MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 872221

PREPARED FOR: Graham Whitmarsh – Deputy Minister of Health, and
Perry Kendall, Provincial Health Officer
- **FOR INFORMATION**

TITLE: Municipal Bylaws Affecting Harm Reduction Services in BC

PURPOSE: To describe options for addressing municipal bylaws that adversely affect provision of harm reduction services in BC.

BACKGROUND:
In the early 2000s, the Ministry of Health (MoH) became concerned about municipal governments using local zoning and bylaw powers in ways that restrict equitable access to health services for some (especially vulnerable) British Columbians. For example, in 2005 Abbotsford passed a zoning amendment bylaw to restrict harm reduction services in the municipality (Bylaw 392). Its definition of harm reduction services includes needle exchanges, mobile dispensing vans, supervised injection sites, or any other type of similar facility. The MoH was concerned that such restriction of health service access through municipal zoning bylaws would not only impact access to health services for people who inject drugs, but could also set a precedent for restricting access to other kinds of health services; however, at the time there were no grounds on which to challenge the bylaw. Subsequently, ministerial authority to override local bylaws was included in the revised *Public Health Act* (Part 9, 120, 2 c): "authorizing the Minister to order a local government to modify or rescind a bylaw, or an operational or strategic plan or planning process." (March 31, 2009).

Section 3 (2) of the *Health Authorities Act* authorizes the Minister of Health to require a regional health board to provide a health service in a region. Therefore, as an alternative option, the Minister of Health could, by regulation, require that regional health boards provide harm reduction services in a region. The *Health Authorities Act* would then create a duty for the regional health board to provide the service as directed. In the event that fulfilling this duty would result in a conflict with municipal zoning bylaws, Section 10 of the *Community Charter* would apply, rendering the zoning bylaw ineffective.

Municipal zoning bylaws in British Columbia do not require the approval of the Minister of Health, nor are there grounds for challenging the bylaws on the basis that they exceed municipal authority.

At the request of the Provincial Health Officer (PHO), a survey of health authorities in which municipal bylaws negatively impact the delivery of harm reductions services was undertaken in late 2010. The survey found the following:

- Abbotsford (Fraser Health Authority (FHA)) continues to significantly restrict harm reduction programs through multiple amendments of zone use definitions (Bylaw 392, adopted 2005). In 2010, after learning of rising hepatitis C infection rates in Abbotsford, city council instructed city planners to review bylaws and practices in other municipalities in FHA; a report for council is expected in 2011.

- In 2010, the City of Langley considered a bylaw to restrict harm reduction services, unless otherwise agreed to by the City and the health authority; however, according to FHA officials, there has been no action since.
- Kelowna (Interior Health) prohibits possession of harm reduction supplies in any park or public space (Bylaw 9453, adopted 2005). A health authority contracted service provider, Living Positive Resource Centre, reports that the bylaw has impacted distribution of safer smoking supplies, but not safer injecting supplies.
- Coquitlam (FHA) restricts the location of methadone clinics to 5 small geographic areas of the municipality (Bylaw 3000, adopted 1996). Bylaw 3684 (2009) categorizes methadone dispensaries as "undesirable businesses".
- Surrey (FHA) prohibits methadone clinics in 15 zones, including business park, commercial, special care housing, single family residential and multiple residential commercial zones (Bylaw 12000, adopted 1993).

DISCUSSION:

BC's support for harm reduction services within its overall health response to substance use problems is reflected in several policies, including *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia* (2010) and *Following the Evidence: Preventing Harms from Substance Use* (2006). Additionally, *Harm Reduction: A British Columbia Guide* (2005)—released at a Union of British Columbia Municipalities (UBCM) annual convention workshop convened by the Minister of Community Services—provides guidance to assist local governments in taking a leadership role in reducing drug-related harm in their communities.

A new PHO report, *Decreasing HIV Infections Among People Who Use Drugs by Injection in BC* (March, 2011), recommends addressing the issue of municipal bylaws that restrict this access to health services for those affected by problematic substance use. In addition, in September 2010, the UBCM passed a resolution recommending that the province ensures base levels of harm reduction services - including needle distribution and recovery and access to safer substance use equipment - are available in every local government area in BC.

ADVICE:

There are several options available to the Minister to ensure municipal zoning supports equitable access to health services, such as harm reduction, for all British Columbians:

s. 13

Program ADM/Division: Andrew Hazlewood, ADM, Population and Public Health
Telephone: 250-952-1731
Program Contact (for content): Kenneth Tupper
Drafter: River Chandler/Gina McGowan
Date: April 12, 2011
File Name with Path: Z:\CDAP\A1 Admin\Executive 280\20 BNs\20 PSU\PSU 2011\872221 - Municipal Bylaws Affecting Harm Reduction Services in British Columbia

Tupper, Kenneth HLTH:EX

From: Byer, Rory <RByer@surrey.ca>
Sent: Wednesday, September 10, 2008 10:46 AM
To: Tupper, Kenneth HLTH:EX
Subject: corporate Report - R163
Attachments: R163.doc

-----Original Message-----
From: Cesario, Lisa
Sent: September 10, 2008 10:03 AM
To: Byer, Rory
Subject: corporate Report

Hi Rory
The following person would like a pdf of Corporate Report R163 that went to Council on July 30,
can you forward it to him?
thanks muchly

kenneth.tupper@gov.bc.ca

SURREY
CITY OF PARKS

Corporate Report

NO: _____

COUNCIL DATE: _____

REGULAR COUNCIL

TO:	**Mayor & Council**	DATE:	**July 29, 2008**
FROM:	**City Solicitor**	FILE:	**3900-20-15039**
SUBJECT:	**Amendments to the Surrey Zoning By-law to Regulate the Location of Small-Scale Drug Stores in the City**		

RECOMMENDATION

Legal Services recommends that Council:

1. Receive this report as information;

2. Adopt amendments to the Surrey Zoning, 1993, No. 12000 (the "Zoning By-law") as documented in Appendix "A" of this report as they relate to the new definitions of "methadone dispensary", "small-scale drug store" and "drug store" and separation distances between small-scale drug stores and between small-scale drug stores and drug stores;

3. Adopt amendments to the Methadone Dispensing By-law No. 15039 (the "Methadone By-law") as documented in Appendix "B" of this report as they relate to the new definitions of "methadone dispensary", "small-scale drug store" and "drug store" and separation distances to be consistent with the above proposed amendments to the Zoning By-law in Recommendation 2 of this report; and

4. Direct staff to work collaboratively with the College of Pharmacists of British Columbia (the "College") and the Fraser Health Authority to address community impact issues related to the methadone program and compliance with the Memorandum of Understanding regarding the Resolution of Methadone Dispensing in the City of Surrey dated June 2, 2003 (the "MOU") and report back to Council with an update of this work.

PURPOSE AND INTENT

The purpose of this report is to provide amendments to the Zoning By-law, that if adopted, will create new definitions of "methadone dispensary", "small-scale drug store" and "drug store", and introduce a minimum separation distance between all of these types of drug stores as a means of regulating their geographic concentration.

Drug stores/pharmacies are considered a "retail store" under the provisions of the Zoning By-law. However, a "methadone dispensary" falls under a separate definition in the Zoning By-law and a rezoning process is necessary for a new methadone dispensary to be established in the City. A small-scale drug store, primarily dispensing methadone, can circumvent being classified as a "methadone dispensary" by including health and beauty products and general merchandise in at least 65% of its gross floor area. To address the potential for proliferation of small-scale drug stores primarily dispensing methadone, the Zoning By-law amendments proposed in this report introduce a new definition of "small-scale drug store", which differentiates them from drug stores on the basis of store floor area. The definition of "small-scale drug store" includes methadone dispensaries and is proposed to be defined as premises having a gross floor area of less than 600 square metres (6450 sq. ft.).

A new definition of "drug store" is proposed to be introduced including requirements that it have a gross floor area of greater than 600 square metres (6450 sq. ft.) and offer a full range of prescription services, health and beauty products and general merchandise.

Consequential amendments are also proposed to the Methadone By-law to make the definitions of "methadone clinic" and "drug store" consistent with the Zoning By-law.

BACKGROUND

Because of a concern over the number and concentration of small-scale methadone-dispensing drug stores in the City Centre, Council amended the Zoning By-law on January 22, 2001 to effectively prohibit new methadone dispensing drug stores in retail zones, with the exception of drug stores having at least 65% of their floor area devoted to the sale of health and beauty products and general merchandise. As noted earlier in this report small-scale drug stores, which primarily dispense methadone, can circumvent the prohibition on methadone dispensaries by devoting 65% of their floor area to other merchandise.

On May 7, 2001 Council enacted an amendment to the Business Licensing By-law (s. 55(1)) that prohibits pharmacists from offering a cash incentive or other inducements for attracting clients to the store for the purpose of methadone prescriptions.

On May 30, 2003 an MOU between the City, the Ministry of Health and the College was signed, which focused on limiting the number of patients served at each methadone dispensary in Surrey and recruiting traditional full service pharmacies to fill methadone prescriptions, with the stated objective of having patient treatment available across all geographic areas of the Lower Mainland, so that patients do not have to locate in any particular neighbourhood to obtain daily treatment. The MOU contained a number of provisions focused on achieving this general objective.

DISCUSSION

At a meeting on May 27, 2008, City staff discussed with College representatives the need to address the proliferation of methadone dispensing pharmacies in City neighbourhoods and in particular the City Centre due to the adverse impacts to neighbourhoods that such a proliferation is causing. Appendix "C" lists all the drug stores and methadone dispensaries that dispense methadone in the City Centre area.

The City of Vancouver has introduced a minimum separation distance of 400 metres between what it defines as "small scale pharmacies" or pharmacies having a gross floor area of less than 600 square metres as a means to control their proliferation. Vancouver's small-scale pharmacies must also be separated by at least 400 metres from existing drug stores.

In response to the discussions with the College and information received from Vancouver, staff is recommending that the Zoning By-law be amended by:

- Introducing a new definition of "drug store", which has a minimum floor area of 600 square metres, provides a full range of pharmacy services and sells health and beauty products and general merchandise;

- Introducing a new definition of "small-scale drug store", which has a floor area of less than 600 square metres and includes any premise that is a "methadone dispensary";

- Including a minimum 400 metre-separation distance between small-scale drug stores and between small-scale drug stores and drug stores.

Staff is having a further meeting in September 2008 with College representatives to discuss the following proposals:

- Limit the maximum number of patients which can be served by each small-scale drug store, drug store or methadone dispensary;

- Require methadone dispensaries to have a separate consultation area, as defined by the College, to encourage best treatment practices;

- To address the neighbourhood and business association's concerns regarding the negative impact of methadone dispensing; and

- Require that all business licenses, including renewals, for drug stores and methadone dispensaries be issued subject to the business license containing, and the drug store or methadone dispensary agreeing to, Good Neighbour Conditions in writing as follows:

  (a) The site shall be maintained in a neat and tidy condition.
  (b) Site operations and procedures to ensure safety inside and outside the facility shall be implemented and maintained in accordance with a prescribed policy manual.
  (c) Procedures shall be implemented at the facility to address any nuisance issues arising as a result of the operations of the facility, including loitering outside, line-ups, litter and congregations of people. Specific strategies include minimizing any potential for service line-ups by offering scheduled appointments and targeting clean-up crews first thing in the morning and at repeated intervals throughout the day. Any and all issues must be dealt with quickly and thoroughly.
  (d) Garbage storage area shall be designed to minimize nuisances, hazardous waste and litter in the area surrounding the facility.
  (e) The owner/operator must work with the RCMP, City staff and other stakeholders to develop and implement a strategy to minimize the amount of visible drug dealing in the vicinity of the facility.
  (f) the owner/operator will agree not to offer incentives, monetary or otherwise, to attract new clients.

(g) There must be clearly defined hours of operation approved by the Manager, By-laws and Licensing Services.

(h) There must be an identified contact person during hours of operation.

CONCLUSION

Based on the above discussion, it is recommended that Council:

- Adopt amendments to the Surrey Zoning as documented in Appendix "A" of this report as they relate to the new definitions of "methadone dispensary", "small-scale drug store" and "drug store" and separation distances between small-scale drug stores and between small-scale drug stores and drug stores;

- Adopt amendments to the Methadone By-law as documented in Appendix "B" of this report as they relate to the new definitions of "methadone dispensary", "small-scale drug store" and "drug store" and separation distances to be consistent with the above proposed amendments to the Zoning By-law in Recommendation 2 of this report; and

- Direct staff to work collaboratively with the College and the Fraser Health Authority to address community impact issues and compliance with the Memorandum of Understanding regarding the Resolution of Methadone Dispensing in the City of Surrey dated June 2, 2003 related to the methadone program and report back to Council with an update of this work.

CRAIG MacFARLANE
City Solicitor

CM:mlg
Attachs.
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saw\lb1-8/11/14 2:45 PM

APPENDIX "A"

Proposed Amendments to Surrey Zoning By-law, 1993, No. 12000, as amended (the "By-law")

That the By-law be further amended as follows:

1. Part 1 – Definitions be amended by adding the following new definition of Drug Store immediately following the existing definition of Driveway:

   Drug Store
   means a commercial establishment with a *gross floor area* of 600 square metres or greater which fills a broad range of pharmaceutical prescriptions, and which includes the display and sale of health and beauty products and general merchandise on at least 65% of its *gross floor area.*

2. Part 1 – Definitions be amended by adding the following definition of "Small-Scale Drug Store" immediately following the existing definition of "Slot Machine Gaming":

   Small-Scale Drug Store
   means:
   (a) a commercial establishment with a *gross floor area* of less than 600 square metres which fills prescriptions and which includes the display for sale of health and beauty products and general merchandise on at least 65% of its *gross floor area*; or
   (b) a *methadone dispensary.*

3. Part 1 – Definitions be amended by deleting the existing definition of "Methadone Dispensary" and replacing it with the following new definition:

   Methadone Dispensary
   means a business selling or filling methadone prescriptions for customers as the primary activity of the business and which does not display for sale health and beauty products and general merchandise on at least 65% of its *gross floor area*, but excludes a *drug store* or a *small-scale drug store.*

4. By adding a new Sub-section 28 to Part 4 – General Provisions, Section E – Regulations Applicable to All Zones as follows:

   28. <u>*Small-Scale Drug Stores*</u>

   No *small-scale drug store* shall locate within 400 metres of the *lot line* of an existing *small-scale drug store* or *drug store.*

APPENDIX "B"

Proposed Amendments to Surrey Methadone Dispensing By-law, 2003, No. 15039 (the "By-law")

That the By-law be amended as follows:

1. Section 2 – Definitions be amended by deleting the existing definition of Drug Store and replacing it with the following new definition:

   "Drug Store"

   means a commercial establishment with a *gross floor area* of 600 square metres or greater which fills a broad range of pharmaceutical prescriptions, and which includes the display for sale of health and beauty products and general merchandise on at least 65% of its gross floor area.

2. Section 2 – Definitions be amended by deleting the existing definition of Methadone Dispensary and replacing it with the following new definition:

   "Methadone Dispensary"

   means a business selling or filling methadone prescriptions for customers as the primary activity of the business, and which does not display for sale health and beauty products and general merchandise on at least 65% of its gross floor area, but excludes a Drug Store.

3. Section 2 – Definitions be amended by adding a following definition:

   "Small-Scale Drug Store"

   means:
   (a) a commercial establishment with a gross floor area of less than 600 square metres, which fills prescriptions and which includes the display for sale health and beauty products and general merchandise on at least 65% of its gross floor area, or
   (b) a Methadone Dispensary.

4. The heading "Pharmacist" be inserted immediately preceding Section 6.

5. By adding a new Section 7.1 immediately following Section 7 as follows:

   Location

   7.1. No Methadone Dispensary shall locate within 400 metres of the lot line of an existing Methadone Dispensary, Small-Scale Drug Store or Drug Store.

6. By updating the Table of Contents to reflect the addition of Section 7.1 to the By-law.

APPENDIX "C"

CITY CENTRE FULL SERVICES DRUG STORES DISPENSING METHADONE

Business Name	Address
Capital Care Pharmacy	13456 – 108 Avenue
Gateway Pharmacy	101 – 10751 King George Highway
Whalley Pharmacy	101 – 10663 King George Highway
Community Care Pharmacy	102 – 9648 – 128 Street
Family Care Pharmacy	B – 12815 – 96 Avenue
Medical Care Prescriptions	10225 King George Highway
Sandell Drug Mart	102 – 10216 – 128 Street
Shoppers Drug Mart (KG Hwy)	1130 – 10153 King George Highway
King George Medic Pharmacy	9808 King George Highway
Kroll's Surrey Pharmacy Ltd.	100 – 9656 King George Highway
London Drugs (KG Hwy)	10348 King George Highway
Pharmasave (120 St.)	9558 – 120 Street
RTCC Consultants	9631 – 137 Street
Shoppers Drug Mart (96 Ave.)	12874 – 96 Avenue
Lancaster Medical Supplies & Prescriptions	101 – 13710 – 94A Avenue
Pharmasave Health Centre	110 – 13798 – 94A Avenue

CITY CENTRE METHADONE DISPENSARIES

Business Name	Address
Gain Pharmacy	10677 King George Highway
Park City Pharmacy	13565 – 105A Avenue
Care Point Pharmacy Ltd.	13640 – 105A Avenue
Early Bird Pharmacy	13672 – 108 Avenue
Kingston's Pharmacy BC Ltd.	13480 – 104 Avenue

Contact: Aileen Murphy
Social Planner
City of Surrey

Harm Reductions Services in the Community:
When asked what types of harm reduction services or policies were available in the community, respondent answered the following:

Type of service	Yes	No	Not Aware	Comments
Impaired driving campaigns and education programs	✓			
Low-threshold housing	✓			
Needle distribution and collection	✓			
Doctors licensed to prescribe Methadone for heroin addiction			✓	There is one in a neighboring community, but not certain there is one within Surrey.
Pharmacies that dispense Methadone			✓	Knows of a recovery house for women on methadone, but not sure of a pharmacy that dispenses it.
Health and social services referral programs	✓			
Outreach and education efforts for at-risk or marginalized citizens	✓			Including: street outreach, employment programs for those with multiple barriers, and peer to peer work for women in the sex trade.

Implementation of Harm Reduction Services – Lessons Learned:

The respondent was not aware of any specific instances where harm reduction services had been implemented or failed as she had only been in the position a few months. However, the respondent did note that mental health and addictions were high on the radar and that addictions is one of the priority issues outlined in the City's social plan. There are several task forces convened by the Mayor and members of Council, including: mental health and addictions, crime reduction and homelessness.

A presenting challenge is the perceived lack of commitment from the present federal government and provincial Ministry of Health.

Responding to Citizens or Advocacy Groups on Issues Relating to Harm Reduction:

Both the respondent and other City employees have been asked to respond to citizens or advocacy groups regarding harm reduction. The respondent noted the following regarding useful resources to have on hand when being called upon to talk about harm reduction:

Examples of resources	Yes	No
Research evidence	✓	
Specific examples from other jurisdictions	✓	
Lessons learned by other local governments	✓	
Examples of ways to address NIMBY	✓	
Innovative strategies to address opposition	✓	
Contact information for individuals who can provide reliable advice	✓	

Concerns Regarding Harm Reduction:

Staff within the City seems to have differing opinions on how to address problematic substance use and addictions. Some are in favor of harm reduction and finding practical solutions to the problem, others favor the treatment option and still others are concerned about attracting drug users from other communities if these services are implemented in Surrey. The sky train seems to play an important role in the latter argument. There is also the concern in a suburban community of becoming like its urban counterpart. As problems in the Downtown Eastside do not appear to be improving, many have concerns around implementing similar services for fear of the situation worsening in their own community.

There is also general concern regarding downloading of services onto municipal governments. At the local level, there appears to be a lack of leadership from health services and if solutions are to come about at the local level, then public health services need to be the champions to speak as experts on the issue.

Suggested Inclusions in a Harm Reduction Resource Toolkit:

Types of Resources	Yes	No	Notes
Examples of best practices	✓		
Best practices for mitigating NIMBY	✓		
Examples of initiatives or policies undertaken by other local governments	✓		
Lessons learned in other communities	✓		
Research evidence	✓		Including statistics on the cost of harm reduction services versus the cost of treating patients with Hep C or AIDS over a lifetime and information on property values when a harm reduction service is implanted in the neighborhood.
International and national examples	✓		

Other feedback included: the Harm Reduction Community Guide felt too heavy on process information (which the respondent noted is already happening in many communities). What would be more useful is to help inform those for whom this is not their primary business, especially if health is not at the discussion table. Any information provided will need to be short, concise and reliable.

Involvement of Substance Users:

When asked if the work undertaken at the local level had involved substance users to better inform the process, the respondent answered yes. Although substance users are not represented on the Task Force on Mental Health and Addictions, Task Force members have spent time visiting services in the community where users of the service spoke rather than the staff at these agencies. The respondent noted this had been a highly educational experience and it had been reported by those who went that it was an eye opening experience.

Tupper, Kenneth HLTH:EX

From: Rai, Amrit <Amrit.Rai@fraserhealth.ca>
Sent: Friday, June 7, 2013 10:10 AM
To: Tupper, Kenneth HLTH:EX
Subject: RE: HR work plan?
Attachments: FHA Harm Reduction Plan_2013 05 15 vsn5.doc

Hi Ken,
It was nice to hear from you.

This is what Erin and I have drafted up. We are at the point of seeking input from MHOs.
The intent of this plan is to be simple so its usable and realistic.

If it is approved to proceed, we will implement and evaluate and make adjustments as needed. I am hoping that next year we will be able to look at a more comprehensive plan (ie 3-5 year)
We are waiting for input and endorsement, but that is not holding us back in moving forward with our initiatives.

Just to give you an idea of what we have done so far and working on:

1.0 Working with our communities such as Port Coquitlam to improve access to HR services. The Mobile van was not welcomed by the Mayor, so we made arrangements with our community service provider to provide the service out of the Health unit instead of the Van.
2.0 Working with Mission to increase access to HR – meeting with Mission PH nurses and "increasing awareness" addressing values and ethics. Trying to move the nurses to provide supplies throughout the day versus one hour service. Erin is also connecting with the peer user groups to eliminate the "aggressive behavior" by the users towards the nurses. Workplace safety is coming up as an issues.
3.0 Training our community service providers so they are up to date with supplies and ordering and latest evidence.
4.0 We have established Abbotsford hospital as a depot for NGOs to drop their used needles off and now close to setting similar process up with Surrey Memorial Hospital. (next on our list is Royal Columbian Hosp)
5.0 In Abbotsford and Surrey – we are getting our NGOs to work together to eliminate duplication of services and set up peer to peer distribution
6.0 Working with City of Abbotsford social planner and community organization to develop a good neighbour agreement so they can start needle distribution programs
7.0 We have nurses and a place set up with the sobering centre and primary care at Quibble Creek in Surrey to provide HR supplies
8.0 I have a call out for proposal to expand our HR services so we can double our numbers and also increase access points. Looking at communities where people are unable to access HR supplies .
9.0 We have looked at FH HR policy and ways to strengthen the policy or procedure by linking it with the Health Equity program.
10.0 Erin and Marika have put on a half day workshop to help remove the stigma with our staff and increase education and awareness around HR. We will hold a second one in late fall. My goal is to have all public Health nurses go through these workshops so they can incorporate HR in their work.

I am pleased at the rate we are moving and the support to continue with this work by our leadership team and executive team. I am sure Erin has shared all this at the HRSS meetings but wanted to let you know that although the plan is not finalized but the work is continuing. I do not see why the plan will not be endorsed by our VP. I have kept him in the loop and he does not appear to have concerns.

So please look at the draft plan and your feedback, thoughts and comments are welcomed. You may be aware of programs that have been successful and I am willing to connect with those folks to learn from them.
Please be critical (you will not hurt my feelings) as I want this to be a success for our community.

Thank you,

Amrit Rai

From: Tupper, Kenneth HLTH:EX [mailto:Kenneth.Tupper@gov.bc.ca]
Sent: Tuesday, June 04, 2013 3:29 PM
To: Rai, Amrit
Subject: HR work plan?

Hi Amrit

Thanks for the update on your harm reduction efforts in FH! Just as a reminder, I'd welcome an opportunity to look at your draft harm reduction work plan, if you can send when you're back in the office.

cheers

Kenneth Tupper, Ph.D.
Director, Problematic Substance Use Prevention
British Columbia Ministry of Health
4-2, 1515 Blanshard St.
Victoria, BC
V8W 3C8
ph: (250) 952-3207
fax: (250) 952-1570
e-mail: mailto:kenneth.tupper@gov.bc.ca

Tupper, Kenneth HLTH:EX

From: Tupper, Kenneth HLTH:EX
Sent: Monday, August 19, 2013 11:54 AM
To: XT:HLTH Rai, Amrit
Subject: RE: FH HR plan

Hi Amrit

I'm sorry for being so slow in responding to this! Anyhow, I have finally had a chance to get around to taking a look at the document you sent and wanted to let you know it looks great. I like how you've framed the workplan around the HRSS goals and specified related FH actions and outcomes. I also appreciate the list you provided in your earlier e-mail on activities that you, Erin and Marika have been engaged in with respect to improving HR policies and services in Fraser.

One suggestion I have is to take a look at a few other recent provincial policy documents that relate to HIV prevention and harm reduction, which have come out within the past year. These include *From Hope to Health: Towards an AIDS-Free Generation* (http://www.health.gov.bc.ca/library/publications/year/2012/from-hope-to-health-aids-free.pdf), *Promote, Protect, Prevent: Out Health Begins Here*, the new BC guiding framework for public health (http://www.health.gov.bc.ca/library/publications/year/2013/BC-guiding-framework-for-public-health.pdf) and *A Path Forward: BC First Nations & Aboriginal People's Mental Wellness and Substance Use – 10-Year Plan* (http://www.health.gov.bc.ca/library/publications/year/2013/First_Nations_Aboriginal_MWSU_plan_final.pdf).

These policy documents all contain further strategic direction with respect to harm reduction services, and so should be helpful in guiding your work (and getting more senior health authority executive attention focused on the issues you're trying to address).

If you and/or Erin would like to have some further discussion about any of your work, I'd be happy to connect by phone as well. Let me know!

cheers

Kenneth Tupper, Ph.D.
Director, Problematic Substance Use Prevention
British Columbia Ministry of Health
4-2, 1515 Blanshard St.
Victoria, BC
V8W 3C8
ph: (250) 952-3207
fax: (250) 952-1570
e-mail: mailto:kenneth.tupper@gov.bc.ca

-----Original Message-----
From: Rai, Amrit [mailto:Amrit.Rai@fraserhealth.ca]
Sent: Wednesday, July 10, 2013 10:22 AM
To: Tupper, Kenneth HLTH:EX
Subject: FH HR plan

Hi Ken,

I hope you are well and enjoying the beautiful weather we have been having.

I am following up with you to see if you had a chance to look. At the Harm Reduction plan?

If so, are there any concerns, thoughts or suggestions?

Let me know if you have any further questions for me.

Thanks

Amrit Rai


BC Guiding Framework for P...


A Path Forward BC FNA MWSU ...


From Hope to Health - MoH 2...

s. 17

PURPOSE OF THIS DOCUMENT:

This document outlines Public Health's coordinated systematic approach to improve health outcomes of People Who Use Drugs (PWUD) across Fraser Health, working towards the stated vision. It is aligned with prevention, public safety, health promotion, and disease/injury prevention programs.

BACKGROUND:

People who use drugs are susceptible to a wide range of viral, bacterial, fungal and protozoal pathogens that can cause pulmonary, endovascular, skin and soft tissue, bone and joint, and sexually transmitted infections r[1] Providing sterile equipment removes one potential source of infection in the equation from sharing or re-use, it also provides an opportunity to share health related information and connection to comprehensive health care.

In 2008, Fraser Health had the lowest distribution rates of needles in B.C., with all three of it's health service delivery areas falling within the bottom five of the total sixteen provincial services delivery areas.[2,3] In more recent years Fraser Health and community partners have been working closely to increase access - resulting in almost double the number of sterile syringes being distributed to prevent infections.

In 2012, FH showed reductions in new HIV positive test results attributed to injection drug use (IDU) and reduction in illicit drug deaths from the previous year. Acknowledging incidences of drug-related harm and overdose are preventable we hope to build on the progress made.

Provincial Harm Reduction supplies are available in varying degrees in Fraser Health through contracted and non-contracted community agencies, some Public Health Units, and peer networks.

Fraser Health currently has contracts with three community partners to provide harm reduction supplies and supports. Partnerships like this have been touted as exemplary models that together are able to mitigate some of the forces that negatively affect the health of people who use drugs, including some of the social structural risk factors for HIV. [4]

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[1] Kaushik KS, Kapila K, Praharaj AK. (2011). Shooting up: the interface of microbial infections and drug abuse. *Journal of Medical Microbiology.*;60:408–422

[2] Harvard SS, Hill WD, Buxton JA. British Columbia Harm Reduction Product Distribution. Can J Public Health. 2008;99:446–50.

[3] Buxton JA, Preston EC, Mak S, Harvard S, Barley J, Strategies BCHR, Committee S. (2008). More than just needles: an evidence-informed approach to enhancing harm reduction supply distribution in British Columbia. Harm Reduction Journal 5(37).

[4] François Gagnon. (2011). *Exemplary Partnerships for Low threshold Services: The PHS Community Services Society and Vancouver Coastal Health.* National Collaborating Centre for Healthy Public Policy retrieved April 2013 from http://www.ncchpp.ca/docs/PHS_En.pdf

Area	Contracted Agency and Distribution Program	Hours/Week	Model	Areas Served
Fraser East	Pacific Community Resources, HIV/HCV Prevention Program	25.5 hrs/week Monday to Friday 5 days/week	Designated Vehicle Site and Mobile	Chilliwack Agassiz Hope Boston Bar
Fraser North	Purpose, Stride with Purpose	8:30 – 5 :00 pm 27 hrs/week *(mobile)* 5 days/week	Imbedded and Mobile	New Westminster, Burnaby, Tri-cities
Fraser South	Keys Housing and Health Solutions, Positive Points	12:00- 6:00 pm 42hrs/week 7 days/week	Fixed	Surrey

Figure 1. Agencies contracted to provide harm reduction distribution, hours, model of delivery, and service areas. (See Appendix A for description of different service models)

In each of the agencies, staff work alone or with unpaid help to provide access to harm reduction services and supplies for individual PWUD, as well other programs within Fraser Health and community. In addition to providing prevention supplies, the community partners:

- engage with marginalized and vulnerable people to provide relevant health information and education on safer substance use and prevention
- work with medical professionals to provide culturally appropriate care to completion
- help people to navigate or remove systemic barriers
- facilitate appropriate referral to ancillary services
- provide crisis intervention response as it arises
- increase familiarity and comfort with testing and treatment
- respond to community concerns of inappropriately discarded syringes
- serve as a conduit of important health related information
- provide placement opportunities for practicum students with educational institutions to inform health care provision of the future

Distribution of harm reduction supplies is also initiated by other community support agencies to address an identified need of their clients. In Abbotsford, there are five community agencies providing supplies in various ways to reduce drug-related harm in their community.

There are a number Substance Use Services within Fraser Health who have moved to include offering harm reduction supplies as part of the comprehensive continuum in which they work with people. Offering harm reduction invites people to connect 'where they are at', potentially new service provider and environment. If and when an individual wants to initiate change, this relationship already exists, prioritizing their autonomy and health over shame and moral judgement.

Public Health Unit (PHU) support for harm reduction and activities engaging PWUD looks different across Fraser Health depending on the community. Two of the eighteen PHUs offer harm reduction supplies at specified times during the week. Some Public Health Units have PHNs who provide outreach to connect with people in the community.

The other service delivery model being strengthened is involving PWUD in service design and delivery. The Canadian HIV/AIDS Legal Network (2005) writes why greater involvement of PWUD is a public health imperative[5]:

> *The limitations of the traditional "provider-client model," in which service providers strive to meet the needs of people who use drugs, are increasingly recognized. People who use illegal drugs have demonstrated they can organize themselves and make valuable contributions to their community, including: expanding the reach and effectiveness of HIV prevention and harm reduction services by making contact with those at greatest risk; providing much needed care and support; and advocating for their rights and the recognition of their dignity (pg. 4)*

Enhancing integration and increasing access to harm reduction supplies will improve health outcomes for individuals, families, and communities affected by substance use across Fraser Health, leading to a more sustainable health system.

Harm reduction (HR) serves to:

- prevent transmission of HIV, HCV, STIs, and other blood-borne infections
- prevent incidence of soft tissue infections
- prevent life-long injury, overdose deaths, and other early deaths among PWUD
- reduce stigma and discrimination towards PWUD which will also help people to connect earlier in their substance use to support
- provide protective factors for women against gendered and sexualized violence[6]
- create relationships and increase connections to health care providers
- empower PWUD and thereby improving health and reducing health inequities

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[5] Jurgens,R. (2008). "Nothing about us without us" - Greater, meaningful involvement of people who use illegal drugs: A public health, ethical, and human rights imperative. Toronto. Canadian HIV/AIDS Legal Network, International HIV/AIDS Alliance, Open Society Institute.

[6] Poole, N., Urquhart, C. and Talbot, C. (2010). Women-Centred Harm Reduction, *Gendering the National Framework Series* (Vol. 4).Vancouver, BC: British Columbia Centre of Excellence for Women's Health.

- reduce-drug related crime and violence
- broaden platform to provide education, effective care, and support such as:
  - access to mental health and substance use services
  - primary care
  - testing and treatment for HIV and Hepatitis C
  - vaccinations
  - housing
  - nutrition and complimentary therapies
- reduce inappropriately discarded syringes in the community
- reduce congestion and health care costs across the continuum
- increase efficacy of health care provision working with patient as full partner

Harm Reduction is recognized as an effective strategy that is utilized in health care from the creation of surgical checklists to fall prevention. Areas understood to be important considerations of comprehensive care and injury prevention and are considered out of scope for these plans are opioid substitution therapy (methadone maintenance), and alcohol or tobacco initiatives. Other FHA Clinical Programs have these areas within their scope.
The four goals of the BC Harm Reduction Strategies and Services (HRSS) Committee will serve as an organizational framework.

HARM REDUCTION:

Harm reduction can be defined as any positive step in a direction for improved health and wellness.

All psychoactive drugs have the potential to both help and harm a person depending on the type of drug used, (e.g., a stimulant such as caffeine or a depressant such as heroin) and the amount, method, frequency and setting of use.[7] Recognizing that an individual's journey to problematic substance use is complex; harm reduction offers a pragmatic approach aiming to improve health outcomes, reduce adverse social and economic consequences, minimize injury and death. It involves a range of support services and strategies to enhance prevention through sharing knowledge, skills, resources and supports for individuals, families, and communities to be safer and healthier.[8,9]

In this way it is a flexible concept working with individuals and communities to co-create a tailored response to preventing harms without specifically seeking cessation of behaviour. As a core Public Health principle, Harm Reduction facilitates an entry point into other healthcare supports for a vulnerable population who may not otherwise seek care.

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[7] Centre for Addictions Research of BC. (2012). Retrieved from: http://carbc.ca/HelpingCommunities/ToolsResources/tabid/166/LiveAccId/6820/Default.aspx
[7]HealthLink BC. File #102a, April 2013. Understanding Harm Reduction. www.healthlinkbc.ca/healthfiles/hfile102a.stm
[9] BC Harm Reduction Strategies and Services Committee Policy. (May 2011) http://www.bccdc.ca/NR/rdonlyres/4Do992FA-0992FA-0972

Despite proven effectiveness at reducing the transmission of HIV and hepatitis C, opioid replacement therapy, distribution of syringes and safer inhalation supplies are not widely accepted.[10] Creation of successful policies influencing practice involve partnerships and input by community stakeholders and most importantly include people who depend on harm reduction supplies to keep them healthy.[11]

PRINCIPLE and VALUES:

The BC Ministry of Health includes the six generally accepted foundational principles in *Harm Reduction: A British Columbia Community Guide*.[12] Many things referred to as 'harm reduction' don't actually have all the components. They are outlined as follows

PRAGMATISM

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

HUMAN RIGHTS

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

FOCUS ON HARMS

The fact or extent of an individual's drug use is secondary to the harms from drug use. The priority is to decrease the negative consequences of drug use to the user and others, rather than decrease drug use itself. While harm reduction emphasizes a change to safer practices and patterns of drug use, it does not rule out the longer-term goal of abstinence. In this way, harm reduction is complementary to the abstinence model of addiction treatment.

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[10] Fraser Health. 2010. Annual Population Health Report. http://www.fraserhealth.ca/your_health/public_health/

[11] Jurgens,R. (2008). "Nothing about us without us" - Greater, meaningful involvement of people who use illegal drugs: A public health, ethical, and human rights imperative. Toronto. Canadian HIV/AIDS Legal Network, International HIV/AIDS Alliance, Open Society Institute.

[12] *Harm Reduction: A British Columbia Community Guide (2005)*. BC Ministry of Health. Can be accessed at http://www.health.gov.bc/library/publications/year/2005/hrcommunityguide.pdf

MAXIMIZE INTERVENTION OPTIONS

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

PRIORITY OF IMMEDIATE GOALS

Harm reduction establishes a hierarchy of achievable steps that taken one at a time can lead to a fuller, healthier life for drug users and a safer, healthier community. It starts with "where the person is" in their drug use, with the immediate focus on the most pressing needs. Harm reduction is based on the importance of incremental gains that can be built on over time.

DRUG USER INVOLVEMENT

The active participation of drug users is at the heart of harm reduction. Drug users are seen as the best source of information about their own drug use, and are empowered to join with service providers to determine the best interventions to reduce harm from drug use. Harm reduction recognizes the competency of drug users to make choices and change their lives.

SOCIAL INCLUSION and HEALTH EQUITY:

In acknowledging drug use as universal phenomenon, Harm Reduction saves lives and improves quality of life by integrating what exists into working with people. Anyone who has contact with people who may be using substances has the opportunity to enable that individual to increase control over their health and reduce risk.[13] Supplies must be readily available and provided in sufficient quantities, in a non-judgmental environment. The alienation and marginalization of people who use drugs often compound the reasons why they engage in unsafe drug use. Unfettered access is paramount in reducing harm and ensuring that people have the means to protect their health (see Appendix B). The consistent provision of collaborative health care demonstrates a prioritization and affirmation of the value of the individual over moral judgments about substance use. Through this alliance, the potential for a new story may be written, initiating important linkages to supports.

Despite proven effectiveness at reducing societal and health care utilization and costs by reducing drug-related overdose, disease transmission, injury and illness, opioid replacement therapy, distribution of syringes and safer inhalation supplies are not widely integrated into provision of care.[14] [15].

Creation of successful policies influencing practice involve partnerships and input by community stakeholders and most importantly include people who depend on harm reduction supplies to keep them healthy.[16]

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[13] Here to Help. (2013). *Helping People Who Use Substances.* Retrieved from http://carbc.ca/Portals/0/PropertyAgent/558/Files/327/HelpingPeople.pdf

[14] Fraser Health. 2010. Annual Population Health Report. http://www.fraserhealth.ca/your_health/public_health/

[15] BC Ministry of Health. (2005). *Harm Reduction: A British Columbia Community Guide* http://www.health.gov.bc/library/publications/year/2005/hrcommunityguide.pdf

VISION FOR FRASER HEALTH:

People who use substances have unrestricted access to high-quality equitable health care which includes evidence-based harm reduction services.

Goals:

Two provincial policy documents: *Following the Evidence: Preventing Harms Associated with Substance Use*, and *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia* outline strategic directions to achieve an integrated and comprehensive approach to preventing and reducing harms from substance use and intended health outcomes. From these documents the BC CDC's Harm Reduction Strategies and Services (HRSS) Committee has four goals with correlating reportable indicators. These goals and indicators will serve as an organizational framework for Fraser Health's Harm Reduction Plan.

HRSS GOALS FOR HARM REDUCTION SERVICE DELIVERY IN BC:

1. Reduce incidence of drug-related health and social harms, including transmission of blood-borne pathogens through equipment sharing by promoting wellness practices

Indicators:

1.1 Number and type of sites distributing safer sex and safer drug use supplies

1.2 Number and rate of new cases of HIV attributable to injection drug use and acute HCV

1.3 Patients Prescribed Methadone

1.4 Number of illegal opioid/stimulant induced deaths and potential years of life lost from such deaths

1.5 Number of emergency room admissions associated with illegal opioid/stimulant induced illness

2. Promote and facilitate referral to public health services, primary health care, mental health and/or substance use services, and social services.

Indicator:

2.1 Number of referrals to and from services

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[16] Jurgens,R. (2008). "Nothing about us without us" - Greater, meaningful involvement of people who use illegal drugs: A public health, ethical, and human rights imperative. Toronto. Canadian HIV/AIDS Legal Network, International HIV/AIDS Alliance, Open Society Institute.

3. Reduce barriers to health and social service, including activities to reduce stigma and discrimination and raise public awareness and understanding of harm reduction principles, policies and programs among professionals in the health, social and criminal justice systems, officials in all levels of government, and the general public.

Indicators:

3.1 Activities by Health Authorities and partners that reduce barriers to accessing primary health care and mental health and substance use services for those who use drugs and engage in risky sexual activity

3.2 Activities by Health Authorities and community that increase awareness of harm reduction philosophy as it pertains to illegal drugs and legal drugs such as alcohol in the health system, municipalities and the general public

4. Ensure full and equitable reach of Harm Reduction Programs (HRPs) to all vulnerable British Columbians who use drugs, to provide education about health promotion and illness prevention to inform decision-making.

Indicators:

4.1 Supply distribution numbers by Health Service Delivery Area

4.2 Safe disposal activities

HRSS Goal 1: Reduce incidence of drug-related health and social harms, including transmission of blood-borne pathogens through equipment sharing by promoting wellness

FHA Aim	Actions	Involved or responsible	Measures	Outcome
Decrease transmission of HIV, Hepatitis C and soft tissue infections in PWUD	Support community service providers to double number of needle distributed: • increase contract funding • provide evidence/new knowledge Support community services to: • diversify service delivery • extend hours of service • expand geographical coverage • enhance staff capacity Support all 18 Public Health Units (PHU) to offer harm reduction supplies: - education to PH staff - collaborate with HU staff to develop local service plans Determine distribution needed to reach WHO's high level indicator target (60%)[17]	Community service providers: • KEYS • Purpose • PCRS • ACS • PLFV • Warm Zone • 5 and 2 Ministries • User groups (BCYADWS, SANSU) • Others as identified FH :EMD, Manager, HR coordinator - Peers	- # of needle distributed (673,100 in 2012 to 1 ,009, 650 by December 2014) - # of HR supply access points - # of public health units offering HR supplies - # of new positive HIV tests in PWUD – continue decrease from 11 in 2010 to 7 in 2011	Short-term Outcomes (1-2 years): 1. Increase % of injections done with new syringe 2. Increased awareness of HR service sites 3. Increase in percentage of users practice safe injections 4. 100% of PH units offering harm reduction supplies 5. Reduction in ER presentations attributed to IDU Long term outcomes (3-5 years): Decrease in transmission of HIV, Hepatitis C and soft tissue infections Fewer AIDS related deaths because people are accessing treatment earlier.

[17] WHO, UNODC, UNAIDS. (2012). Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users.Retrieved February 2013 from: http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf

Fraser Health Authority Harm Reduction Plan 2013 – 2016

FHA Aim	Actions	Involved or responsible	Measures	Outcome
Decrease overdose deaths Reduce hospitalizations associated with opioid use	Implement Take-Home Naloxone (THN) program: • Identify physicians who will prescribe naloxone • Provide 'train the trainer' sessions for overdose prevention and response Develop and implement OD communication and alert strategy	- HR Coordinator - EMD - Manager STIBBI - Stephanie Bale - Roy Thorp - Community Providers - PWUD - Regional Coroner - Emergency Responders - RCMP and Municipal Police	1. # of prescribers participating in THN (nurse practitioners and physicians) 2. #of naloxone kits distributed 3. # of OD reversals reported 4. # of OD deaths 5. # of OD related admission to ER 6. Plan for disseminating alerts around drug related incidents and overdose	<u>Short term Outcomes (1-2 years)</u>: 1. More health care professionals aware of THN initiative and prescribing Naloxone to save lives 2. More opioid users have access to THN 3. Key stakeholders will be aware of strategy to communicate OD alerts and drug related issues 4. Reduce hospitalizations from 1247 in 2011 to 1000 by January 2014 5. OD rate will continue to decrease from 5.46/100 000 in 2012 to 4.46 in 2013 (to ê from 90 in 2012) <u>Long Term Outcomes (3-5 years):</u> Decrease in OD deaths Decrease in hospitalization due to OD

Fraser Health Authority Harm Reduction Plan 2013 – 2016

HRSS Goal 2: Promote and facilitate referral to public health services primary health care mental health and/or substance use services and social services.				
FH Aim	**Actions**	**Involved or responsible**	**Measures**	**Outcome**
Increase number of PWUID into treatment, primary care and support services	- Develop and implement Peer navigators/Peer support workers to engage PWUID and link them into care or support services - Provide resources to community agencies to hire peer navigators/support workers - Increase service provider awareness of potential referrals through knowledge exchange and provider meetings	- Erin Gibson - Community service providers - User groups - Primary Care	# of clients attached to Primary Care provider (GP/NP/HCP) # of referrals made	1. Increase number of PWUID on HIV and Hep C treatment 2. Increase number of PWUID attached to a Primary Care provider 3. Increase reported referrals from 1658 in 2011

HRSS Goal 3: Reduce barriers to health and social service, including activities to reduce stigma and discrimination and raise public awareness and understanding of harm reduction principles, policies and programs among professionals in the health, social and criminal justice systems, officials in all levels of government, and the general public.

FH Aim	Actions	Involved or Responsible	Measures	Outcome
Collaborate with municipalities to assess individual community readiness for HR	- Presence at community tables i.e. City of Surrey Community Health Programs Committee - Collaborate with Municipalities	- Amrit Rai - Erin Gibson - HR Provider Network	- Increased dialogue and HR informed response at the community tables - Increased public dialogue about HR - # of municipalities supporting HR srvices	- Communities feel empowered to engage in topic and have increased capacity to address issues - Municipalities will support Harm Reduction services in their communities
Improve equity in Healthcare for PWUD	- Inclusion of HR in Health Equity policy and topics	- All	- HR plan included on Health Equity webpage - HR included in PH staff orientation pathways	<u>Short term Outcomes (1-2 years)</u>: HR included in PH strategies <u>Long Term Outcomes (3-5 years):</u> - HR adopted as an important strategy to address health inequities
Reduce barriers to accessing health care for PWUD and raise	Provide Education and training to: - 2 workshops will be	- Erin Gibson - Marika Sandrelli	- # of workshops /session for PH staff - # of workshops	<u>Outcomes:</u> 1. Increased capacity to provide

awareness of the existence of barrier to address them in meaningful ways	offered in 2013 for PH frontline staff and leadership - Year 2-5: In collaboration with MHSU offer education to MHSU staff and Primary Care/ER - Review MHSU HR Policy to develop comprehensive FH HR strategy - Support and engage community dialogue about HR through movie screening and SP trainings	(MHSU) - PH leadership - MHSU leadership - KEY internal and external stakeholders	/session for FH staff (not PH) - Plan to implement HR supplies distribution - # of opportunities for community dialogue	appropriate care 2. Conversations about how to reduce threshold to service happen regularly 3. FH Harm Reduction Strategic Plan
Increase harm reduction service providers knowledge around supplies, importance of HR services , inclusion of peers and best practices	- regular harm reduction training for service providers, volunteers, and FHA staff	- Erin - Community Agencies - PHU	- # of trainings provided for HRSP and volunteers	- <u>All service providers will be trained (Keys, Purpose, 5 and 2, etc)</u> - <u>Greater inclusion of peer voices and acknowledgment of expertise</u>

HRSS Goal 3 *cont*.: Reduce barriers to health and social service, including activities to reduce stigma and discrimination and raise public awareness and understanding of harm reduction principles, policies and programs among professionals in the health, social and criminal justice systems, officials in all levels of government, and the general public.				
Strengthening meaningful peer engagement and incorporating voices into design delivery	- Creating opportunities to listen experiential voice by working with peers and agency of records to develop skills - Peer Navigator Programs	- Abbotsford Community Services - Keys	- # of HR supplies distributed by peers	- Peers have increase Visible presence in dialogue
Develop key messaging and response to possible incidents related to HR issues	- develop key messages - identify key spokesperson	- All	# of key messages on the N drive Regional MHO lead identified Local MHO lead for Abbotsford Identified	- Key messages and response on N-drive BBP Team/Harm Reduction/Leadership - MHO regional and local leads will provide leadership and direction around HR programs

HRSS Goal 4: Ensure full and equitable reach of Harm Reduction Programs (HRPs) to all vulnerable British Columbians who use drugs, to provide education about health promotion and illness prevention to inform decision-making.

FH Aim	Actions	Involved or Responsible	Measures	Outcome
Harm Reduction Supplies will be available at all PHU units	- Training and dialogue with PHUs to address concerns and initiate distribution	- Support from leadership - Erin Gibson - PHUs	- # of PH units offering HR supplies	- increased acceptance of HR as nursing practice - All (18) PHU will have supplies available for people who ask
Increase number of FH Hospital as depot for sharps disposal	- Continue to monitor ARH disposal program - develop plan for all FH hospital to act as disposal depot	Victoria Amrit Erin Gibson Hospital site directors Hospital general managers	- # of Hospital part of Hospital disposal program	All hospitals will act as a needle disposal depot

FHA Goal: Increased capacity for informed knowledge exchange and ability to look at trends through increased monitoring, surveillance, and regular reporting structures.

FH Aim	Actions	Involved or Responsible	Measures	Outcome
Improve surveillance, monitoring, and reporting system to track indicators	- Set up surveillance system - Set up monitoring and reporting our process: for: *Supplies distributed, OD deaths, and hospital admissions*	- Data Observatory Team - Community HRP Providers - Erin Gibson - Stephanie Konrad - BCCDC	# of Regular reports generated by Observatory team • Annual evaluation reports.	- Increased awareness around HR distribution, OD deaths and OD hospitalizations

Appendix A: Comparisons of the strengths and limitations of different Needle Distribution Program Models Adapted from Strike C, Leonard L, Millson M, Anstice S, Berkeley N, Medd E. Ontario needle exchange programs: Best practice recommendations. Toronto: Ontario Needle Exchange Coordinating Committee. 2006.

Model Type	Strengths	Limitations
Fixed Site NDP	• Services are free • User friendly • Education and other services available on-site • Disposal of used equipment	• Limited hours of operation • Location – limited and/or identifying • Crowded when program is busy • Clients reluctant to use sites perceived to be too governmental or clinical, concerned about being seen accessing "gay-oriented" or HIV related supports
Mobile NDP	• Services are free • User friendly • Increases accessibility (i.e., go where the clients are) • Reaches hard-to-reach PWUD	• May be insufficient space for counselling sessions, arranging referrals, HIV and other disease testing, helping clients fill out forms and contacting other agencies • Difficult for some of the hard-to reach PWUD to make connection • Cost and maintenance of vehicle
Imbedded Service	• Services are free • Reaches hard-to-reach - Builds credibility in the community - Can build relationships and capacity for HR with "host" organization - Reach people not familiar with service	• Potential staff dynamic challenges • Clients may not want to access supplies there as it may impact services and supports received from host (i.e. shelter bed) • Some individuals who access support through NDP may be banned from everywhere else so cannot or will not access in imbedded site
Outreach to Homes	• Services are free • Reaches hard-to-reach • Builds credibility in the community	• Safety for staff • Potentially intrusive for client
Satellite Sites	• Services are free for IDUs • May attract different groups of IDUs • Increase accessibility in terms of	• Difficult to enforce parent NEP policies on satellite sites • Staff turnover at satellite site may require

	location, time, culture and age group • May offset operational and human resource costs from the parent NEP to the satellite site • Increases service complement at satellite agency without incurring NDP equipment/disposal expenses	frequent training of staff by primary NEP
Pharmacy	• Extended hours of operation • Multiple locations • Less stigmatizing/more anonymous	• Costs to purchase needles • No disposal of used equipment • No harm reduction services, education or support offered • Reluctance to sell to to PWUD • Reluctance to sell small quantities of needles • Limited hours/days of operation
Peer-Based Outreach	- Peer knowledge of drugs, drug use and the drug scene • Peer knowledge and empathy about living conditions and context • Increases reach of the NEP to PWUD who will not/cannot use the NEP • May provide employment skills, and income for peer exchangers • Improve self esteem and self worth • No cost to the NEP if peers are unpaid • More convenient/accessible for clients • Peers have credibility and can be important role models for risk reduction	• Training/supervision of peers can be costly • Conflicting identities as peer worker and IDU community member • Peer worker identity may be used to continue/further street economy activities • May violate worker/client boundaries
Vending Machines	• Location and 24 hour availability • Convenience • Ease of use • Limited staffing required	• No face to face harm reduction services offered • Expensive up front and associated repair costs • Subject to vandalism • Difficult to maintain anonymity when in a public space

Appendix B – Principles of Universal Access
Excerpt from

Universal access encompasses the principles of equity, equality, non-discrimination, comprehensiveness, accessibility and sustainability, which guide the development of interventions in the Comprehensive Package. These interventions must:
- be physically accessible (geographically distributed, e.g. available beyond major cities and to those living in hard-to-reach locations);
- be affordable (cost at the point of service should not be a barrier, e.g. patients should not have to pay for their treatment);
- be equitable and non-discriminatory (there should be no exclusion criteria except medical ones; e.g. OST should not be limited only to those who use drugs who are HIV-infected or who have failed on other drug dependence treatment; likewise, access to ART should not be conditional on the cessation of drug use);
- be unrationed (supply should be determined by need and not limited by cost or other considerations; e.g. NSPs with strict limits on the number of syringes provided to each client are less successful than those that do not impose such restrictions) (106).

Furthermore, access to the interventions included in the Comprehensive Package should not be restricted by socio-demographic or other criteria such as:
- age: programmes should not impose age restrictions (i.e. there should be no minimum age requirement for accessing services; in the case of children and young people who inject drugs, special provisions may be required where parental consent is ordinarily required for children to obtain medical or other services);
- sex/gender, sexual orientation or sexual behaviour; citizenship, nationality, country of origin, race/ethnicity, asylum-seeking status, or religion/ religious convictions; employment status and profession, including sex work, illegal employment, etc. confinement to a facility/setting—imprisonment, military service, health institution, orphanage, etc.; health insurance status;
- substance use status—for example, current injecting should not be a barrier to access; housing status (for example, homelessness); mental health status; pregnancy status.

All interventions should be offered on a voluntary basis in an enabling environment created by supportive legislation, policies and strategies.

Appendix C - Role of HR coordinator:

Health Authorities in British Columbia are responsible for ensuring planning, delivering and evaluating prevention and care services. This includes working with regional and local partners to identify and develop evidence-based responses to disease transmission. Health Authorities are responsible for ensuring services engage and serve vulnerable populations. http://www.health.gov.bc.ca/cdms/pdf/Best%20Practices.pdf

Appendix : Additional information for FH AIMS and Actions identified

FH AIMS or Actions as identified P. 9-17	Activities	Responsible Person	Time Frame
Support community service providers to double number of needle distributed	Develop and alter existing contracts to include expectations of service delivery: - *understand Best practice guidelines distribution vs one to one exchange* - *expectation of training opportunities so staff are equipped to give health related information in an appropriate way* - *#of needles distributed, route of mobile van (increase reach) and geographical areas that will be served* - *client advisory body to communicate changes in service delivery and inform practice.*	Amrit Victoria Amrit	June 2013 – March 2014 June 2013- Aug 2013
Support community services to extend hours of service and expand geographical coverage	- *importance of consistent outreach schedule* - *contracted client contact/outreach hours and record short fall if unable to replace* Review Current contracts and increase funding (see budget report): KEYS, Purpose, PCRS, PLFV Develop contracts for new service providers *PLFV, Warm Zone, Mission Friendship Centre, ACS, 5 & 2, DWS, SANSU (may require sponsor agencies)* to cover areas and populations underserved HR such as, (Langley, Hope, Delta, Aldergrove,) (Youth, Sex Workers, Aboriginal people)	Amrit	June 2013-Aug 2013
- Develop and implement Peer navigators/Peer support workers to engage PWUID and link	Develop a plan for peer to peer distribution program -call for proposals -set deliverables for community groups -provide ongoing support	Erin	July 2013-March 2014

them into care or support services			
Training and dialogue with PHUs to address concerns and initiate distribution	Share HR plan and vision with PH managers and supervisors In collaboration with PH supervisors, PHN, CNE, managers develop a service plan for all PH units to start offering HR Supplies and link users to services in their community Current PHU offering supplies: New West and Mission HU	Amrit Erin	June 2013 –July 2013 April 2013 –on going
Provide education and training to PH staff, MHSU and ER staff	Develop an education plan for Public Health Staff, SU staff, in year 1-2. MH and ER staff in year 2-3 Promote and encourage regular peer engagement meetings Such as SANSU and DWS (see budget report) Encourage service providers to have client advisory board	Erin	Sept 2013-Nov 2013
Develop key messages and response to possible incidents related to HR issues	- Develop key messages - Post on N drive so its accessible in a timely manner for PHN leadership - Develop proactive messages in consultation social marketing communication person and Stephanie Bale	Erin Roy Thorpe	Completed- Jan 2013 and ongoing Fall 2013
Collaboration with municipalities	Continue to strengthen partnership with Abbotsford Citycouncil Represent at appropriate committees led by City in Surrey, Maple Ridge, Langley or as other cities identify need		ongoing
Increase number of FH hospitals as depots for sharps disposal	Collaborate with hospital site directors and general managers to increase number of hospitals used as depot for sharps disposal. 2012/2013 –ARH (completed and monitoring) 2013/2014 - SMH and RCH 2014/2015 – LMH, MGH, CGH 2015/2016 – remaining CEO and CMHO needed to endorse program for quick success	Amrit Erin Victoria	

Fraser Health Authority Harm Reduction Plan 2013 – 2016