Harm reduction in British Columbia

Jane A. Buxton, MBBS, MHSc, FRCP, Ciro Panessa, RN, MSN

Conceptually, harm reduction is an approach that reduces the harmful effects of behavior. It involves a range of nonjudgmental approaches and strategies aimed at providing and enhancing the knowledge, skills, resources, and supports for individuals, their families, and communities to make informed decisions to be safer and healthier.[1]

Harm reduction for illegal and legal psychoactive substances is an integral component of the overall substance misuse prevention, treatment, and care continuum. The range of services available to prevent harms from substance use in British Columbia include creating awareness of the risk of driving under the influence of alcohol, peer support programs, outreach and education to encourage safer behavior, substitution therapies such as methadone, needle distribution programs, and a supervised injection facility. A summary of the results of scientific evaluation of Insite may be found at http://uhri.cfenet.ubc.ca/images/Documents/insight_into_insite.pdf. Participation in a full range of harm reduction programs has been associated with a decreased risk of HIV and hepatitis C virus (HCV) infection.[2]

Those providing harm reduction supplies and services must respect human rights and the dignity of their clients by adhering to basic ethical principles. The populations who are served by harm reduction activities are diverse but often include vulnerable individuals who face considerable drug-related stigma. In many communities across the province, harm reduction services also become an integral access point for marginalized populations to access the health system to engage in care.

These programs do not encourage people to use drugs, but make it as easy as possible for them to get help.

Overarching provincial policies on harm reduction best practices and supply distribution are guided by the BC Harm Reduction Strategies and Services (HRSS) committee. It is composed of representatives from the five BC regional health authorities, BC Centre for Disease Control, BC Ministry of Healthy Living and Sport, and First Nations and Inuit Health. HRSS policy states that each health authority and its community partners must work together to provide a full range of harm reduction services within their respective jurisdictions, including access to supplies and referrals to health care, mental health, addictions, and other relevant community services. It also states that harm reduction supplies should be available to whoever needs them, regardless of the person's age, drug-using status, drug of choice, or residence. HRSS policy also requires health authorities, agencies, and community partners to formulate a community plan for safe harm reduction supply disposal. The plan may address community education, the provision of sharps containers in supervised settings, and the pickup of discarded supplies from streets, parks, and alleys.

Current items funded by the BC Ministry of Health and subsidized by Provincial Health Services Authority include needles and syringes, sterile water, alcohol swabs, male and female condoms, and lubricants. In the fiscal year 2007/08, 5.3 million needles and syringes were distributed in BC.

Since the 1990s, crack cocaine has become more prevalent in BC. People who smoke crack may develop oral lesions and burns from hot or broken crack pipes, and HCV has been detected on crack paraphernalia. People who share crack pipes may therefore be at increased risk of exposure to HCV and other communicable disease.[3,4] Push sticks are used to pack and position the filter or screen (often Brillo) inside the crack pipe. Once the crack has been smoked the push stick is used to recover the crack that has hardened on the inside pipe wall. It was reported that people were using the plunger of syringes as push sticks, discarding the needle and rest of the syringe. Therefore plastic mouth pieces and wooden push sticks were made available through the BC harm reduction supplies in 2008.

A 2008 analysis of supply distribution and qualitative interviews with supply distributors identified a lack of standardized policy and practice.[5,6] To address these issues the HRSS committee has created a BC best practice document available at www.bccdc.org/download.php?item=3791 and a training workshop was held for 80 front-line distribution staff and peers in January 2009.

Community harm reduction services provide referrals, advocacy, edu-

Dr Buxton and Ms Panessa are co-chairs of the BC Harm Reduction Strategies and Services Committee. Dr Buxton is physician epidemiologist and harm reduction lead, BC Centre for Disease Control. Ms Panessa is manager of Harm Reduction and Blood Borne Pathogens at the BC Ministry of Healthy Living and Sport.

cation, and supplies distribution. These programs do not encourage people to use drugs, but make it as easy as possible for them to get help. They increase the engagement of vulnerable and marginalized populations into the health and social service system to reduce transmission of HIV, HCV, and other communicable diseases such as sexually transmitted infections, and support other concurrent mental health conditions and addictions such as alcohol dependency.

References

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Among its resources, the program introduces common screening scales, a tool for organizing patient issues, a cognitive-behavioral skills tool, telephone coaching for mood management, and a patient self-management workbook. "And of course the program is underpinned by the PSP module approach, which involves learning sessions interspersed with action periods to test new skills and knowledge," says Ms Kallstrom.

The module's implementation will be monitored and evaluated carefully, with measures of success including:

- Increased physician confidence in managing depression and other mental health conditions.
- Patient satisfaction.
- Increased referrals to community programs.
- Increased number of patients with a care plan.
- New and enhanced relationships between physicians and mental health clinicians.
- Medical office assistant confidence in dealing with and assisting mental health patients.

Launching the module: Engaging champions and mental health experts

GPs and medical office assistants recruited as mental health module champions attended a train-the-trainer session in early April. After an action period in which they implement what they learned in their own practices, a second session—on coaching—takes place in May.

"The idea is that our champions learn and try out new clinical skills first, to discover what works and what needs to be modified," says Ms Kallstrom. "Then, in the second session, they focus on supporting the provincial roll-out."

The module involves three half-day learning sessions with two intervening action periods. The uniqueness of the module is the support of mental health clinicians and psychiatrists in addition to GP and MOA champions, during the action periods and ongoing. "We see the support of mental health experts as vital for physicians and MOAs in such a complicated area of care," says Ms Kallstrom.

The mental health module is one of five modules offered through the GPSC's Practice Support Program (others are advanced access, group visits, managing patients with chronic diseases, and patient self-management). As well as the PSP, the GPSC administers approximately $100 million annually through incentives in four areas of primary health care: chronic disease management, maternity care, end-of-life care, and mental health care. For more information visit www.bcma.org/committee/general-practice-services-committee-gpsc.

—Greg Dines,
Senior Program Advisor,
BCMA Professional Relations