Bulleted information for Minister of Health's meeting with Mayor of Abbotsford re: Harm Reduction Services in Abbotsford

BACKGROUND

- In 2005, Abbotsford City Council (Council) announced its intention to create a municipal bylaw restricting provision of harm reduction services such as distribution of harm reduction supplies and methadone maintenance treatment in the city.

- The Deputy Minister of Health and Ministry of Health (the Ministry) staff attended aCouncil meeting to convey Ministry concerns about the proposed bylaw. Council subsequently adopted the bylaw (Bylaw 392), significantly restricting harm reduction services through multiple amendments of zone use definitions.

- *Harm Reduction: A British Columbia Community Guide* (the guide) was released at the Union of British Columbia Municipalities 2005 Convention by the Minister of Community Services in collaboration with the Ministry. The guide provides information to assist municipalities in taking a leadership role in reducing drug related harm in their communities.

- Abbotsford's Supporting Wellness and Reducing Harm Committee, composed of members representing community, advocacy and drug user organizations, has been quietly distributing harm reduction supplies in Abbotsford since 2005, independently from Fraser Health Authority (FHA). Additionally, Portland Hotel Society, Vancouver, has been distributing supplies weekly since October 2011 through their mobile services. Portland Hotels Society is seeking funding from FHA to continue this service.

- In the fall of 2011, a new Abbotsford Council, led by Mayor Banman, asked David Portesi, Director of Health Promotion and Prevention for FHA, to provide information for a report on the impact of substance use and the lack of harm reduction services in the municipality. Additionally, in late 2011 and early 2012, the new Council conducted two stakeholder engagement sessions with representatives from the city, community organizations and drug user groups regarding the creation of a service plan for harm reduction.

- Based on the engagement sessions and on evidence-based best practices for harm reduction services, Mr. Portesi created a draft document outlining FHA's plan for the formal introduction of a coordinated harm reduction supply distribution program and related services in Abbotsford. The detailed plan outlines service delivery components and a proposed implementation plan and timeline. Mr. Portesi presented the report to the new Council on Monday, May 28, 2012.

DISCUSSION

- Population level data related to illicit drug use in Abbotsford demonstrates the following:
  - Abbotsford has the highest rate of hospital admissions due to drug overdose compared to Surrey and Burnaby/New Westminster, and other areas in Fraser Health with established harm reduction services;
  - Drug overdose mortality rates in Abbotsford are higher than both the regional rate for Fraser Health and the provincial rate;
  - Abbotsford experiences a high rate of reported hepatitis C virus compared to other municipalities and to Fraser Health as a whole. Injection drug use is the main route for transmission; and
  - New HIV infections have been steadily declining in Fraser Health, as they have in BC overall. Abbotsford has one of the lowest rates of new HIV infections in Fraser Health, although caution needs to be taken when interpreting these rates, as they are based on small counts.

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Proposed Harm Reduction Service Plan for Abbotsford

- Mayor Bruce Banman has indicated that he understands and supports the need for harm reduction services in Abbotsford.

- Council has linked an agreement to moving forward on harm reduction with their desire to see Fraser Health Authority locate stand-alone withdrawal management services in Abbotsford. Fraser Health Authority has emphasized its commitment to a regional plan that includes a mix of both out-patient and in-patient services, organized to best serve Fraser Health population needs as a whole.

- Abbotsford Council has indicated a desire to engage the public in consultations on two topics:
    1. The expansion of harm reduction services in Abbotsford
    2. Withdrawal management and treatment services in Abbotsford

- Council intended to start this engagement process this month (August, 2012), however, council has not yet initiated the process and is not expected meet and finalize any plans before the end of August.

- There are no plans to invoke provincial legislation in this matter at this point in time.

ATTACHMENT B

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A Proposed Abbotsford Harm Reduction Service Plan

Version 1 – April 30, 2012

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PURPOSE and SCOPE

The purpose of this document is to outline a plan for the formal introduction of a coordinated harm reduction supplies distribution program (HRSDP) and related services into the City of Abbotsford. These services include the distribution of clean needles and other supplies provided and governed by the BC Harm Reduction Strategies and Services (BCHRSS) Committee and coordinated by the BC Center for Disease Control.

This plan was created in consultation with substance users, community-based service organizations, municipal representatives and health authority personnel. The opportunity behind this consultation and plan is the creation of a high level road map for harm reduction services that first and foremost meets the health and safety needs of current substance users while addressing the likely concerns of the general public related to crime, public health and safety.

This plan does not address or plan for the implementation of safe-injection sites in Abbotsford or elsewhere in Fraser Health. FHA considers safe-injection sites (SIS) a promising practice in disease prevention and harm reduction. However, the Health Authority is closely reviewing data and practice evidence coming from the Vancouver experience with SIS and any plans to move forward with a similar service in FHA would be preceded by extensive engagement and discussion with municipalities.

BACKGROUND

Indicators of Injection Drug Use in Abbotsford

Injection drug use has been identified as a concern for the city of Abbotsford. Currently, there is little data on the prevalence of injection drug use or the number of injection drug users (IDU) in Abbotsford. Attachment 1 is a fact sheet that provides a summary of population level data related to illicit drug use. Where possible, data was compared to other municipalities in Fraser Health and to provincial and national data.

Key summary points from this data include the following:

- Abbotsford has the highest rate of hospital admissions due to drug overdose compared to Surrey and Burnaby/New West, areas with established HRSDPs.
- Drug overdose mortality rates show a similar trend, with high rates for New Westminster, Surrey and Abbotsford; all three municipalities are above the regional rate for Fraser Health and the provincial rate.
- In BC, Abbotsford, Vancouver and Victoria report relatively high rates of drug offences. These three census metropolitan areas, along with Trois-Rivieres and Gatineua, have reported the highest rates in Canada for the past five years.
- Abbotsford suffers from a high rate of reported HCV compared to other municipalities and Fraser Health overall.
- A crude estimate of Abbotsford's IDU population ranges from 280 to 470 injection drug users, though this is likely to be a significant underestimate; for example, the BC/Yukon Drug Wars Survivors report that their membership of 450 people includes 250 members who consider Abbotsford their home.

Based on the above findings is appears likely that harm reduction services would serve a minimum of approximately **500** IDU living in the Abbotsford area and distribute about **120,000** needles annually.

Value of Harm Reduction

The presence of safe and effective harm reduction services provides tangible benefits for intravenous drug users who access these services as well as the communities that support these services.

Value of Services to Intravenous Drug Users

Intravenous drug users (IDUs) are at an increased risk of transmitting blood borne diseases such as HIV and Hepatitis C. Harm reductions strategies such as needle exchanges have been demonstrated to reduce the risk of blood borne disease transmission among IDUs by providing them with a clean supply of needles.[1,2,3] Needle exchange programs have been endorsed by the Joint United Nations Programme on HIV/AIDS and the United Nations General Assembly.[4]

The success of harm reduction programs are, in part, based on the linkages that exist with other healthcare service providers such as primary care and mental health/substance use. Many clients using harm reduction may also be in need of primary care services such as wound care, STI testing, and vaccinations. Similarly, clients with mental health concerns should be linked with mental health and substance use service providers that can provide the appropriate counselling and treatment.

Value of Services to the Community

It is important to understand that research based evidence proves that HRSDPs:

- Do not increase drug use[5,6,7]
- Do not negatively impact drug treatment[8,9,10,11,12,13]
- Do not increase rates of equipment (needles) in the street[14,15,16,17,18]

Furthermore, in addition to saving human life and allowing drug users to remain integrated in society, HRSDPs also economically benefit communities. A number of studies have shown that HRSDPs are cost-effective because they have the opportunity to help reduce drug use in communities, decrease crime and reduce drug use related incarcerations.[19,20,21,22,23]

Finally, the plan proposed below includes methods to improve communication and coordination across the community. Chief among these is the formation of a community advisory board that can serve as a forum for problem solving, improving services and program effectiveness and addressing the concerns and issues brought forward by the entire community.

Overview of Program Delivery Models and Components

Fixed Site

In a fixed site model, clean needles are distributed through a permanent location in either an area inhabited by IDUs, or an area where there is a fairly open drug scene. Fixed sites have an advantage over other delivery models in that they are able to provide additional services such as education, counselling, testing, and primary healthcare. Features to consider in developing a fixed site include: an office with a door that locks, a lockable storage room, and private rooms for counselling.

Mobile Site

Mobile sites also provide an effective means of distributing clean needles. Generally, these sites are set up in vans or buses. In a van setting, there is usually a driver and a worker that collects used supplies and distributes clean supplies from the back of the van. A bus setting functions more like a fixed site in that there is

an area for distribution, as well as areas for counselling, education, and rooms for medical treatment[24]. There are several benefits from using a mobile set-up. Most notably, a mobile set-up allows harm reduction workers to cover a larger geographical area than a fixed site. The mobile site also reduces some of the community opposition that may exist around establishing a permanent fixed site.

Outreach

An outreach approach generally consists of harm reduction workers going into apartments or other areas where IDUs may reside. The outreach worker carries a backpack that contains new injecting equipment, a puncture-resistant bin for used needles and syringes, and education materials[24]. The advantage of the outreach model is that it is one of the easiest distribution methods to start, partly because it requires the least amount of funding. The disadvantage of outreach is that it provides fewer opportunities for education, counselling, and primary healthcare.

Pharmacy

Pharmacies provide another needle distribution option. The Canadian HIV/AIDS Legal Network recommends that pharmacists' associations and licensing bodies should encourage pharmacists to distribute clean needles[25]. The advantages of using pharmacies is that in most places a network of pharmacies already exist and pharmacies have better hours of operation than many fixed sites. The other advantage that pharmacies offer is that, in rural settings, pharmacies may provide the only convenient location to obtain clean needles. However, many pharmacies are reluctant to offer clean needle distribution to IDUs. Also, because most pharmacies are privately owned, pharmacy owners usually require a financial incentive for their involvement. There are examples of successful needle exchange programs operated out of pharmacies in Australia, Vietnam, and China.[26,27,28]

Peer Distribution

Peer involvement can play a major role in reducing harm among groups at the highest risk for infection[29]. In a peer distribution model, bulk harm reduction supplies are provided to peer groups, who in turn distribute the supplies to fellow IDU. The advantage of using this approach is that it targets IDUs that are reluctant to visit fixed centres or other distribution points. While peer distribution is a low-cost approach to reducing harm, it may not provide the healthcare aspects or treatment referral that fixed or mobile sites can offer.

Needle Collection and Disposal

HRSDPs have an obligation to provide a robust recovery and disposal system because inappropriately discarded used injecting equipment undermines the credibility and sustainability of these services. While the risk of transmission of HIV or HCV infection from discarded needles is low, there tends to be a high level of public concern about this issue. Effective recovery and disposal services require the participation of a variety of stakeholders including municipal governments, business associations, community agencies, and groups of people who use injection drugs. According to the BCCDC Best Practices for British Columbia's Harm Reduction Supply Distribution Program, safe disposal practices include multiple approaches, such as provision of sharps containers to clients, partners and community members; public drop boxes in areas frequented by people who inject drugs; and pick up services through needle hot lines or community agency pick-up services.

Community Engagement

The success of HRSDPs depend greatly on the level of community support afforded to these programs. Because of the variety of views on drug use, societal responsibility to respond to the health and wellness needs of IDUs, and multiple other facets of this issue, the implementation of HRSDPs in a community requires a variety of tactics to build support while addressing public concerns. These tactics can include the development and utilization of an advisory committee with a broad representation of community stakeholders, open discussion of HRSDP implementation in community forums, education efforts with individuals and groups from experts in the field and fostering IDU advocacy groups to take an active, positive role in helping the broader community understand the need for HRSDP. Community engagement efforts should target businesses and business associations, municipal government, community service providers, and cultural and faith-based organizations, among other.

PROPOSED PLAN for ABBOTSFORD

Table 1 (Attachment 2) summarizes the harm reduction service delivery components and proposed implementation plan and timeline for Abbotsford. Note that this plan:

- Is based solidly on the BCCDC document entitle Best Practices for British Columbia's Harm Reduction Supply Distribution Program and includes all of the identified best practice components deemed necessary for HRSDP success
- Assumes that the anti-harm reduction bylaw is no longer in effect in Abbotsford when the plan is implemented
- Requires a broad range of community engagement activities and partnerships with municipal and law enforcement leaders to ensure success.
- Takes a two phased approach with phase 1 (0-12 or 18 months) including the launch of community engagement, peer and partner distribution and street nursing/outreach; phase 2 (12-24 months) includes addition of FHA contracted mobile services, FHA supported fixed site services and pharmacy based distribution.

With respect to the timeline, it is expected that some services, such as partner site distribution and peer-to-peer distribution, will begin fairly immediately upon launch of the plan. Other services, including mobile and fixed site will take longer to plan and implement but timelines could be shortened based on community readiness, availability of resources and early success with other HRSDP services.

Plan Goals

There are three overarching goals of this proposed plan. These goals are shared with The BC Harm Reduction Strategies and Services Policy and are as follows:

- Reduce incidence of drug-related health harms, including transmission of blood-borne pathogens through needle sharing.
- Promote and facilitate referral to primary health care and addiction/mental health services.
- Increase public awareness of harm reduction principles, policies and programs.

Plan Principles

In December 2011 and January 2012, Fraser Health conducted two consultation sessions with a variety of stakeholders. These stakeholders included members from the

Fraser Health HIV/AIDS/Hep C Regional Advisory Committee, representatives from IDU-serving community based organizations in Abbotsford, including Abbotsford Community Services, the Warm Zone and 5 and 2 Ministries, representatives from the BC/Yukon Drug War Survivors Abbotsford Chapter and individual people who identified as IDUs living in Abbotsford.

Using the best practice framework outlined in the *BCCDC Best Practices for British Columbia's Harm Reduction Supply Distribution Program* and focusing on the key areas of outreach, peer distribution, fixed site and mobile distribution, participants identified a number of important issues, ideas and hopes that would be addressed in an Abbotsford harm reduction implementation plan. These are listed in Attachment 3. The major principles or themes arising out of this discussion are as follows:

- Current and previous IDUs need to be consulted in the planning of services and directly involved in the implementation of HSRDPs.
- HSRDPs must be accessible and as low-barrier as possible.
- Services must be integrated and include access to medical and social services.
- While services must be accessible, they should also be low-profile and provide privacy.
- Training for all involved in HRSDPs is critical.
- Services should be provided by a mix of peers and professionals.
- Forging strong supportive connections with law enforcement and other partners is also critical.

The above principles will be incorporated into the detailed implementation of the plans identified in Table 1.

Service Locations and Hours

During the January 2012 consultation meeting, participants were asked to identify locations where HRSDPs would be most successful. These sites could be served by different types of HRSDPs (e.g. fixed, mobile, partner site, etc.).

The top three sites identified are (in rank order):

- The West Railway Street area near the Salvation Army
- The area near the intersection of Peardonville Road and South Fraser Way
- The Jubilee Park area

It is important to note that other areas where HRSDPs could be successful exist elsewhere in Abbotsford. Indeed, the meeting participants clearly stated that co-location with or near other services, such as shelters, is critical for success. Similarly, engagement with the community, including formation of good-neighbour agreements with businesses and others in close proximity to HRSDPs, was specifically identified by the group as a success factor.

Finally, participants stated that 24 hour access to HRSDPs is ideal, but if not a possibility in the short term, hours of operation from 12:00 PM to 12:00 AM would promote access. It was noted that individual services may not be open during this entire timeframe but that, with a mixture of peer, partner, mobile and fixed site distribution, these core service hours would be covered.

Plan Oversight

Fraser Health Authority will assume responsibility for coordination, implementation and evaluation of this plan. This will be done in close partnership and collaboration with

stakeholders in the community including but not limited to IDU, community based organizations, law enforcement, city leaders and local business representatives. To achieve this, the Abbotsford plan includes creating an Abbotsford Harm Reduction Community Advisory Board that will be chaired by FHA and include representation from a broad cross-section of stakeholders from Abbotsford, including the examples mentioned above. The AHRCAB will be responsible for advising Fraser Health on the successful implementation of an HRSDP program, provide a forum for problem solving and addressing concerns from stakeholders and the public, and promote cooperation and coordination of service delivery.

According to the BCCDC document entitled Best Practices for British Columbia's Harm Reduction Supply Distribution Program, *"the development and utilization of an advisory committee with a broad representation of community stakeholders will support and sustain HRSDP services in the community. With the involvement of businesses and business associations, municipal governments, community service providers, and cultural and faith-based organizations, collaboration and shared responsibility will be encouraged, and social and economic resources will be mobilized."*

Program Evaluation

Evaluation of HRSDP successes or need for improvement is critical to building a sustainable program that reduces the spread of disease, promotes health and wellness and engages IDU at their stage of readiness for treatment services. Fraser Health will engage internal expertise as well as partner with BCCDC and a local university to develop an evaluation and monitoring plan for all HRSDP implemented in Abbotsford.

NEXT STEPS

As the current lead for providing harm reduction services in the region, Fraser Health will work collaboratively with community partners and municipal leaders to implement this important work in Abbotsford. Though this plan assumes the removal of the anti-harm reduction zoning by-law in Abbotsford, portions of this plan can begin immediately. These portions include:

- Pre-planning and recruiting for the Abbotsford Harm Reduction Community Advisory Board
- Conducting individual, small group and community engagement events to promote the need for harm reduction services
- Establish needle disposal services at Abbotsford Regional Hospital
- Continued development of IDU engagement efforts, including the development of incentive programs for needle collection and disposal and peer distribution
- Development of a street-nursing outreach plan for Abbotsford (and other areas in the Health Authority)

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Indicators of Injection Drug Use

A focus on Abbotsford, British Columbia

Abbotsford, one of the thirteen local health areas in Fraser Health, is bound by the Fraser River to the North, by the US border to the south, by Chilliwack to the east and the Township of Langley to the West. In 2009, close to 136,900 people reside in Abbotsford. From the population perspective, it's the 4th largest local health area in Fraser Health representing nearly 9% of the total population.

Injection drug use has been identified as a potential concern for the city of Abbotsford. Currently, there is little data on the prevalence of injection drug use (IDU) in Abbotsford. This fact sheet provides a summary of population level data related to illicit drug use. Where possible, data was compared to other municipalities in Fraser Health and to provincial and national data.

Hospital Admissions & Death

Hospitalizations and deaths due to illicit drug overdose are indicators of morbidity and mortality directly associated with drug use. On average, about 29 Abbotsford residents a year are admitted to FH hospitals for an illicit drug overdose; this corresponds to a rate of 21.9 per 100,000. Abbotsford's admission rate is higher than Surrey, Burnaby and Fraser Health overall, yet lower than New Westminster. Mortality rates show a similar trend, with high rates for New Westminster, Surrey and Abbotsford; all three municipalities are above the regional rate for Fraser Health and the provincial rate. Overdose data is not specific to injection drug use.

Illicit drug overdose hospital admission counts and rates, by residence, 2006/07 – 2010/11

	Hospital Admissions	
	Count	Rate*
Abbotsford	29	21.9
Surrey	79	17.3
New Westminster	15	23.6
Burnaby	25	11.4
Fraser Health	261	16.9

*Rate per 100,000 population
Source: Meditech, Discharge DAD

Illicit drug overdose mortality rate, by residence, 2005-2009

	Rate*
Abbotsford	8.08
Surrey	9.01
New Westminster	11.07
Burnaby	4.89
Vancouver	11.79
Fraser Health	6.86
Vancouver Coastal	8.57
BC	7.79

*Rate per 100,000 population
Source: Centre for Addictions Research of BC

Drug Offences

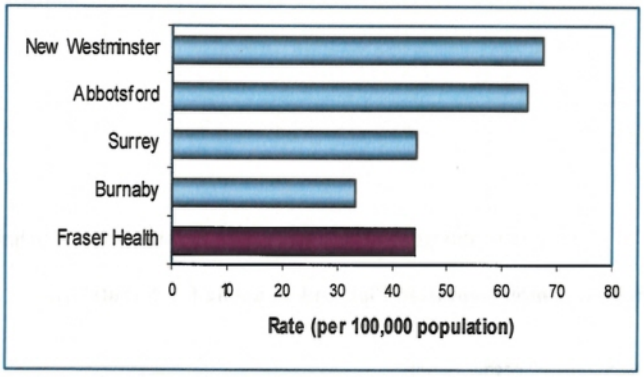
Police reported drug offences provide a proxy measure for the amount of drugs in a community. According to the Uniform Crime Reporting Survey, by the Canadian Centre for Justice Statistics, BC consistently reports the highest rate of drug offences among the provinces, double the rate of the next highest province, Saskatchewan. In BC, Abbotsford, Vancouver, Victoria report relatively high rates of drug offences. These three census metropolitan areas, along with Trois-Rivieres and Gatineua, have reported the highest rates in Canada for the past five years. The table to the left highlights drug offences for cocaine and heroin, commonly injected drugs. While below the provincial rate, Abbotsford's drug offences for cocaine and heroin are roughly double and triple the national rate, respectively.

Police reported drug offence[a] rates*, by type of drug, in select Census Metropolitan Areas, 2007

	Total drug offences	Cocaine	Heroin
Abbotsford	392.7	122.4	7.1
Vancouver	630.1	163.0	17.1
Victoria	471.1	144.9	10.0
BC	653.7	171.3	12.2
Canada	305.3	69.2	2.4

*Rate per 100,000 population
[a] Drug offences include possession, trafficking, production, importing and exporting
Source: Statistics Canada, Canadian Center for Justice Statistics

Newly reported Hepatitis C rates among non-incarcerated population for select municipalities in Fraser Health, by residence, 2010



[a]Rates exclude incarcerated cases
Source: iPHIS, data extracted February 2012

2009 Hepatitis C Rates
BC: 54.9 per 100,000
Canada: 33.7 per 100,000
Source: Hepatitis C and STI Surveillance and Epidemiology, PHAC

Hepatitis C & HIV

Hepatitis C (HCV) & HIV are blood borne pathogens that can be transmitted through the exchange of bodily fluids, such as blood. Unsafe injection practices, such as needle sharing, result in the transmission of these blood-borne diseases. Unlike HIV, sexual transmission of HCV is rare, and thus the main route for transmission of HCV is injection drug use. Since HCV is more easily transmitted than HIV, the prevalence is generally higher. Abbotsford has an estimated HCV rate of 64.4 per 100,000 among its non-incarcerated population. Abbotsford suffers from a high rate of reported HCV compared to other municipalities and Fraser Health overall. New HCV infections can be an indicator for potential risk of HIV transmission.

New HIV infections have been steadily declining in Fraser Health and BC overall. Over the last five years, there were roughly 17 new HIV infections per year attributed to injection drug use, which corresponds to a rate of 1.1 per 100,000. Abbotsford has one of the lowest rates of new HIV infections due to IDU (0.3 per 100,000 or roughly 1 new infection per year due to IDU). In comparison, New Westminster has a rate of 3.3 per 100,000. Caution needs to be taken when interpreting HIV rates, as they are based on small counts, resulting in unstable rates.

Injection Drug Use

Estimating the number of injection drug users (IDUs) in a community can be quite difficult due to the illegal nature of the drugs used. IDUs tend to be hidden and marginalized populations. Nevertheless, estimation methods have been used to across Canada to estimate IDU. Canada wide estimates range from 75,000 to 145,000.[1,2] In 1998, a BC estimate of 15,000 IDUs was put forward in a report by the Ministry of Health.[3] Dividing these estimated counts by the total population (aged 15-64) provides a proportion, which facilitates comparisons. See table on the right.

Using the conservative national percentages of 0.3% - 0.5% on Abbotsford's population (15-64 age group, n=94,462) yields a crude estimate of 280 to 470 injection drug users. Given Abbotsford's high rates of HCV, overdose admissions and deaths, and drug offences, it is reasonable to believe these IDU counts underestimate the real number of IDUs in the community and conservatively is at the top end of the range of at least 500 individuals. Furthermore, based on Harvard et al., it is estimated that 500 users would require approximately 547,500 needles annually. Given the average coverage rate in BC of 21.5% for HRSDPs, the likely number of needles distributed would be at least 120,000, the preferably more to meet need.[8]

Review of estimates of injection drug use counts within Canada

	Year	IDU Estimate	Percentage[a]
Canada[1]	2004	125,000-145,000	0.56-0.66%
Canada[2]	2000	75,000-125,000	0.34-0.57%
BC[3]	1998	15,000	0.60%
Ontario[4]	1997	30,000	0.42%
Saskatchewan[5]	2000	5,000	0.80%
Montreal[6]	1994	6,000-25,000	0.26-1.08%
Saskatoon[5]	2000	2,000	1.30%
Vancouver (DTES)[7]	2000	4,700	11.20%
Greater Vancouver region[7]	2000	12,000	1.45%

[a]Percentages based on 15-64 population age group, according to 1996, 2001, or 2006 census data
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Table 1. Summary of Harm Reduction Service Delivery Components and Proposed Implementation Plan and Timeline for Abbotsford.

Overarching Goals (shared with The BC Harm Reduction Strategies and Services Policy):
(1) Reduce incidence of drug-related health harms, including transmission of blood-borne pathogens through needle sharing.
(2) Promote and facilitate referral to primary health care and addiction/mental health services.
(3) Increase public awareness of harm reduction principles, policies and programs.

Harm Reduction Service Component	Strengths	Limitations	Action Plan/Phase & Timeline	Lead(s)
Community Engagement The development and utilization of an advisory committee with a broad representation of community stakeholders will support and sustain harm reduction supply distribution programs (HRSDP) in the community. With representation from IDU, businesses and business associations, municipal government, community service providers, and cultural and faith-based organizations, collaboration and shared responsibility will be encouraged, and social and economic resources will be mobilized.	➢ Builds community support for sustained harm reduction services ➢ Assists with addressing community concerns ➢ Represents a broader cross-section of the community ➢ Opportunity to engage other, often missed, service providers and community supports in a service network	➢ Requires skilled facilitation that addresses conflict resolution ➢ Must manage expectations and be comfortable with compromise	Co-Sponsor and recruit members for Abbotsford Harm Reduction Community Advisory Board (HRCAB); **Phase 1 - *Month 0-3*** Conduct a series of community engagement and education events on behalf of HRCAB, the Health Authority and the Municipality; **Phase 1 - *Month 0-6***	FHA and Municipality HRCAB, FHA and Municipality
Needle Collection and Disposal HRSDPs have an obligation to provide a robust recovery and disposal system because inappropriately discarded used injecting equipment undermines the credibility and sustainability of these services. While the risk of transmission of HIV or HCV infection from discarded needles is low, there tends to be a high level of public concern about this issue. Effective recovery and disposal services require the participation of a variety of stakeholders including municipal governments, business associations, community agencies, and groups of people who use injection drugs.	➢ Free disposal allows partner organizations to engage in harm reduction without incurred costs from typical disposal services ➢ Offer of service demonstrates commitment to public health and safety	➢ Some financial cost (low to moderate) ➢ Must build public acceptance of drop-box or other collection method, no matter how discrete ➢ Public may still find discarded needles that may not be from harm reduction efforts yet may degrade support	Establish Abbotsford Regional Hospital as a free bulk needle drop off site for registered organizations collecting used needles; ***Pre-implementation*** Develop a low-cost incentive system to encourage IDU to participate in the pick-up and disposal of used needles; ***Pre-implementation*** Work with municipality to establish community drop-box and other disposal options in strategic locations frequented by IDU; **Phase 1 - *Month 0-18***	FHA FHA Municipality, FHA
Partner/Satellite Site Distribution A variety of organizations already exist within the municipality to serve the needs of IDU. Many of these organizations provide the services that would make them ideal service referral partners for harm reduction services.	➢ Services are free for IDUs ➢ May attract different groups of IDUs ➢ Increase accessibility in terms of location, time, culture and age group	➢ Must promote consistent policies and services across many organizations ➢ Staff turnover at satellite site may require frequent training of staff	Recruit 5-10 local organizations that already serve IDU to also distribute clean needles and other harm reduction supplies to their IDU clientele; **Phase 1 - *Month 0-12***	FHA, HRCAB

Encouraging these organizations to provide clean needles and harm reduction supplies to the clients they already serve, with supported needle collection and disposal is a low-barrier way to expand the reach of these health services.	➢ May offset operational and human resource costs from the parent service to the satellite site ➢ Increase service complement for satellite agency without incurring equipment/disposal expenses ➢ Reduced objection from public as partners are already well established in community serving IDU		Provide Harm Reduction training to partner organizations to assure competent staff and effectiveness of service; **Phase 1 - *Month 0-12***	BCCDC, FHA
Peer-to-Peer Distribution Peer distribution increases access to harm reduction supplies for people who use illegal drugs. HRSDPs usually offer bulk harm reduction supplies to peer groups through partner sites, dedicated fixed sites or other distribution points. Peers then distribute supplies to their networks. In rural areas, peer-based secondary distribution services can provide supplies when no fixed site programs exist, and/or where coverage by mobile services is limited.	➢ Peer knowledge of drugs, drug use and the drug scene ➢ Peer knowledge and empathy about living conditions and context ➢ Increases reach to IDUs who will not/cannot use or access the needle distribution service ➢ May provide employment skills and income for peer workers ➢ Improves self-esteem and self-worth ➢ Low cost to parent service through small incentives to peers ➢ More convenient/accessible for clients ➢ Peers have credibility and can be important role models for risk reduction	➢ Training/supervision of peers can be resource intensive ➢ Conflicting identities as peer worker and IDU community member ➢ Must provide and enforce policies that promote peer worker/client boundaries	Partner/Satellite Sites recruit 3-5 peer distributors among their client base who can then redistribute clean supplies; **Phase 1 - *Month 0-12*** Provide modified Harm Reduction training to peer distributors to assure effectiveness of service and adherence to program principles; **Phase 1 - *Month 0-12*** Develop a low-cost incentive system to encourage IDU to participate in the distribution of harm reduction supplies; ***Pre-implementation*** Provide resources, including small amounts of targeted funding, to an IDU support/advocacy organization to create a peer distributor led support network that can work collaboratively with law enforcement, partner/satellite sites, the municipality and the Health Authority to promote and offer safe, effective harm reduction services; **Phase 1 - *Month 0-12***	Partner/Satellite Sites BCCDC FHA FHA, BCCDC, BCYDWS
Outreach Outreach services, also called pedestrian or	➢ Services are free for IDUs ➢ Reaches hard-to-reach IDUs	➢ Safety for staff ➢ Can be costly	Develop a street-nursing outreach plan that provides harm reduction	FHA, BCCDC

backpacking services, can increase access to people who may not otherwise come into contact with HRSDPs through other modes of service delivery. Workers may travel on foot, carrying harm reduction supplies to areas where people who use injection drugs can be found.	➢ Builds credibility in the IDU community		supplies, Public Health nursing services, and referrals to medical and other services; ***Pre-implementation.*** Implement the street-nursing outreach program; **Phase 1 - *Month 6-12***	 FHA, BCCDC
Mobile Mobile HRSDPs should provide a full range of injecting supply, collection and disposal services. In addition to providing and disposing of harm reduction supplies, mobile services should aim to engage marginalized populations, providing education, brief intervention and referral services. Mobile services operate most often from a van, usually with a driver in the front and at least one worker providing and collecting harm reduction supplies from the back.	➢ Services are free for IDUs ➢ User friendly ➢ Increases accessibility (i.e., go where the clients are) ➢ Reaches hard-to-reach IDUs	➢ May have insufficient space for counselling sessions, arranging referrals, HIV and other disease testing, helping clients fill out forms and contacting other agencies ➢ Cost and maintenance of vehicle	Secure funding and seek a request for proposal (RFP) from potential community contractors to provide mobile harm reduction supply distribution; **Phase 1 - *Month 0-12*** Implement mobile harm reduction services in coordination with other identified methods of supply distribution and needle pick-up and disposal; **Phase 2 - *Month 12-24***	FHA Contractor
Fixed Site Comprehensive fixed sites provide a range of injecting and harm reduction supplies, and capacity for equipment collection and disposal. In addition, fixed sites should include basic services such as education about harm reduction, safer drug use, and brief counselling. Further, fixed sites should provide referral to a wide range of health, community and addictions services, or directly offer primary health care services such as blood borne pathogen (HIV,HCV) STI and TB testing, and vaccinations on site.	➢ Services are free for IDUs ➢ User friendly Education and other services on-site ➢ Disposal of used equipment	➢ Hours of operation limited ➢ Location limited and/or identifying ➢ Crowded when program is busy ➢ Clients reluctant to use sites perceived to be too governmental, clinical, gay-oriented or HIV related ➢ Lease and site maintenance costs must be absorbed by HSDP	Secure funding and seek a request for proposal (RFP) from potential community contractors to provide fixed-site harm reduction supply distribution; **Phase 2 - *Month 12-18*** Implement fixed site service in coordination with other identified methods of supply distribution and needle pick-up and disposal; **Phase 2 - *Month 18-24***	FHA Contractor
Pharmacy Provision of injecting equipment by pharmacies increases the availability and the utilization of sterile injecting equipment because pharmacies already exist in most areas. In rural areas, pharmacies are often one of the few locations where individuals can easily obtain supplies.	➢ Hours of operation ➢ Multiple locations ➢ Less stigmatizing/more anonymous	➢ Potential cost for IDUs to purchase needles ➢ Limited harm reduction services offered ➢ Reluctance to sell to IDUs ➢ Reluctance to sell small quantities of needles	Working with a broader coalition of partners, including the HRCAB and representatives of the BC College of Pharmacy, develop a plan to engage pharmacists in the provision of harm reduction supplies; *Month 12-18* Implements a pilot distribution program with select pharmacists; **Phase 2 - *Month 18-24***	FHA, HRCAB, BCCDC, BC College of Pharmacists FHA, HRCAB, BCCDC, BC College of Pharmacists

Harm Reduction Consultation Meeting Notes December 2, 2011

Outreach

- Pre-packaged Ziploc HR supply baggies creates supply wastage since some use heroine and others crack and there are different needs for men and women
- Self-harm reduction kits are free at pharmacy
- Vandu/BC Yukon are the best reps to lead peer-based initiatives
- Combination of peers and service providers, for current and past users, increased responsibilities increase empowerment
- Use stipend as an initiative
- Foot-based outreach locations to include hard-to-reach places including the railway etc.
- Start in locations with highest numbers of users, will lead to community support
- Use different crews for tasks, pick-up/sweeping needles
- Those serving community hours (or probation) can be used for street sweep
- Have ample supplies of sharp containers in various sizes
- Question using 'reputable' dealers handing out supplies
- Need depots for disposal, where can people or organizations call if they find needles
- Service providers need training and support on how to effectively work with peers, sharing best practices and knowledge transfer
- Where should the cost of peer distribution or outreach come from, the city, FHA or businesses?
- What method should be used to measure effectiveness?
- Health care providers plus distribution supplies coupled with nurses and health care providers
- Can we use volunteers?

Peer Distribution

- Needs disposal in pack
- Person handing needles (user)
- "Big Backpack"
- Home site (could be mobile)
- Gloves
- Handout other supplies
- Keep it simple
- Lots of peer distributors
- Low-profile – be discrete
- Paid – needs incentive/pay (cash is best)
- Can be volunteers & promoters advertise
- Former or current user
- Know what's out there
- Know what other users are going through – info (resources)
- Know 'safe' areas to use – stickers on dirty boxes
- Have resources to help (referral resources)
- No violence/no exploitation
- Designate safe areas
- No selling needles
- Basic first-aid
- Be safe calling ambulance (why do police show up?
- Calgary model (DOAPA team?)
- 'Reputable dealers' – who decides need structure
- Friendly/male and female
- Distribute at different locations
- Different size of needle packs and sharps containers – foster others to share clean
- Different sizes of disposal containers
- Orientation and training for dif. situations (e.g. "I just got raped – help me!) and others
- Recognition – highlight success
- Accept alternative containers for dirties
- Peer accountability system – self developed

Fixed Site

- Accessible
- P.H. Unit, HIV/HEP-C, Methadone, MHSUS, H.R., street level services, Chilliwack Contact Centre
- OPC – Abbotsford Community services
- Medical, Walk-in Clinics – welcoming
- Non-clinical drop-in centre
- Possible to hang out without accessing direct services
- Kool-aid, Abby House/SVS-related
- Front Room – Surrey 24 hours
- People can stock up or have knowledge of other access when not open
- 7-11am, 2-10pm
- Different specialists on different days – professional service
- Downtown or Clearbrook
- Lawyer, social worker, MD, counsellors
- Confidential/some measure of anonymity
- Separate from family services
- Friendly workers – 1 person can sour a space
- More than one site
- Attention to different transport methods
- 7-11
- Switzer and Braun
- Meaningful community dialogue – service providers / residents / business owners – good mediator/facilitator
- Anticipate possible problems and pre-think/discuss how they will be handled with all stakeholders
- Open house for community
- Engage volunteers from community
- Encourage a community-building feel
- Land between Mission and Abbotsford
- Safe drug administration (assisted injection, inhalation, etc.)
- Drug testing to ensure more safety
- Warm zone/men's drop-in
- Recognition of results/efforts

Mobile Services

- Downtown East Side "MAP" van (Mobile Access Project) operated by PEERS (non-profit service society)
  - Refurbished ambulance
  - Provides harm reduction supplies and advice; also carries a large urn of hot coffee, plus sandwiches, socks, gloves, etc.
  - Workers record details of bad dates, provide wound care, etc.
  - Experiential workers work side by side with PEERS staff. This alliance is very important to the success of this service.
- Include an emergency cot and allow people to come in and get warmed up for a couple of hours at night (if nowhere else to go)
- Phone from the mobile unit to have clients in need picked up and taken to shelter or services
- Co-ordinate schedules and services with other HR and mobile services, food, pastoral care etc.
- Mobile public health service (for instance, Neal) could travel with this van on a frequent schedule for foot care, wound care, referrals
- Attach to FHA services such as the Addiction Centre, Warm Zone, Youth Health Centre etc.
- Mobile service supports the peer distribution system with supplies, advice, check-in
- Public health professional connected by phone and visit to the mobile service for rapid consultation
- Cell phone always on the van

2) Phone-in delivery service of HR supplies,

	▪ Measure amounts – don't share with police – show value and make dist. better ▪ Crisis intervention capacity ▪ Peer and Professionals working together – trained to work with each other. Training on how to work together ▪ Keep talk confidential – don't share private info	▪ Different sizes of sharp containers – resource stickers ▪	with pickup of dirties ▪ ANKORS (based in Nelson, serving both downtown and rural areas) ▪ and DEYA (Downtown Eastside Youth Activities Society) ▪ This model is said to work well to serve people that don't have easy access to the mobile unit. 3) Pick up people and take them home if intoxicated ▪ Our current Red Nose program only operates through Christmas season, and specifically targets drunken party-goers. We hope for a year-round approach that includes other substance abusers. ▪ Calgary Downtown Outreach Addictions program provides pickup if too high or drunk to drive and no money for taxi etc. ▪ Safe Ride (Vancouver) — similar program ***Additional General suggestions:*** ▪ Security guards' outfits should be involved in any discussion that invites Bylaws and the Police, so that they feel part of the picture. (The informant suggests that security firms tend to echo and amplify the ambient local police response no matter what it is, whether supportive or aggressively opposed.) ▪ Provide drop-boxes all over the city, attached to lamp standards etc. as in Victoria. ▪ In Ontario, Tim Horton's provides drop-boxes in their coffee shops. ▪ Women at the Warm Zone frequently ask to take dirty containers to local shooting galleries; they bring them back full. *—More info: Michele Giordano, WRSFV Warm Zone*