PART 2: BEST PRACTICE RECOMMENDATIONS

FOR CANADIAN HARM REDUCTION PROGRAMS THAT PROVIDE SERVICE TO PEOPLE WHO USE DRUGS AND ARE AT RISK FOR HIV, HCV, AND OTHER HARMS – SERVICE MODELS, REFERRALS FOR SERVICES, AND RELATIONSHIPS WITH LAW ENFORCEMENT

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Best Practices Project Overview

- Cross-Canada, multi-stakeholder team (researchers, service providers, policy makers, and people with lived experience)
- **Project goals**: Develop and widely disseminate a set of user-friendly, evidence-based recommendations; improve program quality and consistency; make the case for investing in harm reduction; inform decisions; provide evaluation benchmarks; and identify targets for improvement at both the program and systems levels
- Best Practice Recommendations (BPR) Part 1 is available from: www.catie.ca/en/programming/best-practices-harm-reduction
- BPR Part 2 covers additional and emerging areas of practice

Methods

- **Narrative synthesis** to search, retrieve, assess, and synthesize the most up-to-date evidence from Canada, United States, United Kingdom, Europe, Australia, New Zealand, and other countries with a public health system similar to Canada
- **Team consensus** to develop usable evidence-based recommendations concerning areas of practice we cover in 13 chapters

BPR Part 2 Contents

- **Program models** – fixed-site NSPs; mobile NSPs; pharmacy distribution; peer-based outreach; and vending machines
- **Equipment distribution** – needles for anabolic steroid injection, hormone injection, and piercing and tattooing; foil distribution; and crystal methamphetamine smoking equipment
- **Basic health care** – injection-related complications; testing; and vaccination
- **Service referrals** – HIV and HCV treatment; substance use treatment; mental health services; and housing services
- **Relationships with law enforcement**
- **Education and other services for the prison context**

Program Models - Rationale

- Evidence demonstrates that needle and syringe programs (NSPs) are generally effective at reducing drug-related harms
- Different program delivery models – fixed-site NSPs, mobile NSPs, pharmacy distribution, peer-based outreach, and vending machines – are complementary, not mutually exclusive
- Each model has its own advantages and disadvantages
- Evidence suggests that having a wide spectrum of delivery models is most beneficial

Program Models - Recommendations

- **Provide NSP services** using a variety of program delivery models (i.e., fixed-site, mobile, pharmacy, peer-based outreach, vending machines) that are convenient for clients in terms of geographic location and time of day, and tailored to reach subpopulations (e.g., youth, women, sex workers, and those who are new to injecting)
- **Expand access** through partnership development with local agencies serving people who use drugs and pharmacies to provide additional venues for clients to receive NSP services
- **Train and support** peer workers, pharmacists, pharmacy assistants, and others who provide NSP services

Service Referrals - Rationale

- Many NSP clients report a need and desire for other services, particularly substance use treatment, mental health services, and housing services
- Many NSPs provide some form of referrals to substance use treatment, whereas referrals to mental health and housing services may be less common; there is a lack of literature on these other types of service referrals from NSPs
- "Referrals" from NSPs take different forms – e.g., program staff providing clients with additional information and resources or a number to call, or more formal referrals involving healthcare providers

Service Referrals - Recommendations

- **Educate clients** about substance use treatment, mental health services, and housing services options
- **Establish and maintain relationships** with a variety of agencies providing substance use treatment, mental health services, and housing services

Relationships with Law Enforcement - Rationale

- Evidence shows that law enforcement activities can negatively affect the health and safety of people who inject drugs
- For example, crackdowns increase anxiety about getting caught by police, leading to injecting in less safe spaces (e.g., alleys), less contact with health and social services, improper disposal of used injection equipment, and rushed or unsafe injecting practices
- Working collaboratively may improve police understanding of the public health benefits of HR programs and reduce incorrect and/or negative perceptions held by law enforcement
- More formal, published evaluations of police training initiatives are needed

Relationships with Law Enforcement - Recommendations

- **Establish and sustain methods for ongoing communication** between harm reduction programs and local law enforcement agencies, including when developing programs
- **Provide in-service training** to law enforcement agents related to harm reduction programs, scientific evidence of NSP and crack kit program impacts, and needle-stick injuries
- **Negotiate agreements** to reduce harassment of clients, surveillance of fixed and mobile sites, and destruction of harm reduction equipment by law enforcement
- **Establish conflict resolution protocols** for harm reduction programs and law enforcement agents

Conclusions

- Ensuring or changing existing harm reduction policies and practices to be in line with newly updated best practices will improve the health of marginalized populations by improved:
  - Access to drug use supplies
  - Program model design (and expanded number)
  - Service referral design
  - Relationships with local law enforcement

Next Steps

- Using varied knowledge exchange methods (including conference presentations, webinars, and fact sheets) by multiple team members, our goal is to ensure awareness of and access to the Best Practice Recommendations among harm reduction practitioners across Canada
- We will translate Part 2 into French
- A cross-Canada evaluation study of BPR Part 1 is underway

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www.catie.ca/en/programming/best-practices-harm-reduction