

Provincial Episodic Overdose Prevention Service (eOPS) Protocol

Land Acknowledgement

We would like to acknowledge the many distinct First Nations communities on whose territories contributions to this document were made. We are grateful to all the First Nations who have cared for and nurtured the lands and waters for all time, including the xʷməθkʷəy̓əm (Musqueam), Skwxwú7mesh Úxwumixw (Squamish Nation), and sə́lílwətaʔ (Tsleil-Waututh Nation) on whose unceded and ancestral territory the BC Centre for Disease Control and the Provincial Health Services Authority Head Office are located, as well as the ləkʷəŋən speaking peoples, the Songhees, Esquimalt and WSÁNEĆ First Nations, on whose unceded and ancestral territory the Ministry of Mental Health and Addictions is located.

Contributions

The BC Centre for Disease Control and the Ministry of Mental Health and Addictions would like to acknowledge and thank the people with lived and living experience of substance use who so graciously shared their stories and experiences to better support people accessing Episodic Overdose Prevention Services (eOPS).

This protocol is based on guidelines developed by Dr. Andrew Gray, Medical Health Officer with the Northern Health Authority and builds upon the BCCDC and Ministry of Health COVID-19: Provincial Episodic Overdose Prevention Protocol published in 2020. This protocol was developed by the Episodic Overdose Prevention Strategies Sub-Group and updated by the Episodic Overdose Prevention Services Provincial Community of Practice and the Housing, Youth, and Perinatal Episodic Overdose Prevention Services Working Groups. The protocol is intended to provide additional guidance to the BC Overdose Prevention Services Guide (2019).

This resource benefited from the feedback and input of the following people who are knowledgeable about substance use, health, cultural safety and humility, and trauma-informed practice. We thank them for their invaluable contributions:

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Special thanks to:

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This document was developed in partnership between the BC Centre for Disease Control, the Ministry of Mental Health and Addictions - Overdose Emergency Response Centre (OERC), and the Ministry of Health.

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Episodic Overdose Prevention Services (eOPS) Background

Increased harms and death from the toxic unregulated drug supply during BC's [toxic drug poisoning crisis](#) highlight the need for ongoing prevention of and response to drug poisoning events (overdose) and deaths for all people who use substances and are at risk of harm.

People who use substances (PWUS) from the toxic unregulated supply are at significant risk for harms and death from drug poisoning. The volatile and unpredictable drug supply often contains extreme concentrations of potent opioids, including fentanyl, as well as adulterants, such as benzodiazepines, that can be harmful to PWUS' health and can complicate drug poisoning response. Supervised consumption sites (SCS) and overdose prevention sites (OPS) provide life-saving drug poisoning prevention and response services at locations across BC. Episodic overdose prevention services (eOPS) is a complementary drug poisoning prevention approach to increase access to life-saving services wherever people may use substances.

eOPS refers to provider-witnessed consumption of substances for the purpose of preventing or responding to drug poisoning delivered outside of established sites (e.g. SCS and OPS) in any setting where drug poisoning prevention may be needed, including inpatient units, emergency departments, long term care facilities, clinics, community-based settings, housing, emergency shelters, outreach, etc. eOPS is facilitated by a provider trained in drug poisoning (overdose) response and equipped with supplies to respond to drug poisoning (e.g. take home naloxone kit) and anyone at risk for harm from drug poisoning.

While eOPS has been a longstanding practice amongst people who use substances and some service providers, emerging evidence continues to inform the development of eOPS best practices.

Purpose

This protocol is intended to provide practical guidance for regulated and nonregulated health and social service providers to deliver eOPS to prevent and respond to drug poisoning in diverse settings across BC.

There are vast differences in health and social service providers' training and experience, availability of material resources (e.g. advanced or basic drug poisoning response equipment), staffing, and setting factors that impact the delivery of eOPS. This protocol may be adapted to guide organizations to

develop eOPS policy and procedures that consider the unique staff, training, resources, and environments in the local and regional context.

This protocol is intended to increase access to drug poisoning prevention and response services across a range of acute and community-based health and social service settings, including substance use related services (e.g. harm reduction services) but extending to all settings wherever services are provided to people at risk of harm or death from drug poisoning (hospitals, youth services, perinatal services, housing sites, emergency shelters, clinics etc.)

In BC, some groups of people, including Indigenous peoples, people who are made vulnerable by poverty, and people experiencing mental illness, experience disproportionate harms from the drug poisoning crisis and face significant barriers to accessing appropriate services to prevent drug poisoning, including youth and people who are pregnant or parenting.

This protocol includes considerations to better support equity-deserving groups, including people who are pregnant or parenting, youth, and people who reside in supportive housing and emergency shelters.

Statement

In the context of the toxic unregulated drug poisoning public health emergency, [Ministerial Order \(M488\)](#) orders British Columbia Emergency Health Services and regional health authorities to provide overdose prevention services for the purpose of monitoring persons who are at risk of overdose, and to provide rapid intervention when necessary in any place there is a need for these services.

Health Canada has granted an exemption from the Controlled Drugs and Substances Act to the Province of B.C. This is effective from January 31, 2023 to January 31, 2026. Under this exemption, adults (18 years and older) in B.C. are not arrested or charged for possessing small amounts of opioids, crack/cocaine, methamphetamine, and MDMA. Adults found in possession of any combination of these drugs that adds up to a combined total of 2.5 grams or less are not subject to criminal charges and drugs are not seized.

Regulations & Disclaimer

This guidance does not replace workplace or organizational policies and procedures, rather it is intended to guide the development of organizational and policies and procedures to be adapted to the local context.

Organizations are encouraged to support staff by providing education, training, and resources to safely and competently provide eOPS. Refer to the section on Provider Training for recommended education and training, and minimum requirements for drug poisoning response.

Providers who are trained in drug poisoning response and are equipped with drug poisoning response equipment, such as a Take Home Naloxone kit, may deliver eOPS.

If eOPS is not available in a health or social service setting, or during outreach, providers and organizations are encouraged to provide timely referral to accessible services or providers that offer immediately available drug poisoning prevention and response services.

In workplaces and organizational settings, it is important for providers to understand what they can and cannot do when providing eOPS. The activities that providers can do during eOPS is based on scope of practice, training, professional and legal regulations, and organizational procedures, which is determined by the following:

- Regulated health professions (e.g. nurse, physician): provincial and federal legislation (e.g. The Health Professions Act, Controlled Drugs and Substances Act), regulatory body standards and guidelines (e.g. WorkSafeBC, BC College of Nurses and Midwives), and organizational policies and procedures.
- Non-regulated staff and volunteers (e.g. peer worker, outreach volunteer): provincial legislation (e.g. WorkSafeBC), federal legislation (e.g. Controlled Drugs and Substances Act), job descriptions and organizational restrictions (e.g. workplace policies and procedures).

Limitations

- This protocol is intended to guide sites to provide urgent drug poisoning prevention and response on a 1:1 basis and at the discretion of the organization and providers. It is not intended to establish a continuous fixed-site overdose prevention services.

- If sites observe high demand for drug poisoning prevention services, consideration should be given to allocating resources for the establishment of a continuous, fixed-site drug poisoning prevention service in the community.
- Providers may be unable to support eOPS if they feel doing so will negatively impact their emotional, physical or mental wellbeing. Providers should make efforts to connect persons seeking eOPS to other providers in the setting who are available to provide the service.
- If multiple people request access to eOPS, consider provider capacity to respond to multiple accidental drug poisonings at the same time. If there is only capacity to respond to one drug poisoning at a time, ask persons to queue for the service or stagger the timing of their substance use.

Inhalation eOPS

- There is high demand for eOPS to support inhalation (smoking). The ability of sites to provide inhalation eOPS will depend on unique factors specific to those sites, employers, and organizations.
- At the time of writing, indoor inhalation (of regulated and unregulated substances), guidance is in development and sites will be required to meet specific occupational health requirements to minimize risks associated with inhalation.
- Organizations are encouraged to consider outdoor inhalation drug poisoning prevention guidance, protocols, and procedures (such as the Outdoor Inhalation OPS guidance on page 75 of the [BCCDC Overdose Prevention Services Guide](#)) to support providers to prevent and respond to drug poisoning while minimizing occupational exposure to hazards (e.g. smoke). Consideration should be given to:
 - Determine if outdoor inhalation eOPS is appropriate for the site(s) with consideration of available resources, distance from doors, windows, and air intakes, provider ability to monitor and respond in a safe and timely way to accidental drug poisoning if it occurs outdoors, while ensuring access to existing health and social service priorities.
 - Consider provider ability to observe and maintain sightlines to monitor the person outside including distance to respond, identifying hazards, and availability of additional providers, occupational health regulations, and safety planning if the person leaves the area or cannot be located.
 - Consider availability of resources to minimize risks including access to personal protective equipment (e.g. N95 mask), equipment, resources, and drug poisoning response supplies and equipment.

- Consider provider comfort level attending to an accidental drug poisoning off-site occupational health guidance and regulations for off-site drug poisoning prevention and response services.

Key Considerations

Health and social service providers are well positioned to provide access to drug poisoning prevention and response services. However, people who use substances are often made vulnerable by judgmental and stigmatizing treatment in health and social systems. Providers who deliver eOPS can greatly impact the quality and accessibility of drug poisoning prevention and response services by incorporating the following key considerations.

General considerations to guide eOPS

- Principles of Indigenous cultural safety, trauma and violence informed care, and harm reduction should guide interactions and delivery of services.
- 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.
- A single episode of substance use may be fatal in the context of the current toxic unregulated drug supply. Providers can support people at risk for drug poisoning and minimize risks by providing access to eOPS.
- Fentanyl in the unregulated drug supply is a major cause of death from drug poisoning. Unregulated fentanyl has unpredictable potency (strength) and often contains extreme concentrations of fentanyl and carfentanil, a highly potent opioid.
- Unknown and harmful substances are routinely detected in the unregulated drug supply. Benzodiazepines (benzos) and analogues (e.g. etizolam) are regularly detected and do not respond to naloxone. Benzos combined with opioids can increase harms and drug poisoning risk.

Considerations for people who are pregnant or parenting

People who are pregnant or parenting experience significant barriers to accessing drug poisoning prevention services due to stigma, fear of child welfare involvement, child separation, punitive policies, and substance use surveillance, combined with a lack of appropriate harm reduction services. These barriers contribute to a lack of safety and fear of disclosing substance use, which increases risk for harms and death from drug poisoning.

To improve access to drug poisoning prevention and response services, providers should meet people where they are at with dignity and trust with the goal of providing non-judgmental support and family togetherness. To achieve this, consider the following:

- Providers should use non-stigmatizing language, avoid assumptions about substance use and family goals, and adapt services to meet the needs of families.
- Building rapport and trust with someone who is pregnant, or parenting is necessary to create safety and access to services. Providers should recognize their position of power and consider how people who are pregnant or parenting and using substances experience significant vulnerabilities from substance use stigma and judgement when interacting with the healthcare system.
- Providers should provide care that aligns with the Provincial Perinatal Substance Use Program's [Blueprint for a Perinatal Substance Use Continuum of Care](#). Guiding principles include: Mother-baby togetherness, trauma informed care, Indigenous cultural safety, harm reduction, women centered and women's voices, recovery oriented, interdisciplinary, evidence informed, and equitable access.
- Include chosen support networks and Indigenous Elders to provide additional resources during pregnancy or parenting for people who use substances.
- Recognize that the colonial nature and approaches of institutions can perpetuate harms and trigger trauma and behavioural responses. These responses are often related to relationships to institutions.
- Using a harm reduction approach, support individuals and use discussions and relationship as an opportunity for engagement.
- Use a trauma and violence informed approach to promote safety and establish a relational space to discuss responsibilities.
- Engage in relational conversations to discuss issues and responsibilities.
- Provide opportunities for collaborative planning and identifying alternatives such as pain management, sleep, food etc. Avoid punitive measures wherever possible.

Child welfare considerations for people who are pregnant or parenting and use substances:

- Birth alerts were a harmful practice discontinued in BC in 2019. Providers should note that BC's child welfare mandate and duty to report guidelines pertain to living children and do not include a fetus.
 - This means, providers should not share information about any individual, including pregnant persons who use substances, to agencies or individuals without the pregnant persons' consent, as doing so would be a breach of confidentiality.

- Not all substance use affects a person’s ability to provide safe care to child(ren). Substance use, without indication or concerns of immediate risks for harm to child(ren), should not be reported to the Ministry of Children and Family Development (MCFD)/ Indigenous Child and Family Serving Agencies (ICFSA).
 - This means that substance use alone—whether the substances are regulated (e.g. alcohol) or unregulated substances (e.g. illegal fentanyl), used rarely or daily, consumed by any mode including inhalation, injection etc.—should not be reported to MCFD/ICFSA.
- Providers have a duty to report to the MCFD/ICFSA if there are immediate concerns the parent or family are unable to provide safe care to child(ren) due to significant impairment in judgement, behaviour, or level of consciousness and has not made adequate arrangements for the child's care.
 - This means that providers should not make a report to MCFD/ICFSA if the parent or family has made adequate arrangements for the child’s care while they are unable to provide safe care due to significant impairments.
- Referral to MCFD/ICFSA supports is voluntary. If the pregnant or parenting person is seeking services, providers can offer information and referral for voluntary supports.
- Providers should refer to decision support tools to guide information sharing and collaborative care for people who are pregnant or parenting: [Collaborative Practice Protocol for Providing Services for Families with Vulnerabilities: Roles and Responsibilities of the Director and the Ministry of Health](#).

Youth considerations

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, including drug poisoning prevention and response services.

Youth face many barriers to accessing harm reduction and drug poisoning prevention and response services. These barriers are even greater for Indigenous youth, youth who experience poverty and homelessness, youth in and from care, and 2SLGBTQ+ youth.

Historically, youth have been excluded in the planning and delivery of harm reduction services and face multiple barriers to accessing critical services to prevent illness, injuries, infections, and death from drug poisoning. Health and social service providers can improve access for youth through consideration of youth needs when planning and delivering 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.

Basic eOPS for youth

- If a youth has experienced drug poisoning and is unconscious, the common law provides that no consent is necessary in order to provide emergency treatment.
- Any person competent in drug poisoning response and adequately equipped to respond (e.g. take home naloxone kit) can provide basic harm reduction services to a youth to prevent and respond to drug poisoning without a formal assessment by a regulated health care provider.
- Basic harm reduction services include providing harm reduction supplies, training and giving out take home naloxone kits, providing drug checking services and education, providing emergency response (including naloxone) during drug poisoning, and any other services that can be provided by someone with basic training and equipment for drug poisoning response.
- Basic eOPS is a harm reduction and drug poisoning prevention and response service. This protocol describes basic eOPS –which is a service that does not have to be administered by a regulated healthcare provider.
- Basic eOPS includes witnessing the youth’s substance use, providing safer use education, providing assistance to clean the skin before substance use, and other basic activities described in this protocol.

Advanced eOPS for youth

Advanced practices in harm reduction and drug poisoning are considered health care 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 in harm reduction and drug poisoning prevention and response:

- Only a regulated health care provider (e.g. nurse, physician, social worker, etc.) can provide advanced practices in harm reduction and drug poisoning prevention and response. 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 include inserting an intravenous line, inserting a nasopharyngeal airway, prescribing safer supply, prescribing opioid agonist therapy (OAT), etc. Advanced eOPS includes interventions provided during eOPS that can only be carried out by a regulated healthcare provider, such as writing a prescription for prescribed safer supply, providing hands-on assistance with venipuncture (injection into the vein), medication administration of injectable opioid agonist treatment (iOAT), etc.

- The Infants Act states that a mature minor may provide a valid consent to health care if the regulated health care provider: has explained the risks and benefits of the health care; is satisfied that the youth understands the nature and consequences and the reasonably foreseeable benefits and risks of the health care; and the care provider has concluded that the healthcare service is in the youth's best interest.
- To assess this, the health care provider must explain to the youth the nature and consequences of the proposed health care, as well as the reasonably foreseeable benefits and risks. The health care 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 advanced eOPS healthcare services from a regulated healthcare provider.
- If the health care provider has made reasonable efforts to determine, and has concluded, that health care 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 health care is in the mature minor's best interests, providers should consider the potentially fatal consequences of not providing drug poisoning prevention and response services.

Duty to report and youth

- 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 MCFD or ICFSA. They are available 24 hours a day, 7 days a week.
- Substance use, accessing harm reduction supplies or take home naloxone 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/ICFSA should be considered carefully and with caution. A mature youth has a reasonable expectation of privacy and confidentiality when accessing health services. 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.

Considerations for supportive housing and emergency shelter

People who use substances alone are at risk of dying from drug poisoning. Housing sites should consider drug poisoning prevention and response services and supports for people who use alone in their rooms, including harm reduction and [safer use education](#), drug poisoning monitoring systems (e.g. Brave sensors and Lifeguard Digital Health application access), and community integration processes for residents.

- Resident wellness checks should use a relational and trauma-informed approach.
- Housing staff should request consent from residents to conduct more frequent wellness checks, as appropriate.
- Wellness checks should align with the rights of tenants/residents under the Residential Tenancy Act or other legislation as applicable.
- If wellness check policies are in place, these policies should be developed collaboratively with residents. Resident wellness checks should use a relational and trauma-informed approach. Housing staff should request consent from residents to conduct more frequent wellness checks, as appropriate. Consideration should be given to peer-led wellness checks.
- Challenges and complexities may arise between drug poisoning prevention and diverse organizational values and aims. Housing providers should review policies and practices (i.e. guest management policies) to ensure they are consistent with and supportive of people who use substances.
- Abstinence should not be a requirement of housing for people who use substances. Abstinence policies may create a judgmental and stigmatizing environment which may cause people not to request eOPS.
- Housing and emergency shelter staff providing eOPS services require ongoing training and supports, including harm reduction and drug poisoning prevention and response, Indigenous cultural safety, trauma and violence informed care, and critical incident stress debriefing.
- Housing sites should consider implementing supportive policies to prevent drug poisoning including by setting up in-house overdose prevention sites (HOPS) or providing eOPS, distributing harm reduction supplies, and implementing guest management policies that recognize the social nature of substance use and the dangers of using alone.

Procedure

Pre-eOPS: before observing substance use

- 1. Offer or support request for witnessed consumption of substance use (eOPS):**
 - i. Witnessed consumption may be requested by the person, or
 - ii. Witnessed consumption may be offered by the provider upon recognition of a person's potential need, or
 - iii. Provider may offer witnessed consumption upon individual accessing harm reduction supplies or a take home naloxone kit.

- 2. Assess setting capacity to provide eOPS, including available resources to:**
 - i. Support the needs of the person seeking eOPS while balancing the need to provide services for others in the setting, depending on the provider role and setting.
 - ii. Safely respond to a drug poisoning event including adequate provider competency and supplies to respond in case of drug poisoning (e.g. take home naloxone kit).
 - iii. Support safer substance use and post-use monitoring by staff who are available and have the time to do so.

- 3. Assess personal competency to safely provide eOPS:**
 - i. Providers assess their own learning needs and readiness to provide eOPS. Further information on provider training is presented later in this protocol.
 - ii. If learning needs are identified, determine ability to provide eOPS for the current person seeking support.
 - iii. If the provider is unable to provide eOPS at present, ensure immediate referral to available drug poisoning prevention and response service, such as another staff in the setting.
 - iv. If no staff are available to provide immediate eOPS, share drug poisoning prevention education and resources with the individual (e.g. use with a buddy who can recognize and respond to drug poisoning, virtual spotting through [Brave](#) or [Lifeguard](#) app, or use nearest community-based OPS).
 - v. If providers identify lack of personal competency and learning needs, seek ongoing education and training on drug poisoning prevention and response. New providers can attend alongside experienced staff to develop and improve their skills and comfort level.

4. Discuss accidental drug poisoning prevention safety plan with person:

- i. Discuss the provider's responsibility to administer naloxone and other required organizational protocols if there is an accidental drug poisoning emergency (e.g. transport to hospital, recommended monitoring on-site, etc.)
- ii. If the person prefers to consume their substances off site and outdoor inhalation eOPS is not available (e.g. inhalation site not available), discuss a safety plan to reduce risk of accidental drug poisoning (see strategies below).
- iii. If requested, discuss strategies to decrease risk of accidental drug poisoning including: use with a buddy who can recognize and respond to an accidental drug poisoning; use a drug checking service, use an app for virtual spotting such as [Brave](#) or [Lifeguard](#); use an overdose prevention hotline such as [NORS](#) 1-888-688-NORS (6677); provide training and a take home naloxone kit, direct the person to the closest OPS/SCS; do a test dose before the full dose.
- iv. If the person chooses to leave a facility to smoke a substance, encourage a safety plan regarding the risk of drug poisoning, including having somebody with them who can recognize and respond to a drug poisoning. Offer safer inhalation supplies as available.

5. Discuss roles and responsibilities during eOPS:

- i. When providing eOPS, the provider should ensure they are trained and equipped to respond to opioid poisoning (overdose) emergency, including administering naloxone when necessary.
- ii. The person using substances can decline additional services (e.g. transport to health services, counselling, etc.) offered by the provider without jeopardizing access to eOPS.
- iii. The provider and person using substances should discuss and agree on the eOPS process including:
 - a. Time, space, and provider available to deliver eOPS
 - b. The activities the provider can do to support safer substance use and limitations during eOPS (e.g. safer injection education, assisted injection, etc.)
 - c. Type of substance(s) being used (if known)
 - d. Preferences for post-use monitoring (e.g. calling name, touching shoulder etc.)
 - e. Emergency equipment available in case of drug poisoning (e.g. take home naloxone kit)
 - f. Other relevant information depending on the setting, person, and provider
- iv. The provider and person using substances should discuss and agree to:
 - a. Respectful communication with each other and others present in the setting, and
 - b. Safe storage, handling, and disposal of substances, substance use equipment, and other supplies.

- c. Availability of alternatives to the unregulated drug supply, including access to immediately available OAT, iOAT, and or prescribed safer supply.

Procedure 1-5 considerations for priority populations

People who are pregnant or parenting:

- Ask for permission from the pregnant or parenting person before engaging them in a discussion about substance use or harm reduction. Consider the need to establish trust and consider the barriers caused by fear of child welfare involvement for people who use substances.
- Ensure privacy and confidentiality when discussing substance use and harm reduction with people who are pregnant or parenting.
- Engage in relationship building and establish trust. If requested, identify opportunities for further education and support (i.e. breastfeeding, health promotion, childcare, etc.).
- Prior to providing the service, clearly communicate what will be documented and with whom it will be shared. Ensure transparency of information sharing including organizational and professional documentation requirements and communication with external agencies. See documentation requirements section below for information for regulated healthcare professions.
- If there are site limitations to providing eOPS due to lack of available on-site inhalation facilities or the provider is unable to deliver eOPS, make every effort to connect the person with timely access to other drug poisoning prevention services.
- Collaboratively identify safe childcare plan for the duration of witnessed consumption or off-site access to drug poisoning prevention services and if there is significant impairment following substance use:
 - If the person is parenting and the child(ren) is present, discuss and collaboratively identify appropriate support person (family member, partner, health or social care provider, etc.) to provide safe care to the child(ren) during and after substance use.
 - Care should be provided until the parent is able to safely provide care and is not experiencing effects of substances that cause significant impairment in judgement, behaviour, or level of consciousness.
 - If staff or family have limited resources or time to provide childcare, ensure there is transparent communication and a backup plan to provide care to the child(ren).
- Discuss drug poisoning safety planning including person's preferences for fetal and maternal monitoring if drug poisoning occurs. Ensure patient choice is supported and providers maintain non-judgmental approach to safety planning.
- Discuss and provide support for changes in substance use and individual tolerance from physical changes during pregnancy and the postpartum period. Individuals may choose to adjust or decrease their dose due to the effects of stressors, physiological changes, etc.

6. Offer alternatives, if available and appropriate:

- i. If requested, discuss options for substance use disorder screening, diagnosis and treatment, including pharmacotherapies such as OAT, iOAT, and non-pharmacological modalities such as psychotherapy and cultural supports.
- ii. If prescribed alternatives to the unregulated drug supply are immediately available, offer connection or prescription for prescribed substances, such as access to prescribed safer supply. Consult the BC Centre on Substance Use [BCCSU Clinical Care Guidance](#) for further information on prescribed substances including guidance on prescribed safer supply, opioid use disorder, and stimulant use disorder etc.
- iii. If the person secures a regulated substance (e.g. prescribed safer supply) and wishes to dispose of the unregulated substance they previously intended to consume, provide safe disposal (see Disposal of Unknown Substance section below).

Procedure 6 considerations for priority populations

People who are pregnant or parenting:

- Prescribers are encouraged to consult appropriate resources including the [BCCSU 24/7 Addiction Clinician Support Line](#) and [BCCSU Clinical Care Guidance](#), such as the [Guideline for the Clinical Management of Opioid Use Disorder—Pregnancy Supplement](#) for further information on providing prescribed pharmaceutical alternatives to the toxic drug supply for people who are prenatal (pregnancy), intrapartum (during labour and delivery), and postpartum (after delivery).

Youth:

- Youth are eligible for prescribed safer supply depending on their ability to provide informed consent to a regulated healthcare professional to access the prescription.
- In the event that a health care provider was of the opinion that a youth could not consent on their own behalf to being prescribed with safer supply, the consent of a parent or guardian could be sought, or the situation brought to the attention of MCFD. A youth should not be denied safer supply because the health care provider cannot proceed on the basis of the youth consenting as provided for in section 17 of the Infants Act.
- Prescribers should consult the appropriate BCCSU Clinical Care Guidance, such as the [Treatment for Opioid use Disorder for Youth](#).
- Consideration should be given to the significant risks for harms and death for youth accessing unregulated substances from the toxic drug supply.

People who live in supportive housing and emergency shelters:

- Housing sites should consider partnerships with healthcare clinics, peer workers, or prescribers to connect residents to prescribed alternatives to the toxic drug supply (e.g. outreach visits, delivery, virtual care, housing/emergency shelter clinic, etc.).
- 7. Offer harm reduction supplies and drug checking (if available):**
 - i. Offer harm reduction supplies, including safer injection and safer inhalation equipment.
 - ii. Offer drug checking services, if the site has available resources and there is a trained provider. If not available, provide information on local drug checking services.
 - 8. Locate a private, safe, and appropriate space that is available to deliver eOPS:**
 - i. The space should ensure accessibility, privacy, emergency access to respond to a drug poisoning, and support the provider and person's safety.
 - ii. The space may be the person's room, a clinic room, resident support room, mobile unit, private waiting area, clean outreach space, etc.
 - 9. If unable to provide eOPS:**
 - i. If providers are unable to provide eOPS for any reason, staff will discuss accidental drug poisoning prevention safety planning and provide resources for nearest SCS/OPS or virtual service (i.e. [Brave](#) or [Lifeguard](#) app, [NORS](#) phone line).

During eOPS: observing substance use

- 10. Maintain infection prevention and control practices:**
 - i. Follow organization occupational health guidance on infection prevention and control practices, including performing regular [hand hygiene](#) and use of appropriate [personal protective equipment \(PPE\)](#), such as gloves.
 - ii. Encourage the person using substances to perform hand hygiene prior to substance use.
 - iii. Clean surfaces and any equipment using the [two-step cleaning method](#) before preparing, handling or using substances.
- 11. Provide supports for safer substance use, as appropriate:**
 - i. See Regulations and Disclaimer section above for guidance on provider activities during eOPS. This will involve understanding individual scope of practice, training and education requirements, professional and legal regulations, and organizational policies and procedures.
 - ii. Due to legal liabilities, the person consuming unregulated substances should handle, prepare, and self-administer substance(s) by the preferred mode of consumption. Providers may not assist with these steps.

- iii. Understand setting-specific limitations to supporting various modes of consumption, such as indoor and outdoor inhalation. See Limitations section.

People who are unable to self-administer substances:

- iv. If self-administration of substances is not possible or cannot be performed safely, provide appropriate supports that consider what the provider can and cannot do during eOPS, mode of consumption, availability of resources, the context, and the needs of the person using substances.
- v. Refer and connect people unable to self-administer substances with supports, including health and social services, treatment, and substitution options, including cannabis. People who are unable to self-inject substances and rely on others are more vulnerable to harms from substance use.

Injection substance use:

- vi. If the person prefers to inject substances, ask preferences and provide safer injection support or education if requested:
- vii. Safer injection education may include vein care, injection sites, injection practices—bevel up, toward the heart, angle of injection, flagging before injection, etc.
- viii. Supports for injection may include providing a hot compress, water to improve hydration, assistance with applying and removing the tourniquet (tie), cleaning skin with an alcohol swab before injection, physical props to stabilize limbs, using vein finding apps, etc.

Peer-assisted injection:

- ix. If education and supports have been offered and the person is unable to self-inject, the person may ask to have a peer or support person perform the injection.
- x. Both the person using substances and the peer support person performing the injection should be aware that assisted injection of unregulated substances causing harm or death could result in legal liabilities for the peer support person performing the injection.
- xi. Providers may offer safer injection coaching and supports to the peer support person doing the injection.
- xii. If the person is unable to safely inject, discuss other routes of consumption (e.g. inhalation, intramuscular injection, etc.) or refer to iOAT program for assisted injection of regulated substance by a healthcare provider, if locally available.

eOPS providers who are regulated health professionals in a clinical setting:

- xiii. If supported by organizational policy and within provider scope of regulated professional practice, consider the use of a peripheral line for venous access for safer injection of substances.

- xiv. If the person using substances has a line established and is using the line to inject substances, provide education and supplies to maintain a patient line and minimize the risk of infection. This may include assessing the site, providing sterile pre-filled saline syringes and education on saline flushing pre and post injection, education on signs and symptoms of infection, and coordination with the relevant care team if requested by the person using substances.

After substance use (post-eOPS)

12. Monitor the person for signs of accidental opioid poisoning:

- i. Monitor the person for respiratory depression (very slow or no breathing) and level of consciousness (unresponsive) for at least 20 minutes following injection or inhalation of substances.
- ii. Consider factors that increase risk for opioid poisoning, including type of substance consumed (e.g. potent opioid, such as fentanyl), the person using substances (e.g. tolerance, recent time away from opioid use, level of consciousness prior to substance use, combined use of respiratory depressants including alcohol, etc.)

13. Responding to suspected opioid poisoning, if it occurs:

- i. Providers should respond to suspected opioid poisoning according to organizational policy and protocols.
- ii. Providers should follow organizational policy and protocols for emergency opioid poisoning/overdose response and other severe outcomes that may occur (e.g. cardiac arrest, etc.)
- iii. Initiate organization's emergency response protocol for suspected opioid poisoning (e.g. code blue, call 911, etc.)
- iv. Respond to suspected opioid poisoning with available resources to give breaths/oxygen and administer naloxone:
 - o Regulated health professions are encouraged to use [BCCDC's Decision Support Tool on the Administration of Naloxone](#) for supplemental guidance on responding to suspected opioid poisoning.
 - o Non-regulated care providers are encouraged to follow [SAVE ME Steps](#) to respond to suspected opioid poisoning.

Procedure 12 considerations for priority populations

If a pregnant person experiences suspected opioid poisoning:

- Naloxone is recommended for people who are pregnant or postpartum (after delivery) to respond to suspected opioid poisoning.
- Naloxone given during pregnancy can cause precipitated withdrawal (sudden and severe withdrawal) in both the pregnant person and fetus. Precipitated withdrawal can cause fetal distress or start premature labour. However, administration of naloxone should be prioritized to save the pregnant person's life.
- Naloxone should be given if a drug poisoning emergency occurs because any risks of using naloxone to reverse an opioid poisoning are significantly less than the harms of oxygen deprivation if naloxone is not given.
- To reduce the risks of maternal and fetal opioid withdrawal, start with the lowest dose of naloxone (0.4 mg IM or 1 ampoule from a take home naloxone kit). Observe for improvement in breathing and level of consciousness while giving breaths/oxygen and ventilation.
- During drug poisoning response, wedge blankets or pillows under the right hip/buttock to tilt the body 15-30 degrees to improve blood flow. After 20 weeks gestation (about 5 months pregnant), the weight of the uterus and fetus can compress blood flow when the pregnant person is lying on their back.
- Depending on individual goals and preferences, offer referral for fetal and maternal monitoring to assess for fetal distress and premature labour. If the person would like monitoring, provide urgent referral. Provide non-judgmental information and allow the pregnant person to determine how they would like to proceed.
- Following drug poisoning, provide support and offer connection to trusted support person or services.
- Providers should remember that there is no duty to report safety concerns for a fetus.

If a person experiences drug poisoning and is breastfeeding/chestfeeding:

- Giving naloxone to a person who is lactating (producing human milk) does not cause child exposure to naloxone through human milk. Naloxone may be passed into human milk, however, it is not absorbed by the breastfeeding child.
- Opioids transfer into human milk. The amount of opioids transferred into the milk depends on the substance taken by the person who is lactating. Due to the potency, unpredictability, and variability of the unregulated drug supply, it is difficult to know the amount of opioids that will be transferred into the milk. There is a risk for opioid poisoning if a child consumes opioids through human milk. Opioid poisoning in a child requires urgent monitoring and care.

- If the lactating person regularly uses unregulated substance, the safest option for the child is to avoid breastfeeding/chestfeeding. For people who prefer to breastfeed/chestfeed, a temporary pause breastfeeding/chestfeeding until the opioid is out of the lactating person’s system can reduce the risk for opioid poisoning.
- Complete cessation of breastfeeding/chestfeeding following opioid poisoning may cause a sudden stop to the amount of opioids in human milk. Depending on the dose and duration of opioid exposure, a sudden stop of opioids may cause opioid withdrawal in the child. Opioid withdrawal in a child requires urgent monitoring and care.
- If naloxone is given to a person breastfeeding/chestfeeding a child, it is important to:
 - Consult with the healthcare team and person who is breastfeeding/chestfeeding to determine the best feeding options. The decision to breastfeed/chestfeed is personal and each situation is different. The amount of opioids in the milk and risk for adverse events are influenced by the opioid poisoning event, patterns of substance use, child’s age, lactation stage, health histories, amongst other factors.
 - Depending on the situation, monitor the child closely and escalate care if the child shows signs of opioid withdrawal or opioid poisoning.

15. Provide safer sharps disposal to discard used substance use equipment

16. Provide information and referrals for appropriate supports:

- If requested, connect the person with appropriate health and social services that meet their needs, including detox and treatment services, prescribed safer supply programs or prescribers, opioid agonist therapy (OAT), housing, income supports, mental health, etc.
- Offer to connect the patient to cultural supports that may be available (e.g. Indigenous Elders, Traditional Healers).

17. Perform hand hygiene

18. Clean and disinfect environment and equipment using a two-step process:

19. If substances are left behind:

Note that this section refers to substances left behind and does not include residue on substance use supplies (e.g. cookers) or debris on surfaces following substances use.

- Substances left behind should be disposed of according to organizational policy which may include the following suggestions:
- Substances left behind should be disposed of safely with a second provider who is familiar with safe disposal practices.

- iii. The two providers should work together to witness substance disposal or transfer of the substances.
- iv. If the substance is in a solid form:
 - a. For a small amount of substance (e.g. enough for personal use):
 - Use a gloved hand to place substance in a tamper-evident bag or a bag with a tamper-evident seal. Fold the bag twice, seal with tape and place in the disposition bucket.
 - Dispose into an appropriate and secure disposal (e.g. clinic pharmaceutical disposal bucket)
- v. If the substance is in a liquid form:
 - a. Handle the container with disposable gloves (and tongs, if left in the barrel of a syringe) and dispose of the substance in a sharps/biomedical waste container in a secure location.
 - b. Do not pour unknown liquid substances down the drain.
- vi. Both providers sign and date the appropriate paperwork to document transfer or disposal of unregulated substances, as per organization requirements.
- vii. Health authority providers should complete a BC Patient Safety and Learning System (PSLS) report as per protocol.
- viii. No paperwork to document substance left behind should have personal identifiers of the person who used substances/left substance(s) behind.

20. Debriefing

- i. Following eOPS delivery, providers may want to debrief with other providers, particularly if there was an emergency drug poisoning response.

Procedure 20 consideration for priority populations

People who are pregnant or parenting:

- If the person who is pregnant or parenting is seeking services, offer information and referral for voluntary health and cultural supports:
- Ask the pregnant or parenting person for consent to provide information on voluntary referrals to health and cultural supports. If consent is provided, offer information on referral to health services such as prenatal healthcare, perinatal substance use services, health promotion and education, housing and income support referrals, Elder support, and cultural medicine and care etc.
- If consent is not provided for referral or information sharing, do not share information.

Provider Training

To safely and competently provide eOPS, organizations are encouraged to support provider education and training in drug poisoning (overdose) prevention and response prior to the delivery of eOPS.

Education and training may differ according to the health and social service setting, provider scope of practice and activities, and drug poisoning response resources available.

At minimum, provider education and training to safely deliver eOPS should include:

- Harm reduction (e.g. [CATIE Harm Reduction Fundamentals](#))
 - Principles and practices
 - Safer substance use and safer sex
- Drug poisoning (overdose) response
- Naloxone administration
- Other organizational requirements (e.g. CPR and use of an AED)

Additional training is recommended for providers on the following principles to inform care:

- Cultural safety and humility (e.g. [San'yas Anti-racism Indigenous Cultural Safety Training Program](#))
- Trauma and violence informed care (TVIC) (e.g. [EQUIP Healthcare TVIC Resources](#))
- Anti-stigma (e.g. [Peer2Peer Compassionate Action Modules](#))
- Take Home Naloxone training (e.g. [BCCDC Naloxone Training](#))

Providers who work with people who are pregnant or parenting:

Providers who support people who are pregnant or parenting and use substances are encouraged to receive further education and training on the guiding principles of the Provincial Perinatal Substance Use Program's [Blueprint for a Perinatal Substance Use Continuum of Care](#), including:

- Mother-baby togetherness
- Trauma informed care
- Indigenous cultural safety
- Harm Reduction based
- Women centered and women's voices
- Recovery oriented
- Interdisciplinary

- Evidence informed
- Equitable access

Providers are encouraged to take [SafeCare](#), a blended, facilitated psychoeducation program available to health professionals and human service workers in community and acute settings. This education includes trauma informed practice, substance use, harm reduction, Indigenous Cultural Safety, and self-care components.

Equipment & Resources

At minimum, providers should have immediate access to the following equipment and resources to safely deliver eOPS:

1. **Access to a safe and appropriate space** that allows access to respond to an accidental drug poisoning emergency, if it occurs.
2. **Access to safer substance use** harm reduction supplies.
3. **Drug poisoning response equipment** to administer naloxone and give breaths/ventilate with routine personal protective equipment (PPE) (e.g. take home naloxone kit with injectable naloxone and a CPR face mask and gloves).
4. **Access to initiate emergency response**, if needed (e.g. code blue button, cell phone to call 911, another person who can call for help, etc.)

Additional equipment and resources to deliver eOPS, depending on the provider and setting:

- Additional [safer substance use and safer sex supplies](#). See the [BCCDC Harm Reduction Site](#) for information on ordering supplies and distribution.
- [Take home naloxone kit](#) training and distribution.
- Access to drug checking including fentanyl and benzodiazepine test strips or access to [FTIR spectroscopy](#).
- Phone for emergency response, referrals, connecting with support person, etc.
- Advanced drug poisoning (overdose) emergency response equipment:
 - Basic equipment available in a [take home naloxone kit](#) or [Facility Overdose Response Box \(FORB\)](#) to administer naloxone and give breaths/ventilate with routine PPE, including: naloxone ampoules and syringes (OR intranasal naloxone), CPR face mask (OR advanced ventilation equipment), alcohol swabs, and gloves, AND

- Equipment for advanced response activities: pulse oximeter, oral and nasopharyngeal airways, bag-valve-mask, simple face mask, oxygen tank, suction and yankauer catheters, AED, blood pressure cuff and stethoscope, glucometer, pen light, emergency medications (e.g. epinephrine, glucose tabs, etc.), and other crash cart supplies.
- See Regulations and Disclaimer section above and individual provider scope and regulations, as most advanced response practices are restricted activities for certain regulated health professions (e.g. inserting a nasopharyngeal airway).
- Additional [personal protective equipment](#) when indicated for elevated risk of communicable disease transmission according to local health authority, organizational policy, and [public health guidance](#).
- Additional cleaning supplies, including disposable pads, disinfectant wipes, etc.
- Individual locked safes to store personal belongings.

Documentation

Documentation includes written and electronic information about a person’s care or services delivered by a care provider. Documentation requirements depend on the setting, organizational policy, and professional standards and regulations.

Documentation requirements may be very different across sites and between regulated and non-regulated providers.

It is important for all providers to know their organizational documentation requirements (if any) for delivering eOPS and drug poisoning response. Regulated health professions should also understand their professional documentation responsibilities.

Providers should be aware that written records of unregulated (illegal) substance use and drug poisoning can deter people who use substances from accessing services due to fears of surveillance and negative impacts on future access to services. Declining to provide personal identifying information should not be a barrier to accessing eOPS.

Organizations may implement documentation systems to support communication, patient safety, and privacy. Consider an anonymous charting system separate from the primary electronic record (e.g. electronic patient chart) for harm reduction sites and drug poisoning (overdose) prevention services. The anonymous charting system may use pseudonyms instead of personal identifiers and can be accessed by providers delivering harm reduction or substance use services.

Documentation for regulated professions in BC

- [Regulated health professions](#) should document eOPS according to their organizational requirements and their professional regulatory body's standards and guidelines for practice.
- Regulated professions documenting eOPS can maintain privacy by using terms that do not reinforce stigma and by not documenting information that is not relevant to care. For example, the term “drug poisoning prevention support” can be used to communicate provider actions while supporting patient privacy and access to care.

Nurses delivering eOPS:

- Nurses make up a significant number of regulated providers who provide care to people at risk of drug poisoning and could benefit from eOPS across healthcare settings.
- Nurses (including licensed practical nurses, nurse practitioners, registered nurses, and registered psychiatric nurses) must meet their regulatory body, the BC College of Nurses and Midwives (BCCNM) guidelines and standards, including the [documentation standard](#).
- Documentation of eOPS should safeguard confidentiality, facilitate access to low barrier drug poisoning prevention and response services, and communicate relevant interventions and potential safety issues.
- Nurses are required to document all medication administration and safety events. Nurses delivering eOPS must document medication administration (e.g. naloxone) and emergency events (e.g. drug poisoning response). This means that if drug poisoning occurs during eOPS, all drug poisoning response interventions and naloxone administration must be documented in the person's medical record.

Documentation for health authority sites in BC

- Provincial and regional health authority sites using the BC Patient Safety and Learning System (PSLS) should report drug poisoning as a patient safety event in PSLS. The PSLS report is not linked to a patient and should not include identifying patient information.
- Sites should follow their health authority policy for guidance on reporting procedures.

Documentation considerations for priority populations

People who are pregnant or parenting:

- Organizations and providers are encouraged to consider potential unintended consequences of written records of irrelevant information on substance use or drug poisoning prevention and response services (e.g. eOPS).
- Consider potential for punitive use of information, such as sensitive information shared with third party agencies through freedom of information requests for health records and potential impacts on future services or family togetherness.

- Organizations and providers should consider how their settings can take measures to safeguard patient confidentiality and facilitate access to drug poisoning prevention and response services while ensuring safe care and timely communication with other members of the care team.

Additional Resources

- [BCCDC Infection Control](#)
- [WorkSafeBC Communicable Disease Prevention Guide](#)
- [BCCSU Clinical Care Guidance](#)
- [BCCSU Drug Checking](#)
- [Toward the Heart: Safer Sex and Safer Substance Use](#)
- [Toward the Heart: Take Home Naloxone](#)
- [Toward the Heart: Naloxone Course](#)
- [BCCDC Unregulated Drug Poisoning Emergency Dashboard](#)
- [BC Government: Access to Prescribed Safer Supply in BC](#)
- [Provincial Perinatal Substance Use Project \(PPSUP\)](#)
- PPSUP [Provincial Blueprint for a Perinatal Substance Use Continuum of Care](#)
- Select Standing Committee on Health: [Closing Gaps, Reducing Barriers: Expanding the Response to the Toxic Drug and Overdose Crisis](#)
- [BC Coroners Service Death Review Panel: A Review of Illicit Drug Toxicity Deaths](#)

Key Terms

Consumption: means administration of a substance by a number of means, including injection, ingestion, inhalation (snorting), and inhalation (smoking).

Harm reduction: means an approach to care and a set of principles that inform policies, programs, and practices that aim to reduce harms associated with substance use, substance use policies, and substance use laws.

Drug poisoning: means suspected or confirmed drug poisoning emergency. The term drug poisoning is used instead of overdose as it is a more accurate term used in toxicology to describe the physiological harms that can occur from consumption of substances. Overdose is used to discuss current programs and initiatives (e.g. overdose prevention services).

Episodic overdose prevention services (eOPS): means provider-witnessed consumption of substances for the purpose of preventing or responding to drug poisoning (overdose).

Indigenous Cultural Safety and Humility:

Cultural safety: is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care.

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 experience.

See First Nations Health Authority (FNHA) [Cultural Safety and Humility Framework](#).

Opioid poisoning: means drug poisoning caused by opioids (e.g. fentanyl, heroin). Drug or opioid poisoning reflects the unpredictability and volatility of the toxic unregulated drug supply used instead of drug poisoning.

Overdose Prevention Service: means observation of a client using unregulated substances, for the primary purpose of responding promptly to any overdose (drug poisoning) that may occur.

Person: means the individual accessing eOPS. Depending on the setting, the person may be referred to as an individual, client, patient, resident, participant, etc.

Postpartum: means the time after birth.

Prenatal: means the time before birth, during or related to pregnancy.

Provider: means regulated and non-regulated health and social service providers. This includes health professions (e.g. nurses, social workers, physicians, etc.), peer workers, overdose responders, outreach workers, mental health workers, housing staff, tenant support workers, educators, administrators, support workers, care aides, paramedics, and countless other occupations, professions, and roles. Providers may be employees, volunteers, or receiving a stipend.

Setting: means the setting or environment where eOPS is delivered. In different contexts, the setting may be a residence, clinic, unit/ward, client room, outreach location, agency, etc.

Supervised Consumption Site: means a type of harm reduction site with federal authorization to provide drug poisoning (overdose) prevention and response for people using substances.

Unregulated drug supply: means substances (drugs) obtained through the unregulated, or illegal, market. Unregulated substances have an unknown composition and often contain adulterants and extreme concentrations of harmful substances.

Youth: means anyone under 19 years old. “Minor” is the legal term for anyone under 19.

Trauma-and Violence-Informed Care (TVIC): means an approach to care that considers how trauma and past and current experiences of violence, between people and at the highest level of society, impacts people’s lives including their health and behavior. TVIC in prioritizes the person’s safety, choice, and control.

Practicing with a TVIC approach means creating emotionally and physically safe environments for providers and persons accessing services, emphasizing safety and trust, offering choices through connection and collaboration, and using a capacity-building and strengths-based approach to deliver services.

See EQUIP Health Care’s [TVIC Toolkit](#).

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