Supervised Consumption Services

Operational Guidance

BRITISH COLUMBIA
Ministry of Health

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

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About the BC Centre on Substance Use

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

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

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

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

About the Process

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

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Executive Summary

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

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

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

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

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

Summary of Recommendations

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

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

1. Introduction

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

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

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

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

1.a. Background and Evidence

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

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

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

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

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

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

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

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

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

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

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

1.b. Indications for Implementation

1.b.i.Determining Need

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

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

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

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

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

1.b.ii. Defining Overall Goals

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

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

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

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

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

2. Supervised Consumption Service Models

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

The basic components of a SCS include:

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

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

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

2.a. Fixed stand-alone model

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

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

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

2.b. Integrated model

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

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

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

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

2.c. Embedded model

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

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

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

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

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

2.d. Mobile outreach model

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

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

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

2.e. Women-only model

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

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

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

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

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

Organizers of SCSs can support women who inject drugs by:

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

2.f. Opportunities to develop novel approaches to SCS

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

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

3. Staffing Models

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

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

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

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

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

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

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

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

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

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

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

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

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

3.b. Alternative staffing models

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

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

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

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

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

4. Clinical Practice

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

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

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

4.a. Overdose

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

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

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

4.b. Harm reduction principles

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

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

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

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

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

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

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

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

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

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

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

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

4.d. Code of conduct/rights and responsibilities

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

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

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

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

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

5. Screening and Informing Clients

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

5.a. Eligibility and user agreement

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

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

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

Typically, SCSs have specific protocols for the following groups:

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

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

5.b. Refusal of service

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

6. Security and the Safety of Clients and Workers

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

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

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

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

6.a. Conflict management

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

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Appendices

Appendix A: Feasibility assessment study

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

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

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

Appendix B: Community consultation and engagement process

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

Objectives:

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

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

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

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

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

1. Key Stakeholder Consultation and Engagement

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

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

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

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

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

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

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

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

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

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

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

i) Develop a take-away packet of information;

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

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

2. Community Consultation and Engagement

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

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

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

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

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

Appendix C. Sample feasibility survey for PWID

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

SECTION 1. DEMOGRAPHIC INFORMATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

❒ Yes ❒ No ❒ Refused to answer

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 2. DRUG USE & INJECTION PRACTICES

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

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

Age: _____ ❒ Refused to answer

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

❒ Yes ❒ No ❒ Refused to answer

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

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

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

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

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

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

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

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

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

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

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

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

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

❒ Yes ❒ No ❒ Refused to answer

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

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

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

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

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

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

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

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

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

46. What is your drug of choice?

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

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

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

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

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

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

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

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

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

51. What do you think it was cut with?

Specify substance: _____

❒ Don't know/Unsure
❒ Refused to answer

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

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

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

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

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

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

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

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

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

❒ Yes

❒ No ***(Skip to Section 3)***

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

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

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

SECTION 3. SUPERVISED INJECTION SERVICES

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

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

❒ Yes

❒ No ***(Go to box below)***

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

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

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

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

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

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

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

❒ No ***(Skip to Question 62)***

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 4. LOCATION AND SERVICE DESIGN PREFERENCES

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

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

❒ Yes ❒ No ❒ Refused to answer

67. Are you willing to walk to a SIS?

❒ Yes

❒ No ***(Skip to Question 69)***

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

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

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

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

❒ Yes

❒ No ***(Skip to Question 71)***

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

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

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

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

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

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

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

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

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

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

❒ Day-time (8 am – 4 pm)
❒ Overnight (midnight – 8 am)
❒ Evening (4 pm – midnight)
❒ Refused to answer

76. Now, what time of the day would be your SECOND CHOICE to use a SIS?
(Read out list. Check one under SECOND CHOICE)

❒ Day-time (8 am – 4 pm)
❒ Overnight (midnight – 8 am)
❒ Evening (4 pm – midnight)
❒ Refused to answer

77. What would be the best set-up for injecting spaces for SISs? ***(Show CORRESPONDING picture to each choice of facility set-ups below. Read out list. Check ONE only.)***

❒ Private cubicles
❒ An open plan with benches at one large table/counter
❒ An open plan with tables & chairs
❒ Combination of the above
❒ Don't know/Unsure
❒ Refused to answer

78. Do you think people who use drugs should be involved in running SISs?

❒ Yes
❒ No ***(Skip to Question 80)***
❒ Refused to answer ***(Skip to Question 80)***

79. ***(If yes)*** How do you think people who use drugs could be involved? ***(Read list out. Check ALL that apply.)***

❒ At the entrance ❒ Greeting clients ❒ Registering clients
❒ In the waiting room ❒ In the injecting room ❒ In the chill-out room
❒ In the post-injection counselling role ❒ Don't know/Unsure
❒ Refused to answer

80. Do you think there should be a separate room for smoking crack or crystal meth at the SIS?

❒ Yes
❒ No ***(Skip to Question 82)***
❒ Refused to answer ***(Skip to Question 82)***

81. Would you use a separate room for smoking crack or crystal meth?

❒ Yes ❒ No ❒ Refused to answer

82. If it was possible to check your drug before injecting at a SIS, how often do you think you would test your drug? ***(Read out list. Show FREQUENCY (2). Check ONE only.)***

❒ Always (100% of the time) ❒ Usually (over 75%)
❒ Sometimes (26-74%) ❒ Occasionally (<25%)
❒ Never (Skip to Section 5) ❒ Refused to answer

83. How long would you wait to get the results of the drug test? ***(Read out list. Check ONE only.)***

❒ 5 min or less ❒ More than 5 min but less than 10 min
❒ More than 10 min but less than 15 min ❒ More than 15 min
❒ I would not wait any amount of time ❒ Refused to answer

SECTION 5. COMMUNITY IMPACT

READ: The next questions are about the possible impact on the community if SISs were opened in the [city] area.

84. I am going to ask if you think the following would be very likely, likely, neutral, unlikely, or very unlikely to occur in the community if SISs were opened in [name of city]? ***(Read out each statement. Ask them how likely they believe the statement. Show LIKELIHOOD prompt card. Check ONE response for each question.)***

If SISs were to open in the [name of city] area:	Very likely	Likely	Neutral	Unlikely	Very unlikely	Refused
a) The number of people injecting outdoors would be reduced	❒	❒	❒	❒	❒	❒
b) The number of used syringes on the street would be reduced	❒	❒	❒	❒	❒	❒
c) Injection with used needles would be reduced	❒	❒	❒	❒	❒	❒
d) People would learn about drug treatment	❒	❒	❒	❒	❒	❒
e) Overdoses would be reduced	❒	❒	❒	❒	❒	❒
f) Street violence would be reduced	❒	❒	❒	❒	❒	❒
g) Crime would be reduced in the area	❒	❒	❒	❒	❒	❒
h) Users would visit the area	❒	❒	❒	❒	❒	❒
i) Users would move to the area	❒	❒	❒	❒	❒	❒
j) Drug dealers would be attracted to the area	❒	❒	❒	❒	❒	❒

SECTION 6. EXPERIENCES OF OVERDOSE, HEALTH AND HIV & HEPATITIS C TESTING

Read: The next questions are about overdosing. Different people have different ideas about what an overdose is.

85. Have you heard of Narcan/naloxone?

❒ Yes ❒ No ❒ Refused to answer

86. Have you heard about take-home Narcan/naloxone kits that you can keep with you for an opiate overdose?

❒ Yes ***(Continue to next question)***

❒ No ***(Skip to Question 91)***

❒ Refused to answer ***(Skip to Question 91)***

87. ***(If yes)*** How did you hear about it? ***(Do NOT read list. Check all that apply.)***

❒ Friend ❒ Methadone Clinic ❒ Outreach Worker

❒ Street Nurse ❒ Needle Distribution Program ❒ Other: _____

❒ Refused to answer

88. Are you aware of the Narcan/naloxone Program in [name of city]?
❒ Yes ❒ No ❒ Refused to answer

89. Do you currently have a take-home Narcan/naloxone kit?
❒ Yes ***(Continue to next question)***
❒ No ***(Skip to Question 91)***
❒ Refused to answer ***(Skip to Question 91)***

90. ***(If yes)*** Where did you get it from? ***(Do NOT read list out. Check ALL that apply.)***
❒ Methadone Clinic ❒ Friend
❒ Other: _____ ❒ Refused to answer

91. If no, why not? ***(Do NOT read list out. Check ALL that apply.)***
❒ I don't know where to get one
❒ I don't feel comfortable using it
❒ I haven't picked up a new kit after using my previous one
❒ I don't think I need one
❒ I've never been offered one
❒ I don't use or hang out with people who use opiates
❒ I found the training hard to access
❒ Other: _____
❒ Refused to answer

92. Have you **ever** administered Narcan/naloxone to anyone?
❒ Yes
❒ No ***(Skip to Question 94)***
❒ Refused to answer ***(Skip to Question 94)***

93. If yes, how many times? ***(Do NOT read list out. Check ALL that apply.)***
❒ 1 or 2 ❒ 3 or 4 ❒ 5 or more ❒ Refused to answer

94. Have you **ever** overdosed by accident?
❒ Yes
❒ No ***(Skip to Question 115)***
❒ Refused to answer ***(Skip to Question 115)***

95. Have you overdosed in the ***last 6 months***?
❒ Yes ❒ No ❒ Refused to answer

96. Altogether, how many times have you overdosed **in your lifetime**?
Times: _____ ❒ Refused to answer

97. When was the **last time** you overdosed?

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

98. The **last time** you overdosed, do you remember which drugs or substances were involved? ***(READ OUT LIST. Check ALL that apply.)***

❒ Yes, I remember ❒ No, I don't remember (Skip to Question 100)

❒ Don't know/Unsure (Skip to Question 100) ❒ Refused to answer ***(Skip to Question 100)***

99. The **last time** you overdosed, which drugs or substances were involved? Did you inject them? ***(READ OUT LIST. Check ALL that apply.)***

	Involved in OD?		**Injected?**	
	Yes	**No**	**Yes**	**No**
Cocaine	❒	❒	❒	❒
Crack	❒	❒	❒	❒
Hydros (HydroMorph Contin or Dilaudid)	❒	❒	❒	❒
Heroin	❒	❒	❒	❒
Methadone	❒	❒	❒	❒
Suboxone	❒	❒	❒	❒
Morphine	❒	❒	❒	❒
Percocet	❒	❒	❒	❒
Wellbutrin	❒	❒	❒	❒
Oxycodone	❒	❒	❒	❒
Fentanyl	❒	❒	❒	❒
Ritalin or Biphentin	❒	❒	❒	❒
Benzodiazepines or Tranquilizers	❒	❒	❒	❒
Speedball	❒	❒	❒	❒
Amphetamines	❒	❒	❒	❒
Crystal Meth	❒	❒	❒	❒
Valium	❒	❒	❒	❒
Gabapentin	❒	❒	❒	❒
Alcohol	❒	❒	❒	❒
Pot	❒	❒	❒	❒
Other injection drugs	❒	❒	❒	❒
Other non-injection drugs	❒	❒	❒	❒

100. What reaction did you have to the drugs? ***(Read out list. Check all that apply.)***

- ❒ Lost consciousness
- ❒ Inability to talk
- ❒ Blue lips
- ❒ Overheating
- ❒ Seizure
- ❒ Elevated breathing
- ❒ Paranoia
- ❒ Irregular heartbeat (i.e., rapid, slow, had hard time breathing, palpitations)
- ❒ Stopped breathing, was given oxygen
- ❒ Other: _____
- ❒ Don't know/Unsure
- ❒ Refused to answer

101. Were other people with you?

- ❒ Yes
- ❒ No ***(Skip to Question 103)***
- ❒ Refused to answer ***(Skip to Question 103)***

102. If yes, who were they? ***(Read out list. Check all that apply.)***

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

103. What neighbourhood were you in when you **last** overdosed? ***(Do NOT read out list. Show NEIGHBOURHOODS prompt card. Check ONLY one.)***

104. Could you tell me the type of place where you overdosed? ***(Do NOT read list out. Check ONE only).***

- ❒ My own place
- ❒ Friend's place
- ❒ Dealer's place
- ❒ Public washroom
- ❒ Abandoned building
- ❒ Drop-in social service
- ❒ Refused to answer
- ❒ Partner's place (if different from my own)
- ❒ Relative's place
- ❒ Street (alley, doorway, under bridge, etc.)
- ❒ Shelter
- ❒ Jail
- ❒ Other: _____

105. Were you assisted by other people?

- ❒ Yes
- ❒ No ***(Skip to Question 107)***
- ❒ Refused to answer ***(Skip to Question 107)***

106. If yes, who? ***(Do NOT read out list. Check all that apply.)***

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

107. Was an ambulance called when you overdosed?

- ❒ Yes
- ❒ No ***(Skip to Q112)***
- ❒ Don't know/Unsure ***(Skip to Q112)***
- ❒ Refused to answer ***(Skip to Q112)***

108. After the ambulance was called, did the police show-up?

- ❒ Yes
- ❒ Don't know/Unsure
- ❒ No
- ❒ Refused to answer

109. Were you taken to an ER/hospital?

- ❒ Yes
- ❒ Don't know/Unsure
- ❒ No
- ❒ Refused to answer

110. Were you offered transport to the hospital but refused?

- ❒ Yes
- ❒ Don't know/Unsure ***(Skip to Q112)***
- ❒ No ***(Skip to Q112)***
- ❒ Refused to answer ***(Skip to Q112)***

111. If yes, why did you refuse? Reason: _____

112. Were you given Narcan/naloxone?

- ❒ Yes
- ❒ Don't know/Unsure ***(Skip to Q114)***
- ❒ No ***(Skip to Q114)***
- ❒ Refused to answer ***(Skip to Q114)***

113. If yes, who administered it? ***(Do NOT read out list. Check all that apply.)***

- ❒ Boyfriend/girlfriend/partner
- ❒ Casual sex partner
- ❒ Casual friend/acquaintance
- ❒ Family member
- ❒ Other: _____
- ❒ Refused to answer
- ❒ Stranger
- ❒ Close friend
- ❒ Date (sex worker)
- ❒ Ambulance or hospital employee
- ❒ Don't know/Unsure

114. Were you in any of the following in the **month** before you overdosed?
(Read out list. Check all that apply.)

- ❒ Methadone/Methadose program
- ❒ Suboxone program
- ❒ Daytox
- ❒ In-patient detox
- ❒ Residential treatment
- ❒ Drug counselling
- ❒ Self-help group (e.g., 12 steps, SMART)
- ❒ Inpatient hospital stay
- ❒ Prison/jail
- ❒ Other: _____
- ❒ Don't know/Unsure
- ❒ Refused to answer

115. Have you witnessed an overdose in the **last 6 months**?

- ❒ Yes
- ❒ No ***(Skip to Q 118)***
- ❒ Refused to answer ***(Skip to Q 118)***

116. Who were they? ***(Do NOT read out list. Check all that apply.)***

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

117. What happened in response to the overdose you witnessed? ***(Read out list. Check all that apply.)***

- ❒ I called 911
- ❒ Someone else helped
- ❒ Someone else called 911
- ❒ Ambulance came
- ❒ Person came to on their own
- ❒ I left
- ❒ I helped
- ❒ I gave naloxone
- ❒ Other person gave naloxone
- ❒ Other: _____
- ❒ Don't know/Unsure
- ❒ Refused to answer

118. Have you **ever** been afraid of being arrested when you or someone else overdosed?

❒ Yes ❒ No ❒ Refused to answer

READ: The next few questions I am going to ask you are about health problems related to your injection drug use.

119. In the **last 6 months** have you had any of the following health problems? If yes, did you receive treatment? ***(Read out list. Check 'Yes' or 'No'. For any health problems experienced, ask if they received treatment and check 'Yes' or 'No'. Show HEALTH PROBLEMS prompt card.)***

	No	Yes, but no treatment received	Yes, treatment received	Don't know/ Unsure	Refused
Abscess	❒	❒	❒	❒	❒
Liver problems	❒	❒	❒	❒	❒
Hepatitis infection	❒	❒	❒	❒	❒
Circulation problems (endocarditis, thrombosis)	❒	❒	❒	❒	❒
Blood infection (septicaemia)	❒	❒	❒	❒	❒
Injuries	❒	❒	❒	❒	❒
Lungs/bronchitis problem	❒	❒	❒	❒	❒
Stomach/gastrointestinal problems	❒	❒	❒	❒	❒
Cold/influenza	❒	❒	❒	❒	❒
Depression, psychosis, trauma	❒	❒	❒	❒	❒
Withdrawal symptoms	❒	❒	❒	❒	❒
Cellulitis	❒	❒	❒	❒	❒
Scarring/bruising	❒	❒	❒	❒	❒
Other: _____	❒	❒	❒	❒	❒

READ: The next few questions are about blood tests for HIV and Hep C. We are asking everyone the same questions. These questions are not about routine bloodwork that you may have had while undergoing treatment for your HIV or Hep C infection.

120. What was the result of your **last** HIV blood test? ***(Read out list. Check ONE only.)***

❒ I've never had a blood test for HIV
❒ Positive ***(Skip to Q122)***
❒ Negative
❒ I didn't go back for the results
❒ I am waiting for the results
❒ Other: _____
❒ Refused to answer

121. ***(If haven't received test),*** For what reasons have you not had an HIV blood test? ***(Read out list. Check ALL that apply.)***

❒ I'm not a t risk for HIV
❒ Getting tested is a hassle
❒ I'm afraid to find out I'm HIV positive
❒ I don't care to get tested
❒ I don't know where to get tested
❒ I've never been offered
❒ Other: _____
❒ Refused to answer

122. Are you **currently** accessing treatment for HIV?

❒ Yes ❒ No ❒ Refused to answer

123. What was the result of your **last** hepatitis C (Hep C) blood test? ***(Read out list. Check ONE only.)***

❒ I've never had a blood test for HIV
❒ Positive ***(Skip to Q 125)***
❒ Negative
❒ I didn't go back for the results
❒ I am waiting for the results
❒ Other: _____
❒ Refused to answer

124. ***(If haven't received test),*** For what reasons have you not had a Hep C blood test? ***(Read out list. Check ALL that apply.)***

❒ I'm not a t risk for Hep C
❒ Getting tested is a hassle
❒ I'm afraid to find out I'm Hep C positive
❒ I don't care to get tested
❒ I don't know where to get tested
❒ I've never been offered
❒ Other: _____
❒ Refused to answer

125. Are you **currently** accessing treatment for Hepatitis C?

❒ Yes ❒ No ❒ Refused to answer

SECTION 7. DRUG TREATMENT

READ: The next set of questions is about any drug treatment you have undertaken and attempts to seek any drug treatment.

126. Have you **ever** in your lifetime been in a drug treatment or detox program?

❒ Yes
❒ No ***(Skip to Q129)***
❒ Refused to answer ***(Skip to Q129)***

127. Have you in the **last 6 months** been in a drug treatment or detox program?

❒ Yes
❒ No ***(Skip to Q129)***
❒ Refused to answer ***(Skip to Q129)***

128. In the **last 6 months**, which treatment programs have you been in?
(Read out list. Check all that apply.)

- ❒ Detox program with methadone/suboxone
- ❒ Detox program with other prescribed drugs
- ❒ Detox program with no drugs
- ❒ Methadone maintenance program
- ❒ Out-patient counselling
- ❒ Self-help group for your drug use
- ❒ Drug treatment with cultural programming
- ❒ Residential treatment
- ❒ Drug court
- ❒ Healing lodge
- ❒ Case management for substance use
- ❒ Managed alcohol program
- ❒ Another drug treatment/detoxification program
- ❒ Other: _____
- ❒ Refused to answer

129. During the **last 6 months**, have you ever tried but been unable to get into any of the treatment programs?

- ❒ Yes
- ❒ No
- ❒ Refused to answer

END OF INTERVIEW

INTERVIEWER COMMENTS:

_____
_____
_____
_____
_____
_____
_____

Appendix D: Sample consent forms for feasibility study interviews

Note: The following form is a comprehensive document that includes information needed to acquire meaningful consent from potential SCS clients. Organizers of SCSs are encouraged to adapt the consent form according to their needs and specificities of the local PWID and drug scene. It is important to consult with your institutional ethics boards before implementing an informed consent procedure.

Participant Information and Consent Document

Study Title: *Supervised Consumption Services Feasibility Study:* [**name of city**]

Study site: ***[locations of data collection]***

Sponsor: ***[if relevant]***

Principal Investigator:

[Name]

[Title and contact info]

Co-Principal Investigators:

[Name]

[Title and contact info]

This consent form may contain words that you do not understand. Please ask the study coordinator, research associate or any member to review this document with you and discuss any information that you do not understand or would like to clarify.

INTRODUCTION

You are being invited to take part in this study because you have injected drugs in the past six months, are 18 years of age or older, and reside in ***[name of city]***.

Before agreeing to participate in this study, it is important that you read and understand this consent form. This form provides all the information we think you will need to know in order to decide whether you wish to participate in the study. Please ask the Research Coordinator, Research Associate or any member of the study team (listed above) to explain any words or information that you do not understand. If you have any questions after you read through this form, please ask the research assistant. Do not sign this form until you are sure you understand everything.

PURPOSE OF THE STUDY

The purpose of this study is to examine acceptability and feasibility of supervised consumption services in ***[name of city]*** from the perspective of people who inject drugs and other key community partners. This study will also explore willingness to use such services, in addition to identifying preferences and potential barriers to running such programs. This study will contribute to information that may be helpful in the future development of supervised consumption services into community health programs for people who inject drugs.

PROCEDURES

If you agree to take part in this study, you will complete a ***[length of time]*** survey where a trained interviewer will ask you questions about your living conditions, drug use behaviours, access and uptake of programs and services, health and treatment questions, as well as your willingness to use supervised consumption services and preferences for design. Please keep in mind that you are not required to answer any questions that may make you feel uncomfortable and you are welcome to stop the interview at any time.

SURVEY DELIVERY METHODS

[Describe method of data collection and data storage. Indicate how confidentiality, anonymity and security of information will be ensured] We will NOT attach your name to any of the information you provide.

COMPENSATION *[Optional but helpful]*

You will be compensated ***[amount]*** cash per interview for your time.

POTENTIAL BENEFITS

You should not expect any direct benefits from taking part in this study, however, the information gathered from the study on supervised consumption services may benefit people who inject drugs in the future.

POTENTIAL RISKS AND/OR DISCOMFORTS

Some of the questions are of a personal nature and may make you feel emotional or upset. You are not required to answer any questions that may make you feel uncomfortable and are welcome to stop the interview at any time without any penalty or effect on access to any type of medical, social support, or other type of services you currently receive or may receive in future. At the end of the interview, the interviewer can provide you with a list of places or people you can contact if you feel that you would like to speak to someone about how you are feeling.

PARTICIPATION AND/OR WITHDRAWAL

Your participation in this study is strictly voluntary. You are free to withdraw from the study at any time. You will not be treated any differently if you choose not to take part. Consenting or refusing to participate in the study will not impact or affect any care or service that you currently receive or plan to receive in the future. You also have the right NOT to answer any questions that make you feel uncomfortable.

The Principal Investigator and/or ***[ethics review board if relevant]*** are entitled to terminate the study at any time without your consent. If this is the case, you will be given a full explanation.

CONFIDENTIALITY

To ensure the highest possible standards of legal and ethical protection of study participants, confidentiality will be guaranteed to the limits of the law.

All information collected for the study will be kept strictly confidential.

The results from this research study may be published; however, your identity ***will not*** be revealed in the combined results.

[Describe in detail where the data will be stored and how it will be disposed of and when.]

FUNDING OF THIS RESEARCH PROGRAM *[If relevant]*

The study is funded by ***[name of funder]***.

CONTROL OF THE ETHICAL ASPECTS OF THE RESEARCH PROJECT

[Name of ethics review board and approval process, if relevant.]

WHO TO CONTACT

If you have any questions or concerns about the study or your rights as a participant, please contact the Study Coordinator, XXXXX, at xxx-xxx-xxxx

For questions about your rights as a participant contact:

[ethics review board]

OTHER CONTACT INFORMATION

If you have any questions concerning matters related to this research, you may contact

[Principal Investigator name and contact info]

On a separate page, include the following:

Participant Information and Consent Document

Signature Page

Please keep a copy of this document for your information throughout the study.

Consent

I understand and consent to the following terms of participation in the study described above:

1. I have read and understand the information and consent form above, and all of my questions have been answered.

2. I understand the information I provide will not identify me at any time, and that it will be entered into a computer program for analysis.

3. I understand that my decision to participate in this study is voluntary and that I may decide not to participate at any time. Consenting or refusing to participate in the study will not impact of affect any care or services that I currently receive of plan to receive in the future.

4. I have received a signed copy of this form to take home with me.

_____	_____	_____
Signature of Participant	Name (please print)	Date
_____	_____	_____
Signature of Person Conducting Informed Consent Interview	Name (please print)	Date

Appendix E. Feasibility study interview guide for key stakeholders

1. Do you believe that there is a problem with injection drug use in your community, and if so, what problems do you believe exist?

    - (Probes: What health problems have emerged? How have these impacted PWID? How has the broader community been affected?)

2. What are the factors that drive drug-related problems in your community?

3. What is currently being done to address injection drug use in your community?

    - (Probes: What's working? What's not working?)

4. What else do you feel should be done to address drug-related harms in your community?

5. Who should play a role in addressing drug-related harms in your community? (e.g. Are there specific key players, stakeholders, community members, etc.?)

6. Are you familiar with supervised consumption services?

    - **If yes**, please tell me what you know about SCSs?

    - **If no**, provide definition: "supervised consumption services are health facilities where people who inject drugs can inject their pre-obtained illegal drugs under the supervision or nurses or other health professionals. Users are provided with sterile equipment, given information on safer injecting, as well as emergency response in the event of an overdose, and are provided with referrals to external health and social services. While there are over 90 SCSs internationally, only two currently exist in Canada, both in the city of Vancouver"

7. Are you familiar with the Vancouver SCSs (Insite/Dr. Peter Centre)? If so, can you tell me what you know about them?

8. What do you know about the benefits of SCSs?

9. What do you know about the negative effects of SCSs?

10. Do you think SCSs have a role to play in your community? If so, why, if not why?

11. What do you think might be the potential benefits of SCSs in your community?

    - (Probe for individual, organizational, and community-level benefits)

12. What do you think might be the negative consequences of a SCS in your community?

    - (Probe for individual, organizational, and community-level negative effects)

13. If you support the creation of a SCS in your community, where do you think SCS facilities should be located? How many SCSs are needed?

14. For what hours do you think it should operate?

15. Do you think SCSs will be accepted and used by local people who inject drugs?

    - If yes/no, please explain?

16. Do you think SCSs will be accepted by the broader community?

    - If yes/no, please explain?

17. If you support the idea of having a SCS locally, who do you think should be involved in establishing a SCS in your community?

18. What other programs or services would need to be in place to help ensure the effectiveness of SCSs?

19. Do you have any remaining concerns about the establishment of SCSs in your community?

20. If a research study of SCS was done in your community, what would you like the research to focus on? (e.g., a pilot project)

21. Do you have any other thoughts or concerns about SCSs that you would like to share?

22. Do you have any other thoughts or concerns about injection drug use in general that you would like to share?

23. What is the best way to gain feedback from you and your organization/ program/service? (e.g., Public forum? Private meeting? Presentation and roundtable discussion? Online survey?)

Thank you.

Appendix F. Ancillary Services

- Safe injection supplies, such as syringes, needles and other drug paraphernalia[7]
- Health education, including harm reduction strategies for drug-use
- Drug-use related medical care (e.g., wound care, vein care, abscess management)
- Primary care (e.g., immunization, STI screening, screening for other communicable diseases such as HIV and viral hepatitis C)
- Naloxone provision and training
- Residential services (e.g., overnight shelters, residential nursing care)
- Chronic illness management
- Psychosocial treatment interventions (i.e., cognitive behavioural therapy)
- Counsellors/social workers
- Mental health care
- Women's health services
- Off-site outreach program
- Drug treatment programs (e.g., medically managed withdrawal management, opioid agonist treatment)
- Employment programs
- Peer support programs
- Recreational activities
- Meals, snacks, coffee/tea
- Possibility to use phone/Internet
- Shower, laundry
- Lockers, postal addresses
- Overnight shelter and other low-threshold housing
- Support recovery housing

(Adapted from EMCDDA, 2016)

7. SCSs often quickly become the busiest needle distribution points wherever they are located, potentially leading to other needle distribution programs closing. Organizers of SCSs should be prepared for a large demand for needle distribution services

Appendix G. Example of fixed stand-alone facility – Insite

Insite is located on Hastings Street in the heart of Vancouver's Downtown Eastside neighbourhood. More than one-third of Vancouver's estimated 12,000 injection drug users live in the Downtown Eastside (Health Canada, 2008). PWID in this area face multiple and complex challenges, including homelessness, poverty, unemployment, mental health concerns, and violence. Insite opened its doors in 2003 as a pilot project and the first SCS in Canada. Insite's clients are more likely to be younger, homeless or precariously housed and are more likely to inject drugs in public, to inject drugs daily and to have recently had a non-fatal overdose—in other words, Insite has been successful in engaging high-risk PWID in harm reduction services through SCSs (Wood et al., 2005).

Insite's staff consists of front line team of nurses, counsellors, mental health workers, and peer support workers. There are 13 injection booths in Insite. Clients inject illegal drugs that they have obtained prior to entering the facility and they inject the drugs under the supervision of nurses and health care staff, who provide safer injecting education and emergency response in the event of an overdose. Insite also provides clean injection equipment, such as syringes, cookers, filters, water and tourniquets. Nurses at Insite also provide other health care services, such as wound care and immunizations.

Insite by itself is a stand-alone facility, but it is part of a network of services in the immediate geographical area. In particular, Insite exists in the same building as Onsite, which is a withdrawal management facility consisting of 12 rooms with private bathrooms. When Insite clients are ready to access withdrawal management, they can often be immediately accommodated at Onsite. Insite is also part of a referral network that consists of two community health centres, a hospital, rehabilitation centre, assertive community treatment (ACT), methadone maintenance programs, and support services for women.

During a 12-month period from 2004 to 2005, over 4,700 individuals registered at Insite and over 2,000 referrals were made, with over one third of referrals for substance use counselling (Tyndall et al., 2005). More recently, over 10,000 unique individuals have registered to use Insite, and the average number of daily visits ranges between 600-1000 (VCH internal data). Over a 13-month period in the same years, 336 overdoses were reported at the facility, none of which were fatal (Kerr et al., 2006). For more research and evaluation on Insite, please visit the Urban Health Research Initiative's website at http://uhri.cfenet.ubc.ca/content/view/57/92/#SEOSI.

Appendix H. Example of integrated facility – Dr. Peter Centre

Since 1997, the Dr. Peter AIDS Foundation has operated the Dr. Peter Centre (DPC). Located in Vancouver's West End, the DPC provides care and support to people living with HIV and coping with significant health and social issues, including: mental health conditions, trauma, substance use, viral hepatitis C, physical disabilities, poverty, and homelessness. Annually, the DPC supports more than 400 people to sustain daily HIV and other treatments to improve health outcomes and quality of life. The DPC's three programs are: day health program, 24-hour licensed nursing care residence, and enhanced supportive housing.

Across its three programs, the DPC provides a range of services that includes access to advanced nursing care, which includes support for adherence to antiretroviral therapy and other medication, including methadone and suboxone, as well as counselling, art, music and recreation therapy, nutrient-dense meals, and a safe place for social engagement and peer interaction. The DPC has always had a broad harm reduction program, including teaching and counselling, as well as provision of sterile needles and other injection equipment, condoms, and other harm reduction supplies. In 2002, supervised consumption service was integrated into nursing care in the day health program and residence, in order to prevent illness and promote health.

The day health program is open 9am-3pm, seven days a week, and provides for over 350 registered clients at a time, with 150 accessing the program on any one day. There is a specifically designated room in which nurse-supervised injection is provided. The space is located adjacent to the nursing area, and is equipped with three open stalls, a foot bath, seating area for a nurse, injection equipment, and call bells in the event of an emergency. Approximately 20% of the DPC clients use the service, totaling approximately 2,500 supervised injections per year.

The Dr. Peter 24-hour Specialized Care Residence, which is a licensed care facility, provides stabilization care, sub-acute care, long-stay, and palliative care. Each resident has a private room and bathroom. Supervised consumption service is provided in the resident's room, as is all other care (e.g., personal care and wound care).

A registered nurse/registered psychiatric nurse supervises injections in both programs. Pre- and post-injection support is provided by other clinical team members when needed. There are specific policies, procedures, and protocols for nursing, as well as other staff in the organization for these services (i.e., nursing, other clinical team members, administration, facilities management, etc.).

Appendix I. Examples of embedded facilities – Frankfurt and Luxemburg

Frankfurt: Embedded in housing environment

The "Eastside" facility in Frankfurt's industrial district opened in the early 1990s as the first SCS in the city. It is now the largest rehabilitation centre and support program hub for PWID in Europe (Deutsche Welle, 2008). The facility offers eight injection spaces (Köthner et al., 2011), beds for 80-100 PWID (Duff, 2016), medical care, opioid agonist treatment, counselling, café, needle distribution, laundry and shower (Broadhead et al., 2002). The residents of the facility are tasked to maintain the facility's premises, including the garden (IDH, n.d.). The facility also offers a work and training program, where clients learn skills and apply them to participate in the community. For example, the facility offers a workshop where clients can learn carpentry and then help restore and replace park benches in Frankfurt (Duff, 2016).

Luxemburg: Embedded in housing environment

Luxembourg's "Abrigado" is a low-threshold centre that offers seven injection spaces, 42 beds, a nursery and a drop-in centre with primary care. The facility also offers HIV and viral hepatitis C testing, as well as needle distribution programs and harm reduction counselling. The facility sees an average of 96 people who use drugs per day. The facility is staffed by an interdisciplinary staff, consisting of medical staff, psychologists, social workers and educators (Schatz and Nougier, 2012).

Paris: Embedded in hospital

The first in-hospital facility in the world opened in Paris' Lariboisière Hospital in October 2016, after much controversy and political resistance (BBC News, 2016). The hospital is located near a busy train station where there is a high rate of drug-related crime. The facility is inside the hospital but has a separate entrance and anticipates approximately 300-400 clients per day (Fox, 2016). The facility consists of a waiting room, a consumption room and a resting area after drug consumption (UNAIDS, 2016). There are twelve spaces for injection and an inhalation room and the facility will be led by a team of doctors, nurses, social workers and security personnel (Fox, 2016).

Appendix J. Example of mobile outreach facility – Berlin

Berlin is one of a handful of cities in the world that offers mobile outreach SCSs. There are estimated 10,000 PWID in Berlin (Senatsverwaltung für Gesundheit, 2008). Rather than being concentrated in a particular area, there are a number of well-established drug scenes in the city, where drug dealing and public consumption take place. Berlin has two fixed-site facilities and are supplemented by a mobile SCS. The mobile SCS program has two vans that are parked at two fixed locations in the city during operating hours (from 2:00PM – 6:00PM Mondays, Fridays and Saturdays).

There are three injecting booths in the van. The vans are staffed by two nurses, with the support of one or two social workers. The staff offer harm reduction services (i.e., needle and syringe distribution), naloxone hydrochloride, assistance in locating veins, blood borne virus testing and referral to other services, including counselling. On a typical busy day, the mobile facility serves 20-30 injections per day. In 2010, the vans accommodated 4,082 drug consumption visits in total, averaging at 11 injections per day (Deitz et al., 2012).

Appendix K. Overarching principles when working with First Nations and Indigenous peoples

- Recognize that culture, traditions, and language are the foundation to healthy individuals, families, and communities.
- Support approaches that ensure First Nations and Indigenous people receive safe and effective care from health providers.
- Find ways to address travel and funding blocks that make it hard for First Nations and Indigenous people to access and reach substance use programs and services.
- Build and strengthen capacity among First Nations and Indigenous communities.
- Make sure that services and programs are kept local, where possible.
- Support broad, collaborative multi-system approaches that consider social and economic determinants of health.
- Build and strengthen partnerships among First Nations and Indigenous communities, the regional, provincial, and federal systems and non-governmental organizations, including improved coordination and leveraging of innovations and resources.
- Make sure that health and human service providers work in a manner that is culturally safe and respects individual customs, values, and beliefs.
- Recognize that the social determinants of health have a key role in mental wellness and empower communities and leadership to address these determinants through inter-sectoral collaboration and action.
- Encourage approaches that are based in and build on individual, family, community, and cultural strengths.
- Reduce stigma against First Nations and Indigenous people who have substance use issues.
- Recognize that responses to addiction and substance use can be gender specific. This includes both men and women, trans-gendered, lesbian, gay, bisexual and two-spirited, queer, and questioning individuals. Programs and supports may need to be modified to support this population.

(Adapted from the BC First Nations and Aboriginal People's Mental Wellness and Substance Use – 10 Year Plan)

Appendix L. Insite's overdose protocol

The registered nurse will be informed of any participant demonstrating signs and symptoms of overdose or drug toxicity. Signs and symptoms of overdose or drug toxicity include:

- Being awake, but unable to talk
- Passing out
- Body very limp
- Face pale or blue, or face that is flushed
- Breathing is slow and/or is shallow, erratic or has stopped
- Complaint of pressure or tightness to chest
- Foaming at the mouth
- Shaking or seizures
- Choking sounds or gurgling noise
- Throwing up
- Skin that is sweaty and hot or cold and clammy
- Complaint of hallucinations or confusion

In this situation, Insite staff will:

- Remain calm
- Attempt to wake up participant
- Shake and talk to participant
- Squeeze participant earlobes
- Get participant to open eyes
- Get participant to talk
- If responsive, assist to walk around
- If above steps are unsuccessful, initiate the Overdose Protocol (please see next page)

Overdose Protocol

Stage	1. "Drowsy"	2. "Nodding"	3. "Unresponsive"
Assessment	• RR >10-12/min • SaO2 >90% on RA* • Glasgow Coma Scale (GCS) 14 to 15	• Spontaneous respirations <10-12/min • SaO2 81% to 90% on RA* • Glasgow Coma Scale (GCS) 10 to 13	• Apneic – no spontaneous respirations or gasping • SaO2 80% or lower on RA* • Glasgow Coma Scale (GCS) <10 • **Call 911 if GCS is 8 or lower**
Management	• Observe according to agency policy/ability • If no improvement or if respiratory rate or mental status worsens proceed to Stage 2 or 3	• Apply O2 mask according to agency policy/availability • Administer naloxone 0.4mg to 0.8mg IM or SC • Repeat dose of 0.4mg every 3-5 min up to a maximum of 2-5 mg and until RR > 10-12/min • Monitor respiratory rate every 5 min for 15 min then every 10 min • Observe for two hours if able. Alternately send to hospital for observation. • If SaO2 decreases to less than 80%, patient appears cyanotic or if respiratory rate or mental status worsens proceed to Stage 3 or refer to hospital.	• Provide cardio respiratory support according to Adult Basic Life Support protocols. If available, bag-valve mask attached to supplemental O2 should be administered prior to and during naloxone administration to reduce the chance of acute lung injury • Administer naloxone 0.4mg to 0.8mg IM or SC. Apneic patients should receive an initial dose of at least 0.8mg naloxone. Repeat dose of 0.4mg every 3-5 min up to a maximum of 2-5 mg and until RR > 10-12/min. Patients in cardio-respiratory arrest following suspected opioid overdose should be given a minimum of 1.6mg of naloxone • Observe for two hours if able. Alternately send to hospital for observation. • If respiratory rate or mental status does not improve refer to hospital.
Call 911?	No	Yes	Yes

*If pulse oximetry is not available, cyanosis is a clinical sign of hypoxia. Under optimal lighting conditions and in a patient who has normal hemoglobin level and no dark skin pigmentation, frank cyanosis corresponds to a SaO2 of about 66%.

Appendix M. Insite's code of conduct/house rules

Rights

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

Responsibilities

- To respect others while on site.
- To help create and maintain a safe place.
- To not cause physical harm to other participants or staff.
- To use the site for self-administration only; no "doctoring."
- To not deal, exchange, share or pass drugs to anyone else on-site.
- To not use alcohol, smoke or ingest drugs other than by injection while on-site.
- To reduce harm by not sharing rigs or equipment, disposing of used supplies in the sharps container, and not walking around with uncapped rigs.
- To not display weapons or money on-site.
- To not bring outside conflicts into the site.
- To not engage in solicitation of any kind on site.
- To respect the property and privacy of others in the site.
- To follow the reasonable directions of Insite staff.
- To bring concerns or complaints to the attention of Manager or RPIC.[8]

8. RPIC, or Responsible Person In Charge, is a staff member who is responsible for ensuring that the SCS's operation complies with the applicable Health Canada requirements.

Appendix N. Insite's user agreement form

*In*site

139 E. Hastings St.
Vancouver, BC CANADA

User Agreement, Release and Consent Form

Prior to using the Vancouver Supervised Injection Site ("*in***site**") facility, I agree to the following:

- I have injected drugs in the past and I am in this facility for the purpose of using injection drugs, and I intend to inject them regardless of any risks to my health or the health of my unborn baby, if I am pregnant.
- I will follow the direction of *in***site** staff and the *in***site** Code of Conduct.
- I will remain in possession of my own drugs for injection at all times.
- I authorize *in***site** staff to provide emergency medical services if necessary.
- I am aware of the harmful effects of drug use and accept full responsibility for all risks to myself, including my death, and on behalf of myself and my heirs, hereby release *in***site** and the Vancouver Coastal Health Authority and its employees, partners and agents from any and all liability for any loss, injury or damage I may suffer as a result of my use of this facility.

I understand the above and am able to give consent.

Name: _____ (must include first & last initials)

Date of Birth: _____

*in***site** staff: _____

Date: _____

*in***site** staff use (for statistical information only)

Gender: _____

Ethnicity: _____

Neighbourhood: _____ (1st 3 letters of postal code)

Identifier: _____ (1st & last initial & DOB)

First-time drug users

Background: Drug users who may be transitioning into injection drug use present both a potential opportunity to provide them appropriate harm reduction information, while at the same time may represent an opportunity to deter them from initiating a potentially high risk behaviour. In most circumstances these would be alienated, vulnerable youth who may be at a crossroads between increasingly high-risk behaviours (Roy et al., 2003) and an opportunity to transition away from a streetentrenched lifestyle. It would be rare for a participant to present to the facility as a firsttime user.

Protocol: Access is granted to the SCS after RN and program staff member assessment. Potential firsttime users may be deterred from transitioning to injection drug use. However, participants who are willing to present themselves to the SCS as a first-time user may have already made the decision to begin injection drug use, and would not be denied the benefits of SCS harm reduction services. For these participants, the negative health consequences of denial of access would be potentially mitigated. Participants who have never used injection drugs are not denied access, but are immediately referred to the senior RN and senior PHS staff on duty after the intake assessment. A concerted attempt to prevent transition to injection drug use would include drug prevention and counseling strategies and appropriate referrals. In the event that firsttime participants are determined to begin injecting drugs in the SCS, they will be granted access to the Injection Room.

Pregnant users

Background: There are inherent risks to both the mother and fetus associated with the lifestyle of injection drug use. Pregnant users are both shamed by their use (Livingston et al., 2012) and traumatized by the harm that they may be causing to their fetus, making them less likely to access health care services. However, this subgroup of users may be amenable to interventions to reduce harm, or even access treatment services if lowthreshold services are provided. By engaging these participants in the SCS, it may be possible to assist them in moving towards safer drugusing behaviours or recovery and prenatal care services. Denying access to pregnant women is unlikely to result in their abstinence from drug injection.

Protocol: Access will be granted following an assessment by the RN and program staff member. Staff will make all possible attempts to discreetly and respectfully identify pregnant participants, provide them with education about the risks associated with injection drug use during pregnancy and offer them access to appropriate medical and social services.

Youth

Background: Youth represent the highest risk group for contracting viral hepatitis C and HIV through injection drug use. Research has shown that younger injection drug users engage in high-risk behaviours to a greater extent than established users, including sharing needles and other drug equipment, engaging in sex trade work and using condoms inconsistently, increasing their vulnerability to blood-borne disease. There is real potential to reduce the harm associated with ongoing injection drug use in this group, given the rapid acquisition of viral hepatitis C and HIV infection following initiation into use of intravenous drugs and their increased risk of drug overdose due to their relative inexperience with injection drugs.

Protocols: Persons aged 16 and over who meet the assessment criteria can access a supervised consumption site. Access is not granted to youth under the age of 19 who are obvious first-time users, do not have a history of injection drug use, and who do not meet the assessment criteria. Supervised injection facilities are generally seen as an intensive intervention along the continuum of harm reduction services for an extremely

marginalized population. Youth who do not have a history of injection drug use should access resources that can more appropriately address their level of need.

Youth under the age of 19 will access the supervised consumption site only when the youth shows obvious signs of substance use with injectable drugs. When a youth presents at the supervised consumption site, the senior RN and senior PHS staff. The RN performs an assessment using the following criteria:

- The assessment determines that the youth has a history of injection drug use and has previously bought injectable narcotics with the intention of self-use; and
- The assessment provides appropriate and expedited referrals to primary health care and/or addiction medicine specialists, shelter and/or mental health services as indicated by information gathered, demonstrated symptoms, and/or desire to access appropriate care for substance use.

For those youth under the age of 19 who request access to the supervised consumption site but do not meet the above criteria, as well as those youth under 19 who are at immediate risk other than that associated with their substance use with injectable drugs, the RPIC[9] collects as much information on the youth as possible, and makes a report to the Ministry of Children and Family Development as appropriate.

Non-self-injectors

Background: There are many injection drug users who are unable to injection themselves and rely on others to perform this challenging procedure. Some have never learned how to inject themselves. Others cannot because of a physical disability such as blindness or paraplegia. This is an important population to engage as research has demonstrated a significantly heightened risk for HIV infection associated with this practice. This issue is one rife with power issues and most often it is women that rely on a man to inject them. Often, on the street, this service is provided in exchange for money, drugs or sexual favours. Only selfinjection is permitted in Insite. No staff person, nor participant may administer an injection.

Protocol: Non-selfinjectors will be identified to a nurse on duty. The nurse will assess whether the barrier to selfinjection is education or a physical disability.

1. If the barrier is education, the nurse will attempt to provide education to support the participant to selfinject in a safer manner.
2. If the barrier is physical disability, the nurse will determine whether any physical supports, not directly related to the provision of the injection, might assist in selfinjection.
3. If education or physical assistance do not result in self-injection, the participant will be respectfully asked to seek assistance elsewhere.

All efforts will be made to connect non-selfinjectors with safe support including treatment services for substance use.

Overtly intoxicated individuals

Background: Intoxicated persons present unique problems due to the likelihood of even higher risk than usual of needlesharing, fatal overdose, assault or otherwise unsafely injecting if they are denied access to clean equipment and a safe location with on-site supervision. However, allowing intoxicated individuals to inject

9. RPIC, or Responsible Person In Charge, is a staff member who is responsible for ensuring that the SCS facility's operation complies with the applicable Health Canada requirements

when they are clearly at greater risk for overdose also presents certain problems.

Protocol: Access is granted to the SCS after a RPIC assessment. Having an overtly intoxicated individual access SCS may increase the likelihood of the individual overdosing on site. However, the likelihood of a positive outcome after this episode is greater than if it occurred outside the SCS. Staff will identify those participants who are overtly intoxicated and provide them with education about the risks associated with injection drug use at this time. The client will be discouraged from using the injection room and encouraged to proceed to the ChillOut Lounge for some food or drink, or to walk around outside the SCS before considering injecting again. Access to the injection room would be granted by the RPIC only if convinced that the participant would likely inject drugs outside the SCS if denied access.

(Adapted from Insite's Policy and Procedure Manual, 2016)

Appendix P. Insite's protocols for refusal of service

Insite's policy is to remain as accessible as possible to all users all the time. However, there are a few circumstances in which the staff may refuse someone entry to the site.

- Individuals may be politely denied admittance to Insite if:
- They refuse to sign a waiver or to give reception their SCS code
- They have a medical condition which needs emergency attention
- They have no intention of injecting drugs on the premises
- They have a child with them
- They are under 16 years of age
- They are currently on the temporarily prohibited list
- The site is full

Insite has three levels of prohibited access to the site:

1. Prohibited from using the site for the rest of the shift/day if:

- Client exhibits behaviour that is extremely difficult to control or refuses to follow staff direction

2. Prohibited from using the site for 24 hours, and access again only after speaking

with RPIC[10] if:

- Client makes threats or engages in violence directed against staff or other clients
- Client deals drugs on site

3. Prohibited from using the site for a period over 24 hours, and access again only after conferring with staff and arranging a meeting with two RPIC if:

- Client repeats or engages in serious threats or violence
- Client incurs two prohibitions requested by staff (via email to explain the incident in more detail than the alert flag note) and set by RPICs

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

- Uttering threats of violence or carrying out violence against anyone on the premises
- Attempting to deal, purchase or share drugs on the premises

Periods of prohibition of more than one day will be set by a RPIC member if they determine that the circumstances are severe enough to warrant it.

10. RPIC, or Responsible Person In Charge, is a staff member who is responsible for ensuring that the SCS's operation complies with the applicable Health Canada requirements.

Documentation of Prohibition:

- Staff must communicate with a RPIC as soon as a prohibition occurs
- The RPIC is responsible for making the decision to place a person on 2 RPIC prohibition
- after a review of the documented events
- The prohibition list will be kept current at the Reception desk. Reason for refusal will be clearly documented
- If a prohibited participant engages in the Vancouver Coastal Health Complaint Management process, the Refusal protocols set out here will always take precedence

Readmission after being prohibited from using the site:

Barred clients must meet with a RPIC. They will be readmitted after RPIC is assured that the behaviour will not continue.

(Adapted from Insite's Policy and Procedure Manual, 2016)

Appendix Q. Insite's protocols for crisis management

All SCS staff should be trained in crisis management. However, the Counselor/Support Worker should have special training in de-escalation approaches and she/he should be prepared to act as a crisis management consultant for SCS staff. The Counselor should also have knowledge of staff defusing and critical incident stress management interventions.

Definitions

- A crisis occurs when unusual stress brought about by unexpected and disruptive events render an individual either physically or emotionally disabled because his/her usual coping mechanisms prove ineffective.
- Crisis intervention is the timely and effective involvement in people's lives when stress is too great for them to manage through their usual coping mechanisms.
- The goal of crisis intervention is to assist the person in crisis to return to their pre-crisis levels of behaviour.

Characteristics of Crisis Intervention

- Immediacy - early intervention to relieve anxiety, prevent further disorientation and to prevent the person in crisis harming themselves or others.
- Proximity - intervention is carried out within physical proximity of the crisis.
- Expectancy - both the person in distress and the interventionist have the expectation that the intervention will be directed towards the goal of symptom reduction, not cure.
- Simplicity - relatively concrete intervention strategies that avoid complex psychotherapy-oriented tactics.
- Brevity - the intervention is short.

Assessment

Crisis assessment continues throughout the crisis intervention process. Initial assessment involves gaining as much information as possible about the crisis scene and the participant. The SCS intervener collects information from a variety of sources, including from records, from the person in crisis, and from others in the vicinity of the crisis. The initial assessment should focus on the present crisis and on the events that precipitated the crisis. The SCS intervener should focus on two key evaluations, level of danger and the participant in crisis.

Questions to evaluate level of danger:

- Is the surrounding safe and secure for me and for the participant?
- How may I best protect my own safety?
- Is there danger to the participant or others in the immediate area?
- Is the participant suicidal or homicidal?
- Are there weapons or potential weapons available to the participant?

Questions to evaluate the participant in crisis:

- Is the participant oriented to time, place and person?
- What is the participant's affective state, e.g., flat, lethargic, hostile or agitated?
- Can a medical condition, e.g. diabetes, head injury, or overdose, explain the participant's behaviour?
- Is the participant intoxicated?
- Is the participant psychotic?
- What is the participant's range and intensity of emotions?

Control

The SCS intervener supplies needed structure until the participant is able to regain control. The degree of control and direction supplied by the intervener depends on the dangerousness of the situation and on the ability of the participant to act on their own behalf.

Guidelines for taking control:

- Be clear about what and whom you are trying to control.
- Enter the crisis scene cautiously.
- Appear stable, supportive and able to establish structure.
- Be clear in your introductory statements. The opening questions, directions and other information you give the participant will often assist in gaining and maintaining control.
- Do not promise anything that you cannot make happen.
- Direct and arrange the pattern of sitting or standing to gain the participant's attention.
- Guide the participant with your eyes and voice rather than with physical force.
- Use physical force only as a last resort, and only if you are trained to use it.
- Remove the participant from the crisis situation if possible. Otherwise, remove the crisis from the participant!
- In a conflict between participants, break eye contact between the disputants and separate if possible.
- Be creative in taking control.
- Allow the participant to express his/her emotions and point of view.
- Be collaborative, when effecting control, ensure that the person feels involved in the decision making process.

Direction

Once the intervener and participant have collaboratively established control, it is possible to act to resolve the crisis. Examine possible solutions. However, before solutions can be explored, the SCS intervener must carry out further assessment to discover precipitating events in order to set the stage for crisis resolution.

Questions that might be asked include:

- Why is the participant in crisis now?
- What is troubling the participant now?
- What factors should be dealt with now and what factors can be dealt with later on in the intervention?
- What resources are available to the intervener and to the participant?
- What coping strategies has the participant used in the past? How successfully were they used?

Could one of these strategies or resources be used now? A successful intervention plan must be practical, immediate, flexible, simple, well organized and be created in cooperation with the person in crisis. The intervener should note the participant's strengths and present the crisis to the participant as a temporary situation.

Referral and Disposition

This is the closing stage of the crisis intervention process. The SCS will have a list of resources to which participants can be referred for further intervention. Referral making can be part of the solution-focused planning of the direction stage. It is an essential part of the closing stage where the intervener ensures that the participant will be able to take care of him/herself- or that some-one else will provide assistance. Some participants may not be receptive to crisis intervention, and when a participant's behaviour indicates she/he poses a safety risk to themselves or to others, SCS staff must arrange immediate disposition to 911 emergency services.

Behavioural and Communication Skills

Basic traits or skills used in counselling, empathy, warmth and genuineness, are important in crisis management. Developing trust and rapport with the participant is essential in bringing control to the situation. The intervener should remain calm and sincere throughout the intervention. The intervener must use clear and direct language. The intervener must be an active listener and an empathic responder. Crisis is in the eye of the beholder, and the intervener must convey to the participant that he/she understands what the situation looks like from the participant's perspective.

Staff Follow-Up Subsequent to a Critical Incident - Informal Debriefing

Immediately following a critical incident, all staff involved in the incident should participate in an informal debriefing. The objectives of the debriefing are as follows:

- Make sure everyone is OK physically and mentally.
- Discuss what went well as a team in handling the participant's behaviour.
- Discuss what needs to be changed in handling future critical incidents.
- Set up a time for a defusing session if needed.

Defusing Session

A defusing session is a meeting organized to investigate/review a critical incident in more depth. The defusing session is useful when conducted as close as possible to the time of the critical incident, and when all the staff

who were involved in the incident are present. However, a defusing session can be done at any time and not all of the staff involved need to be present.

The objectives of the session are to:

- Identify possible/actual precipitating factors.
- Identify possible/actual factors related to practice, physical layout, etc., that may have contributed to the crisis.
- Assist staff to evaluate the part played by their own behaviours and attitudes in the contributing to or handling the crisis.
- Assist staff to gain confidence in preventing, de-escalating and resolving crises.

Critical Incident Stress Debriefing (CISD)

CISD refers to a specific model of psychological debriefing. The CISD is designed to achieve the goal of psychological closure following a critical incident or traumatic event. It usually entails a multi-phase series of groups aimed at psychological and behavioural re-building in the wake of the critical incident. Trained personnel conduct CISD. If informal debriefing and/or defusing interventions are insufficient to meet the needs of the SCS staff subsequent to a critical incident, arrangements should be made to access CISD resources provided by Vancouver Coastal Health.

Appendix R. Insite's protocols for the management of escalating aggressive behaviours

Assessment for Potential Aggression

1. Assess the participant's potential for aggression on admission using the risk indicators outlined below. Assessment information may also be obtained from other professionals, relatives, friends and/or the participant.
2. Assess own personal self-awareness as to thoughts, attitudes, feelings and actions towards people who are aggressive or have the potential to be
3. Assess environment for overall activity, e.g., a highly active, crowded or loud environment may stimulate or exacerbate behaviour.

Risk Factors:

- Previous history of aggression (this is the #1 predictor of aggressive behaviour)
- Chemical dependency (either in an intoxication or withdrawal state)
- Psychological factors, poor mental health:
- Poor problem solving skills
- Inability to cope with stress on a day to day basis
- Cognitive impairment
- Psychosis
- Delirium/dementia
- Lack of inhibition
- Labile mood
- Suicide intent, plan, thoughts or history
- Psychological factors, poor physical health
- Hypoxia
- Electrolyte imbalance
- Head injury
- Sensory impairment
- Sepsis
- Loss/grief
- Loss of central love interest, family member
- Loss of housing
- Loss of income
- Loss of health
- Feelings of powerlessness, anger, fear and failure

- Socio-economic indicators
- Low-income households
- High residential mobility
- Marital status (single)
- Demographic indicators
- Age (20-40 years)
- Gender (male)

Management of Observable Behaviours

Aggression Based in Moderate to Severe Anxiety:

Mild anxiety is not necessarily negative; it can help with motivation, heighten awareness, and can stimulate problem solving. However, moderate to severe anxiety can cripple our ability to perceive, think and conceptualize - in other words, our ability to cope with the situation that faces us. Moderate to severe anxiety can be a contributing factor to aggressive behaviour. Aggressive behaviour may be a coping response to a sense of loss of control. De-escalation response should address anxiety as the root cause of aggression.

Moderate to Severe Anxiety Behaviours:

- Eye contact - loss of soft focus eye contact/avoidance, blank stare, rolling eyes, excessive blinking, eyebrow movement, smiling, frowning.
- Verbal contact - talkative, quiet, laughing, crying, joking, talking faster.
- Physical - rocking, restless, pacing, sitting very still, a need for more personal space, holding their breath.
- Hands - wringing hands, drumming fingers, opening and closing hands.
- Others - asking lots of information seeking questions in an attempt to regain a sense of control (and a general dissatisfaction with answers to these questions), very poor short term memory, procrastination.

Staff Response to Moderate to Severe Anxiety:

- A caring, respectful response to anxiety behaviour generally provides adequate support to lower the anxiety level and prevent escalation to anger and other aggressive behaviours in 95% of the population.

Staff Intervention to Moderate to Severe Anxiety:

- Be respectful of the participant's belongings and personal space (do not touch the participant without their permission).
- Actively listen to the participant, to have an understanding from their point of view and what is driving the behaviour.
- Answer questions to give the participant back a sense of control and reassurance.

- If you cannot answer their question, find out the answer, direct them to who may be able to answer their question, or explain to them it is a question to which there is no answer (do not ignore the question or need).
- Focus on what you can do for the participant and how it will benefit them, not what you cannot do (e.g., "How can I help?").
- Assist the participant to verbalize feelings in their own words, avoid using leading questions.
- Re-direct participant's energy into safe activities.

Verbal Aggression:

As verbal aggression escalates from the lowest to highest,

1. Challenging behaviours;
2. Refusing behaviours;
3. Loud behaviours; and
4. Threatening behaviours.

The person acting out will lose rational control and the ability to process information and think clearly. Eye contact will become focused and intensify as the level of verbal aggression escalates. Personal space will shrink and the acting out person will move closer to you, crowding your personal space.

1. Challenging Behaviour (First Level of Verbal Aggression)

- Relentless questions, with no satisfaction with the answers to these questions or they really do not care what the answer is
- Garden variety questions, which are questions that have nothing to do with the issue at hand but used as a distraction
- Rhetorical questions which are a form of distraction
- Demanding/instant gratification.
- No respect for rules or regulations - challenge and test staff.

If this line of questioning continues, it would become very personal and the individual would challenge you on your credibility, skill or knowledge. They are not satisfied with the answers that you give and this behaviour usually turns out to be a refusal in disguise that is the next level of verbal aggression.

Staff Response to Challenging Behaviour:

Staff have to acknowledge that the person has escalated from the information seeking questions of anxiety to the challenging questioning of the first level of verbal aggression. This acknowledgement is key for staff to match their response to the level of verbal aggression.

Staff Intervention to Challenging Behaviours:

- Do not argue; focus on a common goal.
- Redirect them back to the issue at hand.
- Ask them a question to distract them (e.g., "Can I ask you something?").

- Give a positive directive that will assist them in getting their needs met.
- Give the individual reasonable choices or consequences - positive first, and a specified time to decide.
- Use time and space.

2. Refusing Behaviour (Second Level of Verbal Aggression)

- Disagreeable
- Refusing
- Silence
- Walk away
- Verbally (this can be done in a calm or aggressive manner)
- Distracting behaviours (refusal in disguise)
- Repeated complaints
- Repeated requests
- Repeated demands
- Blaming others
- Exaggerated response of annoyance

Staff Response to Refusing Behaviours:

Remember people in most situations have the right to refuse care. Our role is to give them a clear understanding of the choices they have and the consequences of the choices they make.

Staff Intervention:

- Verify that they are refusing.
- Verify the reason for the refusal.
- Give a positive directive.
- Give the individual reasonable choices or consequences - positive first, and a specified time to decide.

3. Loud Behaviour (Third Level of Verbal Aggression)

- Button-pushing
- Yelling, shouting

Staff Response to Loud Behaviours:

At this level of verbal aggression, loud behaviours are driven by emotions and not rational thought. The participant may be feeling powerless and frightened, and escalate their behaviour in an attempt to create a sense of control for him or herself.

Staff Intervention to Loud Behaviours:

- FIRST PRIORITY IS SAFETY FOR STAFF AND PARTICIPANT.
- Isolate the acting out person if safe to do so, and either move them or clear the area of on-lookers

(people play to a crowd).

- Give a directive to the participant that puts your safety first (e.g., "Please leave the building").
- Time and space.
- Assess the need for additional staff to be present, or call police.

4. Threatening Behaviour (Fourth Level of Verbal Aggression)

Verbal threats are intolerable behaviour and will be managed as intolerable behaviour.

Intolerable Behaviours

The following behaviours have been identified as intolerable to the SCS. All staff must follow this list to present a consistent approach to participants. The key to the successful use of behaviour modification techniques is a consistent approach by all staff. When a staff member asks a participant to leave and restricts access to the service or site, all staff must respect that staff member's decision to enforce limits on the participant's behaviours.

Identified Intolerable Behaviours:

When a participant displays any of the following behaviours, the participant will be asked to leave the services or building for a specified length of time.

a. Verbal Aggression

Verbal threats that are:

- A direct threat of physical harm to a staff member, participant or family member.
- A direct threat to damage the physical environment or the service or building.
- A threat of a weapon (imaginary or real).

Verbal comments that are:

- Intended to dehumanize a staff member, participant or family member.
- Intended to demoralize a staff member, participant or family member.
- Intended to insult a staff member, participant or family member.
- Intended to sexually exploit a staff member, participant or family member.
- Intended to frighten and verbally control a staff member, participant or family member.
- Intended to start a fight in the facility.

b. Physical Aggression

- Sexual touching.
- Physical touching with the intent to harm a person or damage the facility.
- Throwing objects with the intent to harm a person or damage the facility.
- Punching or slapping a staff member or another participant.
- Kicking with the intent to harm a person or damage the facility.
- Spitting that is directed at a staff member or another participant.

- Fighting in the facility.
- Defacing the facility.
- Damaging equipment in the facility.
- Setting fire to the facility.

c. Challenge of Facility Rules

- Refusing to stop drinking alcohol in the facility.
- Stealing.
- Refusing to stop any behaviour that facility staff have requested the participant to stop.

Staff Response to Intolerable Behaviours:

- Staff safety always comes first. If you have any concerns regarding another staff member's behaviour in dealing with the participant, this is not a safe or appropriate time to question or challenge another staff member. These concerns should be brought up in the informal briefing.
- Be aware of your own limitations and the volatility of the situation.
- Assess the need for more staff to be present when asking the participant to leave the facility, or whether it is necessary to contact the police. If more staff is required or the situation is volatile, remove yourself from the situation until appropriate support can be put in place.
- Know what you can and cannot do ahead of time, so that you are always prepared for the unexpected:
- Who is available to assist you?
- What are your options and choices at this time?
- When are you going to request the participant to return to the SCS for follow-up?
- Where are your exits?
- What is your past history with the participant, and do you have a rapport with them?

Staff Intervention to Intolerable Behaviours:

In a calm, clear, matter-of-fact manner,

- State why you are asking the participant to leave the facility.
- Direct the participant to leave the facility.
- State when the participant may return to the facility (e.g., after meeting with RPIC, after 24 hours, etc.).

Intervention for Staff Member Being Assaulted:

A staff member that is being physically assaulted is to:

- Call for help.
- Trigger an emergency call if available.
- Protect the vulnerable areas of the body (e.g., face, neck)
- Move to an area occupied by other staff
- Ensure that help is on the way.

Staff responding to an emergency call intervention to physical aggression:

- Quickly assess the situation
    a. The need to call 911
    b. Weapons in the area
    c. Exits for staff
    d. Bystanders to be removed from the area
- One staff responder is to give direction to the staff member being assaulted to assist them in protecting themselves and removing themselves from the attacker. They need to clearly identify themselves to the staff member being assaulted as the one voice to concentrate on, so more than one person talking to them does not confuse the person being assaulted.
- Call 911 (or ensure 911 has been called).
- A second staff responder will be the responder who directs the participant to stop the attack and leave the facility. The responder can attempt to distract the attacker (e.g., flicking the lights on and off or throwing ice water on the attacker), this can give the victim a window of opportunity to escape.
- Clear bystanders from the area.
- Remove any potential weapons from the area.