

BC Harm Reduction Strategies and Services Policy and Guidelines

2022

Last Update: October, 2023

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1.0 Harm Reduction Definition

Harm reduction (HR) is a set of principles¹, practices and approaches to care that aims to minimise negative health, social, and legal impacts associated with sexual activity, sex work, illicit and licit substance use, substance use policies, and drug laws. Harm reduction is an integral component of the health promotion and illness prevention, treatment, and care continuum², encompassing community actions, service delivery, programs, and policies.

Harm reduction does not require that people stop using substances as a precondition of support. It is grounded in evidence, justice, and human rights; it respects, and represents the right of people to self-determination, and ensures equitable access to services and supports that protect their health.

2.0 Policy Statement

In British Columbia, harm reduction practice goes beyond the distribution and recovery of harm reduction supplies and includes approaches to community engagement and service delivery that can be applied in any community, health, or social services setting. Effective harm reduction policy and programming is cost effective, reduces health and social deficits, and has a positive impact on individual, community, and public health. For harm reduction programming to be successful, it must be a collaboration between Health Authorities, health and social services, community partners, and people with lived and living experiences with substance use and harms related to sexual activity (PWLLE). It also requires buy-in and support from law enforcement and all levels of government.

Together, these stakeholders must collaborate to develop and implement policies, programmes, and services that address the health, social and community conditions that increase susceptibility to harms. This includes addressing social determinates of health³ (SDOH) and identifying and challenging the drivers of stigma and discrimination within health and social service systems and society. This requires that stakeholders question existing policies and practices that increase the risk of harms for PWLLE. (E.g., challenging institutional or community policies and practices that stigmatize or marginalize PWLLE, or raising awareness about the community's willingness to tolerate a high level of overdoses from a toxic street drug supply and advocating for a safe and legal supply of substances). Harm reduction programs must also work to accommodate the needs of diverse population groups within

¹ <https://www.hri.global/what-is-harm-reduction>

² Canadian Nurses Association (2017). Integrating health across the continuum of care. Ottawa, ON.

³ <https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html>

their cultural and social settings, such as lesbian, gay, trans, bisexual, queer, and two spirited (LGTBQ2S), or Black, Indigenous, and people of colour (BIPOC).

Core harm reduction services are based on a respectful relationship between service providers and people who access health and social services. They focus on positive and supportive exchanges, working with people where they are, without judgement, coercion, or discrimination. They are grounded in human rights and dignity, adhering to basic ethical principles such as fairness, doing good for others, not harming others, and respecting peoples' autonomy. Harm reduction service providers must develop competence⁴ in harm reduction service delivery by aligning their harm reduction practices with the principles of harm reduction.

Harm reduction recognizes that substance use may have a mix of benefits and risks for some people. It does not presuppose that reducing or stopping substance use is an objective— although this may be the case for some people. People who access harm reduction services are diverse and have been historically underserved, stigmatized, and discriminated against. The meaningful involvement of PWLLE in the development, implementation, and evaluation of harm reduction services is essential to ensuring those services are effective, accessible, and acceptable to the people they serve. It is vital to the success of harm reduction services that PWLLE have culturally and socially safe opportunities to actively participate in the development and implementation of harm reduction policies and practices as peer workers (Peers, or experiential workers)⁵. This ensures that services are responsive to the specific needs encountered within the diverse and unique population groups within a community.

3.0 Scope

These guidelines support provincial harm reduction strategies and services pertaining to substance use and sexual health in collaboration with the British Columbia Centre for Disease Control's (BCCDC's) Harm Reduction Strategies and Services Program (HRSS)⁶. Their purpose is to support Harm Reduction programs and services to reduce the health and social harms resulting from substance use and sexual activity.

⁴ See Appendix 2 for HR worker Competencies.

⁵ Please see <https://towardtheheart.com/peer-engagement> for more information on engaging Peers in HR work

⁶ <http://www.bccdc.ca/our-services/programs/harm-reduction>

4.0 Education

Evidence and competency-based⁷ harm reduction education builds the knowledge, skills, attitudes, and judgement required to provide and most effectively achieve individual and community benefits from harm reduction services. The relevance and reach of harm reduction education and training is improved through collaboration with PWLLE and Peer groups. This includes encouraging and including the meaningful involvement of Peers as experts in the design, development, and delivery of harm reduction education.

To be effective, it is important that harm reduction education meets the needs of the different groups and populations within the community. For example, Indigenous cultural safety and humility training, or learning about the unique needs of LGBTQ2S, men using alone^{8,9}, and youth¹⁰ populations would enhance the delivery of harm reduction services to the people in those groups. Health Authorities and organizations providing harm reduction services can improve access to educational and capacity building opportunities by maintaining an up-to-date list of available resources and learning opportunities that PWLLE and service providers can access.

Collaboration between Health Authorities and organizations providing harm reduction services ensures that harm reduction education is available to stakeholders in the community. Potential collaborators include:

- People who use harm reduction services
- Direct providers of harm reduction services in the community
- Peer support groups and programs
- Drug user organizations and PWLLE networks
- Health and social services whose work intersects with harm reduction services (e.g., hospital staff, social workers, financial aid and housing workers, community support workers, and police)
- People working in industries that benefit from harm reduction training in the workplace (e.g., construction, hospitality and commerce)
- Members of the larger community within which harm reduction services are provided

⁷ See Appendix 2 for Standards of Practice and Competencies for Peers and HR workers in British Columbia.

⁸ <https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicit-drug.pdf>

⁹ Bardwell G, Kerr T, McNeil R. The opioid overdose epidemic and the urgent need for effective public health interventions that address men who use drugs alone. *Am J Mens Health*. 2019;13(3):1–4

¹⁰ See Appendix 3: Guidelines for Providing Harm Reduction Services to Youth.

4.1 People who use harm reduction services

As an integral part of harm reduction supply distribution practice, each harm reduction service can provide education for clients regarding:

- Overview of harm reduction approaches and practices
- Safer injection practices including discussion about vein health, and prevention of blood borne and other infections;
- Safer substance smoking practices
- Overdose prevention and response (including “overamping”¹¹)
- Overview of how and when to use different supplies
- Supplies for hormone therapy
- Perinatal substance use and supports and services
- Safe needle return, collection and/or disposal
- Safer sex practices, including harm reduction practices for people who do sex work
- Principles of general health and wellness
- Information on poly-substance use and associated risks and harm reduction strategies
- Accessing, navigating, and advocating for health care and social services
- Connection to culture through Indigenous organizations

4.2 Harm reduction service providers

All staff, Peers, and volunteers who provide harm reduction services should receive an appropriate orientation¹² and training¹³ in harm reduction strategies and service delivery. Topics and approaches to service provider education include:

- Overdose prevention and response
- Peer engagement principles and best practices¹⁴
- Harm reduction principles and practices¹⁵
- Health promotion and illness prevention
- Public health ethics
- Connection and communication
- Health equity and inclusion

¹¹ <http://stopoverdose.org/docs/OverAmping.pdf>

¹² See <https://towardtheheart.com/resource/orientation-guidelines-for-experiential-workers/open>

¹³ Consult with Health Authority HR Coordinator regarding HR education programs that are currently available.

¹⁴ <https://towardtheheart.com/peer-engagement>

¹⁵ <https://www.health.gov.bc.ca/library/publications/year/2005/hrcommunityguide.pdf>

- The psycho-social and historical roots of substance use
- Trauma and violence-informed practice
- Mental health and crisis support (e.g., supporting someone who is grieving; de-escalation practices)
- Distribution and recovery of harm reduction supplies
- Safe handling of biohazardous material
- Working with youth
- Completion of Indigenous cultural safety and humility training
- Unconscious bias training
- The relationship between social determinants of health and harms from substance use
- Change management principles and practices

4.3 Peer support groups and programs

Peer support groups advocate and provide support for the Peer community. They also liaise and collaborate with harm reduction service providers to ensure that harm reduction services are designed and delivered to meet the needs of PWLLE in the community.

Peer support groups grow stronger, and individuals build competence, confidence, and resiliency through education and training opportunities. Collaboration between Health Authorities, contracted agencies, PWLLE, and Peer support groups will enhance the design, development, and delivery of training for Peer support group members and health authority staff.

4.4 Other health and social services workers

Health Authorities and contracted agencies can ensure that health and social services accessed by PWLLE have information and support available to develop policies and service delivery models that align with harm reduction principles.

4.5 Broader community in which harm reduction services are provided

Harm reduction services are more likely to succeed when there is support for them within the larger community or municipality. Health Authorities, local, provincial, and national governments, and community-based harm reduction services promote this by providing information to members of the broader community. This can include proactive engagements with municipal governments to provide information about harm reduction principles and practices. It can involve engaging the non-drug using

community in improving safety, such as safe handling, storage, and disposal of illicit substances or used syringes, or how to handle a needle-stick injury¹⁶.

5.0 Distribution, Recovery, and Safe Disposal of Harm Reduction Supplies

The Health Authority and the agencies providing harm reduction services within its boundaries must collaborate with local municipalities, Peers, and community stakeholders to formulate and implement a community plan for distribution, recovery, and safe disposal of used harm reduction supplies. This includes:

- Determining the appropriate location of distribution and recovery sites
- Identifying who will be involved in harm reduction supply recovery
- Protocols (e.g., handling biohazardous material)
- Training in preventing occupational exposure to blood and body fluids, and how to respond to a blood and/or body fluid exposure

Health Authority and community agencies will describe approaches to how supplies are distributed, recovered, or otherwise disposed of, as well as efforts undertaken to reduce inappropriately discarded supplies. Health Authorities will be responsible for ensuring that this information is made available to community partners.

5.1 Distribution

The BC Harm Reduction Strategies and Services (HRSS) recommends that harm reduction programs and services strive to achieve maximum reach of harm reduction supplies according to best practices¹⁷. Service providers must ensure clients can access harm reduction supplies quickly and easily with low-to-no barriers. Access to harm reduction supplies should extend to whoever needs them, regardless of the person's age¹⁸, sex, gender, ethnicity, income level, substance-using status, substance of choice, sexual practices, or place of residence. This includes promoting the full range of harm reduction

¹⁶ <https://towardtheheart.com/resource/best-practices-needle-stick-injury/open>,
<https://towardtheheart.com/resource/accidental-needle-stick-injury/open>

¹⁷ Please refer to the *Best Practice Recommendations for Canadian Harm Reduction Programs*:
https://www.catie.ca/sites/default/files/2021-11/3382_CATIE_CarolStrike_BestPracticeRecommendations_2021-EN-Final.pdf.

¹⁸ See Appendix 3: Guidelines for Providing Harm Reduction Services to Youth.

services (including needle and syringe distribution) in all health care settings, community and social services, shelters, and prisons.

Limits should not be set on the quantity of supplies provided. This ensures that people can access all necessary harm reduction supplies to prevent harms as and when needed. To maximise access to harm reduction supplies, sites may consider innovative distribution modalities, including vending machines and self-service models. HRSS encourages agencies to provide supplies for peer-to-peer distribution to reach people who may not be able to access harm reduction distribution sites (e.g., for health reasons, or due to legal prohibitions like red-zoning, or the distance of their residence from the HR site).

5.2 Recovery and safe disposal

Public health units and agencies that receive supplies from HRSS must ensure that used harm reduction supplies are safely collected¹⁹, handled, and disposed²⁰ of. Harm reduction stakeholders should collaborate to develop community and health authority plans that outline how used supplies will be collected, transported, and disposed of. It should outline approaches to establishing and supporting Peer-led used supply collection.

Used harm reduction supplies must be accepted at all harm reduction services sites, community health and public health sites, and at community pharmacies (where possible). Plans should be developed for discreet and appropriate opportunities for people to dispose of used harm reduction supplies. Transport of used syringes is made safer when small sharps containers are available to people who use drugs for personal use and large sharps disposal containers are situated in key locations throughout the community. Peer needle recovery programs (such as community needle sweep programs) can be utilized to collect used syringes, as required. Some communities also arrange to have used harm reduction supplies picked up either through the Health Authority or by peer-based programs.

¹⁹ <https://towardtheheart.com/resource/safe-needle-pick-up/open>

²⁰ <https://towardtheheart.com/resource/best-practices-safe-needle-disposal/open>

6.0 Overdose Prevention

Overdose prevention strategies and services are essential for preventing death and lifelong health challenges. BC's illicit drug supply is increasingly toxic and adulterated. In 2016, BC's Provincial Health Officer declared a public health emergency in response to the significant increase in illicit drug overdose deaths. Since then, thousands of people have died of overdose in BC²¹, making it the leading cause of unnatural death in BC.

The sharp escalation in overdose deaths is largely attributed to the increased presence of fentanyl and its analogues in the illicit drug supply^{22, 23}, including in depressants and stimulants. These are sometimes mixed with benzodiazepines, which has resulted in changes in the signs and symptoms of an overdose: some of these presentations are unusual or complex and may be more challenging to identify as an overdose (e.g., dyskinesia rigidity, or prolonged sedation, but still breathing). These unusual presentations could result in delayed response to the overdose²⁴, especially if the person unknowingly used an opioid.

Sites providing harm reduction and overdose prevention services may also offer drug checking services. These services can indicate if a substance contains adulterants, contaminants, or if it is a different substance than anticipated. This provides people who use substances with information about the potential effects and harms of using the tested substance and the ability to make informed decisions regarding their substance use²⁵.

All sites providing harm reduction services must offer information or training on preventing, recognizing, and responding to overdose. Harm reduction services should have a plan in place to ensure that everyone who uses drugs can access appropriate overdose prevention and response services. This includes offering overdose prevention and response training, having Take-Home Naloxone (THN) kits on site, providing referrals to nearby sites that operate a THN program²⁶, and facilitating access to safer drug supplies.

²¹ BC Coroners Service (2019).: <https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/fentanyl-detected-overdose.pdf>

²² <https://www.cmaj.ca/content/190/2/E35.short>

²³ Jafari, S., Buxton, J. & Joe, R. (2015). Rising fentanyl-related overdose deaths in British Columbia.

²⁴ Kinshella, M-L. W. (2017). Report: Unusual Opioid overdose presentations at Insite October 2017 to April 2017.

²⁵ <https://www.bccsu.ca/wp-content/uploads/2017/12/Drug-Checking-Evidence-Review-Report.pdf>

²⁶ Sites providing THN training and kits can be found at <http://towardtheheart.com/site-locator>

Where possible, sites distributing harm reduction supplies should work with nearby agencies to facilitate referrals to appropriate services and participate in the THN program. Information about the THN training and training materials are posted on the *Toward the Heart* ²⁷website.

A significant number of opioid overdoses happen among people who use drugs alone. Harm reduction services can reduce this by providing education, information, and support to people who may be at greater risk of using alone, such as access to technologies like the Lifeguard app. Information and training resources about responding to different types of overdoses can be found on the *Toward the Heart* website²⁸, along with alerts about adulterated drugs in BC.

7.0 Facilitating Access to Other Services

Harm reduction services exist within a continuum of health and social services delivery. People who access harm reduction services may require supports for challenges to any of the Social Determinants of Health. Access to health and social services that PWLLE need is improved when harm reduction services collaborate across sectors and work with Peers.

When health and social services accessed by PWLLE have policies and practices that align with harm reduction principles, and are congruent with the local context, they become socially, psychologically, and culturally safer places for people to address their health and wellness, and social needs. Harm reduction service providers can promote these safer and supportive environments by collaborating with Peers and PWLLE to build relationships across health and social service sectors, assisting them to re-orient their policies and approaches service delivery.

Harm reduction services that are familiar with the current health and social services and resources operating in a community will be better able to refer PWLLE to the services they need.

Examples of health services referrals include:

- Clinics for communicable disease, vaccination, and other public health services
- Primary care clinics and/or clinicians who are familiar with the PWLLE population and substance use issues
- Sexual health specific services
- Counselling and screening services for mental health and substance use

²⁷ <https://towardtheheart.com/a-z-resource-page>

²⁸ <https://towardtheheart.com/>

- Cultural supports, including Elders, Traditional Healers, and land-based healing programs²⁹
- Take home naloxone training and kits
- Access to safer supply of opioids
- Substance use treatment services

Examples of social support service and referrals include:

- Aboriginal friendship centers
- Aboriginal Patient Liaison/Navigator workers
- Native court worker and counselling services³⁰
- Métis Nation Regional Health coordinators
- Housing and income support
- Supports for people who do sex work.
- Food and nutrition support services.
- Gender-specific services
- Parenting assistance
- Youth services
- Legal services/survivor services

²⁹ <https://www.fnha.ca/what-we-do/mental-wellness-and-substance-use/overdose-information>

³⁰ <https://nccabc.ca/>

8.0 Glossary

Note: The meanings of some of the terms in this glossary are contested. These definitions are meant specifically for this document and may be updated over time.

Aboriginal

A legal term to identify the first inhabitants of Canada, and includes First Nations, Inuit, and Métis people. In Canada, this term is not favored by Indigenous people, as popular usage originates in the constitution and for some, represents terminology imposed on first peoples by settlers.

BIPOC

Refers to people who are Black, Indigenous, and people of colour. The rationale for adding Black and Indigenous to POC (People of Color) is to bring attention to the systemic and structural racism and the specific experiences of colonialism experienced by Black and Indigenous peoples. If you know the community you are specifically referring to, please be specific.

Competence

The attitudes, knowledge, skills, and judgement required for a person to contribute to, and participate in, an area of practice efficiently and effectively. Competence can be gained through lived experience and/or formal education, and gaining it is an active, life-long process.

Cultural safety and humility

Cultural safety and humility is the ideal result of respectful engagement. Its aim is to address power imbalances in the healthcare system. A culturally safe environment is free of racism and discrimination, where all people feel safe when receiving health care. It is for the patient to decide whether they are receiving culturally safe care, rather than for the provider.

Cultural humility is a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience³¹.

³¹ <https://www.fnha.ca/Documents/FNHA-Creating-a-Climate-For-Change-Cultural-Humility-Resource-Booklet.pdf>

Equity

The actions or processes required to balance the imbalanced. In society this means recognizing both historical and current experiences that disadvantage, prevent, or actively discourage certain people or groups of people from opportunities. Equitable care addresses the impacts of social determinants of health and focuses on “pursuing the highest possible standard of health and healthcare for all people, paying special attention to those in the context of greater risk of poor health, and taking into account broad social, political, and economic influences and access to care”³².

Experiential workers

People whose expertise in their field of work is formed in part from lived experiences with substance use or sexual experiences (including sex work). Often used interchangeably with Peer Workers or Peers.

First Nations

Refers to Aboriginal peoples who are neither Métis nor Inuit. Adopted in the 1970s to replace “Indian”, which is rooted in colonialism and racism, and is considered offensive.

Health Promotion

The personal, organizational, social, and governmental actions required to improve the health of people in a community.

Health Service Delivery Area (HSDA)

Distinct regions within a Health Authority where organizations and programs collaborate to meet health services requirements of the local population.

Illicit

In substance use, illicit refers to using substances in a way that they either were not intended, is illegal, or is not socially accepted³³.

Indian

The legal term used to identify First Nations people registered under the Indian Act³⁴. In Canada, outside of this strict legal context, this term is offensive to many Indigenous people.

³² <https://equiphealthcare.ca/files/2020/11/HEQ-Nov-27-2020.pdf>

³³ <http://www.bccdc.ca/resource-gallery/Documents/Educational%20Materials/Epid/Other/IllicitAlcoholinBritishColumbiashortreportFINAL.pdf>

³⁴ <https://laws-lois.justice.gc.ca/eng/acts/i-5/>

Indigenous

Term popularly used to refer to all First peoples in Canada. Includes First Nations, Inuit, and Métis peoples.

Inuit

Indigenous people who live in or originate from the far northern regions of Canada.

Métis

Métis are Indigenous peoples whose social structure, culture, and identity evolved from the blending of European and Indigenous people and cultures. From this emerged a unique culture, traditions, and language (Michif) that are distinct from other Indigenous populations.

Overamping

Overdosing on stimulants that may result in feeling unsettled, or in hyper-alertness and hyper-activity. In extreme cases can cause seizures, heart attacks, or strokes.

Peers

In harm reduction practice, this refers to people who bring their lived and living experiences to their community engagement, activism, or work. Often used interchangeably with Experiential Workers, or Peer Workers.

People with Lived and Living experience

Community members whose current or past life experiences with drug use informs their knowledge about the personal, social, legal, and health impacts – including benefits and harms – associated with substance use. PWLLE may or may not work as Peers or experiential workers.

Population Health

An approach to health that identifies unique characteristics of distinct populations within society, and identifies steps required to improve the health and reduce health inequities within those populations.

Social Determinants of Health

The conditions in the environments where people are born, live, learn, work, and play that affect a wide range of health outcomes.

Syndemic

A set of connected health or social problems that act together to intensify the negative health outcomes for the individual or population.

9.0 Recommended Reading

British Columbia Centre for Disease Control – HRSS (2011). Harm Reduction Training Manual. <http://www.bccdc.ca/health-professionals/clinical-resources/harm-reduction>

British Columbia Centre for Disease Control (2014). Toward the Heart: A Project of the Provincial Harm Reduction Program. <http://towardtheheart.com/>

British Columbia Centre for Disease Control (2019). *BC Overdose Prevention Service Guide*. http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID19_EpisodicOPSProtocolGuidelines.pdf

British Columbia Centre for Disease Control. Respectful Language and Stigma: <https://towardtheheart.com/assets/uploads/1502392191GWLgqDb5w5GlajwRuiq4lPoSyhSoMkp3T7rL5ml.pdf>

British Columbia Centre for Disease Control. Toward the Heart. Peer Engagement Principles and Best Practices. <http://www.bccdc.ca/resource-gallery/Documents/PEEP%20Best%20Practice%20Guidelines.pdf>

British Columbia Ministry of Health. (2005). Harm reduction: A British Columbia community guide. Victoria, BC: Ministry of Health. <https://www.health.gov.bc.ca/library/publications/year/2005/hrcommunityguide.pdf>

British Columbia Ministry of Health. (2010). Healthy minds, healthy people: A 10-Year plan to address *mental health and substance use*. Victoria, BC: Government of British Columbia http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf

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British Columbia Ministry of Health. Core public health practices for British Columbia practice. <https://www.health.gov.bc.ca/library/publications/year/2009/harms-prevention-core-program-paper.pdf>

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CAAN/ICAD. (2019). Indigenous Harm Reduction = Reducing the Harms of Colonialism. <http://www.icad-cisd.com/pdf/Publications/Indigenous-Harm-Reduction-Policy-Brief.pdf>

Canadian Centre on Substance Abuse. Addiction and mental Health Care: Resources to Support Collaboration. <https://www.ccsa.ca/addiction-and-mental-health-care-resources-support-collaboration-0>

Chandler, R. (2008). Best Practices for British Columbia's harm reduction supply distribution program. <http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/Other/BestPractices.pdf>

Chief Medical Health Officer's Report on Stigma, 2019. <https://www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/addressing-stigma-what-we-heard/stigma-eng.pdf>

European Monitoring Centre for Drugs and Drug Addiction (2013). Professional Profile of the Outreach Worker in Harm Reduction: Retrieved from www.emcdda.europa.eu

First Nations Health Authority. A Path Forward: British Columbia First Nations and Aboriginal People's Mental Wellness and Substance Use 10-year plan. https://www.fnha.ca/Documents/FNHA_MWSU.pdf

Government of British Columbia: A Pathway to hope: A roadmap for making mental health and addictions care better for people in British Columbia. https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/initiatives-plans-strategies/mental-health-and-addictions-strategy/bcmentalhealthroadmap_2019web-5.pdf

Government of British Columbia: The B.C. Handbook for Action on Child Abuse and Neglect: https://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/public-safety/protecting-children/childabusepreventionhandbook_serviceprovider.pdf

Jafari, S., Buxton, J. & Joe, R. (2015). Rising fentanyl-related overdose deaths in British Columbia. Canadian Journal of Addiction, 6.

Jennifer Lavalley et al. CMAJ: Reconciliation and Canada's overdose crisis: responding to the needs of Indigenous Peoples. <https://www.bccsu.ca/blog/publication/reconciliation-and-canadas-overdose-crisis-responding-to-the-needs-of-indigenous-peoples/>

Kerr, T & Wood E. (2006). *Evidence and best practice for the employment of harm reduction activities in programs aimed at controlling communicable diseases.*

http://www.bccdc.ca/NR/rdonlyres/D4DA16EB-9CCB-4D08-86A1-50C6E96CFC19/0/Epi_HarmReduction_Pub_EvidenceandBestPractice_20090608.pdf

Native Youth Sexual Health Network. Indigenizing harm reduction – moving beyond the four-pillar model. <https://www.heretohelp.bc.ca/visions/indigenous-people-vol11/indigenizing-harm-reduction>

Strike et al. (2015). *The Best Practice Recommendations for Canadian Harm Reduction Programs that Provide Service to People Who Use Drugs and are at Risk for HIV, HCV, and Other Harms: Part 1*: <https://www.catie.ca/en/programming/best-practices-harm-reduction#part1>, Part 2. <https://www.catie.ca/sites/default/files/bestpractice-harmreduction-part2.pdf>

Appendix 1: Receiving, Satellite and One-Off Harm Reduction Supply Distribution Site Policy

Purpose

The purpose of this appendix is to define distribution sites that receive publicly funded safer sex and drug use supplies, to provide guidance on establishing these sites, and to explain the process to be completed for receiving sites, satellite sites, or one-off event to receive supplies.

Receiving Site/ Satellite Site Definitions

Receiving site - a site such as a Health Unit that orders supplies directly from BCCDC and receives those supplies directly from the central distributor. This site may also order supplies on behalf of an authorized satellite site(s).

Satellite site - a site that picks-up or is sent their supplies from a receiving site (as defined above).

Decision to designate a site (either as a receiving or satellite site) satellite site is made by the receiving site manager in consultation with the HA HRSS Representative in collaboration with BCCDC Harm Reduction lead(s).

Note: it is important that HRSS representatives and BCCDC know how to contacts satellite sites with important/time sensitive information/alerts and for tracking supply distribution.

Receiving / Satellite site designation distinctions

		Receiving site	Satellite site
Decisional factor	Independency	Can operate independently because: <ul style="list-style-type: none"> • proven accountability • trained staff • ensures ongoing compliance with policies/best practices of the Regional HA and of the HRSS Committee. 	Cannot operate independently because the site needs regular contact/follow up with receiving site to verify accountability and training of staff
	Quantity of Supply	Large supply quantity for each requisition*: <ul style="list-style-type: none"> • shipping cost is justified 	Small supply quantity for each requisition: <ul style="list-style-type: none"> • shipping cost is not justified
	Remoteness	Remote access: Regular pick-up trips to a larger receiving site is not economically justifiable or otherwise feasible	Proximity to a receiving site: Regular pick-up trip to receiving site is feasible or other types of supplies sent/picked up from receiving site. Increase in shipping cost is not justified

**See minimum order size on the Order Form located at <https://towardtheheart.com/resource/hr-req-form/open>

Duties of receiving site (with regards to satellite site)

- Performs due diligence before authorizing satellite site and initiates processes to ensure ongoing compliance with policies/best practices of the HRSS Committee and of the Regional HA where they operate.
- Forwards/updates satellite site contact information to BCCDC by email (harmreduction@bccdc.ca)
- Keeps close contact, aligns strategies, and trains satellite site staff.
- Communicates/trains satellite site regarding change in harm reduction policies and new products.
- Regularly reviews annual supply orders with satellite site.
- Receive requisitions from satellite site in a timely manner to enable inclusion of quantity in receiving site requisitions.
- Submit harm reduction supply distribution reporting as required by HA and BCCDC (contact HA representative for more information).

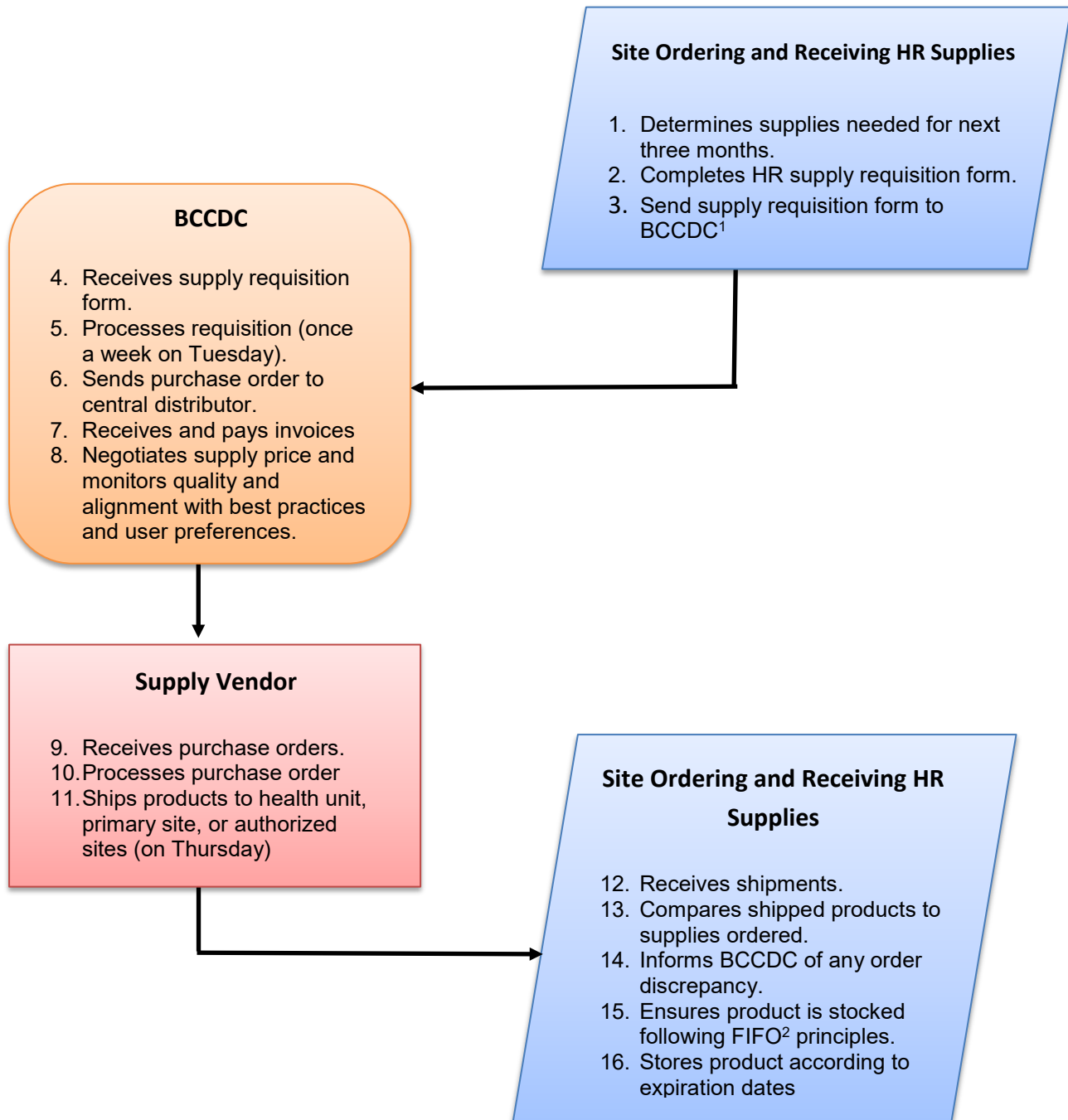
Duties of satellite site

- Complies with HRSS policies and aligns strategy with receiving site and Regional HA.
- Informs receiving site about supply needs in a timely manner.
- Completes the SATELLITE SITE SUPPLY REQUISITION FORM supplied by their Health Authority Harm Reduction Coordinator.
- Stores supplies appropriately and manages inventory.
- Ongoing supply quality assurance processes in place (i.e., checks condition and expiration dates of supplies)

Required Information Needed by Receiving Site to Establish a Satellite Site

SITE Name	
Health Service Delivery Area	
Street-Address	
Street-City	
Street-Postal Code	
Mailing-Address	
Mailing-City	
Mailing-Postal Code	
Operating Hours	
Contact Person	
Contact2	
Phone	
Phone2	
Fax	
Email	
Email2	

Harm Reduction Supplies: Distribution Process Algorithm



¹Cut off time for HR supply orders is end of day Monday, or end of day Friday if the upcoming Monday is a holiday.

² FIFO (First In, First Out) is an inventory valuation method that ensures goods or supplies that are ordered or produced first are utilized first, in order to prevent wasting or expiration of the goods.

Appendix 2: Standards of Practices and Competencies for Peers and Harm Reduction Workers in BC

Standards of Practice and Competencies for Peer Support Workers

The following standards of practice are written for peer support workers to guide their practice. They are also meant to be a guide for organizations and leaders to support the oversight of peer services.

Organizations can use these standards as they develop programs, lead staff, and create job descriptions in the field of peer support.

A: Peer Specialized Proficiencies

- Demonstrates understanding that there is no one-size-fits-all approach to wellness and wholeness. Each person needs to discover what goals, values, and beliefs work for them. Peer Supporters recognize that others' paths may be quite from their own.
- Demonstrates an awareness and understanding of self-determination and can apply it to the peer relationship. Understands that advice-giving and fixing are antithetical to self-determination.
- Peer support is based on mutuality. However, the peer supporter acknowledges and recognizes that there can still be a power differential when in a formal role. The peer supporter actively works to create mutuality, and equality, while honouring boundaries, and deeply respecting the well-being of the recipient of the services.
- Chooses to self-disclose and share aspects of personal story in a way that supports the building of the relationship, connection, and inspiring hope. Understands the importance of avoiding the sharing of traumatic details that can trigger a stress response in someone else.
- Engages in active ongoing learning.

B: Principles of Supporting Wellness, Wholeness, Recovery and Social Belonging

- Actively creates and engages in self-care practices that support one's own well-being.
- Demonstrates awareness of their own stressors and triggers and has a plan to support their well-being through the challenge.
- Actively chooses to practice empathy and compassion in interactions.
- Recognizes the importance of clear, well-defined boundaries. Practices co-creating boundaries with the person they are supporting.
- Demonstrates knowledge of recovery-oriented practices, including but not limited to, harm reduction, trauma-informed care, and the importance of person-first language.
- Supports peers to discover strengths, explore new possibilities, and continue to build resilience.

C. Diversity, Inclusion, and Equity

- Is aware of and actively reflects on one's own set of values and beliefs.
- Is mindfully aware of the fact that they have a set of personal biases, and actively makes space for different perspectives.
- Understands and can apply intercultural sensitivity towards all cultural groups. Works to avoid stereotyping.
- Understands the harmful effects of colonization and privilege and works to reduce the harm.
- Understands how the Social Determinants of Health and stigma can affect someone's life experience.
- Respects a diversity of modalities and interventions, even if different than their personal approach.

D: Facilitating Communication and Connection

- Demonstrates an understanding of and sensitivity towards the effect of personal communication style on others.
- Communicates clearly, respectfully, and effectively through spoken, written, and electronic modalities.
- Recognizes the importance of and chooses to use person-first language.
- Understands the importance of community and belonging that is needed for one's sense of well-being and supports community inclusion.
- Actively practices compassionate and empathetic communication.

E: Collaboration and Ethical Practice

- Works respectfully and effectively with clinical and community staff, and as well with the peer's personal supporters.
- Demonstrates and understanding of the non-negotiable nature of the Code of Conduct.
- Effectively collaborates with stakeholders in a way that supports the overall appearance and respect of peer support in the province.
- Works respectfully and effectively with clinical and community staff, and as well with the peer's personal supporters.
- Demonstrates and understanding of the non-negotiable nature of the Code of Conduct.
- Effectively collaborates with stakeholders in a way that supports the overall appearance and respect of peer support in the province.

General Competencies for Harm Reduction Workers in BC

Competencies: The essential knowledge, skills, judgment, and attitudes necessary for individuals to perform in their given role -OR- sets of intellectual, personal, and social and emotional proficiencies that learners need to develop to engage in learning.

SCOPE: These Harm Reduction Competencies are neither comprehensive nor prescriptive. Their intent is to serve as a resource for educators and trainers to draw from when offering information and support to people engaged in harm reduction work. They may be used as a foundation for the development of programs, workshops, staff, and volunteer training, and may be used by organizations to tailor their specific needs.

The Competencies are directed towards those who work with people at risk of harms related to substance use, sexual practices, and limiting or punitive social and legal contexts. This can include regulated and non-regulated health care providers (including allied health), 'Peers' (typically defined as people with lived experience in the related context), and community outreach workers.

Attitude/Principles
<ul style="list-style-type: none">• Values accountability.• Understands that personal values and beliefs impact the relational engagement process• Acknowledges assumptions, vulnerabilities, triggers, and limitations.• Values continued education/learning to enhance work (place) performance and development.• Embodies personal and cultural safety and humility through trauma and violence-informed practice.• Understands that harm reduction is both set of practices and a movement for health justice.• Respects and recognizes diversity.• Acknowledges individuals are at different places and on their own healing journey.• Recognizes and respects Indigenous peoples' rights to self-determination, to be governed by their own institutions, and to maintain their own cultures and practices - all of which may influence their approaches to harm reduction.• Respects agency, autonomy, knowledge, experience, and right to (or not to) participate.• Emphasizes the dignity and inherent value of each person.• Values the personal autonomy of the client and works to uphold it.• Understands and acts in accordance with the principles of harm reduction.

Knowledge

Harm reduction:

- Definition(s) relevant to harm reduction and its practice.
- Harm reduction best practices.
- Specific harm reduction strategies, services, or practices.
- Awareness of community-specific issues and responses.
- Scope of harm reduction services and practice (organizational, local, and jurisdictional).
- Core principles and policies relevant to harm reduction.
- Historical context as it pertains to harm reduction (e.g., War on Drugs, experience, and influence on Indigenous peoples).
- Legislation and laws relevant to harm reduction practice(s).

Professional and/or Practice Standards:

- Organizational policies and procedures as they relate to harm reduction practices.
- Professional associations' standards and scope of practice as they relate to client and community-centred care and, if applicable, harm reduction.
- Evidence-based and informed decision making to improve practice and range of services offered.
- Implications of harm reduction policies, procedures, services on practice.

Population and Public Health:

- Epidemiology (e.g., trends, burden of disease in a population).
- Social, cultural, and economic conditions impacting and contributing to individual's accessing services and/or the potential to sustain vulnerability.
- Syndemic³⁵ model of health.
- Populations and peoples influencing and affected by harm reduction policies, procedures, and services (e.g., Indigenous peoples, migrant populations, youth, LGBTQ2S).

Engagement:

- Factors that lead an individual to seek and/or engage in harm reduction services (e.g., theories of addiction, physical, emotional, spiritual, and/or mental health, intersecting identities, and oppressions).
- Barriers and facilitators to accessing services (e.g., availability, accessibility, social protection).
- Stigma, discrimination, misconceptions, and assumptions for individuals involved with or accessing harm reduction services.

³⁵ The focus on the biosocial complex, which consists of interacting, co-present, or sequential diseases and the social and environmental factors that promote and enhance the negative effects of disease interaction.

Skills
<p>Relational Engagement in Client-Centred Care:</p> <ul style="list-style-type: none"> • Building of trust and rapport to provide and engage individuals in harm reduction services (e.g., non-transactional engagements, leading with your heart). • Understanding individuals may mistrust and/or reject harm reduction services. • Validation of feelings and experiences. • Supporting and celebrating goals, efforts, and accomplishments (e.g., strength-based approach). • Inclusion of creativity and flexibility in one’s role. • Cultural inclusion (e.g., assisting individuals in including or re-introducing culture back into their lives, connecting individuals to culturally appropriate services or people(s)) • Language (e.g., non-judgemental, person-first, trauma-informed, anti-oppressive).
<p>Recognition and Assessment:</p> <ul style="list-style-type: none"> • Signs and symptoms of opioid overdose and/or stimulant effects. • Need for wound and/or vein care. • Need for referral to acute care, community care, and/or treatment services. • Awareness of emerging drug toxicity issues and available harm reduction strategies at the community and provincial levels.
<p>Planning and Implementation (Response):</p> <ul style="list-style-type: none"> • Tailor services to individuals’ needs (e.g., outreach services). • Engaging individuals in community and peer based or run resources. • Overdose reversal. • Wound or basic first-aid care. • De-escalation/conflict resolution. • Drug contamination alerts.
<p>Evaluation</p> <ul style="list-style-type: none"> • Adjusting approaches according to need.

Judgement
<ul style="list-style-type: none"> • De-escalation use and techniques (e.g., signs of harm or stress). • When to refer and/or consult. • Determining approach and collaborating strategies to assist people based on need. • Optimization of teachable moments. • Ethical decision making. <p>Advocacy strategies including when and which type to use (e.g., in challenging policies and practices that cause unnecessary harm – like criminalization of drug use, refusal of medical care, and/or lack of adequate housing).</p>

Appendix 3: Guidelines for Providing Harm Reduction Services to Youth in BC

November 3, 2023

In BC, youth experience disproportionate harms related to substance use and face significant barriers to accessing appropriate harm reduction services. There are also certain circumstances that may prompt ethical or legal considerations for providers supporting youth seeking harm reduction services.

Harm reduction services operated by nonregulated health and social service providers can mitigate this by developing connections with their health authority for clinical support from regulated healthcare providers (such as RN, NP, paramedic or MD) or a primary care team. This will provide an opportunity to discuss emerging issues and identify additional supports in order to link youth to relevant programs and services.

3.1. Purpose

This appendix has been developed as a guide for organizations and service providers when engaging with youth who are seeking harm reduction supplies and services. It describes considerations to better support youth seeking harm reduction services.

Sometimes staff are unsure if youth are allowed to access harm reduction services on their own or if the youth needs a parent or guardian's consent. This confusion creates unnecessary barriers for youth and distress for providers.

3.2. Priority Population

Youth, also called “minors” in legal terms, refers to anyone under 19 years old. Youth who use substances are a highly underserved population that need access to harm reduction services. Health and social services providers can improve access for youth through consideration of youth needs when planning and delivering harm reduction services. Including youth in harm reduction service delivery can support community building and health promotion³⁶.

³⁶ Poland, B. D., Tupker, E., & Breland, K. (2002). Involving street youth in peer harm reduction education. The challenges of evaluation. *Canadian journal of public health = Revue canadienne de sante publique*, 93(5), 344–348.
<https://doi.org/10.1007/BF03404566>

3.3. Background

Youth requesting access to harm reduction supplies and services require thoughtful and intentional consideration, including additional supports and service referrals unique to their needs. Historically, youth have been excluded in the planning and delivery of harm reduction services, and face multiple barriers to accessing critical harm reduction services and drug poisoning prevention and response services to prevent: blood-borne pathogen transmission and/or sexually transmitted infections³⁷; sexual abuse and assault; exploitation; victimization; gender-based violence; physical abuse and assault³⁸; drug poisoning; and death³⁹. These barriers are even greater for Indigenous youth, youth who experience poverty or are unhoused, youth in and from care, and 2SLGBTQ+ youth.

Additionally, intersecting experiences can increase harms and impact the severity and duration of substance use for youth. Colonialism, racism, discriminatory laws and policies, legacy of residential schools, and theft of territory have contributed to a breakdown of traditional social supports within Indigenous (First Nations, Inuit, and Métis) communities, resulting in an enduring mistrust of institutions and services. This separation from sources of aid and support intensifies even further the risks of substance-related harms for Indigenous youth.

3.4. Key Considerations

Health and social service providers are well positioned to provide access to harm reduction services. However, youth who use substances are often made vulnerable by judgmental and stigmatizing treatment in health and social systems.

Providers who deliver harm reduction services can greatly impact the quality and accessibility of services by incorporating key considerations:

- Integrate principles of Indigenous cultural safety, trauma and violence informed care, and harm reduction should guide interactions and delivery of services.

³⁷ Fletcher, A. & Krug, A. (2012). Excluding youth? A global review of harm reduction services for young people. Stoicescu, Claudia, ed. *Global State of Harm Reduction 2012: Towards an Integrated Response*, *Harm Reduction International*, pp. 137-146.

³⁸ Poulin C. & Canadian Centre on Substance Abuse. (2006). Harm reduction policies and programs for youth: Politiques et programmes de réduction des méfaits pour les jeunes. *Canadian Electronic Library*. Retrieved from: <https://canadacommons.ca/artifacts/1220109/harm-reduction-policies-and-programs-for-youth/1773185/> on 05 Oct 2023. CID: 20.500.12592/64bp7g.

³⁹ Penn, Rebecca & Barnaby, Lorraine & Erickson, Patricia. (2010). Drugs, homelessness and health: Homeless youth speak out about harm reduction. *The Shout Clinic Harm Reduction Report, 2010*. Retrieved from: <https://www.homelesshub.ca/resource/drugs-homelessness-health-homeless-youth-speak-out-about-harm-reduction>

- Reflect on the knowledge that substance use is not limited to urban settings, certain groups of people, or just persons with substance use disorder. Diverse groups of people both with and without substance use disorder use substances and are at significant risk for harms and death from the unregulated drug supply.
- Support, don't punish. Provide a welcoming environment for youth and support youth to identify their needs access services.
- Demonstrate knowledge of provider legal responsibilities including access to harm reduction services, when to refer to a regulated care provider, duty to report, and confidentiality.
- Respect confidentiality. Youth have a reasonable expectation of confidentiality when accessing services. Premature or inappropriate reporting could damage trust and create barriers to accessing healthcare in the future.
- Recognize the unique nature of youth, potential harms youth may experience, and harms that may arise if youth are not able to access harm reduction services.
- Realize every youth's situation and needs are different and should be considered individually.
- Acknowledge many youths have a mistrust of institutions.
- Consider the role service providers have in a youth's trust of the healthcare system, and their decisions to seek care in the future⁴⁰.
- Deliver accessible youth services that are consistent, reliable, and transparent.
- Realize the historical and ongoing colonialism and discrimination that contributes to a health system that is inaccessible and underserves Indigenous youth. As a result, Indigenous youth are less likely to access health services⁴¹.
- Consult and partner with Indigenous youth organizations and communities to ensure culturally appropriate care, support, and harm reduction services⁴².

3.5. Guidelines

If a person who appears to be a youth under 19 years of age accesses services:

- Provide consistent and reliable services. This requires service providers to invest time and effort to establish rapport and earn trust. Service providers should strive to cultivate an atmosphere of support, enhancing coping skills, promoting wellness, and with the goal to minimize substance use harms.

⁴⁰ BC Centre for Disease Control (2023). *Key Considerations for Episodic Overdose Prevention Services (eOPS) for Youth*. <http://www.bccdc.ca/Documents/Quick%20Reference%20Guides%20eOPS%20Geal%20Youth%20Housing%20Infographics%20Youth.pdf>

⁴¹ BC Ministry of Health (2020). *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care*. Retrieved from: <https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Summary-Report.pdf>

⁴² Truth and Reconciliation Commission of Canada (2001). *Call to Action #22*. Retrieved from: <http://courseware.acadiau.ca/trctalk/call-to-action-22/>

- Provide access to basic harm reduction services without requiring guardian consent:
 - Basic harm reduction services include providing harm reduction supplies, witnessing substance use, providing safer substance use education and coaching, supporting safer substance use practices, delivering overdose prevention services, training and giving out take home naloxone kits, providing drug checking services and education, and any other services that can be delivered by a provider with basic training and equipment for drug poisoning response.
 - Any provider who is competent to deliver harm reduction services and adequately equipped to respond to drug poisoning (e.g. take home naloxone kit) can provide basic harm reduction services to a youth.
- Provide emergency drug poisoning response without requiring guardian consent:
 - If a youth experiences drug poisoning, provide emergency drug poisoning response (including naloxone) without guardian consent.
- Refer the youth to a regulated healthcare provider (e.g. physician, nurse practitioner, etc.) if the youth wishes to access advanced practices in harm reduction.
 - Advanced services are considered healthcare interventions that go beyond basic harm reduction and drug poisoning prevention and response and can only be performed by a regulated healthcare provider. Advanced practices in harm reduction and drug poisoning are considered healthcare services under the Infants Act and require formal capacity assessment (also referred to as “mature minor consent”) by a regulated healthcare provider, and in accordance with the provider’s professional standards of practice.
 - Advanced practices include inserting an intravenous line, inserting a nasopharyngeal airway, prescribing safer supply, prescribing opioid agonist therapy (OAT), etc.
- Assess a youth’s readiness to engage in harm reduction services. Every effort should be made to follow the youth’s lead and provide them with appropriate and expedited wraparound care including referrals to primary healthcare, substance use/addictions services, sexual health services, shelter/housing, mental health supports, cultural supports, and any others identified by the youth.
- Reach youth through lower barrier service models such as the Take Home Naloxone (THN) program, Supervised Injection/Consumption Services (SIS/SCS), Overdose Prevention Sites (OPS), and overdose prevention services

All providers have a legal duty to report to a child welfare agency Ministry of Children and Family Development (MCFD) or [the Indigenous Child and Family Service Agency \(ICFSA\)](#) if they believe a child under 19 is being abused or neglected.

- Substance use alone or accessing harm reduction services are not reasons to report.
- Duty to report should be done thoughtfully and together with the youth and with any support people identified by the youth.

Regulated healthcare providers delivering advanced harm reduction health services should follow the [Infants Act](#), which states that:

- A mature minor may provide a valid consent to healthcare if the regulated healthcare provider: has explained the risks and benefits of the healthcare; is satisfied that the youth understands the nature and consequences and the reasonably foreseeable benefits and risks of the healthcare; and the care provider has concluded that the healthcare service is in the youth's best interest⁴³.
- To assess this, the healthcare provider must explain to the youth the nature and consequences of the proposed healthcare, as well as the reasonably foreseeable benefits and risks. The healthcare provider should be satisfied that the youth understands this information and is able to apply the information to their own situation.
- In BC, there is no set age when an individual can be considered a mature minor. This means that there is no set age for youth accessing healthcare services from a regulated healthcare provider.
- If the healthcare provider has made reasonable efforts to determine, and has concluded, that healthcare is in the mature minor's best interests, then the provider should administer care if appropriate consent has been given. Consent from the youth's parent or legal guardian is not required.
- When determining if healthcare is in the mature minor's best interests, healthcare providers should consider the potentially fatal consequences of not providing drug poisoning prevention and response services.

⁴³ BC Infants Act (2023). Section 17: Consent of infant to medical treatment. *Part 2 – Medical treatment*. Retrieved from: https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96223_01#part2

3.6. Duty to Report

According to [Section 14 of the Child, Family and Community Service Act](#) (CFCSA), if a provider believes a youth under 19 years of age is being abused or neglected, there is a legal duty to report their concerns to MCFD⁴⁴ or ICFSA. They are available 24 hours a day, 7 days a week.

Considerations for duty to report:

- Substance use, accessing harm reduction supplies or take home naloxone, or STI testing does not mean there is immediate risk of harm. These are not appropriate reasons to report. This means there is no duty to report youth based on substance use, access to harm reduction, or take home naloxone.
- Reporting to authorities such as police or MCFD/ICFSA⁴⁵ should be considered carefully and with caution. A mature youth has a reasonable expectation of privacy and confidentiality when accessing health services⁴⁶. Making a premature or inappropriate report could damage any trusting and therapeutic relationship developed with the youth and impact their decisions on accessing health or social services in the future.
- If there are additional concerns for a youth, including lack of food, shelter, clothing, or medical care, discuss with the youth about making a report or requesting support services to an MCFD or ICFSA. Communicate and ensure transparency with the youth about what information will and will not be shared with MCFD or ICFSA.
- There may be circumstances where a provider has significant concerns about a youth in care's well-being and safety. In collaboration with the youth, consider sharing, discussing or planning with their social worker at MCFD/ICFSA. If the youth does not provide consent to share with their MCFD or ICFSA social worker, contact may still be necessary to ensure the youth's safety and well-being.

⁴⁴ BC Government (2017). The BC handbook for action on child abuse and neglect: For service providers. Retrieved from: https://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/public-safety/protecting-children/childabusepreventionhandbook_serviceprovider.pdf

⁴⁵ BC Child, Family and Community Service Act (2023). Section 27: Child in Immediate Danger. *Part 3 – Child Protection*. Retrieved From: https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96046_01#section27

⁴⁶ BC Public Health Act (2023). Section 91: Confidentiality of personal information. *Part 7 – Inquiries and Other Matters, Division 2: Other matters*. Retrieved from: https://www.bclaws.ca/civix/document/id/complete/statreg/08028_01#section91

3.6.1. Who should I call?

If a youth is in immediate danger, call 911.

If you believe a youth under 19 years of age is being abused or neglected, call the Provincial Centralized Screening line at 1-800-663-9122 any time of the night or day.

For more information, access the [BC Handbook for Action on Child Abuse and Neglect⁴⁷](#)

If a youth would like to talk to someone, call the Helpline for Children 310-1234 (no area code needed). The call will be answered by a trained child protection worker.

3.7. Other Inquiries about Youth

If a service provider has ethical concerns they should connect with a regulatory body or other resources available through your organization. Your health authority harm reduction representative may be able to help you to identify additional resources.

Providers should refer to the [BCCDC MMHA Provincial Episodic Overdose Prevention Services \(eOPS\) Protocol](#) for information on delivering episodic overdose prevention services for youth.

⁴⁷ BC Government (2017). The BC handbook for action on child abuse and neglect: For service providers. Retrieved from: https://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/public-safety/protecting-children/childabusepreventionhandbook_serviceprovider.pdf