
i) Access to an opiate (methadone or buprenorphine) prescribed by a health professional	❒	❒	❒	❒	❒	❒
j) Needle distribution	❒	❒	❒	❒	❒	❒
k) Injection equipment distribution	❒	❒	❒	❒	❒	❒
l) HIV and hepatitis C testing	❒	❒	❒	❒	❒	❒
m) Withdrawal management	❒	❒	❒	❒	❒	❒
n) Special times for women or a women's only SIS	❒	❒	❒	❒	❒	❒
o) Referrals to drug treatment, rehab, and other services when you're ready to use them	❒	❒	❒	❒	❒	❒
p) A 'chill out' room to go after injecting, before leaving the SIS	❒	❒	❒	❒	❒	❒
q) Preventing or responding to overdose	❒	❒	❒	❒	❒	❒
r) Access to health services	❒	❒	❒	❒	❒	❒
s) Assistance with housing, employment and basic skills	❒	❒	❒	❒	❒	❒
t) Harm reduction education	❒	❒	❒	❒	❒	❒
u) Drug testing (a service to check if your drug may have been cut with another potentially dangerous substance)	❒	❒	❒	❒	❒	❒
v) Other: _____	❒	❒	❒	❒	❒	❒

SECTION 4. LOCATION AND SERVICE DESIGN PREFERENCES

READ: Now, I'm going to ask you more specific questions about your preferences in the location and design of services for SIS.

66. Would you use a SIS if it was located in a community health centre, hospital, family doctor's clinic, walk-in clinic, or social service agency?

❒ Yes ❒ No ❒ Refused to answer

67. Are you willing to walk to a SIS?

❒ Yes

❒ No ***(Skip to Question 69)***

❒ Refused to answer ***(Skip to Question 69)***

68. How long would you be willing to walk to use a SIS in the SUMMER/WINTER?
(Read out list. Check ONE only.)

	In Summer	In Winter
5 minutes	❒	❒
10 minutes	❒	❒
20 minutes	❒	❒
30 minutes	❒	❒
40 minutes or more	❒	❒
Refused to answer	❒	❒

69. Are you willing to take a bus to a SIS?

❒ Yes

❒ No ***(Skip to Question 71)***

❒ Refused to answer ***(Skip to Question 71)***

70. How long would you be willing to travel by bus to get to a SIS in the SUMMER/WINTER?
(Read out list. Check ONE only.)

	In Summer	In Winter
5 minutes	❒	❒
10 minutes	❒	❒
20 minutes	❒	❒
30 minutes	❒	❒
40 minutes or more	❒	❒
Refused to answer	❒	❒

71. What other ways do you see yourself accessing a SIS? ***(Read list out. Check ALL that apply.)***

❒ With a bike
❒ With a friend
❒ Other: _____
❒ Carpooling
❒ Supporting transformational services
❒ Refused to answer

72. In which neighbourhood, or region would be your FIRST CHOICE for seeing a SIS?
(Read out list. Show NEIGHBOURHOODS prompt card. Check one under FIRST CHOICE.)

73. In which neighbourhood, or region would be your SECOND CHOICE for seeing a SIS?
(Read out list. Show NEIGHBOURHOODS prompt card.)

74. If a SIS was established in a location convenient to you in [name of city], how often would you use it to inject? ***(Read out list. Show FREQUENCY (2) prompt card. Check ONE only.)***

❒ Always (100% of the time)
❒ Sometimes (26-74%)
❒ Never
❒ Usually (over 75%)
❒ Occasionally (<25%)
❒ Refused to answer

75. What time of the day would be your FIRST CHOICE to use a SIS?
(Read out list. Check one under FIRST CHOICE.)

❒ Day-time (8 am – 4 pm)
❒ Overnight (midnight – 8 am)
❒ Evening (4 pm – midnight)
❒ Refused to answer

76. Now, what time of the day would be your SECOND CHOICE to use a SIS?
(Read out list. Check one under SECOND CHOICE)

❒ Day-time (8 am – 4 pm)
❒ Overnight (midnight – 8 am)
❒ Evening (4 pm – midnight)
❒ Refused to answer

77. What would be the best set-up for injecting spaces for SISs? ***(Show CORRESPONDING picture to each choice of facility set-ups below. Read out list. Check ONE only.)***

❒ Private cubicles
❒ An open plan with benches at one large table/counter
❒ An open plan with tables & chairs
❒ Combination of the above
❒ Don't know/Unsure
❒ Refused to answer

78. Do you think people who use drugs should be involved in running SISs?

❒ Yes
❒ No ***(Skip to Question 80)***
❒ Refused to answer ***(Skip to Question 80)***

79. ***(If yes)*** How do you think people who use drugs could be involved? ***(Read list out. Check ALL that apply.)***

❒ At the entrance ❒ Greeting clients ❒ Registering clients
❒ In the waiting room ❒ In the injecting room ❒ In the chill-out room
❒ In the post-injection counselling role ❒ Don't know/Unsure
❒ Refused to answer

80. Do you think there should be a separate room for smoking crack or crystal meth at the SIS?

❒ Yes
❒ No ***(Skip to Question 82)***
❒ Refused to answer ***(Skip to Question 82)***

81. Would you use a separate room for smoking crack or crystal meth?

❒ Yes ❒ No ❒ Refused to answer

82. If it was possible to check your drug before injecting at a SIS, how often do you think you would test your drug? ***(Read out list. Show FREQUENCY (2). Check ONE only.)***

❒ Always (100% of the time) ❒ Usually (over 75%)
❒ Sometimes (26-74%) ❒ Occasionally (<25%)
❒ Never (Skip to Section 5) ❒ Refused to answer

83. How long would you wait to get the results of the drug test? ***(Read out list. Check ONE only.)***

❒ 5 min or less ❒ More than 5 min but less than 10 min
❒ More than 10 min but less than 15 min ❒ More than 15 min
❒ I would not wait any amount of time ❒ Refused to answer

SECTION 5. COMMUNITY IMPACT

READ: The next questions are about the possible impact on the community if SISs were opened in the [city] area.

84. I am going to ask if you think the following would be very likely, likely, neutral, unlikely, or very unlikely to occur in the community if SISs were opened in [name of city]? ***(Read out each statement. Ask them how likely they believe the statement. Show LIKELIHOOD prompt card. Check ONE response for each question.)***

If SISs were to open in the [name of city] area:	Very likely	Likely	Neutral	Unlikely	Very unlikely	Refused
a) The number of people injecting outdoors would be reduced	❒	❒	❒	❒	❒	❒
b) The number of used syringes on the street would be reduced	❒	❒	❒	❒	❒	❒
c) Injection with used needles would be reduced	❒	❒	❒	❒	❒	❒
d) People would learn about drug treatment	❒	❒	❒	❒	❒	❒
e) Overdoses would be reduced	❒	❒	❒	❒	❒	❒
f) Street violence would be reduced	❒	❒	❒	❒	❒	❒
g) Crime would be reduced in the area	❒	❒	❒	❒	❒	❒
h) Users would visit the area	❒	❒	❒	❒	❒	❒
i) Users would move to the area	❒	❒	❒	❒	❒	❒
j) Drug dealers would be attracted to the area	❒	❒	❒	❒	❒	❒

SECTION 6. EXPERIENCES OF OVERDOSE, HEALTH AND HIV & HEPATITIS C TESTING

Read: The next questions are about overdosing. Different people have different ideas about what an overdose is.

85. Have you heard of Narcan/naloxone?

❒ Yes ❒ No ❒ Refused to answer

86. Have you heard about take-home Narcan/naloxone kits that you can keep with you for an opiate overdose?

❒ Yes ***(Continue to next question)***

❒ No ***(Skip to Question 91)***

❒ Refused to answer ***(Skip to Question 91)***

87. ***(If yes)*** How did you hear about it? ***(Do NOT read list. Check all that apply.)***

❒ Friend ❒ Methadone Clinic ❒ Outreach Worker

❒ Street Nurse ❒ Needle Distribution Program ❒ Other: _____

❒ Refused to answer

88. Are you aware of the Narcan/naloxone Program in [name of city]?
❒ Yes ❒ No ❒ Refused to answer

89. Do you currently have a take-home Narcan/naloxone kit?
❒ Yes ***(Continue to next question)***
❒ No ***(Skip to Question 91)***
❒ Refused to answer ***(Skip to Question 91)***

90. ***(If yes)*** Where did you get it from? ***(Do NOT read list out. Check ALL that apply.)***
❒ Methadone Clinic ❒ Friend
❒ Other: _____ ❒ Refused to answer

91. If no, why not? ***(Do NOT read list out. Check ALL that apply.)***
❒ I don't know where to get one
❒ I don't feel comfortable using it
❒ I haven't picked up a new kit after using my previous one
❒ I don't think I need one
❒ I've never been offered one
❒ I don't use or hang out with people who use opiates
❒ I found the training hard to access
❒ Other: _____
❒ Refused to answer

92. Have you **ever** administered Narcan/naloxone to anyone?
❒ Yes
❒ No ***(Skip to Question 94)***
❒ Refused to answer ***(Skip to Question 94)***

93. If yes, how many times? ***(Do NOT read list out. Check ALL that apply.)***
❒ 1 or 2 ❒ 3 or 4 ❒ 5 or more ❒ Refused to answer

94. Have you **ever** overdosed by accident?
❒ Yes
❒ No ***(Skip to Question 115)***
❒ Refused to answer ***(Skip to Question 115)***

95. Have you overdosed in the ***last 6 months***?
❒ Yes ❒ No ❒ Refused to answer

96. Altogether, how many times have you overdosed **in your lifetime**?
Times: _____ ❒ Refused to answer

97. When was the **last time** you overdosed?

Specify: _____ ❒ Don't know/Unsure ❒ Refused to answer

98. The **last time** you overdosed, do you remember which drugs or substances were involved? ***(READ OUT LIST. Check ALL that apply.)***

❒ Yes, I remember ❒ No, I don't remember (Skip to Question 100)

❒ Don't know/Unsure (Skip to Question 100) ❒ Refused to answer ***(Skip to Question 100)***

99. The **last time** you overdosed, which drugs or substances were involved? Did you inject them? ***(READ OUT LIST. Check ALL that apply.)***

	Involved in OD?		**Injected?**	
	Yes	**No**	**Yes**	**No**
Cocaine	❒	❒	❒	❒
Crack	❒	❒	❒	❒
Hydros (HydroMorph Contin or Dilaudid)	❒	❒	❒	❒
Heroin	❒	❒	❒	❒
Methadone	❒	❒	❒	❒
Suboxone	❒	❒	❒	❒
Morphine	❒	❒	❒	❒
Percocet	❒	❒	❒	❒
Wellbutrin	❒	❒	❒	❒
Oxycodone	❒	❒	❒	❒
Fentanyl	❒	❒	❒	❒
Ritalin or Biphentin	❒	❒	❒	❒
Benzodiazepines or Tranquilizers	❒	❒	❒	❒
Speedball	❒	❒	❒	❒
Amphetamines	❒	❒	❒	❒
Crystal Meth	❒	❒	❒	❒
Valium	❒	❒	❒	❒
Gabapentin	❒	❒	❒	❒
Alcohol	❒	❒	❒	❒
Pot	❒	❒	❒	❒
Other injection drugs	❒	❒	❒	❒
Other non-injection drugs	❒	❒	❒	❒

100. What reaction did you have to the drugs? ***(Read out list. Check all that apply.)***

- ❒ Lost consciousness
- ❒ Inability to talk
- ❒ Blue lips
- ❒ Overheating
- ❒ Seizure
- ❒ Elevated breathing
- ❒ Paranoia
- ❒ Irregular heartbeat (i.e., rapid, slow, had hard time breathing, palpitations)
- ❒ Stopped breathing, was given oxygen
- ❒ Other: _____
- ❒ Don't know/Unsure
- ❒ Refused to answer

101. Were other people with you?

- ❒ Yes
- ❒ No ***(Skip to Question 103)***
- ❒ Refused to answer ***(Skip to Question 103)***

102. If yes, who were they? ***(Read out list. Check all that apply.)***

- ❒ Boyfriend/girlfriend/partner
- ❒ Casual sex partner
- ❒ Casual friend/acquaintance
- ❒ Family member
- ❒ Other: _____
- ❒ Stranger
- ❒ Close friend
- ❒ Date (sex worker)
- ❒ Fellow inmate
- ❒ Refused to answer

103. What neighbourhood were you in when you **last** overdosed? ***(Do NOT read out list. Show NEIGHBOURHOODS prompt card. Check ONLY one.)***

104. Could you tell me the type of place where you overdosed? ***(Do NOT read list out. Check ONE only).***

- ❒ My own place
- ❒ Friend's place
- ❒ Dealer's place
- ❒ Public washroom
- ❒ Abandoned building
- ❒ Drop-in social service
- ❒ Refused to answer
- ❒ Partner's place (if different from my own)
- ❒ Relative's place
- ❒ Street (alley, doorway, under bridge, etc.)
- ❒ Shelter
- ❒ Jail
- ❒ Other: _____

105. Were you assisted by other people?

- ❒ Yes
- ❒ No ***(Skip to Question 107)***
- ❒ Refused to answer ***(Skip to Question 107)***

106. If yes, who? ***(Do NOT read out list. Check all that apply.)***

- ❒ Boyfriend/girlfriend/partner
- ❒ Casual sex partner
- ❒ Casual friend/acquaintance
- ❒ Family member
- ❒ Other: _____
- ❒ Stranger
- ❒ Close friend
- ❒ Date (sex worker)
- ❒ Fellow inmate
- ❒ Refused to answer

107. Was an ambulance called when you overdosed?

- ❒ Yes
- ❒ No ***(Skip to Q112)***
- ❒ Don't know/Unsure ***(Skip to Q112)***
- ❒ Refused to answer ***(Skip to Q112)***

108. After the ambulance was called, did the police show-up?

- ❒ Yes
- ❒ Don't know/Unsure
- ❒ No
- ❒ Refused to answer

109. Were you taken to an ER/hospital?

- ❒ Yes
- ❒ Don't know/Unsure
- ❒ No
- ❒ Refused to answer

110. Were you offered transport to the hospital but refused?

- ❒ Yes
- ❒ Don't know/Unsure ***(Skip to Q112)***
- ❒ No ***(Skip to Q112)***
- ❒ Refused to answer ***(Skip to Q112)***

111. If yes, why did you refuse? Reason: _____

112. Were you given Narcan/naloxone?

- ❒ Yes
- ❒ Don't know/Unsure ***(Skip to Q114)***
- ❒ No ***(Skip to Q114)***
- ❒ Refused to answer ***(Skip to Q114)***

113. If yes, who administered it? ***(Do NOT read out list. Check all that apply.)***

- ❒ Boyfriend/girlfriend/partner
- ❒ Casual sex partner
- ❒ Casual friend/acquaintance
- ❒ Family member
- ❒ Other: _____
- ❒ Refused to answer
- ❒ Stranger
- ❒ Close friend
- ❒ Date (sex worker)
- ❒ Ambulance or hospital employee
- ❒ Don't know/Unsure

114. Were you in any of the following in the **month** before you overdosed?
(Read out list. Check all that apply.)

- ❒ Methadone/Methadose program
- ❒ Suboxone program
- ❒ Daytox
- ❒ In-patient detox
- ❒ Residential treatment
- ❒ Drug counselling
- ❒ Self-help group (e.g., 12 steps, SMART)
- ❒ Inpatient hospital stay
- ❒ Prison/jail
- ❒ Other: _____
- ❒ Don't know/Unsure
- ❒ Refused to answer

115. Have you witnessed an overdose in the **last 6 months**?

- ❒ Yes
- ❒ No ***(Skip to Q 118)***
- ❒ Refused to answer ***(Skip to Q 118)***

116. Who were they? ***(Do NOT read out list. Check all that apply.)***

- ❒ Boyfriend/girlfriend/partner
- ❒ Stranger
- ❒ Casual sex partner
- ❒ Close friend
- ❒ Casual friend/acquaintance
- ❒ Date (sex worker)
- ❒ Family member
- ❒ Fellow inmate
- ❒ Other: _____
- ❒ Refused to answer

117. What happened in response to the overdose you witnessed? ***(Read out list. Check all that apply.)***

- ❒ I called 911
- ❒ Someone else helped
- ❒ Someone else called 911
- ❒ Ambulance came
- ❒ Person came to on their own
- ❒ I left
- ❒ I helped
- ❒ I gave naloxone
- ❒ Other person gave naloxone
- ❒ Other: _____
- ❒ Don't know/Unsure
- ❒ Refused to answer

118. Have you **ever** been afraid of being arrested when you or someone else overdosed?

❒ Yes ❒ No ❒ Refused to answer

READ: The next few questions I am going to ask you are about health problems related to your injection drug use.

119. In the **last 6 months** have you had any of the following health problems? If yes, did you receive treatment? ***(Read out list. Check 'Yes' or 'No'. For any health problems experienced, ask if they received treatment and check 'Yes' or 'No'. Show HEALTH PROBLEMS prompt card.)***

	No	Yes, but no treatment received	Yes, treatment received	Don't know/ Unsure	Refused
Abscess	❒	❒	❒	❒	❒
Liver problems	❒	❒	❒	❒	❒
Hepatitis infection	❒	❒	❒	❒	❒
Circulation problems (endocarditis, thrombosis)	❒	❒	❒	❒	❒
Blood infection (septicaemia)	❒	❒	❒	❒	❒
Injuries	❒	❒	❒	❒	❒
Lungs/bronchitis problem	❒	❒	❒	❒	❒
Stomach/gastrointestinal problems	❒	❒	❒	❒	❒
Cold/influenza	❒	❒	❒	❒	❒
Depression, psychosis, trauma	❒	❒	❒	❒	❒
Withdrawal symptoms	❒	❒	❒	❒	❒
Cellulitis	❒	❒	❒	❒	❒
Scarring/bruising	❒	❒	❒	❒	❒
Other: _____	❒	❒	❒	❒	❒

READ: The next few questions are about blood tests for HIV and Hep C. We are asking everyone the same questions. These questions are not about routine bloodwork that you may have had while undergoing treatment for your HIV or Hep C infection.

120. What was the result of your **last** HIV blood test? ***(Read out list. Check ONE only.)***

❒ I've never had a blood test for HIV
❒ Positive ***(Skip to Q122)***
❒ Negative
❒ I didn't go back for the results
❒ I am waiting for the results
❒ Other: _____
❒ Refused to answer

121. ***(If haven't received test),*** For what reasons have you not had an HIV blood test? ***(Read out list. Check ALL that apply.)***

❒ I'm not a t risk for HIV
❒ Getting tested is a hassle
❒ I'm afraid to find out I'm HIV positive
❒ I don't care to get tested
❒ I don't know where to get tested
❒ I've never been offered
❒ Other: _____
❒ Refused to answer

122. Are you **currently** accessing treatment for HIV?

❒ Yes ❒ No ❒ Refused to answer

123. What was the result of your **last** hepatitis C (Hep C) blood test? ***(Read out list. Check ONE only.)***

❒ I've never had a blood test for HIV
❒ Positive ***(Skip to Q 125)***
❒ Negative
❒ I didn't go back for the results
❒ I am waiting for the results
❒ Other: _____
❒ Refused to answer

124. ***(If haven't received test),*** For what reasons have you not had a Hep C blood test? ***(Read out list. Check ALL that apply.)***

❒ I'm not a t risk for Hep C
❒ Getting tested is a hassle
❒ I'm afraid to find out I'm Hep C positive
❒ I don't care to get tested
❒ I don't know where to get tested
❒ I've never been offered
❒ Other: _____
❒ Refused to answer

125. Are you **currently** accessing treatment for Hepatitis C?

❒ Yes ❒ No ❒ Refused to answer

SECTION 7. DRUG TREATMENT

READ: The next set of questions is about any drug treatment you have undertaken and attempts to seek any drug treatment.

126. Have you **ever** in your lifetime been in a drug treatment or detox program?

❒ Yes
❒ No ***(Skip to Q129)***
❒ Refused to answer ***(Skip to Q129)***

127. Have you in the **last 6 months** been in a drug treatment or detox program?

❒ Yes
❒ No ***(Skip to Q129)***
❒ Refused to answer ***(Skip to Q129)***

128. In the **last 6 months**, which treatment programs have you been in?
(Read out list. Check all that apply.)

- ❒ Detox program with methadone/suboxone
- ❒ Detox program with other prescribed drugs
- ❒ Detox program with no drugs
- ❒ Methadone maintenance program
- ❒ Out-patient counselling
- ❒ Self-help group for your drug use
- ❒ Drug treatment with cultural programming
- ❒ Residential treatment
- ❒ Drug court
- ❒ Healing lodge
- ❒ Case management for substance use
- ❒ Managed alcohol program
- ❒ Another drug treatment/detoxification program
- ❒ Other: _____
- ❒ Refused to answer

129. During the **last 6 months**, have you ever tried but been unable to get into any of the treatment programs?

- ❒ Yes
- ❒ No
- ❒ Refused to answer

END OF INTERVIEW

INTERVIEWER COMMENTS:

_____
_____
_____
_____
_____
_____
_____

Appendix D: Sample consent forms for feasibility study interviews

Note: The following form is a comprehensive document that includes information needed to acquire meaningful consent from potential SCS clients. Organizers of SCSs are encouraged to adapt the consent form according to their needs and specificities of the local PWID and drug scene. It is important to consult with your institutional ethics boards before implementing an informed consent procedure.

Participant Information and Consent Document

Study Title: *Supervised Consumption Services Feasibility Study:* [**name of city**]

Study site: ***[locations of data collection]***

Sponsor: ***[if relevant]***

Principal Investigator:

[Name]

[Title and contact info]

Co-Principal Investigators:

[Name]

[Title and contact info]

This consent form may contain words that you do not understand. Please ask the study coordinator, research associate or any member to review this document with you and discuss any information that you do not understand or would like to clarify.

INTRODUCTION

You are being invited to take part in this study because you have injected drugs in the past six months, are 18 years of age or older, and reside in ***[name of city]***.

Before agreeing to participate in this study, it is important that you read and understand this consent form. This form provides all the information we think you will need to know in order to decide whether you wish to participate in the study. Please ask the Research Coordinator, Research Associate or any member of the study team (listed above) to explain any words or information that you do not understand. If you have any questions after you read through this form, please ask the research assistant. Do not sign this form until you are sure you understand everything.

PURPOSE OF THE STUDY

The purpose of this study is to examine acceptability and feasibility of supervised consumption services in ***[name of city]*** from the perspective of people who inject drugs and other key community partners. This study will also explore willingness to use such services, in addition to identifying preferences and potential barriers to running such programs. This study will contribute to information that may be helpful in the future development of supervised consumption services into community health programs for people who inject drugs.

PROCEDURES

If you agree to take part in this study, you will complete a ***[length of time]*** survey where a trained interviewer will ask you questions about your living conditions, drug use behaviours, access and uptake of programs and services, health and treatment questions, as well as your willingness to use supervised consumption services and preferences for design. Please keep in mind that you are not required to answer any questions that may make you feel uncomfortable and you are welcome to stop the interview at any time.

SURVEY DELIVERY METHODS

[Describe method of data collection and data storage. Indicate how confidentiality, anonymity and security of information will be ensured] We will NOT attach your name to any of the information you provide.

COMPENSATION *[Optional but helpful]*

You will be compensated ***[amount]*** cash per interview for your time.

POTENTIAL BENEFITS

You should not expect any direct benefits from taking part in this study, however, the information gathered from the study on supervised consumption services may benefit people who inject drugs in the future.

POTENTIAL RISKS AND/OR DISCOMFORTS

Some of the questions are of a personal nature and may make you feel emotional or upset. You are not required to answer any questions that may make you feel uncomfortable and are welcome to stop the interview at any time without any penalty or effect on access to any type of medical, social support, or other type of services you currently receive or may receive in future. At the end of the interview, the interviewer can provide you with a list of places or people you can contact if you feel that you would like to speak to someone about how you are feeling.

PARTICIPATION AND/OR WITHDRAWAL

Your participation in this study is strictly voluntary. You are free to withdraw from the study at any time. You will not be treated any differently if you choose not to take part. Consenting or refusing to participate in the study will not impact or affect any care or service that you currently receive or plan to receive in the future. You also have the right NOT to answer any questions that make you feel uncomfortable.

The Principal Investigator and/or ***[ethics review board if relevant]*** are entitled to terminate the study at any time without your consent. If this is the case, you will be given a full explanation.

CONFIDENTIALITY

To ensure the highest possible standards of legal and ethical protection of study participants, confidentiality will be guaranteed to the limits of the law.

All information collected for the study will be kept strictly confidential.

The results from this research study may be published; however, your identity ***will not*** be revealed in the combined results.

[Describe in detail where the data will be stored and how it will be disposed of and when.]

FUNDING OF THIS RESEARCH PROGRAM *[If relevant]*

The study is funded by ***[name of funder]***.

CONTROL OF THE ETHICAL ASPECTS OF THE RESEARCH PROJECT

[Name of ethics review board and approval process, if relevant.]

WHO TO CONTACT

If you have any questions or concerns about the study or your rights as a participant, please contact the Study Coordinator, XXXXX, at xxx-xxx-xxxx

For questions about your rights as a participant contact:

[ethics review board]

OTHER CONTACT INFORMATION

If you have any questions concerning matters related to this research, you may contact

[Principal Investigator name and contact info]

On a separate page, include the following:

Participant Information and Consent Document

Signature Page

Please keep a copy of this document for your information throughout the study.

Consent

I understand and consent to the following terms of participation in the study described above:

1. I have read and understand the information and consent form above, and all of my questions have been answered.

2. I understand the information I provide will not identify me at any time, and that it will be entered into a computer program for analysis.

3. I understand that my decision to participate in this study is voluntary and that I may decide not to participate at any time. Consenting or refusing to participate in the study will not impact of affect any care or services that I currently receive of plan to receive in the future.

4. I have received a signed copy of this form to take home with me.

_____	_____	_____
Signature of Participant	Name (please print)	Date
_____	_____	_____
Signature of Person Conducting Informed Consent Interview	Name (please print)	Date

Appendix E. Feasibility study interview guide for key stakeholders

1. Do you believe that there is a problem with injection drug use in your community, and if so, what problems do you believe exist?

    - (Probes: What health problems have emerged? How have these impacted PWID? How has the broader community been affected?)

2. What are the factors that drive drug-related problems in your community?

3. What is currently being done to address injection drug use in your community?

    - (Probes: What's working? What's not working?)

4. What else do you feel should be done to address drug-related harms in your community?

5. Who should play a role in addressing drug-related harms in your community? (e.g. Are there specific key players, stakeholders, community members, etc.?)

6. Are you familiar with supervised consumption services?

    - **If yes**, please tell me what you know about SCSs?

    - **If no**, provide definition: "supervised consumption services are health facilities where people who inject drugs can inject their pre-obtained illegal drugs under the supervision or nurses or other health professionals. Users are provided with sterile equipment, given information on safer injecting, as well as emergency response in the event of an overdose, and are provided with referrals to external health and social services. While there are over 90 SCSs internationally, only two currently exist in Canada, both in the city of Vancouver"

7. Are you familiar with the Vancouver SCSs (Insite/Dr. Peter Centre)? If so, can you tell me what you know about them?

8. What do you know about the benefits of SCSs?

9. What do you know about the negative effects of SCSs?

10. Do you think SCSs have a role to play in your community? If so, why, if not why?

11. What do you think might be the potential benefits of SCSs in your community?

    - (Probe for individual, organizational, and community-level benefits)

12. What do you think might be the negative consequences of a SCS in your community?

    - (Probe for individual, organizational, and community-level negative effects)

13. If you support the creation of a SCS in your community, where do you think SCS facilities should be located? How many SCSs are needed?

14. For what hours do you think it should operate?

15. Do you think SCSs will be accepted and used by local people who inject drugs?

    - If yes/no, please explain?

16. Do you think SCSs will be accepted by the broader community?

    - If yes/no, please explain?

17. If you support the idea of having a SCS locally, who do you think should be involved in establishing a SCS in your community?

18. What other programs or services would need to be in place to help ensure the effectiveness of SCSs?

19. Do you have any remaining concerns about the establishment of SCSs in your community?

20. If a research study of SCS was done in your community, what would you like the research to focus on? (e.g., a pilot project)

21. Do you have any other thoughts or concerns about SCSs that you would like to share?

22. Do you have any other thoughts or concerns about injection drug use in general that you would like to share?

23. What is the best way to gain feedback from you and your organization/ program/service? (e.g., Public forum? Private meeting? Presentation and roundtable discussion? Online survey?)

Thank you.

Appendix F. Ancillary Services

- Safe injection supplies, such as syringes, needles and other drug paraphernalia[7]
- Health education, including harm reduction strategies for drug-use
- Drug-use related medical care (e.g., wound care, vein care, abscess management)
- Primary care (e.g., immunization, STI screening, screening for other communicable diseases such as HIV and viral hepatitis C)
- Naloxone provision and training
- Residential services (e.g., overnight shelters, residential nursing care)
- Chronic illness management
- Psychosocial treatment interventions (i.e., cognitive behavioural therapy)
- Counsellors/social workers
- Mental health care
- Women's health services
- Off-site outreach program
- Drug treatment programs (e.g., medically managed withdrawal management, opioid agonist treatment)
- Employment programs
- Peer support programs
- Recreational activities
- Meals, snacks, coffee/tea
- Possibility to use phone/Internet
- Shower, laundry
- Lockers, postal addresses
- Overnight shelter and other low-threshold housing
- Support recovery housing

(Adapted from EMCDDA, 2016)

7. SCSs often quickly become the busiest needle distribution points wherever they are located, potentially leading to other needle distribution programs closing. Organizers of SCSs should be prepared for a large demand for needle distribution services

Appendix G. Example of fixed stand-alone facility – Insite

Insite is located on Hastings Street in the heart of Vancouver's Downtown Eastside neighbourhood. More than one-third of Vancouver's estimated 12,000 injection drug users live in the Downtown Eastside (Health Canada, 2008). PWID in this area face multiple and complex challenges, including homelessness, poverty, unemployment, mental health concerns, and violence. Insite opened its doors in 2003 as a pilot project and the first SCS in Canada. Insite's clients are more likely to be younger, homeless or precariously housed and are more likely to inject drugs in public, to inject drugs daily and to have recently had a non-fatal overdose—in other words, Insite has been successful in engaging high-risk PWID in harm reduction services through SCSs (Wood et al., 2005).

Insite's staff consists of front line team of nurses, counsellors, mental health workers, and peer support workers. There are 13 injection booths in Insite. Clients inject illegal drugs that they have obtained prior to entering the facility and they inject the drugs under the supervision of nurses and health care staff, who provide safer injecting education and emergency response in the event of an overdose. Insite also provides clean injection equipment, such as syringes, cookers, filters, water and tourniquets. Nurses at Insite also provide other health care services, such as wound care and immunizations.

Insite by itself is a stand-alone facility, but it is part of a network of services in the immediate geographical area. In particular, Insite exists in the same building as Onsite, which is a withdrawal management facility consisting of 12 rooms with private bathrooms. When Insite clients are ready to access withdrawal management, they can often be immediately accommodated at Onsite. Insite is also part of a referral network that consists of two community health centres, a hospital, rehabilitation centre, assertive community treatment (ACT), methadone maintenance programs, and support services for women.

During a 12-month period from 2004 to 2005, over 4,700 individuals registered at Insite and over 2,000 referrals were made, with over one third of referrals for substance use counselling (Tyndall et al., 2005). More recently, over 10,000 unique individuals have registered to use Insite, and the average number of daily visits ranges between 600-1000 (VCH internal data). Over a 13-month period in the same years, 336 overdoses were reported at the facility, none of which were fatal (Kerr et al., 2006). For more research and evaluation on Insite, please visit the Urban Health Research Initiative's website at http://uhri.cfenet.ubc.ca/content/view/57/92/#SEOSI.

Appendix H. Example of integrated facility – Dr. Peter Centre

Since 1997, the Dr. Peter AIDS Foundation has operated the Dr. Peter Centre (DPC). Located in Vancouver's West End, the DPC provides care and support to people living with HIV and coping with significant health and social issues, including: mental health conditions, trauma, substance use, viral hepatitis C, physical disabilities, poverty, and homelessness. Annually, the DPC supports more than 400 people to sustain daily HIV and other treatments to improve health outcomes and quality of life. The DPC's three programs are: day health program, 24-hour licensed nursing care residence, and enhanced supportive housing.

Across its three programs, the DPC provides a range of services that includes access to advanced nursing care, which includes support for adherence to antiretroviral therapy and other medication, including methadone and suboxone, as well as counselling, art, music and recreation therapy, nutrient-dense meals, and a safe place for social engagement and peer interaction. The DPC has always had a broad harm reduction program, including teaching and counselling, as well as provision of sterile needles and other injection equipment, condoms, and other harm reduction supplies. In 2002, supervised consumption service was integrated into nursing care in the day health program and residence, in order to prevent illness and promote health.

The day health program is open 9am-3pm, seven days a week, and provides for over 350 registered clients at a time, with 150 accessing the program on any one day. There is a specifically designated room in which nurse-supervised injection is provided. The space is located adjacent to the nursing area, and is equipped with three open stalls, a foot bath, seating area for a nurse, injection equipment, and call bells in the event of an emergency. Approximately 20% of the DPC clients use the service, totaling approximately 2,500 supervised injections per year.

The Dr. Peter 24-hour Specialized Care Residence, which is a licensed care facility, provides stabilization care, sub-acute care, long-stay, and palliative care. Each resident has a private room and bathroom. Supervised consumption service is provided in the resident's room, as is all other care (e.g., personal care and wound care).

A registered nurse/registered psychiatric nurse supervises injections in both programs. Pre- and post-injection support is provided by other clinical team members when needed. There are specific policies, procedures, and protocols for nursing, as well as other staff in the organization for these services (i.e., nursing, other clinical team members, administration, facilities management, etc.).

Appendix I. Examples of embedded facilities – Frankfurt and Luxemburg

Frankfurt: Embedded in housing environment

The "Eastside" facility in Frankfurt's industrial district opened in the early 1990s as the first SCS in the city. It is now the largest rehabilitation centre and support program hub for PWID in Europe (Deutsche Welle, 2008). The facility offers eight injection spaces (Köthner et al., 2011), beds for 80-100 PWID (Duff, 2016), medical care, opioid agonist treatment, counselling, café, needle distribution, laundry and shower (Broadhead et al., 2002). The residents of the facility are tasked to maintain the facility's premises, including the garden (IDH, n.d.). The facility also offers a work and training program, where clients learn skills and apply them to participate in the community. For example, the facility offers a workshop where clients can learn carpentry and then help restore and replace park benches in Frankfurt (Duff, 2016).

Luxemburg: Embedded in housing environment

Luxembourg's "Abrigado" is a low-threshold centre that offers seven injection spaces, 42 beds, a nursery and a drop-in centre with primary care. The facility also offers HIV and viral hepatitis C testing, as well as needle distribution programs and harm reduction counselling. The facility sees an average of 96 people who use drugs per day. The facility is staffed by an interdisciplinary staff, consisting of medical staff, psychologists, social workers and educators (Schatz and Nougier, 2012).

Paris: Embedded in hospital

The first in-hospital facility in the world opened in Paris' Lariboisière Hospital in October 2016, after much controversy and political resistance (BBC News, 2016). The hospital is located near a busy train station where there is a high rate of drug-related crime. The facility is inside the hospital but has a separate entrance and anticipates approximately 300-400 clients per day (Fox, 2016). The facility consists of a waiting room, a consumption room and a resting area after drug consumption (UNAIDS, 2016). There are twelve spaces for injection and an inhalation room and the facility will be led by a team of doctors, nurses, social workers and security personnel (Fox, 2016).

Appendix J. Example of mobile outreach facility – Berlin

Berlin is one of a handful of cities in the world that offers mobile outreach SCSs. There are estimated 10,000 PWID in Berlin (Senatsverwaltung für Gesundheit, 2008). Rather than being concentrated in a particular area, there are a number of well-established drug scenes in the city, where drug dealing and public consumption take place. Berlin has two fixed-site facilities and are supplemented by a mobile SCS. The mobile SCS program has two vans that are parked at two fixed locations in the city during operating hours (from 2:00PM – 6:00PM Mondays, Fridays and Saturdays).

There are three injecting booths in the van. The vans are staffed by two nurses, with the support of one or two social workers. The staff offer harm reduction services (i.e., needle and syringe distribution), naloxone hydrochloride, assistance in locating veins, blood borne virus testing and referral to other services, including counselling. On a typical busy day, the mobile facility serves 20-30 injections per day. In 2010, the vans accommodated 4,082 drug consumption visits in total, averaging at 11 injections per day (Deitz et al., 2012).

Appendix K. Overarching principles when working with First Nations and Indigenous peoples

- Recognize that culture, traditions, and language are the foundation to healthy individuals, families, and communities.
- Support approaches that ensure First Nations and Indigenous people receive safe and effective care from health providers.
- Find ways to address travel and funding blocks that make it hard for First Nations and Indigenous people to access and reach substance use programs and services.
- Build and strengthen capacity among First Nations and Indigenous communities.
- Make sure that services and programs are kept local, where possible.
- Support broad, collaborative multi-system approaches that consider social and economic determinants of health.
- Build and strengthen partnerships among First Nations and Indigenous communities, the regional, provincial, and federal systems and non-governmental organizations, including improved coordination and leveraging of innovations and resources.
- Make sure that health and human service providers work in a manner that is culturally safe and respects individual customs, values, and beliefs.
- Recognize that the social determinants of health have a key role in mental wellness and empower communities and leadership to address these determinants through inter-sectoral collaboration and action.
- Encourage approaches that are based in and build on individual, family, community, and cultural strengths.
- Reduce stigma against First Nations and Indigenous people who have substance use issues.
- Recognize that responses to addiction and substance use can be gender specific. This includes both men and women, trans-gendered, lesbian, gay, bisexual and two-spirited, queer, and questioning individuals. Programs and supports may need to be modified to support this population.

(Adapted from the BC First Nations and Aboriginal People's Mental Wellness and Substance Use – 10 Year Plan)

Appendix L. Insite's overdose protocol

The registered nurse will be informed of any participant demonstrating signs and symptoms of overdose or drug toxicity. 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 this situation, Insite staff will:

- Remain calm
- Attempt to wake up participant
- Shake and talk to participant
- Squeeze participant earlobes
- Get participant to open eyes
- Get participant to talk
- If responsive, assist to walk around
- If above steps are unsuccessful, initiate the Overdose Protocol (please see next page)

Overdose Protocol

Stage	1. "Drowsy"	2. "Nodding"	3. "Unresponsive"
Assessment	• RR >10-12/min • SaO2 >90% on RA* • Glasgow Coma Scale (GCS) 14 to 15	• Spontaneous respirations <10-12/min • SaO2 81% to 90% on RA* • Glasgow Coma Scale (GCS) 10 to 13	• Apneic – no spontaneous respirations or gasping • SaO2 80% or lower on RA* • Glasgow Coma Scale (GCS) <10 • **Call 911 if GCS is 8 or lower**
Management	• Observe according to agency policy/ability • If no improvement or if respiratory rate or mental status worsens proceed to Stage 2 or 3	• Apply O2 mask according to agency policy/availability • Administer naloxone 0.4mg to 0.8mg IM or SC • Repeat dose of 0.4mg every 3-5 min up to a maximum of 2-5 mg and until RR > 10-12/min • Monitor respiratory rate every 5 min for 15 min then every 10 min • Observe for two hours if able. Alternately send to hospital for observation. • If SaO2 decreases to less than 80%, patient appears cyanotic or if respiratory rate or mental status worsens proceed to Stage 3 or refer to hospital.	• Provide cardio respiratory support according to Adult Basic Life Support protocols. If available, bag-valve mask attached to supplemental O2 should be administered prior to and during naloxone administration to reduce the chance of acute lung injury • Administer naloxone 0.4mg to 0.8mg IM or SC. Apneic patients should receive an initial dose of at least 0.8mg naloxone. Repeat dose of 0.4mg every 3-5 min up to a maximum of 2-5 mg and until RR > 10-12/min. Patients in cardio-respiratory arrest following suspected opioid overdose should be given a minimum of 1.6mg of naloxone • Observe for two hours if able. Alternately send to hospital for observation. • If respiratory rate or mental status does not improve refer to hospital.
Call 911?	No	Yes	Yes

*If pulse oximetry is not available, cyanosis is a clinical sign of hypoxia. Under optimal lighting conditions and in a patient who has normal hemoglobin level and no dark skin pigmentation, frank cyanosis corresponds to a SaO2 of about 66%.

Appendix M. Insite's code of conduct/house rules

Rights

- To feel safe, respected and treated with dignity.
- To be in a place of respite.
- To be unharmed physically, emotionally, or psychologically by Insite staff.
- To receive appropriate support and attention.
- To access services even while under the influence of drugs or alcohol.
- To have a voice in the operations and functioning of the site, in conflict resolution processes and in regards to complaints or concerns.

Responsibilities

- To respect others while on site.
- To help create and maintain a safe place.
- To not cause physical harm to other participants or staff.
- To use the site for self-administration only; no "doctoring."
- To not deal, exchange, share or pass drugs to anyone else on-site.
- To not use alcohol, smoke or ingest drugs other than by injection while on-site.
- To reduce harm by not sharing rigs or equipment, disposing of used supplies in the sharps container, and not walking around with uncapped rigs.
- To not display weapons or money on-site.
- To not bring outside conflicts into the site.
- To not engage in solicitation of any kind on site.
- To respect the property and privacy of others in the site.
- To follow the reasonable directions of Insite staff.
- To bring concerns or complaints to the attention of Manager or RPIC.[8]

8. RPIC, or Responsible Person In Charge, is a staff member who is responsible for ensuring that the SCS's operation complies with the applicable Health Canada requirements.

Appendix N. Insite's user agreement form

*In*site

139 E. Hastings St.
Vancouver, BC CANADA

User Agreement, Release and Consent Form

Prior to using the Vancouver Supervised Injection Site ("*in***site**") facility, I agree to the following:

- I have injected drugs in the past and I am in this facility for the purpose of using injection drugs, and I intend to inject them regardless of any risks to my health or the health of my unborn baby, if I am pregnant.
- I will follow the direction of *in***site** staff and the *in***site** Code of Conduct.
- I will remain in possession of my own drugs for injection at all times.
- I authorize *in***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 *in***site** and the Vancouver Coastal Health Authority and its 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: _____

*in***site** staff: _____

Date: _____

*in***site** staff use (for statistical information only)

Gender: _____

Ethnicity: _____

Neighbourhood: _____ (1st 3 letters of postal code)

Identifier: _____ (1st & last initial & DOB)

First-time drug users

Background: Drug users who may be transitioning into injection drug use present both a potential opportunity to provide them appropriate harm reduction information, while at the same time may represent an opportunity to deter them from initiating a potentially high risk behaviour. In most circumstances these would be alienated, vulnerable youth who may be at a crossroads between increasingly high-risk behaviours (Roy et al., 2003) and an opportunity to transition away from a streetentrenched lifestyle. It would be rare for a participant to present to the facility as a firsttime user.

Protocol: Access is granted to the SCS after RN and program staff member assessment. Potential firsttime users may be deterred from transitioning to injection drug use. However, participants who are willing to present themselves to the SCS as a first-time user may have already made the decision to begin injection drug use, and would not be denied the benefits of SCS harm reduction services. For these participants, the negative health consequences of denial of access would be potentially mitigated. Participants who have never used injection drugs are not denied access, but are immediately referred to the senior RN and senior PHS staff on duty after the intake assessment. A concerted attempt to prevent transition to injection drug use would include drug prevention and counseling strategies and appropriate referrals. In the event that firsttime participants are determined to begin injecting drugs in the SCS, they will be granted access to the Injection Room.

Pregnant users

Background: There are inherent risks to both the mother and fetus associated with the lifestyle of injection drug use. Pregnant users are both shamed by their use (Livingston et al., 2012) and traumatized by the harm that they may be causing to their fetus, making them less likely to access health care services. However, this subgroup of users may be amenable to interventions to reduce harm, or even access treatment services if lowthreshold services are provided. By engaging these participants in the SCS, it may be possible to assist them in moving towards safer drugusing behaviours or recovery and prenatal care services. Denying access to pregnant women is unlikely to result in their abstinence from drug injection.

Protocol: Access will be granted following an assessment by the RN and program staff member. Staff will make all possible attempts to discreetly and respectfully identify pregnant participants, provide them with education about the risks associated with injection drug use during pregnancy and offer them access to appropriate medical and social services.

Youth

Background: Youth represent the highest risk group for contracting viral hepatitis C and HIV through injection drug use. Research has shown that younger injection drug users engage in high-risk behaviours to a greater extent than established users, including sharing needles and other drug equipment, engaging in sex trade work and using condoms inconsistently, increasing their vulnerability to blood-borne disease. There is real potential to reduce the harm associated with ongoing injection drug use in this group, given the rapid acquisition of viral hepatitis C and HIV infection following initiation into use of intravenous drugs and their increased risk of drug overdose due to their relative inexperience with injection drugs.

Protocols: Persons aged 16 and over who meet the assessment criteria can access a supervised consumption site. Access is not granted to youth under the age of 19 who are obvious first-time users, do not have a history of injection drug use, and who do not meet the assessment criteria. Supervised injection facilities are generally seen as an intensive intervention along the continuum of harm reduction services for an extremely

marginalized population. Youth who do not have a history of injection drug use should access resources that can more appropriately address their level of need.

Youth under the age of 19 will access the supervised consumption site only when the youth shows obvious signs of substance use with injectable drugs. When a youth presents at the supervised consumption site, the senior RN and senior PHS staff. The RN performs an assessment using the following criteria:

- The assessment determines that the youth has a history of injection drug use and has previously bought injectable narcotics with the intention of self-use; and
- The assessment provides appropriate and expedited referrals to primary health care and/or addiction medicine specialists, shelter and/or mental health services as indicated by information gathered, demonstrated symptoms, and/or desire to access appropriate care for substance use.

For those youth under the age of 19 who request access to the supervised consumption site but do not meet the above criteria, as well as those youth under 19 who are at immediate risk other than that associated with their substance use with injectable drugs, the RPIC[9] collects as much information on the youth as possible, and makes a report to the Ministry of Children and Family Development as appropriate.

Non-self-injectors

Background: There are many injection drug users who are unable to injection themselves and rely on others to perform this challenging procedure. Some have never learned how to inject themselves. Others cannot because of a physical disability such as blindness or paraplegia. This is an important population to engage as research has demonstrated a significantly heightened risk for HIV infection associated with this practice. This issue is one rife with power issues and most often it is women that rely on a man to inject them. Often, on the street, this service is provided in exchange for money, drugs or sexual favours. Only selfinjection is permitted in Insite. No staff person, nor participant may administer an injection.

Protocol: Non-selfinjectors will be identified to a nurse on duty. The nurse will assess whether the barrier to selfinjection is education or a physical disability.

1. If the barrier is education, the nurse will attempt to provide education to support the participant to selfinject in a safer manner.
2. If the barrier is physical disability, the nurse will determine whether any physical supports, not directly related to the provision of the injection, might assist in selfinjection.
3. If education or physical assistance do not result in self-injection, the participant will be respectfully asked to seek assistance elsewhere.

All efforts will be made to connect non-selfinjectors with safe support including treatment services for substance use.

Overtly intoxicated individuals

Background: Intoxicated persons present unique problems due to the likelihood of even higher risk than usual of needlesharing, fatal overdose, assault or otherwise unsafely injecting if they are denied access to clean equipment and a safe location with on-site supervision. However, allowing intoxicated individuals to inject

9. RPIC, or Responsible Person In Charge, is a staff member who is responsible for ensuring that the SCS facility's operation complies with the applicable Health Canada requirements

when they are clearly at greater risk for overdose also presents certain problems.

Protocol: Access is granted to the SCS after a RPIC assessment. Having an overtly intoxicated individual access SCS may increase the likelihood of the individual overdosing on site. However, the likelihood of a positive outcome after this episode is greater than if it occurred outside the SCS. Staff will identify those participants who are overtly intoxicated and provide them with education about the risks associated with injection drug use at this time. The client will be discouraged from using the injection room and encouraged to proceed to the ChillOut Lounge for some food or drink, or to walk around outside the SCS before considering injecting again. Access to the injection room would be granted by the RPIC only if convinced that the participant would likely inject drugs outside the SCS if denied access.

(Adapted from Insite's Policy and Procedure Manual, 2016)

Appendix P. Insite's protocols for refusal of service

Insite's policy is to remain as accessible as possible to all users all the time. However, there are a few circumstances in which the staff may refuse someone entry to the site.

- Individuals may be politely denied admittance to Insite if:
- They refuse to sign a waiver or to give reception their SCS code
- They have a medical condition which needs emergency attention
- They have no intention of injecting drugs on the premises
- They have a child with them
- They are under 16 years of age
- They are currently on the temporarily prohibited list
- The site is full

Insite has three levels of prohibited access to the site:

1. Prohibited from using the site for the rest of the shift/day if:

- Client exhibits behaviour that is extremely difficult to control or refuses to follow staff direction

2. Prohibited from using the site for 24 hours, and access again only after speaking

with RPIC[10] if:

- Client makes threats or engages in violence directed against staff or other clients
- Client deals drugs on site

3. Prohibited from using the site for a period over 24 hours, and access again only after conferring with staff and arranging a meeting with two RPIC if:

- Client repeats or engages in serious threats or violence
- Client incurs two prohibitions requested by staff (via email to explain the incident in more detail than the alert flag note) and set by RPICs

Participants 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
- Attempting to deal, purchase or share drugs on the premises

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

10. RPIC, or Responsible Person In Charge, is a staff member who is responsible for ensuring that the SCS's operation complies with the applicable Health Canada requirements.

Documentation of Prohibition:

- Staff must communicate with a RPIC as soon as a prohibition occurs
- The RPIC is responsible for making the decision to place a person on 2 RPIC prohibition
- after a review of the documented events
- The prohibition list will be kept current at the Reception desk. Reason for refusal will be clearly documented
- If a prohibited participant engages in the Vancouver Coastal Health Complaint Management process, the Refusal protocols set out here will always take precedence

Readmission after being prohibited from using the site:

Barred clients must meet with a RPIC. They will be readmitted after RPIC is assured that the behaviour will not continue.

(Adapted from Insite's Policy and Procedure Manual, 2016)

Appendix Q. Insite's protocols for crisis management

All SCS staff should be trained in crisis management. However, the Counselor/Support Worker should have special training in de-escalation approaches and she/he should be prepared to act as a crisis management consultant for SCS staff. The Counselor should also have knowledge of staff defusing and critical incident stress management interventions.

Definitions

- A crisis occurs when unusual stress brought about by unexpected and disruptive events render an individual either physically or emotionally disabled because his/her usual coping mechanisms prove ineffective.
- Crisis intervention is the timely and effective involvement in people's lives when stress is too great for them to manage through their usual coping mechanisms.
- The goal of crisis intervention is to assist the person in crisis to return to their pre-crisis levels of behaviour.

Characteristics of Crisis Intervention

- Immediacy - early intervention to relieve anxiety, prevent further disorientation and to prevent the person in crisis harming themselves or others.
- Proximity - intervention is carried out within physical proximity of the crisis.
- Expectancy - both the person in distress and the interventionist have the expectation that the intervention will be directed towards the goal of symptom reduction, not cure.
- Simplicity - relatively concrete intervention strategies that avoid complex psychotherapy-oriented tactics.
- Brevity - the intervention is short.

Assessment

Crisis assessment continues throughout the crisis intervention process. Initial assessment involves gaining as much information as possible about the crisis scene and the participant. The SCS intervener collects information from a variety of sources, including from records, from the person in crisis, and from others in the vicinity of the crisis. The initial assessment should focus on the present crisis and on the events that precipitated the crisis. The SCS intervener should focus on two key evaluations, level of danger and the participant in crisis.

Questions to evaluate level of danger:

- Is the surrounding safe and secure for me and for the participant?
- How may I best protect my own safety?
- Is there danger to the participant or others in the immediate area?
- Is the participant suicidal or homicidal?
- Are there weapons or potential weapons available to the participant?

Questions to evaluate the participant in crisis:

- Is the participant oriented to time, place and person?
- What is the participant's affective state, e.g., flat, lethargic, hostile or agitated?
- Can a medical condition, e.g. diabetes, head injury, or overdose, explain the participant's behaviour?
- Is the participant intoxicated?
- Is the participant psychotic?
- What is the participant's range and intensity of emotions?

Control

The SCS intervener supplies needed structure until the participant is able to regain control. The degree of control and direction supplied by the intervener depends on the dangerousness of the situation and on the ability of the participant to act on their own behalf.

Guidelines for taking control:

- Be clear about what and whom you are trying to control.
- Enter the crisis scene cautiously.
- Appear stable, supportive and able to establish structure.
- Be clear in your introductory statements. The opening questions, directions and other information you give the participant will often assist in gaining and maintaining control.
- Do not promise anything that you cannot make happen.
- Direct and arrange the pattern of sitting or standing to gain the participant's attention.
- Guide the participant with your eyes and voice rather than with physical force.
- Use physical force only as a last resort, and only if you are trained to use it.
- Remove the participant from the crisis situation if possible. Otherwise, remove the crisis from the participant!
- In a conflict between participants, break eye contact between the disputants and separate if possible.
- Be creative in taking control.
- Allow the participant to express his/her emotions and point of view.
- Be collaborative, when effecting control, ensure that the person feels involved in the decision making process.

Direction

Once the intervener and participant have collaboratively established control, it is possible to act to resolve the crisis. Examine possible solutions. However, before solutions can be explored, the SCS intervener must carry out further assessment to discover precipitating events in order to set the stage for crisis resolution.

Questions that might be asked include:

- Why is the participant in crisis now?
- What is troubling the participant now?
- What factors should be dealt with now and what factors can be dealt with later on in the intervention?
- What resources are available to the intervener and to the participant?
- What coping strategies has the participant used in the past? How successfully were they used?

Could one of these strategies or resources be used now? A successful intervention plan must be practical, immediate, flexible, simple, well organized and be created in cooperation with the person in crisis. The intervener should note the participant's strengths and present the crisis to the participant as a temporary situation.

Referral and Disposition

This is the closing stage of the crisis intervention process. The SCS will have a list of resources to which participants can be referred for further intervention. Referral making can be part of the solution-focused planning of the direction stage. It is an essential part of the closing stage where the intervener ensures that the participant will be able to take care of him/herself- or that some-one else will provide assistance. Some participants may not be receptive to crisis intervention, and when a participant's behaviour indicates she/he poses a safety risk to themselves or to others, SCS staff must arrange immediate disposition to 911 emergency services.

Behavioural and Communication Skills

Basic traits or skills used in counselling, empathy, warmth and genuineness, are important in crisis management. Developing trust and rapport with the participant is essential in bringing control to the situation. The intervener should remain calm and sincere throughout the intervention. The intervener must use clear and direct language. The intervener must be an active listener and an empathic responder. Crisis is in the eye of the beholder, and the intervener must convey to the participant that he/she understands what the situation looks like from the participant's perspective.

Staff Follow-Up Subsequent to a Critical Incident - Informal Debriefing

Immediately following a critical incident, all staff involved in the incident should participate in an informal debriefing. The objectives of the debriefing are as follows:

- Make sure everyone is OK physically and mentally.
- Discuss what went well as a team in handling the participant's behaviour.
- Discuss what needs to be changed in handling future critical incidents.
- Set up a time for a defusing session if needed.

Defusing Session

A defusing session is a meeting organized to investigate/review a critical incident in more depth. The defusing session is useful when conducted as close as possible to the time of the critical incident, and when all the staff

who were involved in the incident are present. However, a defusing session can be done at any time and not all of the staff involved need to be present.

The objectives of the session are to:

- Identify possible/actual precipitating factors.
- Identify possible/actual factors related to practice, physical layout, etc., that may have contributed to the crisis.
- Assist staff to evaluate the part played by their own behaviours and attitudes in the contributing to or handling the crisis.
- Assist staff to gain confidence in preventing, de-escalating and resolving crises.

Critical Incident Stress Debriefing (CISD)

CISD refers to a specific model of psychological debriefing. The CISD is designed to achieve the goal of psychological closure following a critical incident or traumatic event. It usually entails a multi-phase series of groups aimed at psychological and behavioural re-building in the wake of the critical incident. Trained personnel conduct CISD. If informal debriefing and/or defusing interventions are insufficient to meet the needs of the SCS staff subsequent to a critical incident, arrangements should be made to access CISD resources provided by Vancouver Coastal Health.

Appendix R. Insite's protocols for the management of escalating aggressive behaviours

Assessment for Potential Aggression

1. Assess the participant's potential for aggression on admission using the risk indicators outlined below. Assessment information may also be obtained from other professionals, relatives, friends and/or the participant.
2. Assess own personal self-awareness as to thoughts, attitudes, feelings and actions towards people who are aggressive or have the potential to be
3. Assess environment for overall activity, e.g., a highly active, crowded or loud environment may stimulate or exacerbate behaviour.

Risk Factors:

- Previous history of aggression (this is the #1 predictor of aggressive behaviour)
- Chemical dependency (either in an intoxication or withdrawal state)
- Psychological factors, poor mental health:
- Poor problem solving skills
- Inability to cope with stress on a day to day basis
- Cognitive impairment
- Psychosis
- Delirium/dementia
- Lack of inhibition
- Labile mood
- Suicide intent, plan, thoughts or history
- Psychological factors, poor physical health
- Hypoxia
- Electrolyte imbalance
- Head injury
- Sensory impairment
- Sepsis
- Loss/grief
- Loss of central love interest, family member
- Loss of housing
- Loss of income
- Loss of health
- Feelings of powerlessness, anger, fear and failure

- Socio-economic indicators
- Low-income households
- High residential mobility
- Marital status (single)
- Demographic indicators
- Age (20-40 years)
- Gender (male)

Management of Observable Behaviours

Aggression Based in Moderate to Severe Anxiety:

Mild anxiety is not necessarily negative; it can help with motivation, heighten awareness, and can stimulate problem solving. However, moderate to severe anxiety can cripple our ability to perceive, think and conceptualize - in other words, our ability to cope with the situation that faces us. Moderate to severe anxiety can be a contributing factor to aggressive behaviour. Aggressive behaviour may be a coping response to a sense of loss of control. De-escalation response should address anxiety as the root cause of aggression.

Moderate to Severe Anxiety Behaviours:

- Eye contact - loss of soft focus eye contact/avoidance, blank stare, rolling eyes, excessive blinking, eyebrow movement, smiling, frowning.
- Verbal contact - talkative, quiet, laughing, crying, joking, talking faster.
- Physical - rocking, restless, pacing, sitting very still, a need for more personal space, holding their breath.
- Hands - wringing hands, drumming fingers, opening and closing hands.
- Others - asking lots of information seeking questions in an attempt to regain a sense of control (and a general dissatisfaction with answers to these questions), very poor short term memory, procrastination.

Staff Response to Moderate to Severe Anxiety:

- A caring, respectful response to anxiety behaviour generally provides adequate support to lower the anxiety level and prevent escalation to anger and other aggressive behaviours in 95% of the population.

Staff Intervention to Moderate to Severe Anxiety:

- Be respectful of the participant's belongings and personal space (do not touch the participant without their permission).
- Actively listen to the participant, to have an understanding from their point of view and what is driving the behaviour.
- Answer questions to give the participant back a sense of control and reassurance.

- If you cannot answer their question, find out the answer, direct them to who may be able to answer their question, or explain to them it is a question to which there is no answer (do not ignore the question or need).
- Focus on what you can do for the participant and how it will benefit them, not what you cannot do (e.g., "How can I help?").
- Assist the participant to verbalize feelings in their own words, avoid using leading questions.
- Re-direct participant's energy into safe activities.

Verbal Aggression:

As verbal aggression escalates from the lowest to highest,

1. Challenging behaviours;
2. Refusing behaviours;
3. Loud behaviours; and
4. Threatening behaviours.

The person acting out will lose rational control and the ability to process information and think clearly. Eye contact will become focused and intensify as the level of verbal aggression escalates. Personal space will shrink and the acting out person will move closer to you, crowding your personal space.

1. Challenging Behaviour (First Level of Verbal Aggression)

- Relentless questions, with no satisfaction with the answers to these questions or they really do not care what the answer is
- Garden variety questions, which are questions that have nothing to do with the issue at hand but used as a distraction
- Rhetorical questions which are a form of distraction
- Demanding/instant gratification.
- No respect for rules or regulations - challenge and test staff.

If this line of questioning continues, it would become very personal and the individual would challenge you on your credibility, skill or knowledge. They are not satisfied with the answers that you give and this behaviour usually turns out to be a refusal in disguise that is the next level of verbal aggression.

Staff Response to Challenging Behaviour:

Staff have to acknowledge that the person has escalated from the information seeking questions of anxiety to the challenging questioning of the first level of verbal aggression. This acknowledgement is key for staff to match their response to the level of verbal aggression.

Staff Intervention to Challenging Behaviours:

- Do not argue; focus on a common goal.
- Redirect them back to the issue at hand.
- Ask them a question to distract them (e.g., "Can I ask you something?").

- Give a positive directive that will assist them in getting their needs met.
- Give the individual reasonable choices or consequences - positive first, and a specified time to decide.
- Use time and space.

2. Refusing Behaviour (Second Level of Verbal Aggression)

- Disagreeable
- Refusing
- Silence
- Walk away
- Verbally (this can be done in a calm or aggressive manner)
- Distracting behaviours (refusal in disguise)
- Repeated complaints
- Repeated requests
- Repeated demands
- Blaming others
- Exaggerated response of annoyance

Staff Response to Refusing Behaviours:

Remember people in most situations have the right to refuse care. Our role is to give them a clear understanding of the choices they have and the consequences of the choices they make.

Staff Intervention:

- Verify that they are refusing.
- Verify the reason for the refusal.
- Give a positive directive.
- Give the individual reasonable choices or consequences - positive first, and a specified time to decide.

3. Loud Behaviour (Third Level of Verbal Aggression)

- Button-pushing
- Yelling, shouting

Staff Response to Loud Behaviours:

At this level of verbal aggression, loud behaviours are driven by emotions and not rational thought. The participant may be feeling powerless and frightened, and escalate their behaviour in an attempt to create a sense of control for him or herself.

Staff Intervention to Loud Behaviours:

- FIRST PRIORITY IS SAFETY FOR STAFF AND PARTICIPANT.
- Isolate the acting out person if safe to do so, and either move them or clear the area of on-lookers

(people play to a crowd).

- Give a directive to the participant that puts your safety first (e.g., "Please leave the building").
- Time and space.
- Assess the need for additional staff to be present, or call police.

4. Threatening Behaviour (Fourth Level of Verbal Aggression)

Verbal threats are intolerable behaviour and will be managed as intolerable behaviour.

Intolerable Behaviours

The following behaviours have been identified as intolerable to the SCS. All staff must follow this list to present a consistent approach to participants. The key to the successful use of behaviour modification techniques is a consistent approach by all staff. When a staff member asks a participant to leave and restricts access to the service or site, all staff must respect that staff member's decision to enforce limits on the participant's behaviours.

Identified Intolerable Behaviours:

When a participant displays any of the following behaviours, the participant will be asked to leave the services or building for a specified length of time.

a. Verbal Aggression

Verbal threats that are:

- A direct threat of physical harm to a staff member, participant or family member.
- A direct threat to damage the physical environment or the service or building.
- A threat of a weapon (imaginary or real).

Verbal comments that are:

- Intended to dehumanize a staff member, participant or family member.
- Intended to demoralize a staff member, participant or family member.
- Intended to insult a staff member, participant or family member.
- Intended to sexually exploit a staff member, participant or family member.
- Intended to frighten and verbally control a staff member, participant or family member.
- Intended to start a fight in the facility.

b. Physical Aggression

- Sexual touching.
- Physical touching with the intent to harm a person or damage the facility.
- Throwing objects with the intent to harm a person or damage the facility.
- Punching or slapping a staff member or another participant.
- Kicking with the intent to harm a person or damage the facility.
- Spitting that is directed at a staff member or another participant.

- Fighting in the facility.
- Defacing the facility.
- Damaging equipment in the facility.
- Setting fire to the facility.

c. Challenge of Facility Rules

- Refusing to stop drinking alcohol in the facility.
- Stealing.
- Refusing to stop any behaviour that facility staff have requested the participant to stop.

Staff Response to Intolerable Behaviours:

- Staff safety always comes first. If you have any concerns regarding another staff member's behaviour in dealing with the participant, this is not a safe or appropriate time to question or challenge another staff member. These concerns should be brought up in the informal briefing.
- Be aware of your own limitations and the volatility of the situation.
- Assess the need for more staff to be present when asking the participant to leave the facility, or whether it is necessary to contact the police. If more staff is required or the situation is volatile, remove yourself from the situation until appropriate support can be put in place.
- Know what you can and cannot do ahead of time, so that you are always prepared for the unexpected:
- Who is available to assist you?
- What are your options and choices at this time?
- When are you going to request the participant to return to the SCS for follow-up?
- Where are your exits?
- What is your past history with the participant, and do you have a rapport with them?

Staff Intervention to Intolerable Behaviours:

In a calm, clear, matter-of-fact manner,

- State why you are asking the participant to leave the facility.
- Direct the participant to leave the facility.
- State when the participant may return to the facility (e.g., after meeting with RPIC, after 24 hours, etc.).

Intervention for Staff Member Being Assaulted:

A staff member that is being physically assaulted is to:

- Call for help.
- Trigger an emergency call if available.
- Protect the vulnerable areas of the body (e.g., face, neck)
- Move to an area occupied by other staff
- Ensure that help is on the way.

Staff responding to an emergency call intervention to physical aggression:

- Quickly assess the situation
    a. The need to call 911
    b. Weapons in the area
    c. Exits for staff
    d. Bystanders to be removed from the area
- One staff responder is to give direction to the staff member being assaulted to assist them in protecting themselves and removing themselves from the attacker. They need to clearly identify themselves to the staff member being assaulted as the one voice to concentrate on, so more than one person talking to them does not confuse the person being assaulted.
- Call 911 (or ensure 911 has been called).
- A second staff responder will be the responder who directs the participant to stop the attack and leave the facility. The responder can attempt to distract the attacker (e.g., flicking the lights on and off or throwing ice water on the attacker), this can give the victim a window of opportunity to escape.
- Clear bystanders from the area.
- Remove any potential weapons from the area.

Overdose prevention

Strategies to help to prevent and respond to overdoses.

Overdose prevention sites

Overdose prevention sites are managed by health authorities in co-operation with community partners across the province. These designated spaces, which are integrated into existing social service or health care settings or in newly established locations, provide on-site monitoring for people at risk of overdose and allow for rapid response when an overdose occurs. While supervised consumption services require municipalities to seek an exemption from federal drug laws, the same process is not required to establish an overdose prevention site.

Overdose prevention services are uniquely positioned as a low-barrier point of introduction to health and/or social services for people with substance use issues. Each site provides various levels of services, including overdose prevention education and Take Home Naloxone training and distribution. Some sites may also distribute harm reduction supplies (such as sterile needles, filters, cookers, condoms, etc.) offer safe disposal options, and facilitate referrals to mental health and substance use services. Currently, each British Columbia overdose prevention site offers drug-checking services.

Supervised consumption services

Supervised consumption services provide clean, safe environments where people can use substances under the supervision of trained staff without the risk of arrest for drug possession. These sites help reduce the transmission of disease, reduce fatal overdoses, and help connect people to health care services, including treatment.

Complementary health services

Supervised consumption and overdose prevention sites offer a wide range of complementary health services including:

- Distribution of supplies for safer injection
- Education on safe injection technique and infection prevention
- Overdose prevention and intervention
- Medical and counselling services
- Referrals to substance use treatment
- Connection to housing and other support services
- Drug-checking

Island Health

- Services in Campbell River, Courtenay, Duncan, Nanaimo, Port Alberni and Victoria

Interior Health

- Services in Kamloops and Kelowna

Fraser Health

- Services in Abbotsford, Langley, Surrey, Maple Ridge
- Services in Surrey

Vancouver Coastal Health

- Services in Vancouver

Drug checking

Currently, fentanyl test strips are provided in all supervised consumption and overdose prevention sites in B.C. The test strips, originally developed to check urine for drugs, test for the presence of fentanyl in illegal substances. To check their drugs, people who use substances dilute their substances with a few drops of water and the test strip will indicate a positive or negative result for fentanyl within seconds. This method has recently been discovered effective in detecting several other fentanyl analogues, including carfentanil.

Another new drug-checking service is being tested in Vancouver – the first of its kind in Canada. The pilot study uses a portable drug checking machine called a Fourier-Transform Infrared Spectrometer (FTIR), and aims to determine whether greater access to drug-checking services will help prevent overdose deaths. The machine can test a range of substances, including opioids like heroin, stimulants like cocaine and other psychoactive drugs such as MDMA, also known as ecstasy. Testing with the FTIR can identify multiple compounds at once in a matter of minutes.

Research into drug-checking can help to answer key questions about how effective and reliable these technologies could be in reducing the devastating number of overdose deaths in B.C.

Supervised consumption research

International research on supervised consumption services has found that these sites are beneficial to people who use substances as well as the surrounding community. Evidence has shown that supervised consumption services:

- Save lives
- Reduce sharing of needles that cause HIV and hepatitis C
- Increase use of detox and addiction treatment services
- Provide opportunities to connect people to health care services, housing and other supports
- Reduce public drug use
- Reduce the numbers of inappropriately discarded needles
- Do not contribute to increased crime in the surrounding area

Emergency 911

If you suspect an overdose, call 911 right away and follow SAVE ME protocol while waiting for first responders.

Healthlink BC 811

2022-2023 Community Coaches

for BOARD APPROVAL – April 24th, 2023

School / Department	Name of Coach	Coaching
NPSS	Kenneth Peters	Rugby
	***** *Superintendent approved above coach by email –April 12th, 2023*	
NPSS	Jamieson Stewart	Rugby

SCHOOL DISTRICT NO. 60 (PEACE RIVER NORTH)

OUT-OF-DISTRICT SPORTS / FIELD TRIPS 2022-2023

FOR BOARD APPROVAL

SCHOOL: NORTH PEACE

Sports/Activity & Grade/Team:	Dates of Travel	Destination	Transportation	Description of Activities: (names of chaperones, dates & description of activities) Description of Sports: (name of coach, chaperones & locations)
Girl's Soccer Tournament	April 12-15, 2023	Victoria, BC	Air Canada AC8370 AC8371 BC Ferries Public Transit/Taxi	Teacher Sponsors: Jamielia Turner, Kathy Macdonald Coach: Dan Turner
Badminton Match	April 22, 2023	Dawson Creek, BC	School Bus	Teacher Coaches: Matt Laur, Cat Imray
Rugby League Game	April 26, 2023	Grande Prairie, AB	School Bus	Teacher Sponsors: Crystal Dutchak, Scott Hyde or Jaclyn McNicol Non-Staff Coaches: Sean Dignan, Ellen Pedersen, Jason Dutchak, Barry Holloway
Rugby League Game	May 3, 2023	Grande Prairie, AB	School Bus	Teacher Sponsors: Crystal Dutchak, Scott Hyde or Jaclyn McNicol Non-Staff Coaches: Sean Dignan, Ellen Pedersen, Jason Dutchak, Barry Holloway

approved by Superintendent prior to departure

BC Badminton Zones	May 5-7, 2023	Prince George, BC	School Bus	Teacher Coaches: Matt Laur, Cat Imray
Track & Field Meet	May 5-6, 2023	Prince George, BC	School Bus	Teacher Coaches: Jaclyn McNicol, Tyson Collier
Track & Field Meet	May 13, 2023	Grande Prairie, AB	School Bus	Teacher Coaches: Jaclyn McNicol, Tyson Collier
BC Rugby Zones	May 12-15, 2023	Williams Lake, BC & 100 Mile House, BC	School Bus	Teacher Sponsors: Crystal Dutchak, Scott Hyde Non-Staff Coaches: Sean Dignan, Ellen Pedersen, Jason Dutchak, Barry Holloway *Boys play in 100 Mile House, will stay in Williams Lake * Girls play in Williams Lake
BC Track & Field Zones	Prince George, BC	May 17-18, 2023	School Bus	Teacher Coaches: Jaclyn McNicol, Tyson Collier
Rugby League Game	May 25, 2023	Peace River, AB	School Bus	Teacher Sponsors: Crystal Dutchak, Scott Hyde or Jaclyn McNicol Non-Staff Coaches: Sean Dignan, Ellen Pedersen, Jason Dutchak, Barry Holloway
Rugby League Game	June 5, 2023	Grande Prairie, AB	School Bus	Teacher Sponsors: Crystal Dutchak, Scott Hyde or Jaclyn McNicol Non-Staff Coaches: Sean Dignan, Ellen Pedersen, Jason Dutchak, Barry Holloway
Rugby League Game	June 9, 2023	Grande Prairie, AB	School Bus	Teacher Sponsors: Crystal Dutchak, Scott Hyde or Jaclyn McNicol Non-Staff Coaches: Sean Dignan, Ellen Pedersen, Jason Dutchak, Barry Holloway

Substance Abuse Prevention & Education

Counselling

- ➔ Counsellors are available to meet with students & help them connect with outside agencies
- ➔ Counsellors support programs already in place with outside agencies
- ➔ Northern Health & Addiction sets up a kiosk in the hallway outside of the cafeteria during "Drug & Alcohol Awareness Week". They hand out information and talk to students about supports available. (NPSS)
- ➔ Sr Alt Program has presentations on a semi-monthly basis from a member of Northern Health & Addictions. Students have access to one-on-one counselling if needed. (NPSS)
- ➔ *Strength First Program* - our SF Program has presentations on a regular basis from a member of the Northern Health and Addiction. Students have access to one-on-one counselling if needed. (DKMS)
- ➔ School-based team referral process – align supports for those needing support. (BBMS)
- ➔ Students who are caught using during the school day or use is an issue are directed to NP Mental Health & Addiction services for support. (BBMS)
- ➔ Vulnerable students — our SBT meet throughout the school year to identify and determine strategies to support vulnerable students (sometimes the concern/supports are substance related). (HH)
- ➔ A part-time teacher/counsellor who, as part of the SBT, provides support and direction whenever needed. (HH)
- ➔ CYMH, as well as the Northern Health Stabilization Program, provide counselling and support whenever needed. (HH)

Physical & Health Education

- ➔ Ongoing lessons on substance abuse throughout the year. (DKMS)
- ➔ Teachers cover a few lessons & some have brought in guest speakers to assist in the delivery of the content. (BBMS)
- ➔ Some lessons provided address substance abuse prevention. (HH)

Career Life Education

- ➔ Presentations at Northern Health Career Fair — some on healthy lifestyles for students during a walk-through career fair. (BBMS)
- ➔ *Career Life & Education* - grades 10-12 - includes units on this topic. (HH)

Cultural Events

- ➔ Presentations for whole school in the gym that cover this topic and it's affects on their lives. (DKMS)
- ➔ Presentations focused on addictions and/or substance abuse through an Indigenous lens. (BBMS)
- ➔ Presenters who address these issues specifically or provide focus/benefits of a healthy lifestyle. (HH)

Curriculum & Special Programs

- ➔ Direct teaching during *Healthy Habits Time*. Students split into grade groups & lessons are adjusted accordingly. Class is 40 minutes long & daily. Students rotate through all the teachers to get different topics throughout the year. (Prespatou)
- ➔ *Classroom Champions* for elementary grades promote healthy lifestyles and positive choices. (HH)

SD 60 Operating Financial Report - July 1 2021 to January 31, 2023

Operating Revenue	Actual	Budget	% of budget received	# of Months	Explanations
Ministry of Education Grants	$ 43,001,518	$ 70,219,175	61.2%	12	Funding varies as some SPF comes later in the school year.
Provincial Grants - School Age Therapy	$ 143,356	$ 121,519	118.0%	12	On Track
Offshore Tuition	$ 338,310	$ 825,000	41.0%	10	Offshore Tuition recognized each month
Alberta Students, DL, 3rd Party Billings	$ 87,382	$ 85,000	102.8%	10	Invoiced Student Funding Only
LEA Revenue	$ 663,501	$ 929,640	71.4%		Billed 50% to Doig; 70% to Blueberry & Halfway as per LEA
Miscellaneous Revenue	$ 165,468	$ 324,000	51.1%	12	This includes Apple schools funding, ITA, and other miscellaneous funds that come into the District. Have now recieved $56k from ITA
Rentals	$ 72,153	$ 101,200	71.3%	12	Includes Daycare Rental, Teacherage Rentals, Cameron Lake Rentals & Indigenous Rent
Interest	$ 239,867	$ 80,000	299.8%	12	Interest rates have increased from 1.7% in May to 4.50% in December
					Have not recived funding, but have been given our amount
Operating Revenue Before LEA Adjustment	**$ 44,711,555**	**$ 72,685,534**	61.5%		
LEA Revenue	-$663,501	-$929,640			
Operating Revenue with LEA Adjustment	**$44,048,054**	**$71,755,894**			
Accumulated Surplus - Educational Initiatives	$ 78,200	$ 936,900	8.3%	10	
Accumulated Surplus - Inflationary Contingency	$ 330,396	$ 495,593	66.7%	12	
Accumulated Surplus - Furniture	$ 96,000	$ 96,000	100.0%		
Accumulated Surplus - Learning Support Model	$ 206,960	$ 400,000	51.7%	10	
Funding from Accumulated Surplus	**$ 711,555**	**$ 1,928,493**			
Total Operating Revenue	**$44,759,609**	**$73,684,387**			

Operating Expense	Actual	Annual Budget	% of budget expended	# of Months	Explanations
Salaries					
Teachers	14,109,383	26,896,882	52.5%	10	Higher due to increases; will be more aligned once using the amended budget
Principals and Vice-Principals	3,072,550	5,229,188	58.8%	12	Higher due to increases; will be more aligned once using the amended budget
Educational Assistants	2,414,128	4,993,525	48.3%	10	On Track as should be approx 50% YTD
Support Staff	4,415,829	7,977,811	55.4%	10	On Track as should be approx 50% YTD
Other Professionals	1,101,766	1,870,622	58.9%	12	On Track as should be approx 60% YTD
Substitutes (TOC's)	731,721	2,148,363	34.1%	10	Lower than expected as should be approx 50% YTD - we budgeted higher based on previous years
Total Salaries	25,845,377	49,116,391	52.6%		
Employee Benefits	5,564,580	13,352,372	41.7%		On Track with 40%- dependant on how pay periods fall
Total Salaries and Benefits	**$31,409,957**	**$62,468,763**	**50.3%**		
Services and Supplies	5,074,610	10,715,624	47.4%	12	Lower than expected as should be approx 60% YTD; Supply chain issues contributing to this. This number varies throughout the year.
Total Operating Expenses	**$36,484,567**	**$73,184,387**	**49.9%**		
Capital Purchases from Operating	$408,044	$500,000	81.6%	12	Purchases vary through year
Application of Reserves	$0				
Operating Net Revenue (Expense)	**$7,866,998**	**$0**			
Application of Reserves					
Balanced		$0			

The retro pay salary increases for Teachers, PVP, and exempt have been included in the above salary numbers. We are will be receiving $1,925,098 in funding for the year to cover theses increases. The CUPE adjustments will be reflected in the February 2023 Pay.

Educational Initiatives

		Budget Amount	Spent		Inflationary Contingen
0604	MAP	326,980	55,550	55,550	
0612	Literacy	209,920	22,649	22,649	
0501	Choice	96,000	236,820		

LSM

Total LSM Budget	7,932,324
Accumulated Surplus	400,000
%	0.050426582
Current Spends	4,104,181
Recognize	206,960

cy	495,593	
	/12	
	41,299.44	per month
	330,395.50	July-February (8)

SD 60 Operating Financial Report - July 1 2021 to March 31, 2023

Operating Revenue	Actual	Amended Budget	% of budget received	# of Months	Explanations
Ministry of Education Grants	$ 51,213,342	$ 73,113,806	70.0%	12	On Track as should be approx 70%
Provincial Grants - School Age Therapy	$ 97,122	$ 127,502	76.2%	12	On Track
Offshore Tuition	$ 480,801	$ 659,289	72.9%	10	Offshore Tuition recognized each month
Alberta Students, DL, 3rd Party Billings	$ 78,433	$ 85,000	92.3%	10	Invoiced Student Funding, received transportation funding - adjust made for Grade 12 and 2 kindergarten students
LEA Revenue	$ 759,234	$ 1,041,556	72.9%		Billed 100% for LEA; revenue for 7 months
Miscellaneous Revenue	$ 283,709	$ 317,983	89.2%	12	This includes Apple schools funding, ITA, and other miscellaneous funds that come into the District. Have now recieved $105k from ITA
Rentals	$ 85,264	$ 101,200	84.3%	12	Includes Daycare Rental, Teacherage Rentals, Cameron Lake Rentals & Indigenous Rent
Interest	$ 282,713	$ 320,000	88.3%	12	Interest rates have increased from 1.7% in May to 4.87% in March
Operating Revenue Before LEA Adjustment	**$ 53,280,618**	**$ 75,766,336**	70.3%		
LEA Revenue	-$759,234	-$1,041,556			
Operating Revenue with LEA Adjustment	**$52,521,384**	**$74,724,780**			
Funding from Accumulated Surplus	**$ 207,200**	**$ 1,573,877**			
Total Operating Revenue	**$52,728,584**	**$76,298,657**			

Operating Expense	Actual	Annual Budget	% of budget expended	# of Months	Explanations
Salaries					
Teachers	19,794,152	28,212,741	70.2%	10	On Track as should be approx 70% YTD
Principals and Vice-Principals	3,967,508	5,325,599	74.5%	12	On Track as should be approx 70% YTD
Educational Assistants	3,605,277	5,372,471	67.1%	10	On Track as should be approx 70% YTD
Support Staff	5,701,645	8,786,152	64.9%	10	On Track as should be approx 70% YTD
Other Professionals	1,423,311	1,890,448	75.3%	12	On Track as should be approx 70% YTD
Substitutes (TOC's)	1,482,690	2,163,772	68.5%	10	Lower than expected as should be approx 50% YTD - we budgeted higher based on previous years
Total Salaries	35,974,583	51,751,183	69.5%		
Employee Benefits	8,068,841	11,831,576	68.2%		On Track with 70% dependant on how pay periods fall
Total Salaries and Benefits	**$44,043,424**	**$63,582,759**	**69.3%**		
Services and Supplies	7,595,532	12,015,898	63.2%	12	On Track as should be approx 70% YTD; Supply chain issues contributing to this. This number varies throughout the year. Large purchases are generally made later in the year.
Total Operating Expenses	**$51,638,956**	**$75,598,657**	**68.3%**		
Capital Purchases from Operating	$441,579	$700,000	63.1%	12	Purchases vary through year
Application of Reserves	$0				
Operating Net Revenue (Expense)	**$648,049**	**$0**			
Application of Reserves					
Balanced		$0			

The retro pay for all staff has been included in the wages above as of March 31, 2023. This includes the new labour market adjustments for custodians and bus drivers. We have been paid for all negotiated increases for Teachers, CUPE and Exempt staff at this time. We will be paid monthly for these increases until June 30, 2023. We are currently showing a surplus, but there

School District No. 60
Peace River North
DISTRICT ADMINISTRATION OFFICE
10112 – 105 Avenue, Fort St. John, British Columbia V1J 4S4 Phone: (250) 262-6000
OFFICE OF THE SECRETARY-TREASURER

MEMORANDUM

TO: BOARD OFFICE STAFF

FROM: Angela Telford
Secretary-Treasurer

DATE: April 6, 2023

RE: **OFFICE CLOSURE - SUMMER SHUTDOWN**

The office will be closed for the summer shutdown from Monday, July 17, 2023 to August 18, 2023. We will re-open on August 21, 2023.

Please complete and return an Absentee request form to the Payroll department.

Angela Telford

AT:lr

School District #60 (Peace River North)
Administration Office
Summer Hours and Summer Closure

Please see the following change in hours and Board Office closure:

Change in Hours
July 3 – July 14
8:00 a.m. – 4:00 p.m.
Closed for lunch (12:00 – 1:00 p.m.)

August 21 – 25
8:00 a.m. – 4:00 p.m.
Closed for lunch (12:00 – 1:00 p.m.)

Closure
The School District Board Office will be closed during the period of July 17 to August 18, re-opening on August 21, 2023.

Deputy Minister's Bulletin
Ministry of Education and Child Care

Feeding Futures School Food Programs Fund – Instructions to School Districts **April 4, 2023**

The Ministry is allocating $71.5 million per year in dedicated, multi-year funding to school districts to increase food security for students by expanding or creating school food programs.

This new funding is part of government's broader Feeding Futures School Food Programs Framework, which is a commitment to ensure students are properly fed for learning in order to enhance positive academic and healthy outcomes. Feeding Futures School Food Programs (FFSFP) funding addresses the top two barriers identified by schools in the province: sustainable and consistent food funding and human resources.

Funding is allocated in a similar manner to the Student and Family Affordability Fund (SFAF). This means it is proportional to preliminary September operating grants, with a floor funding level of $350,000. This first year of funding is intentionally flexible to provide districts with time to develop a longer-term approach to delivering school food programs.

School Year (SY) 23/24 Foundational Year
Districts will have the flexibility over the foundational year (SY 2023/24), to continue supports established with SFAF that increase student food security as longer-term food programming supports are put into place. Criteria will be adjusted over time; districts can expect standardized FFSFP spending criteria in place for SY 2025/26.

This new FFSFP funding may free up district operating funding that has been previously dedicated to school food program budgets to use for other non-educational supports (e.g., mental health).

FFSFP spending criteria:

- Food
    - Must be towards the delivery of food programs to feed students who need it most (e.g., maintain current programs, increase number of students served, increase nutrition of food).
    - Spending may support Culinary Arts programs if the food produced by the program is provided to students in need.
    - Program delivery may include the procurement of third-party food service providers, or expansion of existing contracts.
    - Districts are encouraged to use nutritious and B.C. grown/produced food where possible.
    - Program delivery should be stigma-free, flexible, and respect student privacy.
- Staff
    - Flexibility to hire up to one School Food Coordinator FTE if needed or offset existing costs to a School Food Coordinator.
    - Functions of role may include coordination and/or delivery of the program (e.g., prepare food, build community connections, seek local partnerships and procurement opportunities, work with local First Nations and Indigenous partners).

- Other (for foundational year only)
    - Small appliances or equipment to prepare, store, cook and transport food from a school with a kitchen to another school (e.g., kitchen utensils, insulated containers, microwaves).
    - Continuity of SFAF supports that improve student food security (e.g., grocery store gift cards, food for weekends and school closures).

Reporting

- Spending plans will be required in July 2023.
- A draft spending plan reporting template will be distributed shortly and will ask for budgeted **Spending on Food Security** including:
    - Utilization of third-party food service providers: caterers; food distributors; First Nations; and not-for-profit organizations or non-government organizations.
    - Food purchased and provided using district staff: food produced in BC; and other.
    - Other goods, services and/or programs to feed students that are within the policy direction.
    - Spending to provide food security supports.
    - Staffing costs to directly support the provision of food programs: Administration; Management/Professionals; Teachers; and Support Staff.
    - Operational spending targeted to food programs prior to the FFSFP funding announcement redirected to supporting educational programs.
    - There should be no space enhancement spending in this category.
    - Administration or overhead spending (e.g., equipment, non-food supplies) in this category must be minimal and limited to SY 2023/24 only to transition to longer-term sustainable programming.
- An interim report will be required in early spring 2024 to support Ministry understanding of spending patterns.
- Reporting will be required at the end of the school year, in addition to the reporting in the Annual Budget and audited Financial Statements for 2023/24. Reporting categories will mirror those in the Spending Plan.
- School districts will also be asked to report on decisions making processes regarding the funding:
    - What processes were used to identify students who could benefit from this funding, including those from diverse communities where equity is a consideration?
    - Did you engage with your Indigenous Education Council (IEC or local equivalent) to identify the needs of Indigenous students?
        - If so, who did you engage with and how?
        - If not, what other engagement with Indigenous peoples did you undertake?
    - How did you support First Nations students living on reserve/other First Nations students and other Indigenous students attending your schools with this funding?
        - Number of students
        - Amount of funding
        - Types of support

Future Considerations

- Building the capacity in each district to work towards stigma-free access to nutritious food for any students who need it will take time.
- Each district's long-term delivery model of school food programs is expected to be stigma-free in addition to supplementing with coordination from the surrounding community.
- Community inclusion (e.g., non-profit organizations, corporate donors and parent advisory councils) will be an essential component of each district's long-term model. District Parent Advisory Councils should be included in the long-term planning process.
- The multi-year funding commitment supports districts to enter into long-term agreements (e.g., food service management companies, non-profit organizations, local catering companies and food suppliers/distributors).

SCHOOL DISTRICT #60 (PEACE RIVER NORTH)
POLICY COMMITTEE NOTES
TUESDAY, APRIL 11, 2023
12:30 P.M.

Present: Helen Gilbert, Chair, Board of Education
Madeleine Lehmann, Vice-Chair
Ida Campbell, Trustee
Bill Snow, Trustee
Thomas Whitton, Trustee *(via Zoom)*

Stephen Petrucci, Superintendent
Angela Telford, Secretary Treasurer
Leah Reimer, Executive Assistant

Absent: Nicole Gilliss, Trustee
David Scott-Moncrieff, Trustee

Policy Committee
Chair Gilbert

Policy 4024 Teachers – Early Retirement Incentive Payout

- It is an old policy that was put in place when we had an overabundance of teachers geared towards retention
- In our district now, we're paying this incentive and then recalling teachers to help fill positions
- If you take out e) it takes out the purpose of the policy so recommending just remove 6 and reviewing wording in Schedule A

ACTION: Make recommended changes and bring forward to the next Policy Committee Meeting for further review of Procedures and Schedule A

Communication

- Need a communication document or policy that clearly explains our processes to the community. This type of protocol is in every organization…the need to let the public know how we're communicating with them
- BCSTA Learning Guide gives an overview to check what kind of language is needed
- Suggest we incorporate this into policy (ie. SD60 Framework for Communications and Community Engagement)

ACTION: Bring forward to the next Policy Committee Meeting for further review

Policy 4027 Teacher Leaves

- Housekeeping, updating language to make it in line with the current Collective Agreement

ACTION: Bring forward to the next Policy Committee Meeting for further discussion

Next Meeting Dates

- ???

Regional meeting – Northern Interior

April 17, 2023

BRITISH COLUMBIA
PUBLIC SCHOOL
EMPLOYERS' ASSOCIATION

Territorial acknowledgement

BRITISH COLUMBIA
PUBLIC SCHOOL
EMPLOYERS' ASSOCIATION

Icebreaker

- Self-introduction of each participant
- Name of your pet and/or what is your superpower

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION

Agenda and Purpose

BRITISH COLUMBIA
PUBLIC SCHOOL
EMPLOYERS' ASSOCIATION

Agenda

Time	Duration	Topic	Speaker
1:00pm	5 min	Territorial acknowledgement	Trustee Rep for area
1:05pm	5 min	Icebreaker	Bruce
1:10pm	5 min	Agenda and Purpose	Bruce
1:15pm	20 min	BCPSEA - Our strategic plan, our goals and actions, our team and services, collective bargaining update and what's next	Bruce
1:35pm	55 min	MAF - our team and services, Northern Recruitment & Retention Initiative, French Recruitment Initiative, the recruitment landscape, and roundtable discussion	MAF / District Liaison
2:30pm	20 min	Break	
2:50pm	35 min	Recruitment and retention – LR considerations and roundtable discussion	District Liaison
3:25pm	25 min	Key provincial-level grievances	District Liaison
3:50pm	10 min	Other topics	Bruce
4:00pm		End	

BCPSEA Strategic Plan 2023-2025

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION

Vision

An inclusive and thriving BC public education sector with a workforce that fosters student success.

Mission

BCPSEA provides trusted sectoral leadership in labour relations and human resources by working together with school districts, partners and stakeholders to ensure the success of the public education system.

Core Values

- Accountability
- Service excellence
- Collaborative leadership
- Trusted expertise
- Adaptability

BCPSEA Strategic Plan 2023-2025

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION

Our Goals

Sectoral Leadership and Service Excellence

Stakeholder and Partner Relations

Effective Resource Management and Sustainable Operations

Diversity, Equity and Inclusion

Reconciliation

BCPSEA Strategic Plan 2023-2025

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION

Our Goals

Sectoral Leadership and Service Excellence

Stakeholder and Partner Relations

Effective Resource Management and Sustainable Operations

Diversity, Equity and Inclusion

Reconciliation

BCPSEA Strategic Plan 2023-2025

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION

Key actions taken on Diversity, Equity and Inclusion Goal

- BCTF LOU 17 – Employment Equity
- Partnering with Burnaby and North Van SDs on DEI training
- DEI session held at BCPSEA's Symposium
- *New* DEI course for ONCORE training programs
- Updated BCPSEA's policies to reflect DEI goal
- Revised/updated BCPSEA's recruitment process and practices
- Added DEI statement to BCPSEA job postings
- Working with MOECC regarding updating data collected in EDAS
- Joined UBC Community Based Work Learn Program

- **BCPSEA staff training taken:**
  - DEI fundamentals training (by CCDI)
  - Unconscious bias training (by CCDI)
  - Transgender awareness training (by Adrienne Smith)
  - Disability Awareness training (by Heather McCain)
  - 5-part DEI deep dive seminar series (by Elevate Inclusion)
  - 2-part DEI leadership training for BCPSEA Board members (by Elevate Inclusion)

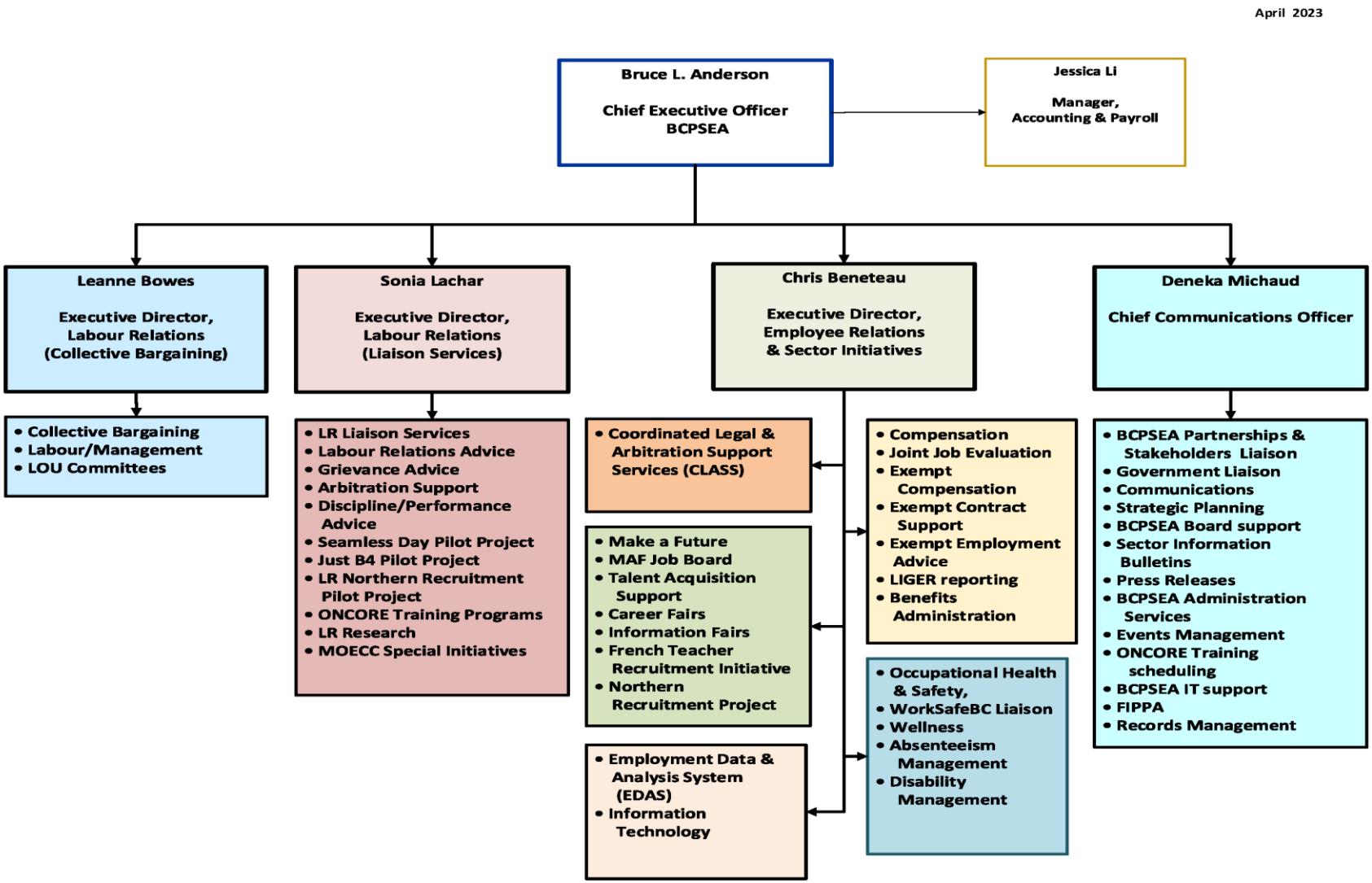
BCPSEA Strategic Plan 2023-2025

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION

Key actions taken on Reconciliation Goal

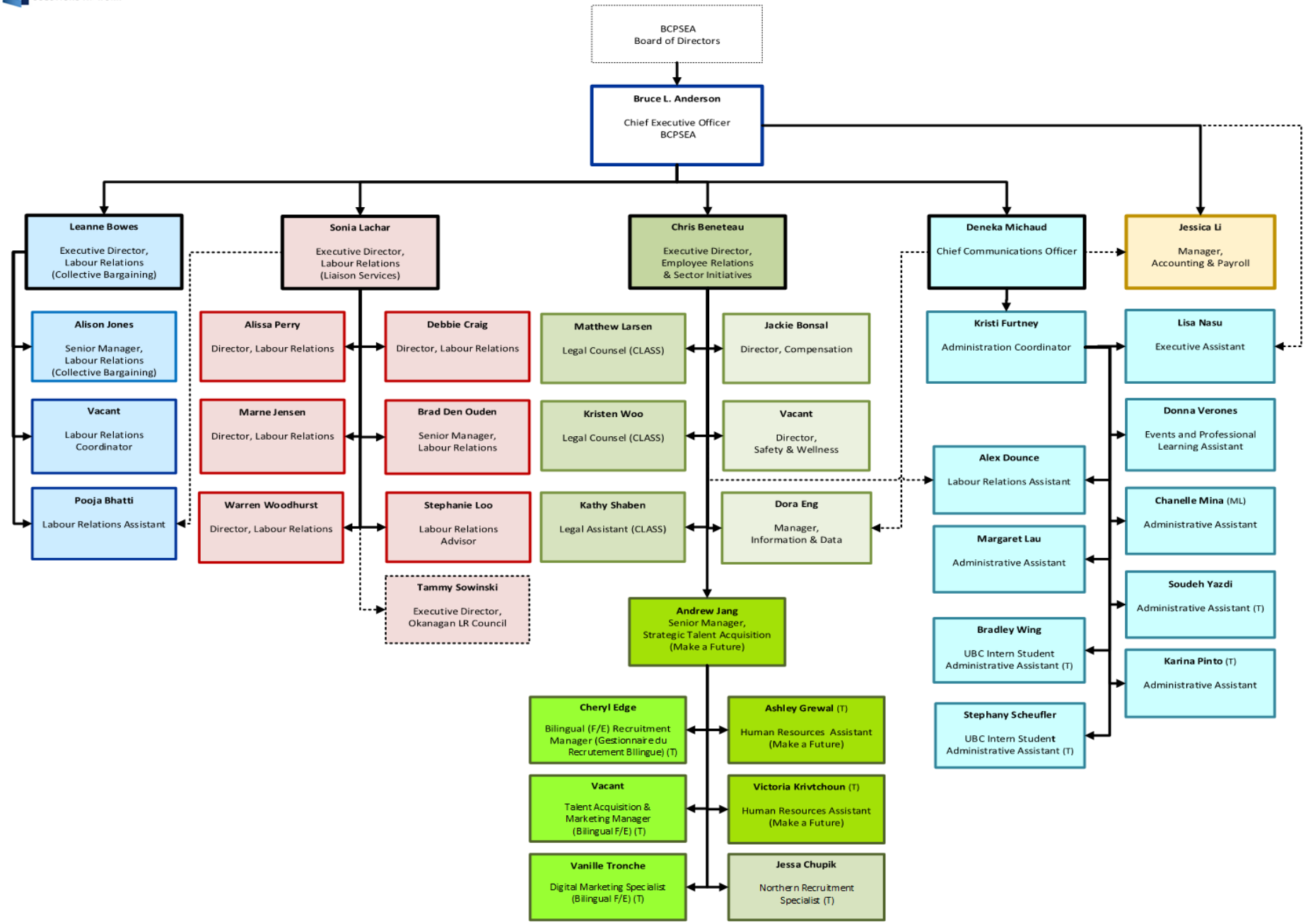
- FNESC (First Nations Education Steering Committee) invited to bargaining sessions
- BCTF LOU 4: Employment Equity – Indigenous Peoples
- BCTF LOU13: education on *Declaration of Rights of Indigenous Peoples Act*
- Supported *new* Cultural Leave (2 days)
- Updated BCPSEA's policies to reflect Reconciliation goal, and added cultural leave to our policies
- Revised/updated BCPSEA's recruitment process and practices
- Added territorial acknowledgement to BCPSEA email signatures, website, website banner, beginning of all staff events and sector meetings
- Joined UBC Community Based Work Learn Program
- **BCPSEA staff training taken:**
  - Indigenous Awareness training (by Indigenous Corporate Training)
  - Talking Trees tour (by Talaysay Tours)
  - Blanket exercise (by Brad Baker)

BCPSEA Services



BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION
SOLUTIONS AT WORK

April 2023



Collective Bargaining 2022 - Status

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION

Leanne Bowes

As at March 15, 2023, all 72 Collective Agreements 2022-2025 have been negotiated and fully ratified.

BCTF commentary on bargaining

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION

BCTF Teacher Magazine: January/February 2023

Sarah: *"I can't decide if my answer here is everything or nothing. At the table, the thing that surprised me the most is that the employer's representatives were just normal human beings doing a job. Just like us. No acrimony. In terms of the bargaining process, what surprised me was the wide variety of work involved in being on the team and how the work evolved over the trajectory of bargaining."*

Carla: *"In previous rounds, we all heard about the acrimony at the table and the employer's attempt to strip our contract. As a result, I was prepared for more of a fight. So, I was surprised that, despite the employer being resolute on certain issues, in other areas they were open and collaborative."*

2023 - teacher post-bargaining activities

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION

- New Collective Agreement – Working Documents
- **LOU 4: Employment Equity – Indigenous Peoples**
- LOU 5: Review criteria, demographics, data, costs, etc. regarding Teacher Supply and Demand Initiatives
- LOU 9: parties to discuss potential changes to the Provincial Extended Health Benefit Plan
- **LOU 13: parties to discuss ways to support *Declaration on the Rights of Indigenous Peoples Act*,** specifically, education commitments of the Declaration Act Action Plan
- LOU 15: parties review split of issues (Provincial vs. Local Matters); and review 2022 Local Bargaining Procedure
- **LOU 17: Employment Equity** - parties develop communications and training

2024 - teacher collective bargaining preparation

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION

- 2024: Bargaining consultation (K-12 sector-wide and MOECC)
- **2024: Build 2025 bargaining plans – local and provincial**
- 2024: Consultation with PSEC-Secretariat (next mandate)
- **2024: Preparation and commencement of local teacher bargaining** (date: late fall 2024)

- 2025: January Trustee Reps meeting on provincial bargaining plan (date: end of January 2025)
- 2025: Local teacher bargaining concluded (date: TBD)
- **2025: Commencement of provincial collective bargaining** (date: TBD)

2022 - local support staff bargaining trends

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION

- Labour Market Adjustments for certain key positions (positions and amounts varied depending on the SD's specific recruitment and retention issue):
  - Certified trades/red seal
  - Forepersons
  - Information technology
  - Payroll clerk
  - Education assistant

- Paid cultural leave days for Indigenous employees
- Gender neutral pronouns and language
- Increases to premiums, especially safety boot & clothing
- First Aid certificate premium
- Benefits/Health Wellness funds
- Additional days of leave

2024 - support staff bargaining preparation

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION

- 2024: Bargaining consultation (K-12 sector-wide and MOECC)
- **2024: Build 2025 bargaining plans – provincial and local**
- 2024: Consultation with PSEC-Secretariat (next mandate)

- **2025: Preparation of Provincial Framework Agreement (PFA) for support staff bargaining** (date: TBD)
- 2025: January Trustee Reps meeting on PFA bargaining plan (date: TBD)
- **2025: PFA bargaining commences and concludes** (dates: TBD)
- **2025**: **Commencement of local support staff collective bargaining** (date: TBD)

BCPSEA Services

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION

What services do you think BCPSEA should focus on for 2023-2024?

What services would you like BCPSEA to improve going forward?

What services should BCPSEA stop doing or make less of a priority?

Make a Future – Careers in BC Education

Make a Future
CAREERS IN BC EDUCATION

Make a Future

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION

- MAF started as a joint initiative in 2008, between BCPSEA, MOECC and the 60 Boards of Education, and is managed by BCPSEA's MAF team.
- Its original purpose to unify all job postings and applicant tracking for 60 School Districts into one branded on-line job postings board platform for the K-12 education sector, with linkages to other recruitment platforms (e.g., Indeed).
- MAF job postings (pre-COVID ➡ COVID ➡ post-COVID):

Calendar Year	Exempt	Support	Teacher	Total	
2019	490	1788	5556	**7834**	- 31% (COVID)
2020	307	1808	3858	**5973**	+15%
2021	435	2313	4127	**6875**	+30%
2022	501	3095	5379	**8975**	

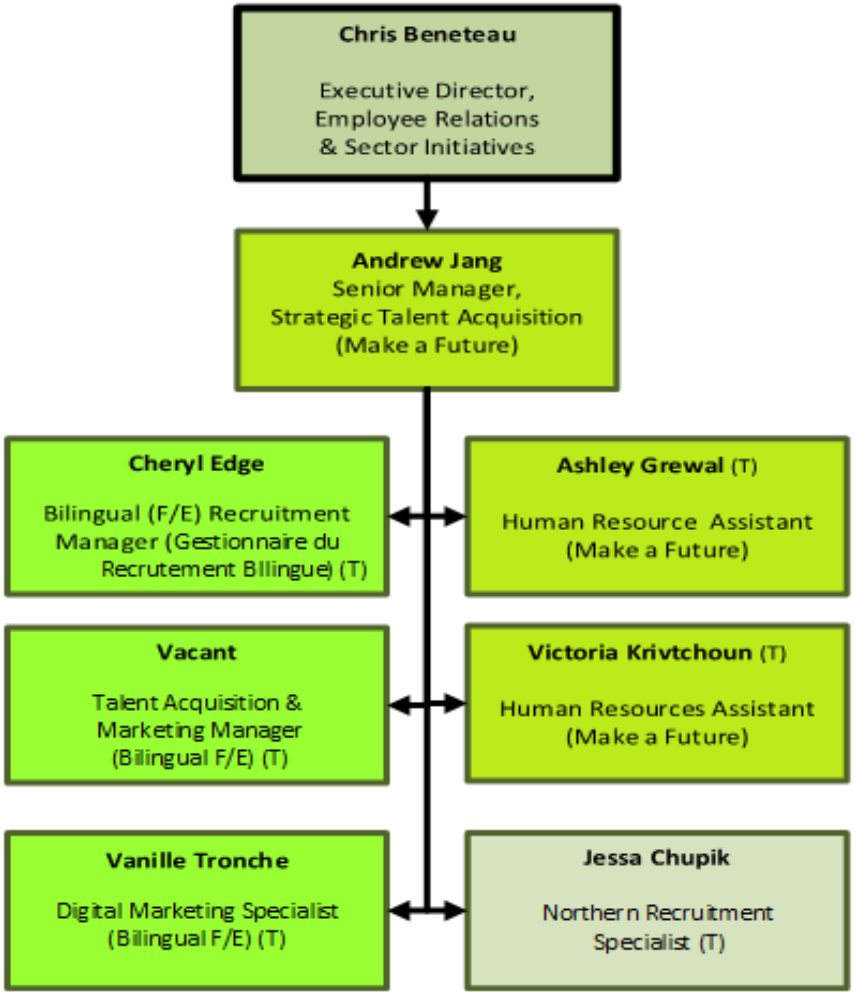
Note: The total number of candidates hired related to job postings is higher as many districts hire multiple candidates from one job posting.

- The core MAF team is composed of the Sr. Mgr., Strategic Talent Acquisition; Manager, Recruitment & Digital Marketing; and an HR Assistant.
- In addition, there are four additional MAF staff hired on specific grant funding for French Teacher Recruitment (2 positions) and Northern Recruitment (1 position).

Make a Future Team

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION
SOLUTIONS AT WORK

April 2023



Make a Future - Core services

Recruitment Advertising Services

- Cross-posting to promote and spotlight jobs
- Email Newsletter
- Email listservs & distribution lists
- Social Media Ads & Updates
- 400+ free & paid job boards

Candidate Outreach Services

- Career Fair Representation
- Career Fair Partnerships
- Post-Secondary Presentations

Branding Services

- Sharing stories & communicating your employer value proposition
- Info Sessions
- Social sharing
- Blogging

Northern Recruitment & Retention Initiative

North School Districts Labour Market

Realities of the North in a *tight* Labour Market.

Staff Shortages as at September 30, 2022

- **327** non-certified TTOCs
- **150** LOPs
- **51** active teacher postings
- No teacher coverage: **122 days in September**
- Short **91 bus drivers**
- Short **10 management positions**

Source: Ministry of Education and Child Care

Northern Recruitment Pilot Project

- Working Group established with representatives from five northern SDs, and MOECC and BCPSEA staff
- Recruitment and Retention incentive funding being provided by MOECC
- *new* **Northern Recruitment Specialist** position created and hired
- Initial pilot has identified to support recruitment activities in four northern school districts (SD82 Coast Mountains - Hazelton Region; SD87 Stikine; SD91 Nechako Lakes – Fort St. James Region; SD92 Nisga'a)
- MCM-LOU, for four SDs, agreed to between BCPSEA and BCTF regarding new hire qualified teacher incentive bonus and retention allowances for 2023-2024 School Year.

Northern Recruitment Specialist

Jessa Chupik jessac@makeafuture.ca

- Hired as at February 23, 2023, for a one-year term with BCPSEA's Make a Future Team (MOECC funding)
- Living and working in Daajing Giids on Haida Gwaii

  **currently temporarily located in Vanderhoof*
- 15 years of senior recruitment and DEI & R experience
- Previously at BIPOC Executive Search, Canada Education Leader partner for Boyden Executive Search, MobSquad, BC Public Service, Nunavut Government, and Toronto Metropolitan University
- Honours Bachelor of Arts degree in Indigenous Studies and a Master of Arts degree in Canadian Studies and Indigenous Studies

Northern Recruitment Specialist – Recent Activities

- Recruitment Specialist has met with each Northern School District to discuss recruitment and retention challenges and to understand the operational needs specific for each SD
- Recruitment Specialist has met with key MOECC representatives
- Attending the northern BCPSEA Regional Meetings and meeting with key SD attendees
- Initiated recruitment support for northern and remote SDs

Northern Working Group: current work and n*ext steps.*

- Gathering information on **current state** and **best practices**
- Reviewed collective agreements and labour relations best practices and legal decisions to determined initial **incentives options**
- Reviewing design of **mentorship opportunities**
- Exploring appetite for teacher education **programs for the north**
- Developing **evaluation tools**


French Teacher
Recruitment Initiative

French teacher recruitment initiatives

- Federal funding w/ MOECC support to promote French teaching opportunities in BC and recruit teachers to districts and the CSF

  $229K(2022/2023) + $229K(2023/2024) and $1.944M (2023/2024 – 2024/2025)

- Key activities:
  - New staff hires:
    - Bilingual (F/E) Recruitment Manager (*Cheryl Edge, see next slide*)
    - Bilingual (F/E) Talent Acquisition & Marketing Manager *(job posted)*
    - Bilingual (F/E) Digital Marketing Specialist *(Vanille Tronche – new hire)*
  - French teacher candidate pool
  - Cross-Canada and international outreach
  - Canada-wide promotions campaign
  - French teacher recruitment video
  - Recruitment website for French teachers
  - ***Grants to fund French teacher recruitment activities***

Bilingual (F/E) Recruitment Manager

Cheryl Edge enseigner@makeafuture.ca

- Recently retired senior school administrator/principal from the Delta School District
- Long-time educator who has held various roles, including French Immersion teacher, teacher mentor, school administrator and has worked on French recruitment for Delta SD
- Cheryl is a enthusiastic and strong supporter of French programs

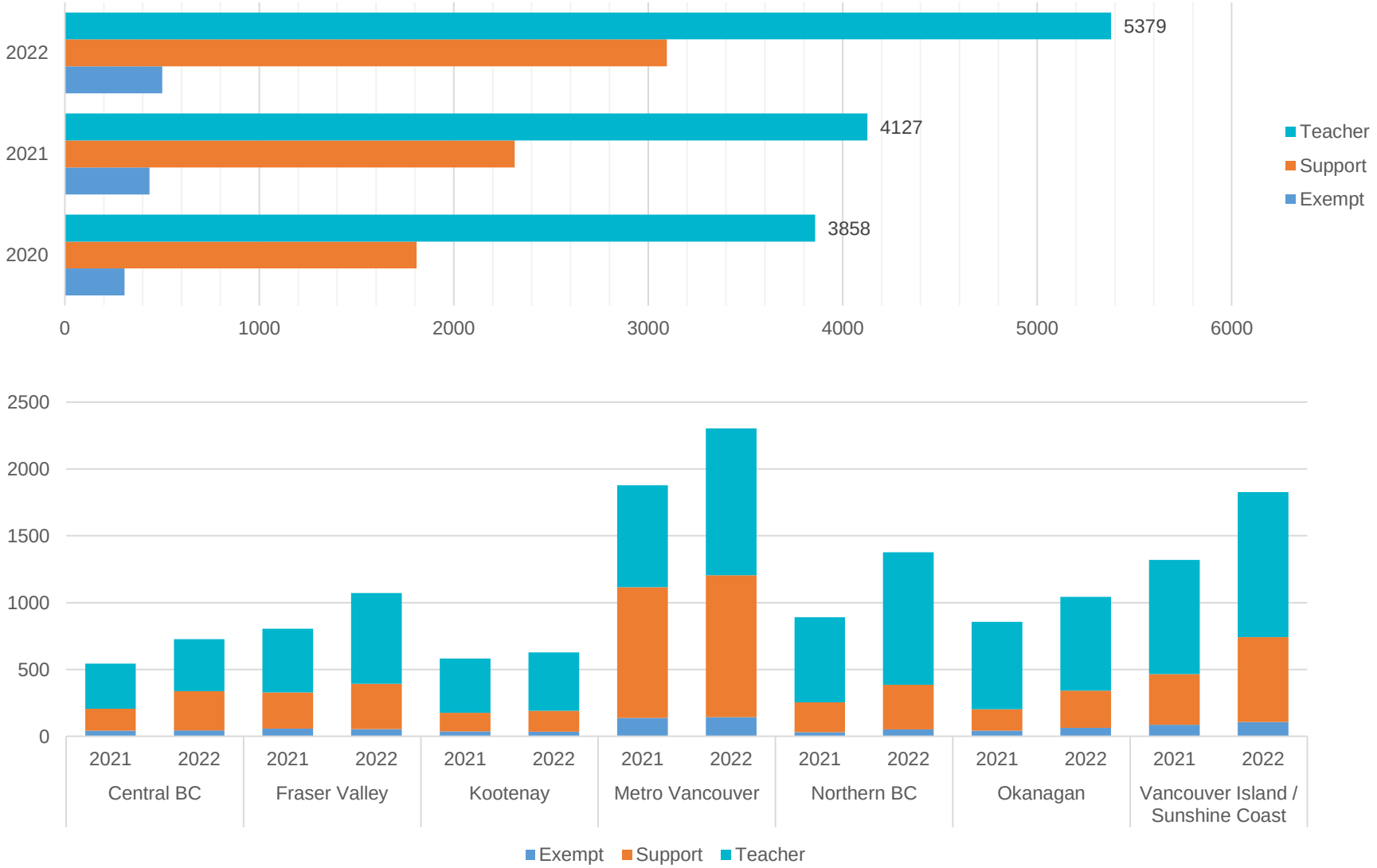
French teacher recruitment job fairs attended

Career Fair/Information session	Host School(s) / Orgs.	City, Province	Date
Education Career Fair	Simon Fraser University (SFU)	BC	16-Sep-22
Careers Day Job Fair	University of Regina	SK	26-Sep-22
Careers Day Job Fair	University of Regina	SK	28-Sep-22
Teacher info session	Make a Future	BC	5-Oct-22
ACPI Conference	ACPI	ON	3-Nov-22
Teacher info session	Simon Fraser University (SFU)	BC	10-Nov-22
Destination Canada Mobility Forum		Paris, France	17-Nov-22
Destination Canada Mobility Forum	Government of Canada	Rabat, Morocco	22-Nov-22
Destination Canada Mobility Forum (Virtual)	Government of Canada		28-Nov-22
Teacher info session - French cohort	Simon Fraser University (SFU)	BC	2-Dec-22
French Teacher Job Fair	Apply to Education	ON	7-Dec-22
Options Career Fair	Queen's University	Kingston, ON	9-Jan-23
Teacher info session (French)	University of British Columbia (UBC)	BC	11-Jan-23
Education Career Fair	University of British Columbia	Vancouver, BC	20-Jan-23
Education Fair	University of Alberta	Edmonton, AB	23-Jan-23
Education Fair	Campus St. Jean	Edmonton, AB	23-Jan-23
Education Fair	Université Saint Boniface	Winnipeg	27-Jan-23
Education Fair	Mount Saint Vincent University (MSVU)	Halifax, NS	28-Jan-23
Education Fair	McGill University	QC	8-Feb-23
Education Fair	University of Ottawa	ON	9-Feb-23
French Teacher Job Fair	Apply to Education	ON	1-Mar-23
Ed Talent Spring Job Fair	Apply to Education	Toronto, ON	21-Apr-23

Job Fairs are one of the talent pipeline methods to attract candidates

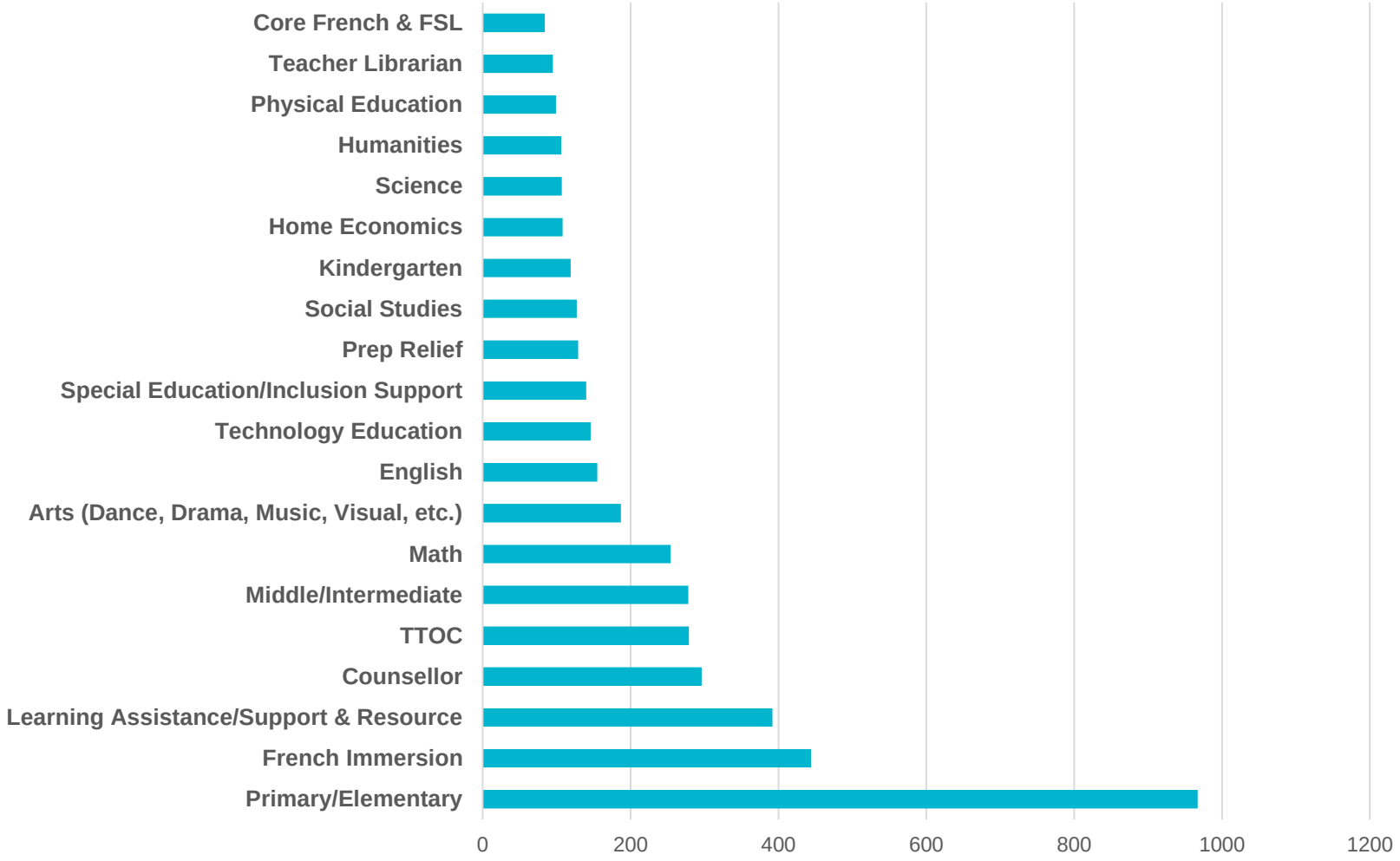

Recruitment
Landscape

Job postings



Source: MAF

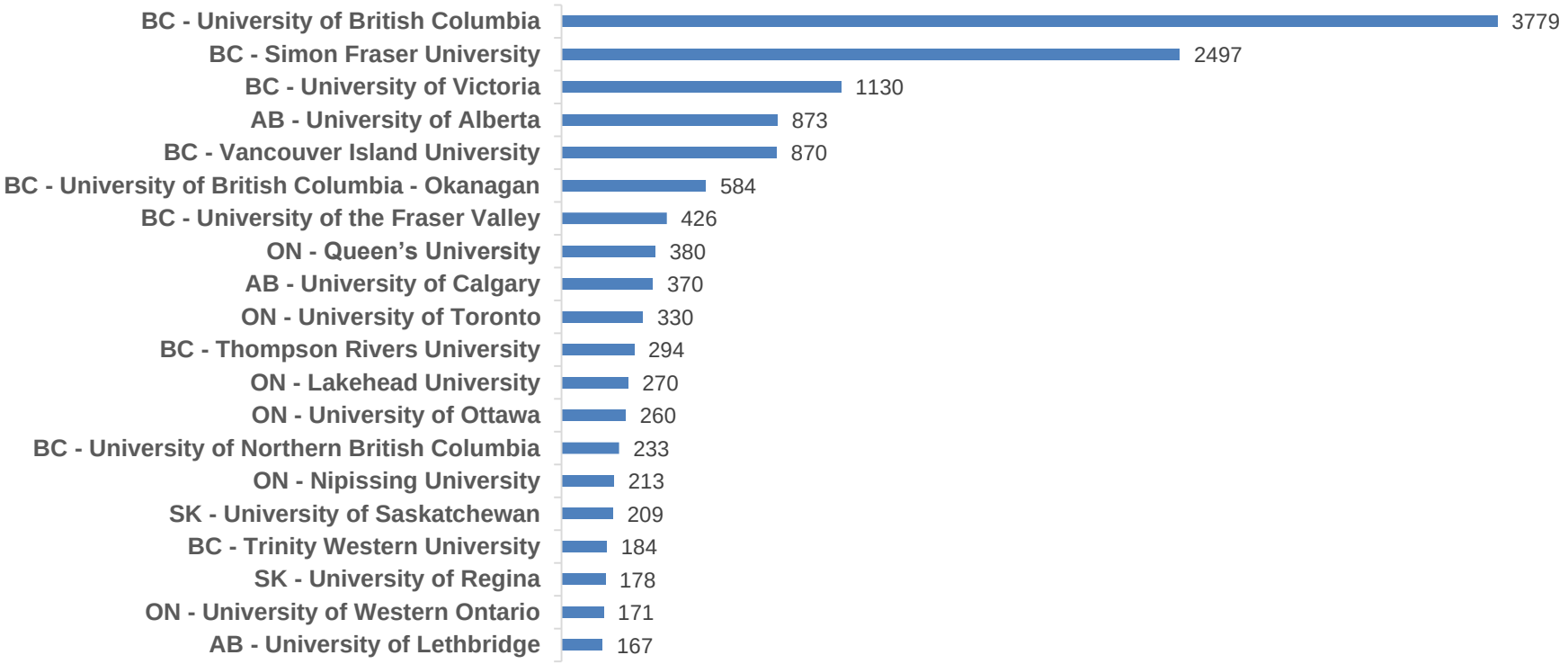
In-demand (job postings) roles – teachers



Source: MAF

Data: Calendar year 2022

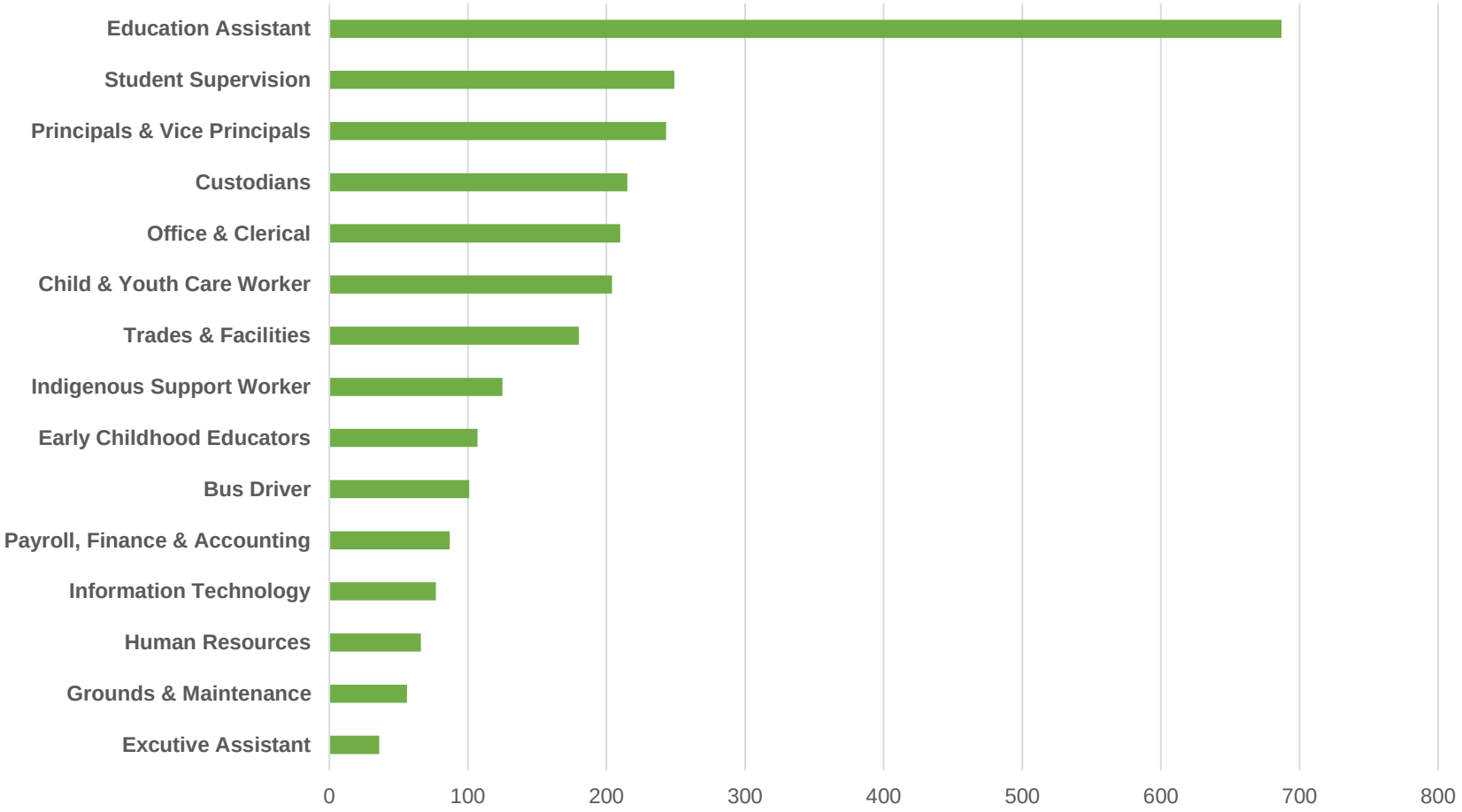
Post-secondary teacher supply pipeline



- BC grads make up 59% of new COQ holders in BC; 25% of COQs are from UBC
- Ontario teachers are now a smaller proportion of COQ holders in BC (10% vs 14%)
- Alberta grads continue to be 10% of the new COQ holders.
- Increasing number of international TEP graduates applying for a BC COQ

Source: Ministry of Education and Child Care *Data: New Hire Graduates from 2016-2017 to 2021-2022*

In-demand (job postings) roles – exempt/support



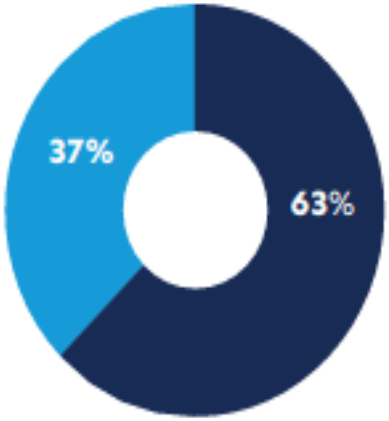
Source: MAF

Data: Calendar year 2022

BC Total Labour Market – the future forecast outlook

FIGURE 1-1: JOB OPENINGS, B.C., 2022-2032

Total job openings: 1,017,000

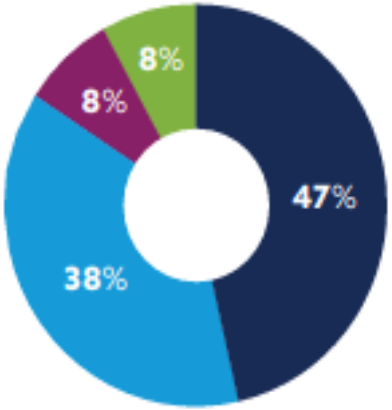


63%
Replacement (636,000)

37%
Expansion (381,000)

FIGURE 1-2: SOURCES OF NEW LABOUR SUPPLY, B.C., 2022-2032

Supply additions: 1,020,000



47%
Young people starting work (474,000)

38%
Immigrants (387,000)

8%
Migrants from other provinces (78,000)

8%
Additional supply requirement (81,500)

Projected shortfall of talent for BC

Source: BC Labour Market Outlook: 2022-2032 Forecast

Recruitment landscape

- There are more jobs available than people to fill them
- Young people and immigrants will take these jobs (2022-2032), but we will still need more people to fill all the available opportunities
- There are not enough locally trained teachers to meet the demand
- There is a large pool of COQ holders that are not in the job market
- Visible minorities and Indigenous workforce complement (*note: the following is MOECC's estimate for 2021/2022 school year based on 2016 census data*):
  - 15% of BC's teaching workforce are visible minorities; however, 35% of students are visible minorities (i.e. 20% gap)
  - 4% of BC's teaching workforce are Indigenous; however, 11% of students are Indigenous (i.e. 7% gap)

What we're hearing from districts

- Traditionally sought after positions are not being filled
- Retired TTOCs are filling
- Revolving door of TTOCs, SDs are always short staffed
- Lots of new hires don't want to work full-time
- General feeling that people are absent from work more often
- Because of no coverage, teachers are suffering through when they are sick
- Constant morning scrambles to figure out coverage
- Impacting morale for existing staff (retention issue)
- French immersion students often without qualified staff
- Lack of consistency for students, assessment is impacted, specialty programs impacted (classes cancelled), students worry about impact on graduation
- Stressful for parents
- Safety concerns

What candidates are telling us

Job seekers value: compensation; growth opportunities; flexibility to work from home; work/life balance; health benefits

Teachers are motivated by:

1. Wanting to make a difference
2. Love of a subject
3. Job security
4. Encouragement from parents/family
5. Giving back to the community

TTOCs are:

1. Seeking work/life balance
2. Concerned with cost of living
3. Working less than 3 days/week
4. Retired teachers
5. Interested in mentorship

How to leverage recruitment best practices and Make a Future's services to recruit teachers

HOW CAN WE SUPPORT YOU?

1. What are your top recruitment challenges?

2. To what extent does your district currently use MAF (BCPSEA) for recruitment services?

3. What recruitment services does your district want BCPSEA to provide that we are not doing and/or could do better, or more of?

4. For those expanded/improved services, what is the district's willingness / ability to invest in recruitment services?

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Break

Recruitment and retention

- **Labour Relations considerations**

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Labour Relations challenges

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- Collective Agreement

- Recruitment LR Challenges

- New Hot Topics Provincial Grievances

Recruitment LR challenges

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What collective agreement limitations and/or union resistance are you facing, if any, with your recruitment initiatives?

Strategies and Solutions

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- What can we do locally?
- What would be helpful provincially?

Provincial grievances

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Employment Standards Act (ESA)

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Casual and TTOC eligibility for ESA sick leave

BCTF Position	BCPSEA Position
TTOCs are eligible for the 5 days paid ESA sick leave regardless of whether the person has accepted work	TTOCs are only eligible if they have accepted work and then become sick and are unable to attend work

- John Hall appointed as arbitrator
- Hearing likely in January 2024

Employment Standards Act (ESA)

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TTOC entitlement to experience credits while on "leave"

BCTF Position	BCPSEA Position
TTOCs accrue experience credits while "on leave under the ESA"	TTOCs are not eligible for leaves under the ESA as they do not own positions from which to take leave.

Harassment Report Disclosure Process

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION

- BCTF position that the current harassment report disclosure process results in delay, breach of privacy, and lack of fair process
  - Alleges breach of Article E.2 and FIPPA
- BCPSEA is working to understand the specific concerns and areas of possible agreement
- Grievance has not yet been referred to arbitration
- Currently, harassment investigation reports are disclosed to BCTF and the teacher complainant/respondent using the Dorsey Protocol

Questions?

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What have we not talked about today that you'd like to ask and or discuss further?

Session feedback

BRITISH COLUMBIA PUBLIC SCHOOL EMPLOYERS' ASSOCIATION

Margaret Little,
13213 281 Road
Charlie Lake, BC
V1J K6
Phone: 250-785-5365 Cell/Text 250-262-7840
E-mail: mackeno35@gmail.com

Helen Gilbert, Chair and Trustees
Board of School Trustees,
Peace River North SD #60
10223 – 105th Ave.,
Fort St. John, BC
V1J 4S4

April 17, 2023

Dear Trustees,

Vision Screening for Kindergarten 2023

As Grade 1 teacher for many years, I relied on our Public Health system to ensure that our little ones were screened for hearing and for vision. To find out that the government had stopped the screening programme in schools for Kindergarten was heartbreaking and appalling. I am requesting that School District #60 join with me and lobby our government for the reinstatement of the public programme which supports all children.

Vision screening is extremely important especially in those very early years. **Every child deserves to have the best possible opportunity for success and it starts in Kindergarten.** In my beginning teaching days, I did not truly understand the importance of vision testing.

Prior to Kindergarten being implemented District wide, Jackie Horst began the first Readiness Class at Robert Ogilvie. She was adamant that the little ones be screened for vision. Those early days convinced me of the importance of screening although it would have been a small sampling, there were children who would be having potential learning difficulties.

One's school career starts in Kindergarten giving our little ones success for their future endeavors. It is up to everyone concerned to ensure that every opportunity is freely available for all. Having our Public Health system do the screening as the little ones begin their school career helps to provide that success.

I would hope that our School District will join me in lobbying the Government for the reinstatement of the Vision screening programme to ensure that ALL children are screened.

Thank you.

Margaret A. Little

Margaret Little
Bachelor of General Studies – Simon Fraser
Teacher – Ministry of Education Certificate #L024480 (Retired)

BRITISH COLUMBIA

April 12, 2023

Ref: 284154

Helen Gilbert, Chair
Board of Education
School District No. 60 (Peace River North)
Email: hngilbert@prn.bc.ca

Dear Mrs. Gilbert:

I am responding to a letter dated September 27, 2022, from Angela Telford, Secretary-Treasurer, requesting approval for the Peace River North Board of Education to underspend its targeted Indigenous Education funding amount for the 2021/22 school year. As this is targeted funding under Section 106.4 of the *School Act*, Boards of Education must request permission from the Minister of Education and Child Care to underspend their target on an annual basis. As Deputy Minister of Education and Child Care, I am pleased to respond on the Minister's behalf.

Pursuant to Section 106.4(2) of the *School Act*, approval is granted for the Board to underspend its 2021/22 school year Indigenous Education target in an amount up to $36,054. This variation of direction is granted on the condition that these funds will be brought forward and added to the 2022/23 school year Indigenous Education targeted amount to be expended on Indigenous Education programs. I encourage you to discuss your Indigenous Education targeted funding plans with the District Indigenous Education Council or equivalent, including the Nations and Métis Chartered communities whom you serve, to ensure respectful and meaningful engagement with Indigenous Peoples on the use of these funds.

Appendix to this letter contains statistics about your school district's Indigenous student outcomes. I hope we will see you build upon these achievements and strive for strong academic results for all your students in the current and subsequent school years.

If you have any questions or require further information regarding the financial reporting of Indigenous Education expenses, please contact Ian Aaron, Director, School District Financial Reporting, Resource Management Division, by phone at (250) 415-1073 or by email at Ian.Aaron@gov.bc.ca.

If you have any questions or require further information regarding how the Ministry is supporting delivery of Indigenous Education programs, please contact Stephanie Sinitsin, A/Director, Indigenous Education, Learning Division, by phone at (250) 896-4603 or by email at Stephanie.Sinitsin@gov.bc.ca.

.../2

Ministry of Education and Child Care
Office of the Deputy Minister

Mailing address:
PO Box 9179 Stn Prov Govt
Victoria BC V8W 9H8

Telephone: (250) 387-2026
Facsimile: (250) 356-6007

Again, thank you for writing.

Sincerely,

C. A. Zacharuk

Christina Zacharuk
Deputy Minister

pc: Stephen Petrucci, Superintendent of Schools
Angela Telford, Secretary-Treasurer
Pat Jansen, Principal of Indigenous Education
Stephanie Sinitsin, A/Director, Indigenous Education, Learning Division, Ministry of Education
Jonathan Foweraker, Executive Director, Resource Management Division, Ministry of Education
Ian Aaron, Director, School District Financial Reporting, Resource Management Division

.../3

Appendix – SD60 (Peace River North) Indigenous Student Achievements

In 2021/22 on the Grade 4 Literacy assessment, 71% of Indigenous students were "On Track" or "Extending" expectations on the revised FSA compared to 77% of Non-Indigenous students in SD60.

In 2021/22 on the Grade 4 Numeracy assessment, 53% of Indigenous students were "On Track" or "Extending" expectations on the revised FSA compared to 69% of Non-Indigenous students in SD60.

In 2021/22 on the Grade 7 Literacy assessment, 61% of Indigenous students were "On Track" or "Extending" expectations on the revised FSA compared to 67% of Non-Indigenous students in SD60.

In 2021/22 on the Grade 7 Numeracy assessment, 37% of Indigenous students were "On Track" or "Extending" expectations on the revised FSA compared to 53% of Non-Indigenous students in SD60.

Six-year completion rate for Indigenous students has decreased from 63.7% in 2017/18 to 60.0% in 2021/22.

Six-year completion rate for Non-Indigenous students have increased from 79.8% in 2017/18 to 84.1% in 2021/22.

Of 74 Indigenous graduates from SD60 in 2016/17, 16 (22%) immediately transitioned to B.C. public post-secondary institutions, and 4 years after grad, 25 (34%) had transitioned into post-secondary.

Of 286 Non-Indigenous graduates from SD60 in 2016/17, 88 (31%) immediately transitioned to B.C. public post-secondary institutions, and 4 years after grad, 125 (44%) had transitioned into post-secondary.

Of 54 Indigenous non-graduates from SD60 in 2016/17, 6 (11%) immediately transitioned to B.C. public post-secondary institutions, and 4 years after grad, 12 (22%) had transitioned into post-secondary.

Of 200 Non-Indigenous non-graduates from SD60 in 2016/17, 16 (8%) immediately transitioned to B.C. public post-secondary institutions, and 4 years after grad, 23 (12%) had transitioned into post-secondary.

North East Round Table Chair Report April 2023

Attached you will find the agenda for the March 22, 2023 NE Roundtable Meeting. The link to the North East Round Table Minutes and full reports is at the bottom of the page. The Treaty 8 negotiated agreements overview has also been attached. The agreement is a follow up to the court decisions around the Blueberry. The overview provides information about what will be happening in the region as well as background related to Truth and Reconciliation.

I have been attending the Round Table to follow up on Treaty Land Entitlement process because Cameron Lake Outdoor Education Site is included in the Moberly Lake Treaty Land Entitlement area. The Treaty Land Entitlement Report given at this meeting was very brief and it was said that MIRR's energy had been going into the negotiated agreements referenced above. The TLE process was moving into the implementation phase. This phase will take a long time perhaps up to 10 years. Some still have concerns regarding the land selections.

The next North East Round table meeting is in June.

April 16th Alaska Highway News reported that the TLE Agreements have been signed with BC, the Federal Government and Blueberry River First Nation, Doig River First Nation, Halfway River First Nation, Saulteau First Nation and West Moberly First Nation.

March 22, 2023

Morning Session: 9:00 AM – 12:00 PM (pst)
Afternoon Session: 1:00 PM – 3:00 PM (pst)

Location: Pomeroy Hotel & Conference Centre
Microsoft Teams Click here to join the meeting

Topic	Time	Lead	Purpose / Objectives
1. Welcome and Housekeeping	9:00 –9:05	Jason Lawson	• Additional business • Actions from previous meeting
2. Participant introductions	9:05–9:20	Shayla Blue	• Who is present
3. Agreements with Treaty 8 First Nations	9:20–10:10	Dale Morgan	• Provide overview and answer questions regarding agreements (Blueberry and Treaty 8) signed between governments to better protect treaty rights and support responsible resource development. • Agreements available by Nation at: First Nations A-Z Listing - Province of British Columbia (gov.bc.ca)
4. BC Energy Regulator and Ministry of Forest Permitting	10:10-10:30	Garth Thoroughgood Marianne Johnson	• Update on status of permitting processes
Break	**10:30 – 10:45 AM**		**Break**
5. Together for Wildlife	10:50-11:10	Aviva Jones	• Update on Together for Wildlife in NE
6. Indigenous Protected and Conserved Areas and BC's Commitment to Protect 30 % of the province by 2030.	11:10-12:00	Rhonda Cage Chris David	• Overview of provincial planning related to IPCAs and 30x30 • Kaska IPCA
Lunch	**12:00 – 1:00 PM**		**Lunch**
7. Treaty Land Entitlement	1:00-1:20	Dale Morgan	• TLE Settlement and Lands Agreements
8. Boreal Caribou Protection and Recovery Plan	1:20 –1:30	Mike Huck	• Current status and next steps • https://engage.gov.bc.ca/caribou/boreal-caribou/
9. BC Wildlife Federation	1:30 – 2:00	Gerry Paille	• Highlights of BCWF activities
10. Legacy Site Restoration Program	2:00-2:30	Matthias Loeseken	• Community-led restoration projects focused on restoring legacy petroleum & natural gas disturbances
11. Meeting closure	2:30-3:00	Jason Lawson	• Discuss any new business, future topics, and meeting dates

All meeting notes and materials available online **https://nestakeholderroundtable.ca/**

Protecting Treaty 8 rights & supporting responsible resource development

New agreements overview

BC & Blueberry River First Nations

BC & four Nations: Halfway River, Doig River, Saulteau, Fort Nelson

NE Roundtable Overview
March 22, 2023

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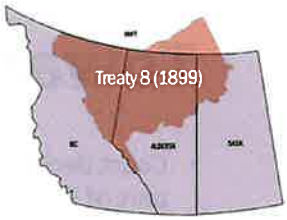
Today's presentation

- Start with context
- Overview agreements at high level
- Walk through some early, anticipated questions, with responses
- Open floor for additional questions
- Direct any offline follow-ups over today/tomorrow/Friday to Shayla.Blue@gov.bc.ca then prepare grouped set of responses either by email, webinar or recorded video.
- Continue the discussion at future NE Roundtable meetings, specific to implementation actions completed or underway.

***

- Agreements available online at: First Nations A-Z Listing - Province of British Columbia (gov.bc.ca)

Why are agreements needed?



- **1899** – Treaty signed in agreement of sharing the lands – Eight BC based Nations as signatories, adhering over time.
- **June 2021** – BC Supreme Court determined infringement of Blueberry River First Nations' Treaty 8 rights.
  - The Province chose to not to appeal decision and negotiate with Blueberry River.
- **Court declarations** re: Blueberry River's case:
  1. "...The Province's mechanisms for **assessing and taking into account cumulative effects are lacking** and have contributed to the breach of its obligations under Treaty 8,"
  2. "...there are **not sufficient and appropriate lands** in the Blueberry Claim Area to allow for Blueberry's **meaningful exercise of their treaty rights,**"
  3. "The **Province may not continue to authorize activities** that breach the promises included in the Treaty, ...or that **unjustifiably infringe** Blueberry's exercise of its treaty rights,"
  4. "...**establish timely enforceable mechanisms to assess and manage the cumulative impact of industrial development**...ensure these constitutional rights are respected."
- Good summary background on history created by Blueberry River - **Where Happiness Dwells** - Blueberry River First Nations (blueberryfn.com) or Treaty 8 itself – Treaty 8 Tribal Association website.

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Towards Agreements

- Court declarations prevent further resource activities in large part of B.C (3.8 million hectares, or ~4%) without justification.
- Treaty 8 First Nations share Treaty 8 territory and have Treaty 8 rights – to hunt, fish and trap and carry out a traditional way of life.
- In 2021, 6/8 Treaty 8 Nations came together seeking negotiated path to reconcile on cumulative impacts on their treaty rights.
- Two BRFN agreements since court decision:
  - **Interim Agreement Oct 2021**.
  - **Implementation Agreement Jan 2023**.
- Four Nations signed (Halfway River, Doig River, Saulteau, Fort Nelson First Nations):
  - **Letters of Agreement (Consensus Document)**.
  - **Revenue Sharing Agreements.**

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New Agreements: *Expected and Anticipated Outcomes*

- Better recognition and respect for Treaty 8 rights.
- Timely and enforceable policies and procedures that address cumulative effects.
- A large restoration investment and program, to heal the land and people.
- New land use plans for the BRFN Claim Area, providing greater clarity for future conservation and development interests, and predictability for projects.
- New protected areas from new industrial activities, as possible Indigenous Protected and Conserved Areas.
- New regime / system for all natural resource sector activities, including new rules, requirements for pre-planning for permits or projects.
    - With BRFN: Introduce ecosystem-based management principles and approach for sustainable resource development. Initial emphasis on PNG, forestry and water use.
- If implemented as intended, agreement with Blueberry River will satisfy court's fourth declaration.

BRFN Implementation Agreement: *Overarching Purposes, Goals, Structure*

Purposes	Goals	Structure
1. New approach to natural resource management which protects treaty rights 2. Balance treaty rights and healing of the environment with sustainable regional economy 3. Reduce greenhouse gas emissions	1. Enhance restoration to heal the land 2. Create new areas protected from new industrial activities 3. Both support and constrain development activities	• Interim approaches, forestry and oil & gas focused, • Longer term processes applicable to all land-based activities.

A framework for change: The Consensus Document (BC & six Nations)

- Set of initiatives in what we call the "Consensus Document:"
- Priority areas for action will:
  1. Address the cumulative impacts of industrial development,
  2. Develop ways to manage for cumulative effects going forward, to protect treaty rights,
  3. Create predictability for proponents and our governments on future resource development,
  4. Support responsible resource development paired with a significant investment in restoration to heal the land, and
  5. Share the message that *we are all treaty people.*

Priority change areas in agreements

- Wildlife management
- Restoration
- Land use planning (interim, longer term)
- Natural resource sector development: PNG, forestry, water (interim, longer term)
- Cumulative effects assessment and management / stewardship
- Economic measures
- Honouring the Treaty

Wildlife and Wildlife Management

Access to wildlife is integral to the practice of Treaty 8 rights and the way of life promised in the treaty.

PATH FORWARD:

- Work together **towards wildlife co-management**, starting with improving shared, trusted information on wildlife populations, bringing together Indigenous knowledge and western science.
- Substantial focus on moose management and caribou, including hunting regulations, to aid in the meaningful practice of Treaty Rights.
- Support cultural burning to promote wildlife habitat improvements.
- Continue support for caribou recovery and associated predator management.
- Support continued guardian and stewardship work.
- Create a **regional wildlife working group**, to bring together First Nations, the Province and interest groups on future shared management priorities.

Restoration

Decades of uncoordinated industrial disturbance have fragmented ecosystems and wildlife habitat, degrading the meaningful practice of treaty rights.

PATH FORWARD:

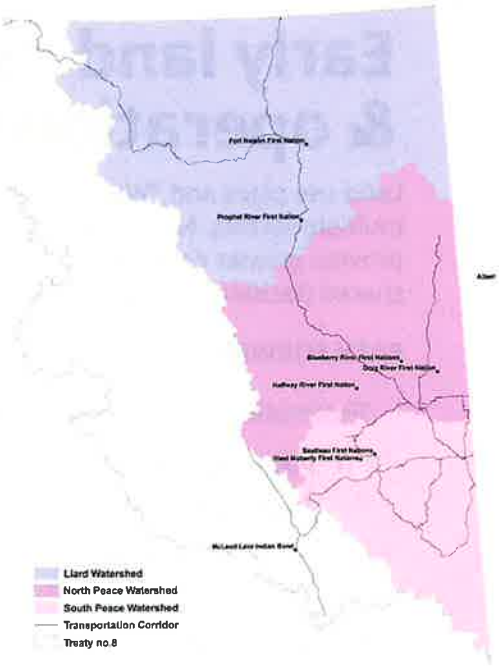
- Establish two BC-First Nation restoration funds, independent of all governments involved.
- Purpose = **heal the land and heal the people**.
- Joint oversight with Board of Directors, and **Indigenous-led delivery** and restoration standard setting for activities that are **incremental to existing obligations**.
- Provincial contribution shared between funds at >$600M over ten years; can be offset by contributions from industry, non-government organizations, federal government.
- BRFN Example: PNG-related new land disturbance fees of $60,000 / hectare in HV1 areas and Priority WMB Plan areas. In Trapline Areas outside of these two zones, disturbance fee applies / shared between BRFN and Other Treaty 8 Nations.

Land use planning

Land use plans from 1990s didn't adequately recognize or protect Treaty 8 rights. Treaty 8 First Nations treated as a stakeholder at the table, not independent governments with constitutionally protected rights.

PATH FORWARD:

- Develop new land use plans in the **Liard, North Peace and South Peace** areas.
- Work with BRFN in watersheds of greatest interest = Watershed Management Basin plans or "WMB plans."
- WMB plans are intended to implement **four agreed principles of ecosystem-based management** applicable for all natural resource sector activities:
  - Ensure old growth forest levels reflect what would be a natural condition for the ecosystems,
  - Establish reserved areas that protect, connect and recover important values,
  - Effectively protect and recover water, riparian and wildlife features, and
  - Promote sustainable economies and resilient communities.
- Four WMB plans from BRFN IA projected for completion within three years.



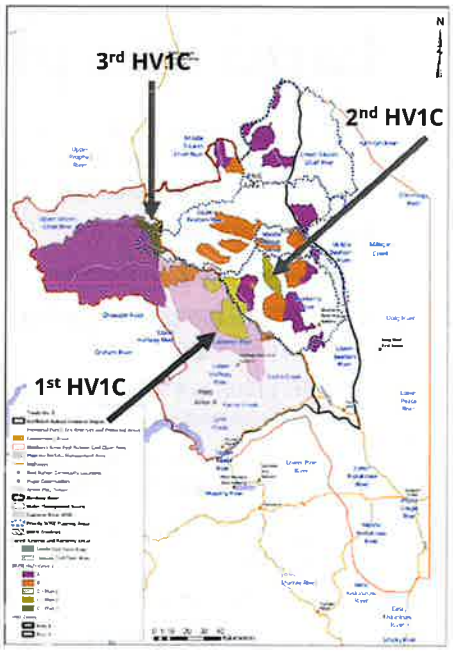
BRITISH COLUMBIA

Early land use planning & operations

Land use plans and "WMB plans" are complex and will take years bringing multiple sectors, Nations and the public together, covering larger areas. To provide greater continuity for activities now, and a practical approach to shared decision making, a different approach is being advanced.

PATH FORWARD:

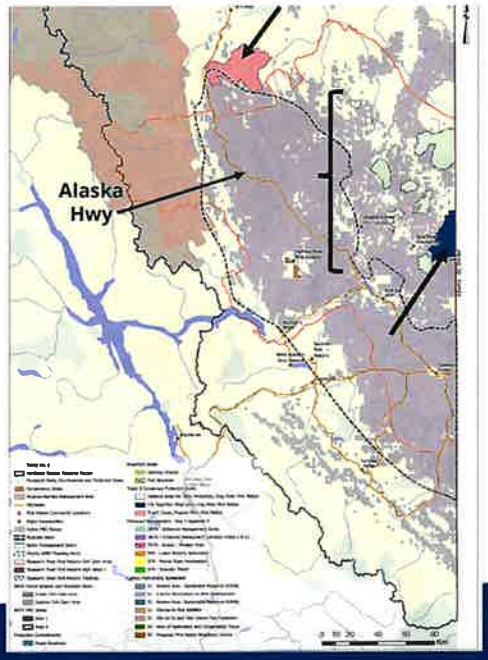
- 'Restoration and development plans' with Nations and industry:
  - Planning pilots with one or more sectors, with Halfway River and Saulteau First Nations (to start).
  - HV1 Plans with BRFN, focused on PNG activities (new intensive, up front planning approach).
- With BRFN, short term timber harvesting and oil and gas activities confirmed, to support economic activities while planning & restoration actions progress.

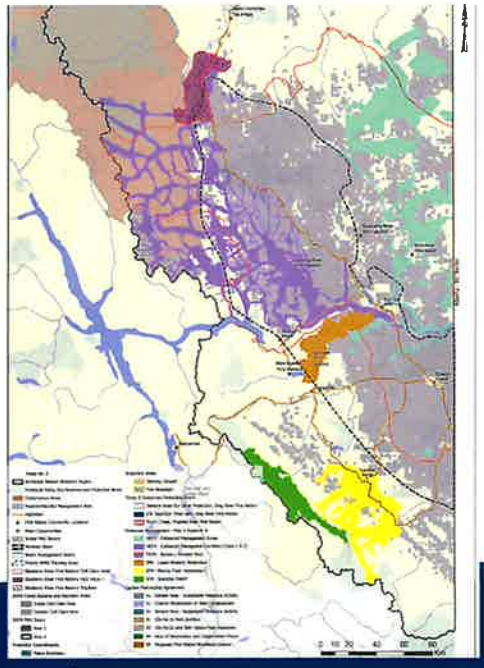


BRITISH COLUMBIA

Land use measures: Consensus Document

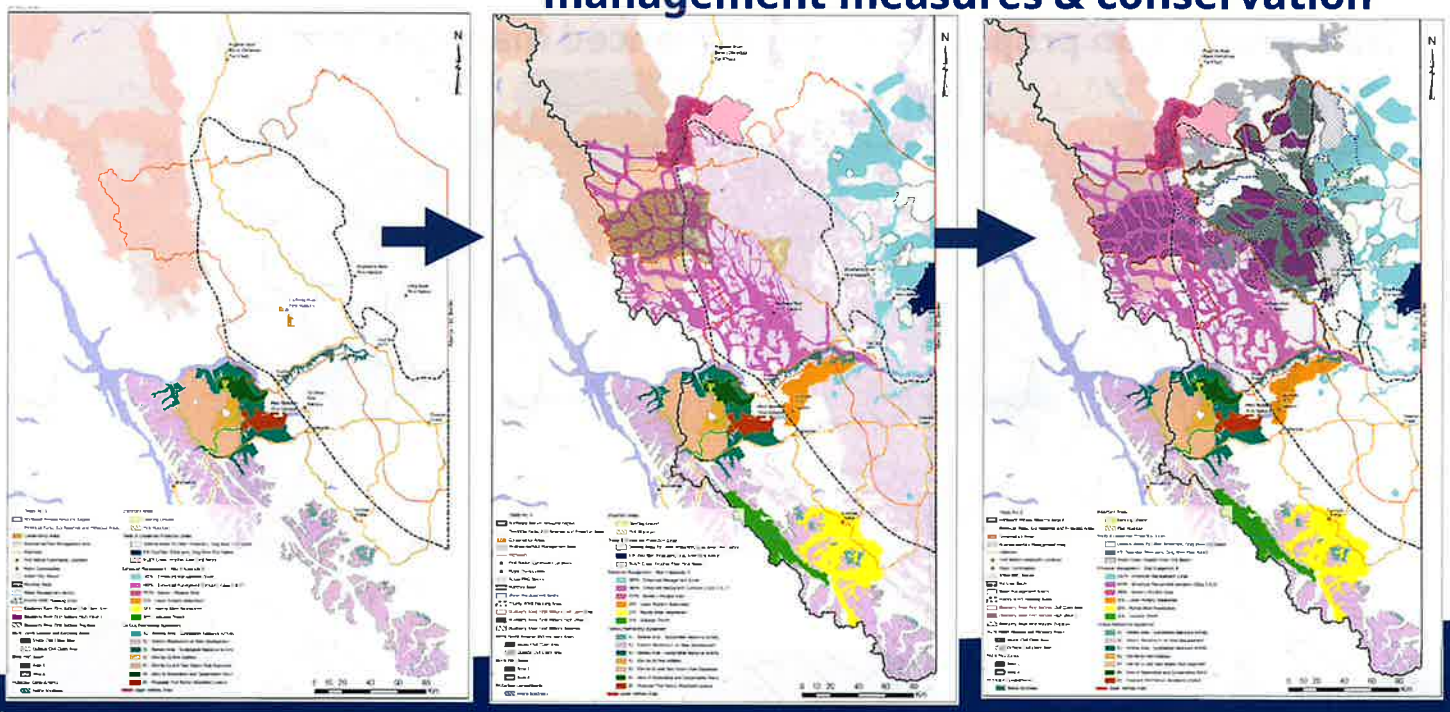
New protection proposals **+** **Enhanced management areas**





Today

Future State – better rights protection via management measures & conservation

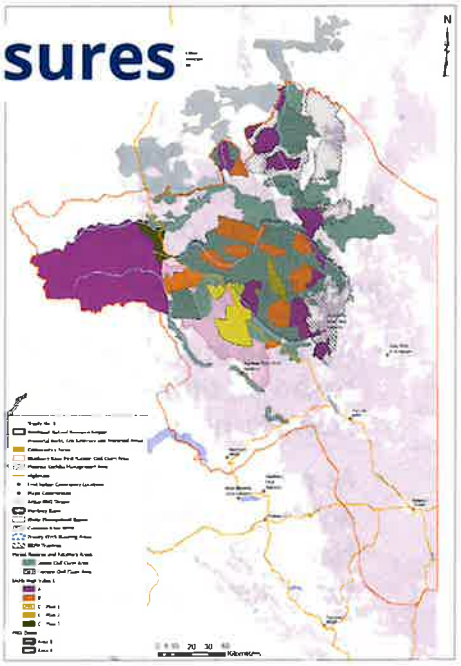


BRFN IA CE management measures

The layered effect of multiple resource sectors developing in different patterns in similar and different areas, lacking coordination and an overall plan to protect treaty rights led to a nationally significant court decision.

PATH FORWARD:

- Reduce timber harvesting in HV1 by approximately 350,000 cubic metres per year; tenure holders to be compensated. Allow several woodlots to continue.
- Revise the Allowable Annual Cut and Sustainable Forest Management Plan, and intensity of forestry in the Timber Supply Area. Apply ecosystem-based management principles for future forestry planning.
- Prohibit aerial herbicide use, and only use it in ground-based applications in exceptional circumstances.
- New oil and gas regime, with new development principles, protection targets, an annual disturbance cap, new operating rules, etc.
- Set protection targets within HV1 Areas (no new PNG disturbance):
  a) HV1A = 100% protection [Purple]
  b) HV1B – 80% protection [Orange]
  c) HV1C = 60% protection [Chartreuse]
- New water policy measures and decision support tool.



Economic measures

First Nations – like all governments – require sources of revenues to deliver service and accountabilities to their citizens. Implementing this Agreement will be complex and require fiscal supports on components like the land planning to complete it.

PATH FORWARD:

- Agree to economic benefits package for all Nations, including new revenue sharing model based on similar formula, and supports for agreement implementation (e.g., planning, stewardship).
- As part of implementing the United Nations Declaration on the Rights of Indigenous Peoples, agree to further negotiations on a new fiscal framework which enables a future where Treaty 8 Nations can fulfil their responsibilities, care for their citizens and manage Treaty 8 territory and their core areas in ways that reflect their values, and support some natural resource activities.

Honouring the Treaty

British Columbia has few historic treaties, unlike the rest of Canada. As a result, British Columbians are not as familiar with Treaty 8, what it says and what it means.

PATH FORWARD:

- Agree to develop a shared approach to enhance awareness, education, understanding and appreciation for our shared treaty.
- Measures will differ between Nations, and they are all anticipated to include work such as:
  - shared public communications over time,
  - shared training and awareness building (for public, public servants, those living and working in NE BC), and
  - education and community services.
- Develop a stronger local and provincial understanding that *we are all treaty people.*

Resetting the Balance

Resetting the balance for Treaty 8 rights and responsible resource development:

- Better recognition and respect for Treaty 8 rights.
- Timely and enforceable policies and procedures that address cumulative effects.
- A large restoration investment and program, to heal the land and people.
- New land use plans for Northeast BC, starting in Blueberry River's "core" areas, providing greater clarity for future conservation and development interests, and predictability for projects.
- New protected areas from new industrial activities, as possible Indigenous Protected and Conserved Areas.
- New approach for all natural resource sector activities, including new rules, requirements for pre-planning for permits or projects.
    - In BRFN Claim Area, will be based on principles of ecosystem-based management.

Q & A - General

- Where are the agreements posted?
- When does BC anticipate completing agreements with the three remaining Treaty 8 Nations?
- How long are these agreements in effect for?
- How will the NE Roundtable be part of, or informed of, the implementation of the various measures?
- What role could the NE Roundtable play in honouring the treaty?

Your questions: put them in the chat box, or raise your hand, or send them in offline to Shayla.Blue@gov.bc.ca to get answered

50-30 Challenge Board Chair Report

NLC is one of four hubs in the country for the 50-30 Challenge. They have federal funding to carry out this initiative.

What is the 50-30 Challenge?
The 50-30 Challenge is working with organizations across Canada to support an increase in diversity in places where decisions are being made. There are approximately 1,900 organizations signed on at this point, with the collective goals to:

1. Gender parity (50% women and/or non-binary people) on Canadian boards and/or in senior management; and
2. Significant representation (30%) on Canadian boards and/or senior management of members of other equity-deserving groups, including those who identify as Racialized, Black, and/or People of colour ("Visible Minorities"), People with disabilities (including invisible and episodic disabilities), 2SLGBTQ+ and/or gender and sexually diverse individuals, and Aboriginal and/or Indigenous Peoples. The program and participants recognize Indigenous Peoples, including First Nations, Métis and Inuit, as founding Peoples of Canada and underrepresented in positions of economic influence and leadership.

I attended a pilot meeting that was actually a chance for the group to trial their presentation before using it with other groups and communities. Prior to attending I made it clear that as a single trustee I could not make a commitment for the board and district staff involvement in a decision like this would be essential.

There were elements of the presentation that I thought would be of interest to the board. The demographic information presented is good to have as we move into Strategic Planning.

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50/30 Challenge

March 21, 2023

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Land honouring

Introduction of speakers

- Karen Mason-Bennett
- Marleen Morris
- Mindy Gobbi

Community guidelines

- Act with mindfulness and care in discussions. Being respectful in your interactions and sharing.
- Awareness of power dynamics
- Learning can be uncomfortable.

Agenda

- 50/30 Challenge – Who, What, Why
- The numbers
- Journey of 50/30
- Break
- 50/30 Challenge Website and What Works Toolkit
- Next Steps
- Q & A

What is the 50/30 Challenge

- Why was it established?
  - Recognize and realize the potential of Canada's greatest asset: our people
  - Understand the implications of Canada's changing population and demographic profile
  - Embrace the benefits of a equitable, diverse, and inclusive workplace

What is the 50/30 Challenge

- Goals of the program
  - For boards and senior management
    - Gender parity (50% women and/or non-binary people)
    - Significant representation (30%) of:
      - Indigenous Peoples (including First Nations, Metis, and Inuit)
      - Racialized, Black, and/or People of Colour (Visible Minorities)
      - People with disabilities (including invisible and episodic disabilities)
      - 2SLGBTQ+ and/or gender and sexually diverse individuals

What is the 50/30 Challenge

- Philosophy of the program
  - That diversity and inclusion
    - Help organizations and businesses thrive
      - Better anticipate the needs and wants of Canadians
      - Achieve better business outcomes and outperform peers (8 times more likely)
    - Promote innovation and access to more diverse markets
      - 19% higher revenue due to innovation
      - 70% more likely to capture new markets
    - Increase employee/workplace satisfaction
      - Overcome skill gaps, foster greater loyalty and retention

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Story sharing

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Diversity & Inclusion by the numbers

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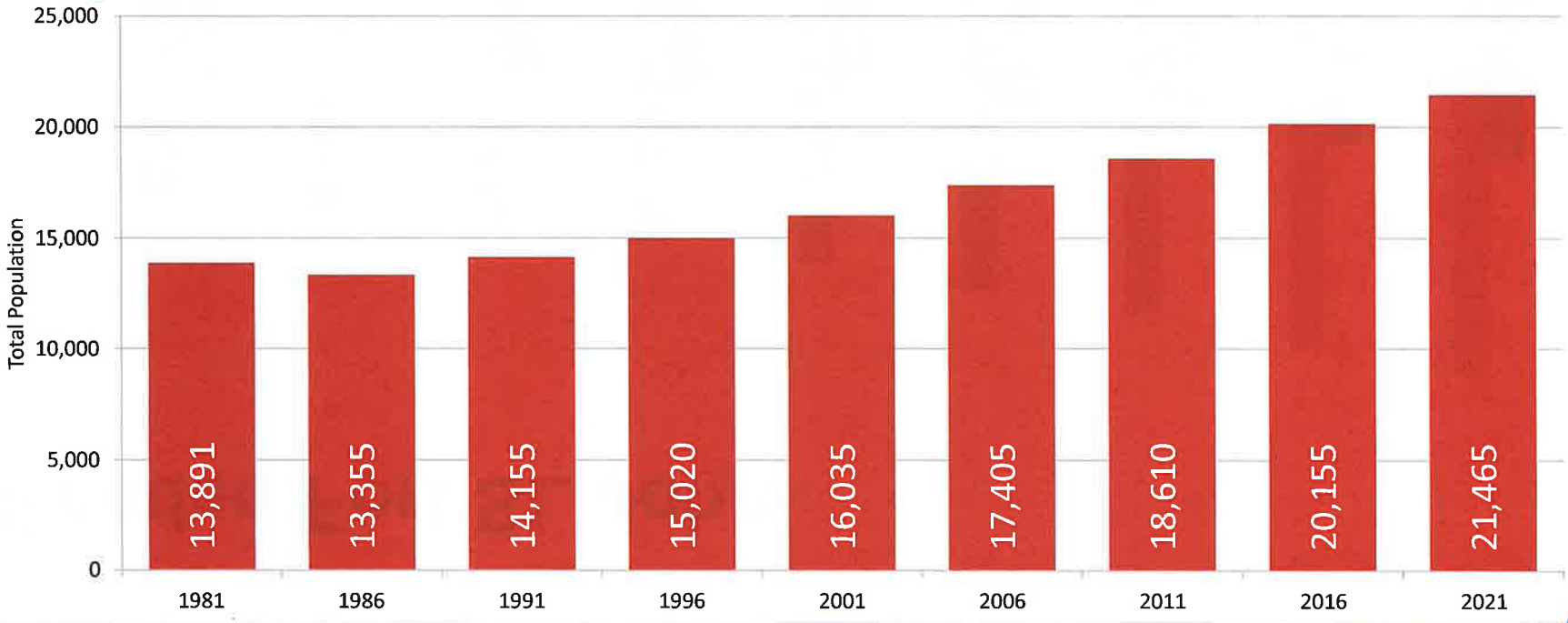
Population, Fort St. John



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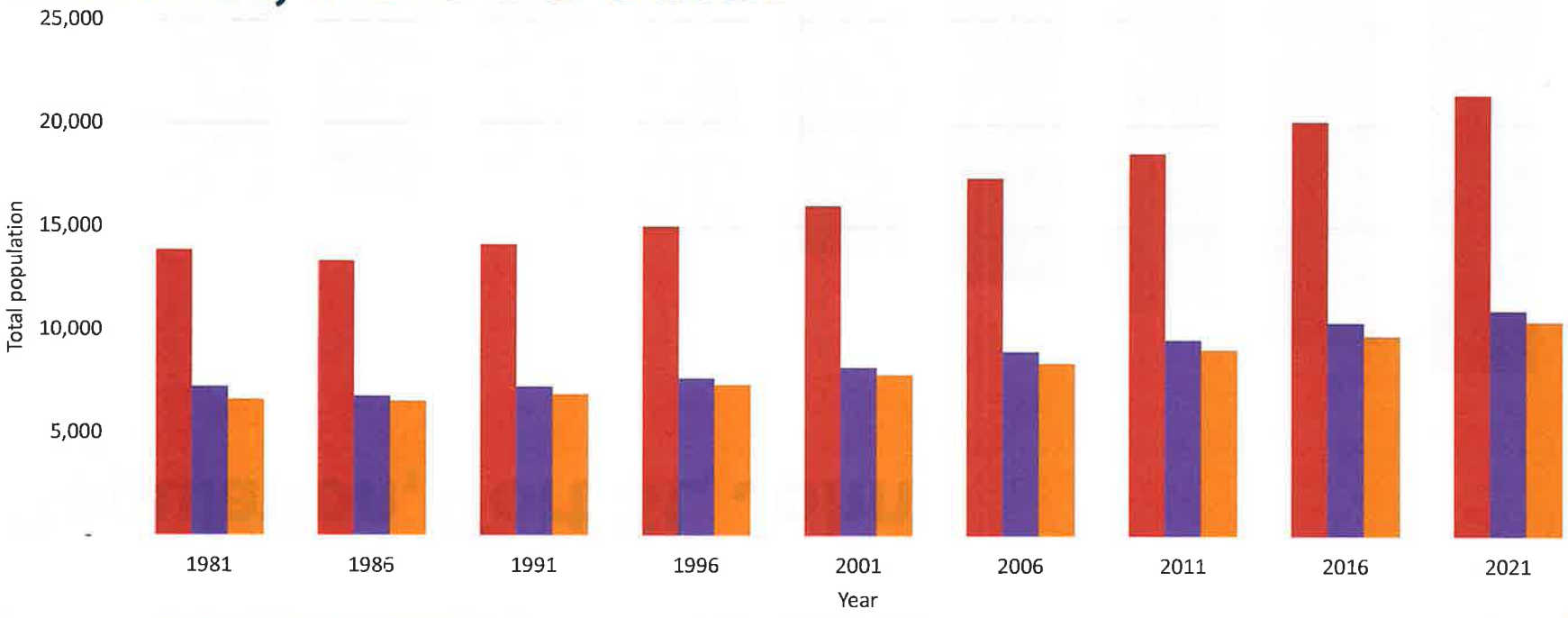
Gender, Fort St. John



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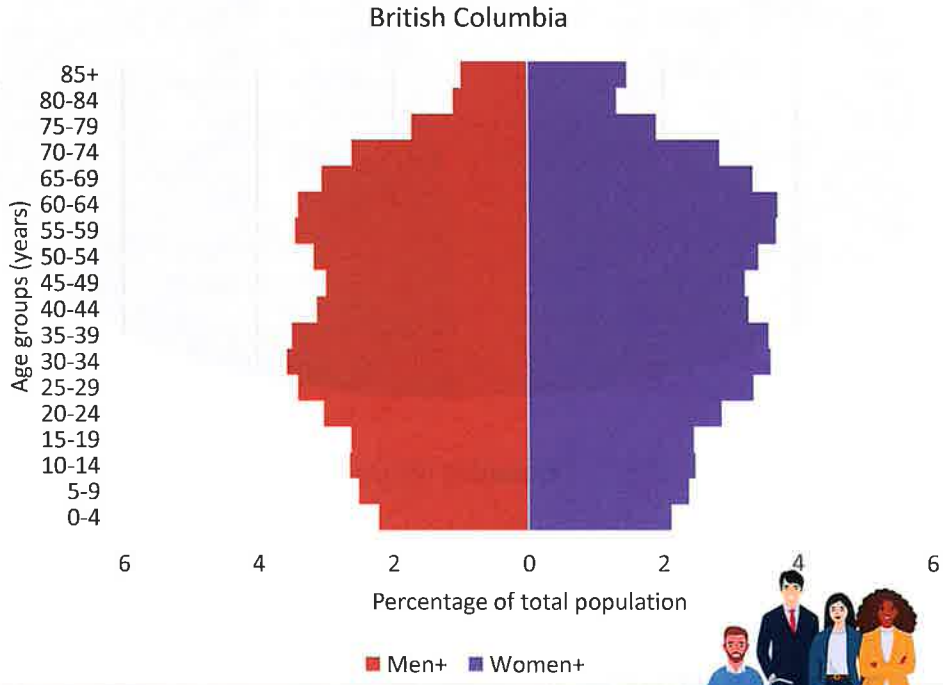
Population Pyramids, 2021



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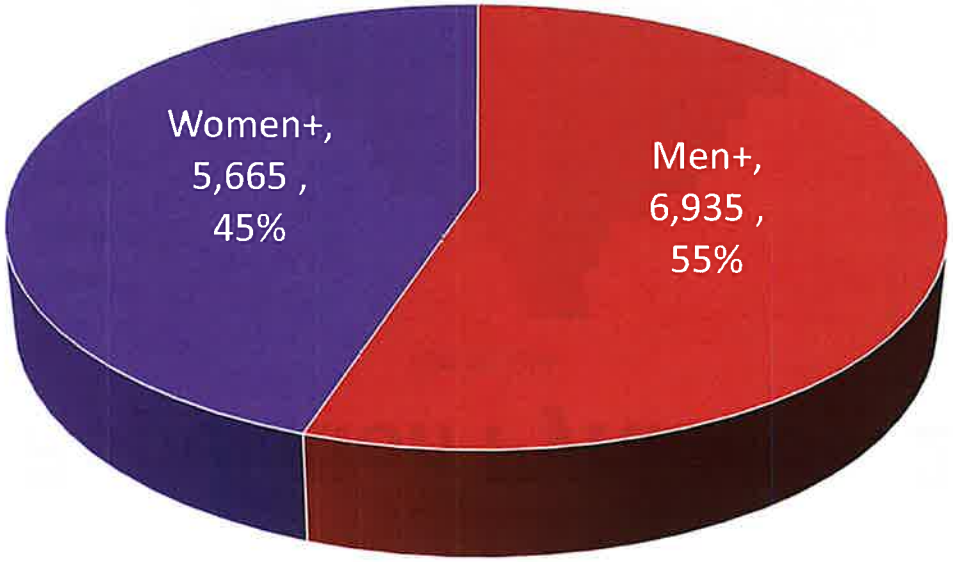
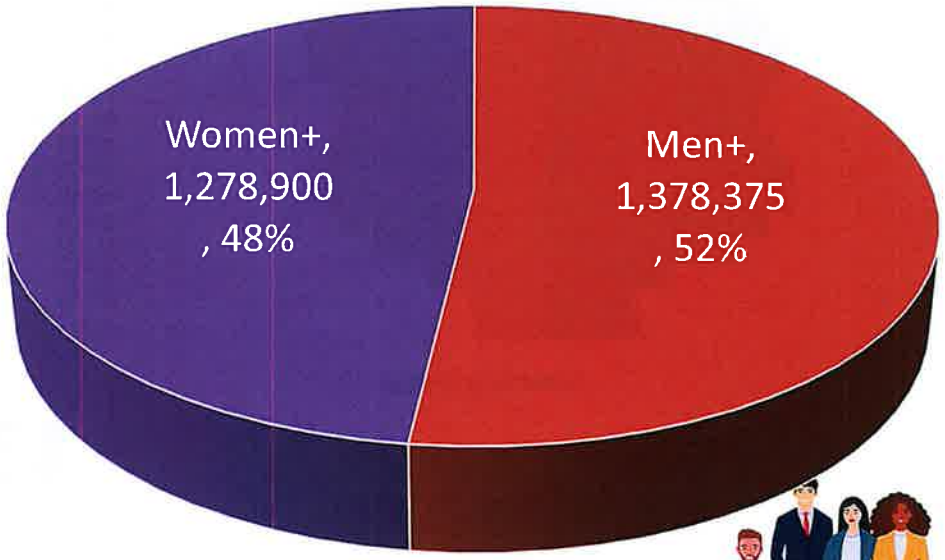
Labour Force, 2021

Fort St. John



British Columbia



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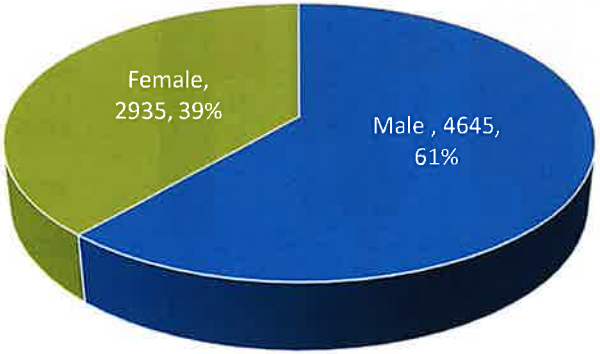
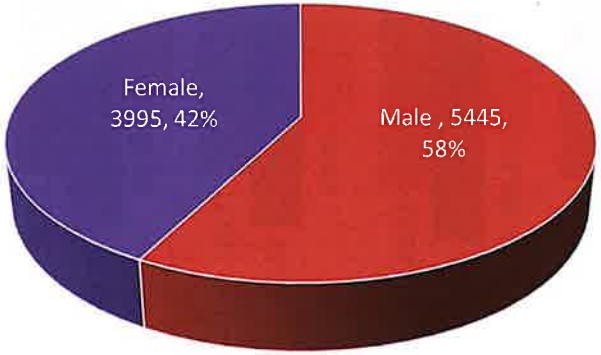
Labour Force, Fort St. John

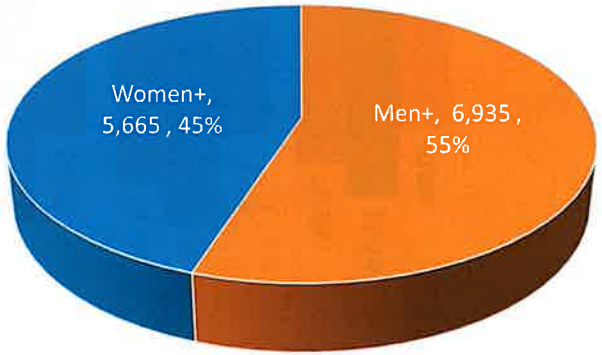
1981



2001



2021



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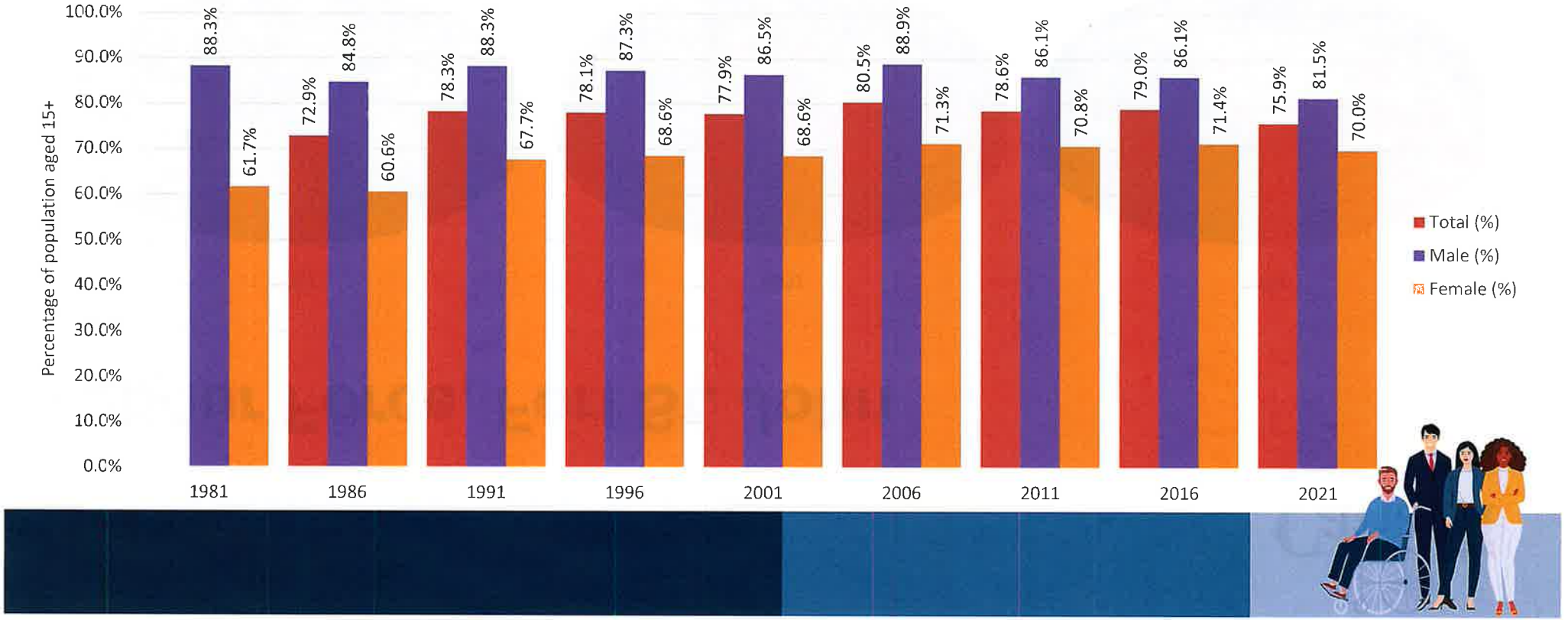
Participation Rate, Fort St. John



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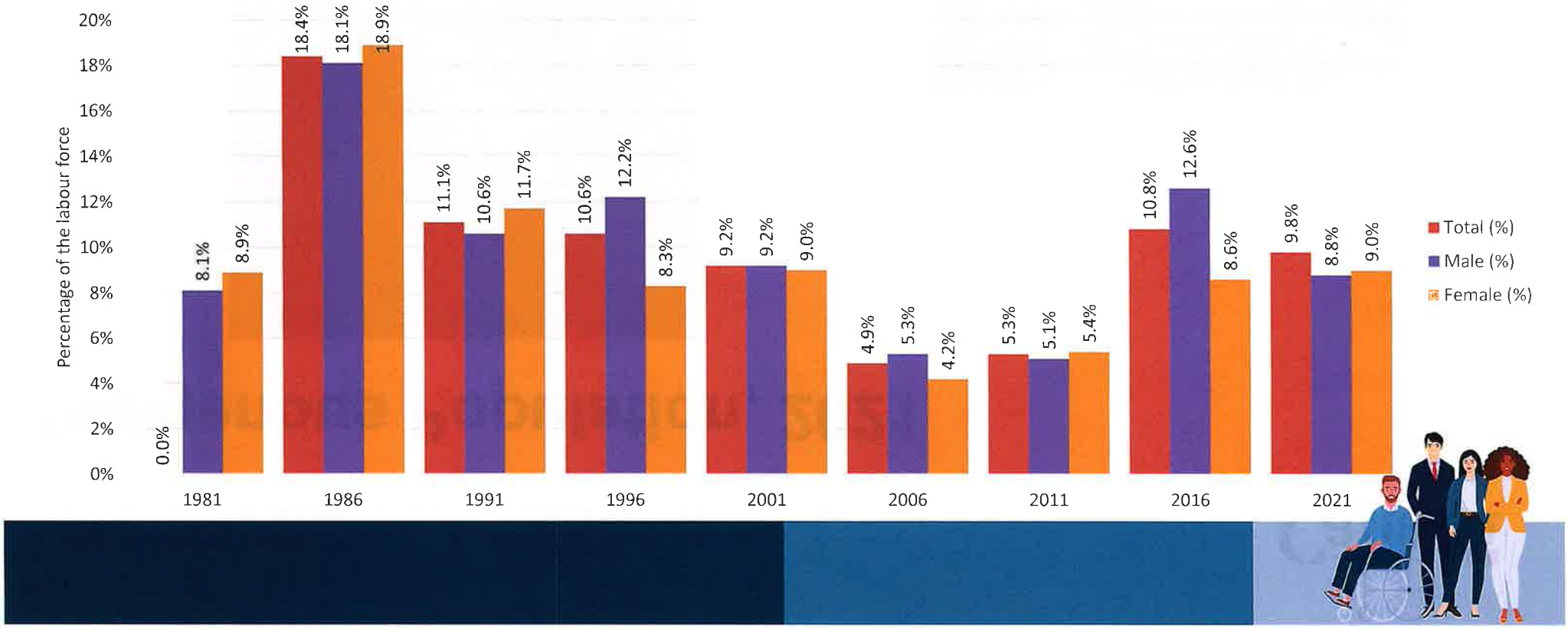
Unemployment, Fort St. John



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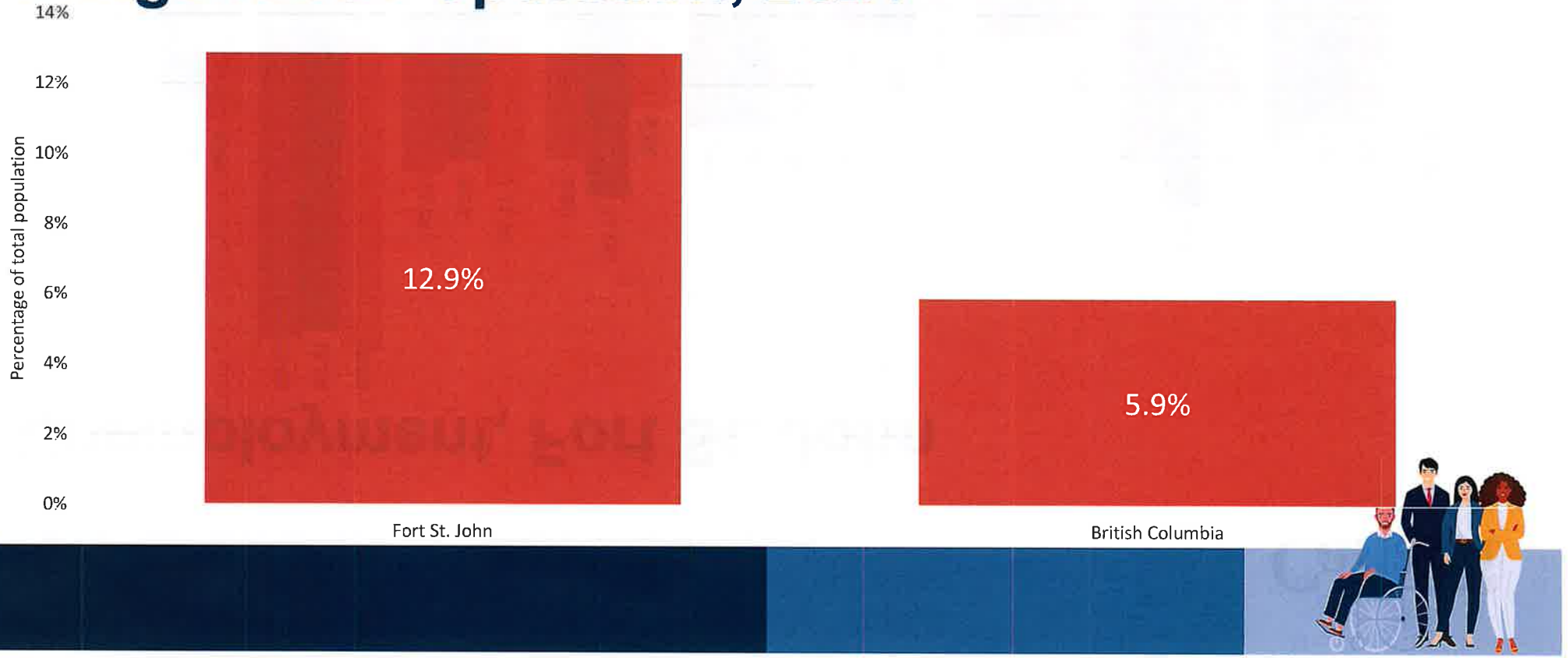
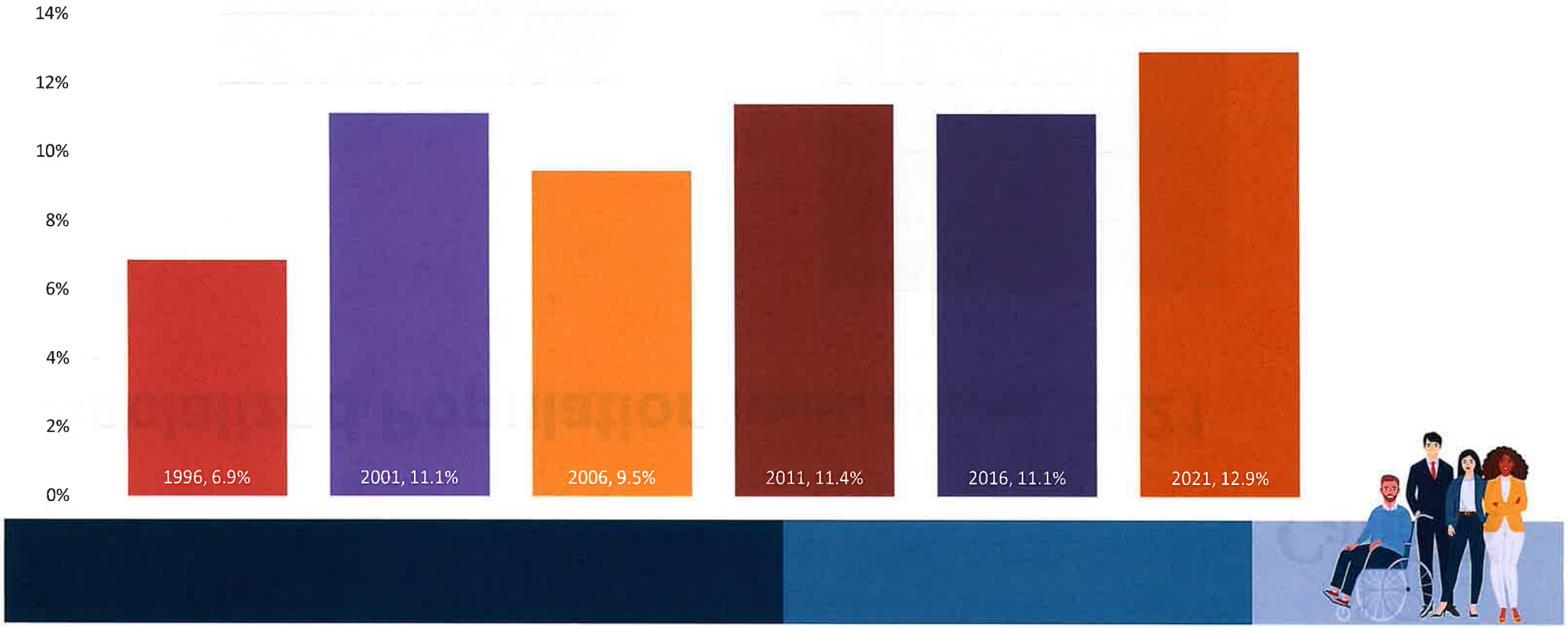
Indigenous Population, 2021



Indigenous Population, Fort St. John



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Racialized Population (*Visible Minority*), 2021

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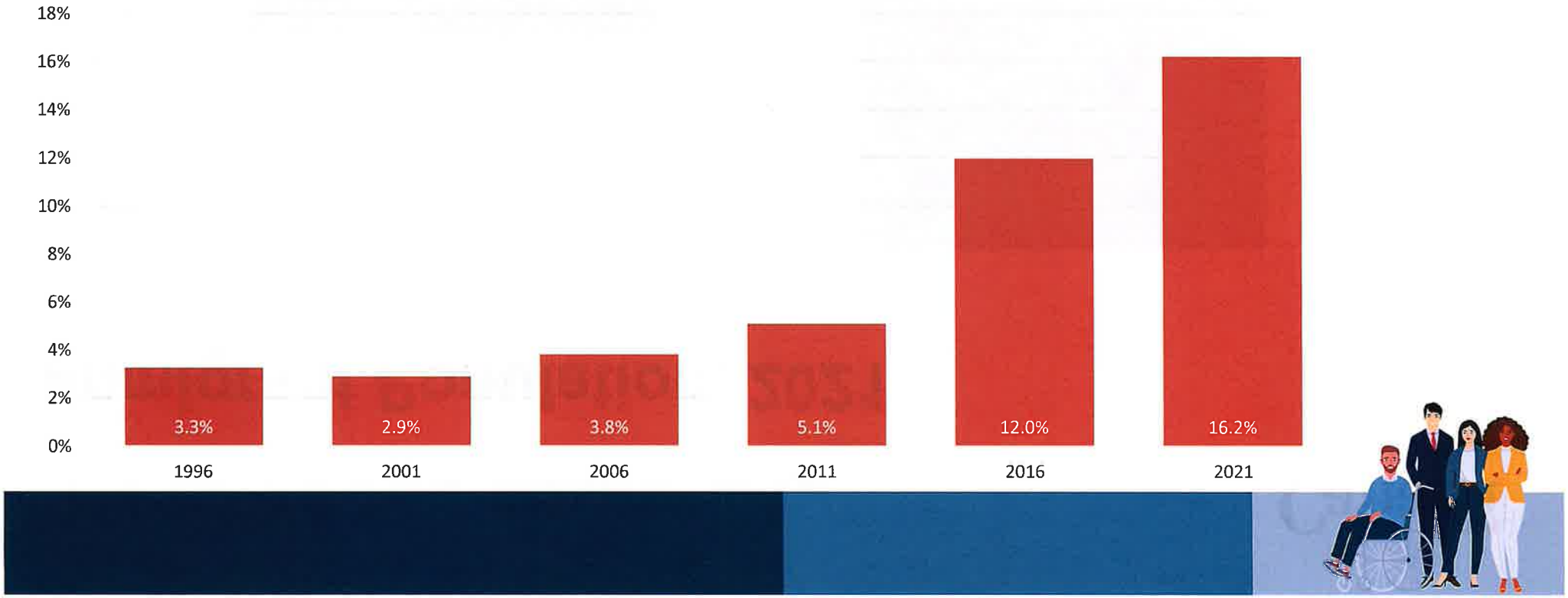
Racialized Population (*Visible Minority*), Fort St. John



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Immigrant Population, 2021

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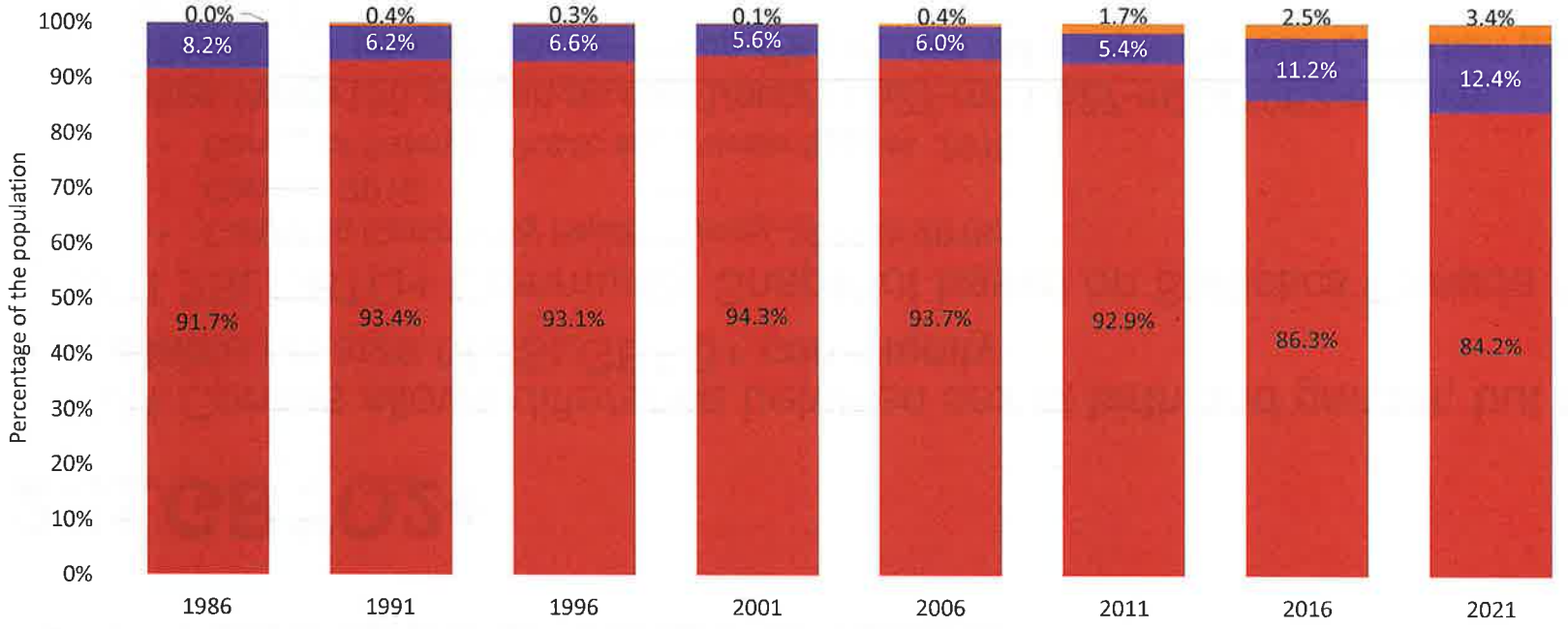
Immigration, Fort St. John



2SLGBTQ2+

- 2021 Census allows difference between sex at birth and gender, but no data available on size of 2SLGBTQ+ community
- 2021 2SLGBTQ+ Community Snapshot based on Statistics Canada data:
  - Canadian Community Health Survey, 2015 to 2018;
  - Census, 2016;
  - Survey of Safety in Public and Private Spaces, 2018
  - https://www150.statcan.gc.ca/n1/pub/11-627-m/11-627-m2021062-eng.htm
  - 2SLGBTQ+ community makes up 4% (around 1M people) of total Canadian population aged 15+.
  - Half of all 2SLGBTQ+ persons lived in Toronto, Montreal, Vancouver, Ottawa-Gatineau

Persons with a Disability

- No Census data available on health/disability
- Canadian Survey on Disability, latest 2017, 2022 data collection ongoing
  - Stat Can report on disability rates from 2017, might be used to give general idea. https://www150.statcan.gc.ca/n1/pub/89-654-x/89-654-x2018002-eng.htm
  - No community or regional profiles available
  - In 2017: 16.2% of population aged 25-64 by National Occupational Classification are persons with disabilities

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Occupations of Persons with a Disability, Canada, 2017

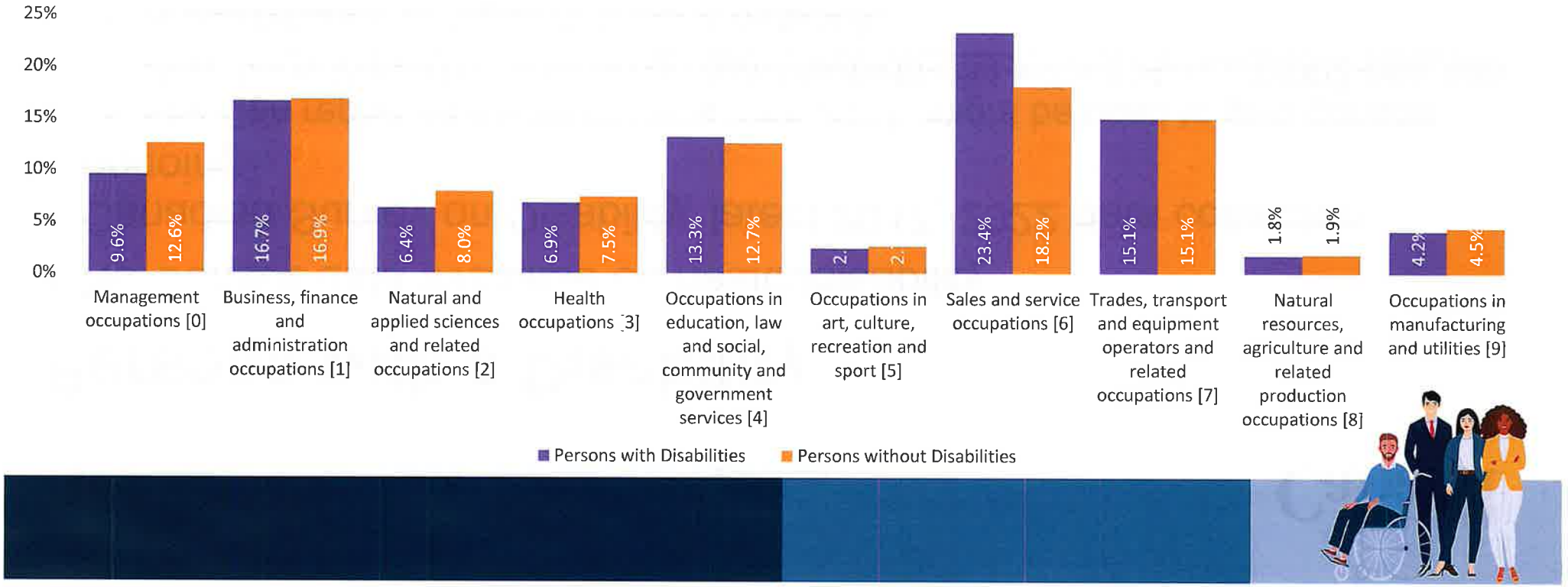

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Table Discussion

- Did any of these numbers surprise you?
- What resonated with you after reviewing the numbers?

What do these terms mean?

Term	Diversity	Inclusion	Anti-Racism and Anti-Oppression	Equity	Belonging
What it means	The ways in which individuals differ	Respect, support and removal of barriers to contribution	Actively opposing racism by challenging and changing systems and structures	Fair treatment, access and opportunity for all people	A feeling of security, support and acceptance

Accessibility

- Individuals differ in what they can access and how
- It is key to remove barriers to improve accessibility for all
- Building equitable access and opportunity for everyone is key to fostering a sense of belonging for all

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JEDI slide

Journey to 50/30

- Why is diversity and inclusion so important?
  - Canadian population and demographic profile is changing
  - Global skills shortages
  - Workplace and employee satisfaction
  - Community harmony
  - Opportunity to integrate and understand different ways of knowing

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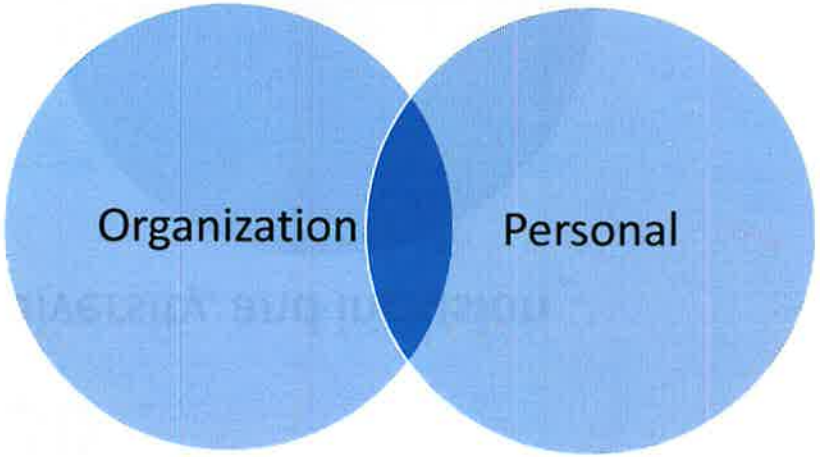
Journey to 50/30

- Committing to equity, diversity, and inclusion

Journey to 50/30

- Committing to equity, diversity, and inclusion



Journey to 50/30

- Committing to equity, diversity, and inclusion

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Elements of the 50-30 Challenge

Change

Personal
- Self
- Colleagues
- Family
- Friends

Workplace
- Board
- Sr. Management
- Staff

Community
- Voluntary
- Non-Profits
- Business
- Government

Practice

- Attitudes
- Culture
- Leadership
- Conversations
- Learning
- Recruitment
- Systems of support
- Reflection
- Evaluation

Individual:

- Where are you on this journey?
- What does your organization have in place?
- What does your organization need?

Discuss as a group

Reflection

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50/30 Challenge Website and Resources

50/30 Challenge Website and Resources

- What Works Toolkit

Mapping Your Journey	Topics and Actions
Interactive map	10 Actions You Can Take
Step-by-step guide	Starting the Conversation
Role-based	Talent Processes Tool
Tools for each step	Board and Leader Guidebook
'Game' approach	Guide to Sustaining Organizational Change

Different Paths, Same Destination

50/30 Challenge Website and Resources

- 50-30 Hub (Northern Lights College)
  - Team of Advisors:
    - Provide mentoring, coaching, training services
    - Supply links to resources, outside experts
    - Review and assess plans, processes, evaluation criteria
    - Guidance on using the What Works Toolkit and 50-30 Website

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Hopes and Fears Exercise

Next Steps

- Assessment to determine the starting point
- Resources and educational sessions
- Regular check-ins

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Collaboration