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# A Public Health Guide to Developing a COMMUNITY OVERDOSE RESPONSE PLAN

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## Overdose Deaths in BC

**Between January and December 2016, almost 1000 people died of an overdose in BC, an 80% increase over 2015.** Overdose deaths have been increasing since 2012, leading the BC Public Health Officer to declare a public health emergency in April 2016. The number of overdose deaths continues to rise monthly in 2017 with overdose a leading cause of death in the province. Fentanyl and its analogues have been identified as a key contributor to this increase in illicit drug overdose deaths.

**80% increase in overdose deaths in BC in 2016**

***The purpose of this guide is to outline four key elements of a public health overdose response and suggest a process for implementing a community overdose response plan.***

## Four Key Elements of a Comprehensive Overdose Response

The goals of a comprehensive overdose response plan is to prevent overdose deaths, promote access to substance use services on demand and strengthen systems responses to promote health equity and social justice. In order to achieve this goal, it is critical to

1) strengthen system resilience and community capacity for responding to and preventing overdoses,
2) recognize and disrupt social and personal stigma and discrimination associated with substance use and addiction,
3) implement a broad range of health promotion and harm reduction interventions to prevent overdoses
4) assess and strengthen pathways to substance use services and supports.*[1]

To prevent overdoses, a range of strategies are needed to reach everyone regardless of their social or economic circumstances. While substance use of all types is a common feature of society, illicit substance use is often stigmatized and as a result hidden. Programs, policies and services must be developed and offered without judgment of the specific type of use.

1 Substance use services refers to preventive, harm reduction and treatment services

## 1. System Resilience and Community Capacity

We must ensure our systems have the capacity to meet needs and the resilience to adapt to changing needs in the face of challenges and crises, such as the current public health emergency. Communities must assess and effectively mobilize the resources available to them.

### Peer Capacity Building and Response

Central to overdose responses is the important role that peers (people with lived experience and past or current substance use) play in contributing to the design, development and delivery of acceptable and effective overdose response strategies and harm reduction services. Peer engagement and peer-led services are a critical feature of an effective and efficient response.

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**Meaningful involvement of peers has numerous benefits** including:

- ☐ Peers have unique knowledge and experience that is essential to designing safe and accessible services that are trustworthy
- ☐ Peers have insider knowledge of the community and can provide valuable knowledge of drug use and factors influencing drug use that others on the team do not have
- ☐ Peers can help shift common perceptions and misperceptions of substance use among professional service providers and reduce stigma
- ☐ Peers can provide appropriately tailored education on safer use and overdose prevention.
- ☐ Peers are known, respected, and trusted by people accessing services and they can pave the way for other service providers
- ☐ Peers can act as navigators to support others to access the system and improve experiences of those accessing the system.

In areas where there are already peer workers, leaders or organizations and where they are developing or evolving, they should be key partners in any response. If there are no existing peer leaders or groups established, identify natural leaders in the community and support building the capacity of peer groups and organizations. Important guidelines for working with peers are set out in "Nothing About Us Without Us" (www.aidslaw.ca/site/wp-content/uploads/2013/04/Greater+Involvement+-+Bklt+-+Drug+Policy+-+ENG.pdf) and in "From One Ally to Another" (www.uvic.ca/research/centres/carbc/assets/docs/bulletin-14-from-one-ally-to-another.pdf) and "Peerology" (http://librarypdf.catie.ca/PDF/ATI-20000s/26521E.pdf).

The following suggested questions might be useful as you **assess and plan your community utilization of peer capacity**.

- ☐ Who are the peer leaders, groups or organizations in your community?
- ☐ How are they involved in leading and mobilizing the response?
- ☐ Are they resourced and supported to participant in development and implementation of the response?
- ☐ How could community peer led responses be strengthened? You might want to look at "Street College" (http://solidvictoria.org/education-and-advocacy/).

### Housing Availability and Housing and Shelter Policies

Housing plays an important role in preventing overdoses, providing people with safer places for use and the experience of a sense of home, community and belonging. Although unintentional, some housing and shelter policies push substance use into hidden spaces including private rooms, bathrooms or outside where people are isolated and alone in unsafe or unhygienic circumstances. Examples of restrictive policies are "no guest policies," "no substance use on-site policies" and the failure to provide safe spaces for use on-site [2].

In **assessing your community's housing capacity and policies**, you might find questions like the following useful.

- ☐ Is there access to permanent housing for those without housing? What is or can be done to advocate or address deficits in housing?
- ☐ Are there current housing policies related to substance use that might increase isolation and risks associated with using alone such as 'no guest policies', 'no use onsite' or police attending 911 calls?
- ☐ What role do or can peers play in providing safe spaces for use in housing?
- ☐ Have housing staff and peers received training on recognizing and responding to overdoses including administering Naloxone and support for implementation?
- ☐ Have staff received training on the impacts of stigma, harm reduction and cultural safety principles of practice for working with people who use drugs?

### Drug Policy Reform

The Global Commission on Narcotic Drugs has identified that prohibition and subsequent criminalization of substances is creating considerable harm including contributing to the spread of blood borne diseases and overdoses. Canada has long taken a prohibitionist approach to certain drugs, which has resulted in increased criminalization and stigma. Criminalization has disproportionately impacted those living in poverty and experiencing racism, sexism and other forms of discrimination. Both nationally and internationally there is a call for evidence-based, humanitarian policy and approaches to currently illegal drugs (see http://drugpolicy.ca). This means treating illicit drug use as a public health rather than a criminal issue. Countries such as Portugal have focused on decriminalization of all drugs for personal use and increasing access to treatment and harm reduction with considerable positive (and few, if any, negative) outcomes [3]. Other countries such as Uruguay have taken the approach of regulating drugs that have been illicit (see www.cpha.ca/uploads/policy/ips_2014-05-15_e.pdf).

These suggested questions might be useful in creating dialogue about drug policy reform.

- ☐ What are historical and current impacts of drug policy on people in your community?
- ☐ What actions can be taken to increase awareness of different approaches to drug policy reform including decriminalization and regulation?
- ☐ How might your community contribute to or advocate for national drug policy reform?

## 2. Addressing Social and Personal Stigma and Discrimination

In seeking to address overdose deaths, communities must increase awareness of, and develop strategies to address, social and personal stigma and discrimination associated with substance use and addiction.

In our Canadian context, with our history of prohibition and criminalization, illicit drug use is highly stigmatized and people who use illicit drugs often feel unsafe in accessing life saving interventions and health care services regardless of their socio-economic situation. Stigma of drug use is increased when combined with other forms of discrimination such as racism and gender bias. The key issue is to save lives not make moral judgments about substance use.

**Stereotypes about people who use substances are pervasive and often inaccurate.**

How we talk about substance use and addiction, to each other and in the media, matters. Disrupting stigmatizing language and ensuring the use of non-stigmatizing language requires vigilance and humility (see www.bccdc.ca/about/news-stories/news-releases/2017/language-matters). For example, calling all people who use drugs "addicts" is inaccurate and stigmatizing. Anyone who uses illicit drugs, regularly or occasionally, is at risk for an overdose. Not everyone who uses illicit drugs has an addiction. Promoting respectful and accurate dialogue on substance use in our communities is important (see www.uvic.ca/research/centres/carbc/assets/docs/community-guide.pdf).

Understanding the broad phenomenon of substance use, including the use of both legal and illegal drugs can reduce stigma. Recognizing the benefits people get from substance use, the risks and harms associated with use, as well as the role of harm reduction and treatment – all are important in reducing stigma (see www.heretohelp.bc.ca/sites/default/files/understanding-substance-use-a-health-promotion-perspective.pdf).

Stereotypes about people who use substances are pervasive and often inaccurate. They tend to blame people for their problems rather than recognize that substance use has benefits and can be a response or solution to problems. We can recognize myths and stereotypes that assume those who use drugs are deviant and untrustworthy – in need of surveillance and control. Likewise we can question the assumption that people who use substances are victims and lacking in self-control [1]. These stereotypes and the resulting stigma are increased when they intersect with racism, poverty, and homelessness. This discrimination leads to unequal access to services. For example, those who are poor are more likely to experience stigma in spite of the fact that illicit drug use occurs across all economic strata of society. See www.unodc.org/documents/ungass2016/Contributions/Civil/INPUD/DUPI-Stigmatising_People_who_Use_Drugs-Web.pdf

While many people are familiar with abstinence-based approaches to substance use and addiction, not everyone is knowledgeable about harm reduction as an evidence based and effective approach. However, when surveyed on the basic premises of harm reduction (e.g., meeting people where they are, providing judgment-free, life-affirming services) the public tends to support harm reduction principles. The critical feature of harm reduction is that individuals are respected regardless of whether or not they are using substances. The emphasis is on preventing harms rather than use. Recovery is possible regardless of substance use.

A public health approach to substance use and addiction means that people get the help and support they need based on where they are at. This requires moving away from an emphasis on criminalization and law enforcement to a focus on promoting the capacity of individuals and communities to increase control over their own health and wellbeing and strengthening community responses as described above. The regulation of currently illicit drugs in a way that promotes health and wellbeing is a primary element of a public health approach.

**The critical feature of harm reduction is that individuals are respected regardless of whether or not they are using substances.**

In **addressing social and personal stigma and discrimination in your community**, you are encouraged to reflect individually and engage others in dialogue about these issues. Questions like the following may be useful in building understanding.

- ☐ Where inaccurate and stigmatizing stereotypes exist, what can be done to disrupt these?
- ☐ What can be done to promote compassion and a compassionate response to drug use in our community?
- ☐ Recognizing that language is important, how can we influence the way the media and citizens talk about drug use and people who use drugs in our community?
- ☐ How can we promote understanding of the role that current drug policies play in promoting stigma?
- ☐ What policies or regulations are currently in place that reinforce stigma? How might these be addressed?

## 3. Health Promotion and Harm Reduction Interventions to Prevent Overdoses

Mobilizing communities to implement a broad range of health promotion and harm reduction interventions to prevent overdoses is an essential component of a comprehensive overdose response plan. Such a network of interventions helps people connect to information, services and each other, all of which contributes to increased resilience.

The importance of peer-delivered and peer-informed services cannot be overemphasized. Consistent with health equity and social justice, health promotion and harm reduction services should be culturally safe (as defined by those who use the services) and should recognize past histories and life experiences that have been shaped by the current system of criminalizing

use, colonization, historical and ongoing trauma, and social exclusion (see http://www2.gov.bc.ca/assets/gov/overdose-awareness/fnha_overdosedataandfirstnationsinbc_preliminaryfindings_finalweb_july20.pdf).

**... the administration of Naloxone is a key first line emergency response that saves lives ...**

Provision of overdose prevention services is stressful for those providing services, so it is important to provide services and supports for all providing overdose response services. Harm reduction workers, professional first responders and peers, all have different access to resources and different needs for support (see http://towardtheheart.com/assets/naloxone/naloxone-staff-resiliency-final_185.pdf). Community based peer and harm reduction workers, and families often have fewer systemic resources and supports.

The following sections provide examples of health promotion and harm reduction interventions that should be readily available in your community. The list is suggestive rather than exhaustive.

### Widespread Availability of Naloxone

The widespread availability of Naloxone and training in the administration of Naloxone is a key first line emergency response that saves lives by temporarily reversing severe respiratory distress caused by opioid (heroine, methadone, fentanyl, morphine) overdose. Naloxone can be administered by anyone with training and is available without a prescription in BC. Training can be done by a wide range of people including peers, harm reduction workers, and nurses. Peer-to-peer training as well as service-provider-to-service-provider training is ideal. See Toward the Heart for the most current information on Naloxone availability, administration and training (http://towardtheheart.com/naloxone/). Good Samaritan Drug Overdose Act provides immunity from simple possession charges for those that call 911 in the case of an overdose (See https://www.canada.ca/en/health-canada/news/2017/05/good_samaritan_drugoverdoseactbecomeslawincanada.html).

The following questions provide a checklist for **planning Naloxone availability in your community**.

- ☐ Where can Naloxone be accessed in your community?
- ☐ Is it easy for people who use substances to access Naloxone quickly and without judgment? How do you know?
- ☐ In each setting, who is trained or requires training? Are peers trained and part of the team? Are all healthcare and community agency staff trained in Naloxone?
- ☐ Who is currently providing Naloxone training? Peers? Nurses?
- ☐ Who else could provide training?

## Supervised Consumption and Overdose Prevention Sites

Supervised consumption services (SCS) are effective in preventing a broad range of harms including overdoses. SCS provide supervised injection and/or inhalation with the full scope of primary nursing care, peer education and support, counselling, referrals to treatment and housing. At this time, SCS require an exemption to the federal Controlled Substances Act. To obtain this exemption requires an application to Health Canada.

A key aspect of preventing overdose deaths is witnessing or supervising injections and/or inhalation. Overdose prevention sites (OPS) in British Columbia are being established as a result of a provincial BC Ministerial order. Peers and/or harm reduction workers with or without paramedics/nurses are providing witnessed injections and/or safer smoking spaces in shelters, housing complexes and other settings. OPS provide a safer place for people to consume substances while being observed (see http://towardtheheart.com/naloxone/ops/).

The following questions provide a checklist for **planning supervised consumption services in your community**.

- ☐ How can your community support supervised consumption services?
- ☐ Where and how could your community establish OPS?
- ☐ What agencies already have experience and knowledge of offering harm reduction services and are viewed as safe and trusted by the community of people who use substances?
- ☐ What strategies are needed to ensure that SCS and/or OPS are established? What considerations are needed to reach those who do not access services or are restricted from accessing services (youth, pregnant women)?

## Opioid Substitution Therapy

An important aspect of treatment for an opioid use disorder is ensuring that people have access to safe opioids through prescriptions rather than accessing the illicit drug market. Traditionally, this has been methadone but more recently Suboxone® has become first line treatment. As well, there is evidence that some persons with opioid use disorder will benefit from injectable hydromorphone or prescribed heroin.

Please see current guidelines for managing opioid use disorder from the BC Centre on Substance Use at http://www.bccsu.ca/care-guidance-publications/. For a patients' guide to opioid substitution therapy see www.uvic.ca/research/centres/carbc/about/news/current/new-carbc-handbook-patients-helping-patients-understand-opioid-substitution-treatment.php.

The following questions provide a checklist for **planning OST services in your community.**

- ☐ Who is currently providing OST in the community? How many primary care providers are able to provide OST? What other professionals are involved in the program?
- ☐ Are prescribing physicians trained in harm reduction approaches to working with people who use substances? What resources are available for training?
- ☐ Is there rapid access to Methadone or Suboxone®? What barriers exist to delivery of evidence-based OST?
- ☐ How do we support people to get on and maintain OST? How can we support people through the initial withdrawal to get on Suboxone®?
- ☐ What role could home based detox play?
- ☐ What other OST services are or could be offered?
- ☐ Are people with an opioid use disorder connecting to psycho-social supports and what other supports such as housing and income supports are available with OST services?

## Accessible Tools and Resources that Support Empowerment

Essential to health promotion is helping people build their capacity to manage their own health and wellbeing. This means we need to do more than just provide services and supports delivered by others. It involves providing people with the training and tools to increase control of their own lives. Examples of useful self-management tools include Safer Injecting (http://www.heretohelp.bc.ca/sites/default/files/safer-injecting-heroin-crack-and-crystal-meth.pdf), Toward the Heart (http://towardtheheart.com), You and Substance Use (http://www.heretohelp.bc.ca/sites/default/files/you-and-substance-use-stuff-to-think-about-and-ways-to-make-changes.pdf).

Since substance use is not just a personal choice but a social phenomenon, it is critical to increase public awareness of substance use, the risks for overdose, how to support people who use substances and how to recognize overdose signs and symptoms. General background is available at http://www.uvic.ca/research/centres/carbc/publications/h2h/index.php. The province of BC has developed a public awareness campaign related to overdose and that includes resources for parents (see www2.gov.bc.ca/gov/content/overdose).

**For a competency based approach to drug education in schools see www.iminds.ca.**

Capacity building should start long before there is a potential problem. We can begin by helping children and adolescents develop the drug literacy competencies that will help them survive and thrive in our world in which psychoactive substances abound. This involves helping them be aware of, and manage, themselves, their relationships and their environments. This involves not only personal skills but also a sense of empathy and care for others that contribute to healthy communities. For a competency based approach to drug education in schools see www.iminds.ca.

In **assessing your community's capacity to empower individuals and groups** to increase control of their own wellbeing, you might find questions like the following useful.

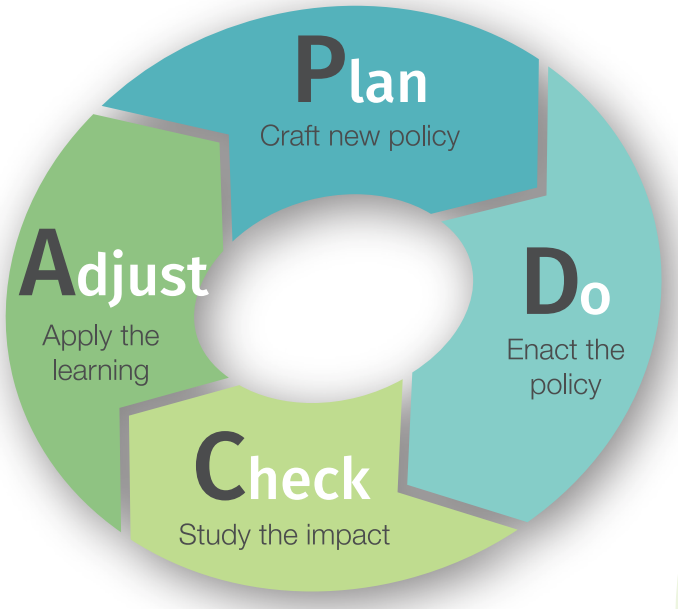
- ☐ What self-management tools and resources are available in your community? How easily can people access them? How could access be improved?
- ☐ How well do people in your community understand the issues related to substance use and overdose? How could you promote dialogue to enhance understanding?
- ☐ How well are schools and families in your community equipped to support drug literacy competencies in young people? How could this be improved?
- ☐ What training is provided for professionals and volunteers that helps them support self-management among those for whom they provide services and supports?
- ☐ What resources and supports are available for people providing overdose prevention services and responses? What opportunities are there to debrief, acknowledge shared losses and contribute to resilience?

## 4. Pathways to Substance Use Services and Supports

The provision of key health promotion and harm reduction services like those outlined above can provide an opportunity to connect people to other health and social services such as counselling, treatment services, income supports, and housing. Building trust is foundational to effective relationships that facilitate access to services and supports. Trust is facilitated by non-judgmental acceptance of individuals and their choices related to substance use. Trust is a key component in health promotion and harm reduction approaches. Trust based relationships may be more readily developed when services are provided by peers and consistent providers rather than episodic care in emergency departments or drop-in services – however, all settings should be seen as an opportunity to build trust and form therapeutic relationships.

The following suggested questions might be useful as you **assess and plan service pathways in your community**.

- ☐ Are all health care providers aware and knowledgeable regarding health promotion and harm reduction philosophies and approaches?
- ☐ Do they have the knowledge and skills to develop trusting relationships and build clients' autonomy and capacity? Do they possess skills in providing cultural safety and trauma informed care?
- ☐ What do we think of as treatment? How can we provide forms of treatment where people are already accessing services (e.g. harm reduction services, shelters, peer organisations)
- ☐ What treatment, wellness or healing programs are available (e.g., withdrawal management, pharmacological and psycho-social treatments, community and peer support services) within the community? How can we provide more community based treatment?
- ☐ What case management, care coordination or system navigation is available?
- ☐ Are there well-defined pathways for persons accessing a care provider site or emergency department and who want to access a substance use service or support? If someone has overdosed or needed emergency response services, how seamless is it for them to access desired substance use services or supports in your community?
- ☐ How could these pathways be made more navigable for those needing services and supports?
- ☐ Given that expediency is important, what are the time frames for each step in the pathways to treatment? How could expediency be improved?




## Plan

**CREATE A COMPREHENSIVE COMMUNITY PLAN** using questions like those provided above to assess the current status of each of the four elements of a comprehensive overdose response in your community and develop a plan of action outlining priority areas, lead individuals/agencies, key activities and timelines. See Appendix A for a template.

**DETERMINE KEY COMMUNITY PARTNERS** who have a role to play in mounting an overdose response in your community. Some examples are harm reduction workers, people with lived experience, families, emergency departments, primary care physicians and mental health and substance use workers. Determine whether or not an established committee with key players already exists or establish a committee. Identify who is best placed to convene the work (e.g., public health, MHSU, community organization). Try to make your group as inclusive of all relevant voices (eg. Peers, families, local government, law enforcement, housing).

**IDENTIFY AVAILABLE INFORMATION** to help inform your plan. Public health leaders can provide current up-to-date data on overdoses (regionally and locally). Community level reporting may be based on observations, program stats and/or knowledge from the field. Some potential indicators and sources of data are:

- **Public health surveillance data:** # of overdose fatalities # of overdose calls (911 calls), demographic information, emergency department use, overdose events from community reports, events in which Naloxone is administered and number of Naloxone kits distributed, type of drug and client demographics
- **Community agencies and shelter programs:** # of overdose events and/or deaths, locations of overdoses and drug use if known (e.g., bathrooms, outdoors)
- **Police:** community profile and "problematic locations" (e.g., houses, neighborhoods)
- **Others with info:** school district, MCFD, youth outreach programs, etc.

# Do

**IDENTIFY SHORT-TERM IMPLEMENTATION CYCLES** within the comprehensive overdose response plan. This allows you to adapt and adjust to changing circumstances. Implement the plan according to identified priorities but in manageable chunks.

**BE GUIDED BY PRINCIPLES AND PRACTICES** that promote personal capacity, health equity and social justice with implementation of interventions informed by principles of harm reduction, cultural safety and trauma informed care.

Reflecting on **PERSONAL CAPACITY** reminds us that people are not objects to be acted upon but citizens with freedom and responsibility. In order to build the health capacity of individuals, service providers must resist the reflex to fix and instead focus on helping people increase control of their own health and well-being.

**HEALTH EQUITY** means addressing inequitable social conditions that are impacting poor health for all. While all people who use illicit drugs are subject to inequities as a consequence of criminalization and current drug policy, those at the intersections of colonization, poverty and homelessness are disproportionately affected. An overdose plan should therefore include both universal and targeted approaches known as "proportionate universality" in which targeted approaches are embedded within a universal approach so that the right services reach the right people at the right time.

The goal of **SOCIAL JUSTICE** is to ensure that systems operate equitably and do not further disadvantage those with less power and fewer resources. For example, providing Naloxone and rapid access to Suboxone® without administrative costs removes socio-economic barriers. A focus on social justice involves sharing the power in decision-making in designing and developing services and polices. People who use substances must be accorded respect and opportunities to participate in decision-making relevant to their interests and in a way that supports and does not further stigmatize.

**HARM REDUCTION** is an essential part of a comprehensive approach to addressing problematic substance use—both as a guiding philosophy and set of strategies—and is official British Columbia provincial health policy [4, 5, 6]. Staff work with participants to reduce the negative consequences of use whether or not they continue to use substances. Harm Reduction services are evidence based and provided without judgement of substance use, respectfully and in ways that promote dignity and compassion.

## Do

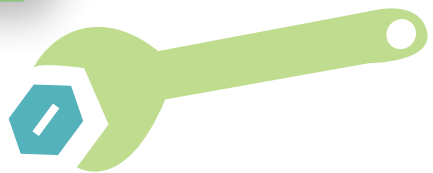
**CULTURAL SAFETY** is grounded in critical reflection on history, one's own privilege, and recognizing marginalizing stereotypes and discrimination in health care policy and practices. Health care providers recognize that there is an imbalance of power between themselves and those they are serving as well as potential differences in life experiences, resources and situations [7, 8]. This approach has been widely used to improve care for Indigenous populations to counter racism in healthcare. Cultural safety can be extended to situations of stigma associated with illicit substance use (see www.uvic.ca/research/centres/carbc/assets/docs/bulletin11-creating-culturally-safe-care.pdf) and to create spaces and care for people who identify as LGBTQ2S.

**ACKNOWLEDGING TRAUMA AND TRAUMA INFORMED PRACTICE** recognizes the link between adverse life experiences (violence, abuse), substance use and societal conditions that contribute to trauma. For example, homelessness is a form of trauma as well as being associated with other sources of trauma and abuse [9]. This recognition can help providers to understand client behaviours and inform approaches to working with clients that is sensitive to unique life histories and experiences and social processes such as colonization and criminalization that contribute to trauma. Trauma informed practice ensures that health and social services are provided in a manner that is sensitive to understanding historical and other forms of trauma and care is provided in a way that does not further traumatize individuals (see bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf).

## Check

**SET A REGULAR CYCLE TO ASSESS** the implementation of the plan through ongoing public health surveillance and community level reporting. Ensure that all voices in the community are heard in this process. Indicators for monitoring each element being implemented can be developed as part of the overall response plan and can include progress on each activity as well as specific indicators for progress in meeting identified goals.

## Adjust



**MAKE INCREMENTAL ADJUSTMENTS AS NEEDED** after each review process. Adjustments should take into account progress to-date in addressing previous priorities and the consideration of new priorities based on current assessment.

## References


1. Pauly, B.M., et al., *Toward cultural safety: Nurses' and patients perceptions of substance use in hospitals.* Advances in Nursing Science, 2015. **38**(2): p. 121-135.
2. Pauly, B.M., B. Wallace, and K. Barber, *Turning a blind eye: Implementation of harm reduction in transitional shelter settings.* Drugs: Education, Prevention & Policy, under review
3. Drug Policy Alliance. *Drug decriminalization in Portugal: a health-centered approach.* 2015; Available from: https://www.drugpolicy.org/sites/default/files/DPA_Fact_Sheet_Portugal_Decriminalization_Feb2015.pdf.
4. British Columbia Ministry of Health, *Harm Reduction: A British Columbia community guide*. 2005, British Columbia Ministry of Health: Victoria, BC.
5. British Columbia Harm Reduction Strategies and Services, *Best Practices for British Columbia's Harm Reduction Supply Distribution Program*, B.C.C.f.D. Control, Editor. 2008, British Columbia Harm Reduction Strategies and Services: Vancouver, BC.
6. International Harm Reduction Association. *What is harm reduction?* 2015; Available from: http://www.ihra.net/what-is-harm-reduction.
7. Ramsden, I., *Kawa Whakaruruhau. Cultural safety in nursing education in Aotearoa, New Zealand.* Nursing Praxis in New Zealand, 1993. **8**(3): p. 4-10.
8. Nursing Council of New Zealand, *Guidelines for cultural safety, the treaty of Waitangi and Maori health in nursing education and practice*. 2005, Nursing Council of New Zealand.: Wellington, New Zealand.
9. Hopper, E.K., E.L. Bassuk, and J. Olivet, *Shelter from the storm: Trauma-informed care in homelessness services settings.* The Open Health Services and Policy Journal, 0210. **3**: p. 80-100.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