

FEBRUARY 2018

Implementing Supervised Injection Services



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Implementing Supervised Injection Services

Greetings from Doris Grinspun,

Chief Executive Officer, Registered Nurses' Association of Ontario



The Registered Nurses' Association of Ontario (RNAO) is delighted to present the new best practice guideline *Implementing Supervised Injection Services*. Evidence-based practice supports the excellence in service that health professionals are committed to delivering every day.

We offer our heartfelt thanks to the many stakeholders who are making our vision for best practice guidelines a reality, starting with the Government of Ontario for recognizing RNAO's ability to lead the program and for providing multi-year funding. This important Guideline provides an evidence-based resource as health systems around the globe face an unprecedented opioid crisis. For their invaluable expertise and stewardship of this Guideline, I wish to thank the co-chairs of the RNAO expert panel, Dr. David McKeown and Marjory Ditmars. I also want to thank members of the senior management team, Dr. Valerie Grdisa and Dr. Lucia Costantini, for their expertise and leadership. Thanks also to Tasha Penney, Glynis Gittens, Nafsin Nizum, Laura Ferreira-Legere, and the rest of the RNAO Best Practice Guideline Development Team for their intense work in the production of this new Guideline. Special thanks to the members of the RNAO expert panel for generously providing their time and expertise to deliver a rigorous and robust resource. We couldn't have done it without you!

Successful uptake of best practice guidelines requires a concerted effort from educators, clinicians, employers, policy-makers, and researchers. The nursing and health-care communities, with their unwavering commitment and passion for excellence in patient care, have provided the expertise and countless hours of volunteer work essential to the development and revision of each best practice guideline. Employers have responded enthusiastically by nominating best practice champions, implementing guidelines, and evaluating their impact on patients and organizations. Governments at home and abroad have joined in this journey. Together, we are building a culture of evidence-based practice.

We invite you to share this Guideline with your colleagues from other professions and with the patient advisors who are partnering within organizations because we have so much to learn from one another. Together, we must ensure that the public receives the best possible care every time they come into contact with us—making them the real winners in this important effort.

A handwritten signature in black ink that reads "Doris Grinspun". The signature is written in a cursive style and is underlined with a thick, horizontal stroke.

Doris Grinspun, RN, MSN, PhD, LLD (Hon), O. ONT.
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Dedication

This Guideline is dedicated to Raffi Balian (1956–2017). Raffi was a tireless advocate, teacher, and friend to countless harm reductionists around the globe. He was a champion for harm reduction that is based on universal human rights and evidence, including epidemiological, clinical, and public health science and, most importantly, the experience of people who use drugs. The RNAO Best Practice Guideline Development Team and expert panel would like to express their sincere gratitude for Raffi’s generous and invaluable contributions to the development of this Guideline.



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How to Use This Document

This nursing^G best practice guideline (BPG) is a comprehensive document that provides an overview of principles, resources, and structures for delivering evidence-based supervised injection services (SIS). It is not intended to be a manual or “how-to” guide; rather, it supports best practices and decision making for nurses, health workers^G, and health system leaders. This Guideline should be reviewed and applied in accordance with individual SIS facilities and the needs and preferences of persons accessing SIS. This document provides evidence-based recommendation statements and descriptions of (a) pragmatic practice, education, and policy considerations, (b) benefits and harms, and (c) values and preferences. This Guideline predominantly focuses on policy issues related to SIS and highlights relevant supporting documents that directly address clinical practices.

Nurses, health workers, and system leaders who lead and facilitate practice changes will find this document invaluable for developing policies, procedures, protocols, and educational programs to support service delivery. Nurses and health workers in direct care will benefit from reviewing the recommendations and supporting evidence. We encourage SIS facilities adapt this Guideline in formats that are user-friendly for daily use.

If your organization is adopting this Guideline, we recommend you follow these steps:

1. Assess your existing policies, procedures, protocols, and educational programs in relation to the recommendations in this Guideline.
2. Identify existing needs or gaps in your policies, procedures, protocols, and educational programs.
3. Note the recommendations that are applicable to your setting and that can be used to address your organization’s existing needs or gaps.
4. Develop a plan for implementing recommendations, sustaining best practices, and evaluating outcomes.
5. Lobby governments to ensure that legislation and regulation support the implementation of the recommendations (e.g., scope of practice, affordable housing, and health human resources).
6. Advocate for funding to support the implementation of recommendations.

Implementation resources, including the Registered Nurses’ Association of Ontario (RNAO) *Toolkit: Implementation of Best Practice Guidelines* (2012), are available at RNAO.ca.

All of the RNAO BPGs are available for download on the RNAO website at RNAO.ca/bpg. To locate a particular BPG, search by keyword or browse by topic.

We are interested in hearing how you have implemented this Guideline. Share your story with us at RNAO.ca/contact.

* Throughout this document, terms that are marked with a superscript G (^G) can be found in the Glossary of Terms (see [Appendix A](#)).

Purpose and Scope

RNAO's BPGs are systematically developed, evidence-based documents that include recommendations on specific clinical, healthy work environment, and system topics that are intended for nurses, health workers, educators, leaders, policy-makers, and persons/families with lived experience. Guidelines promote consistency and excellence in clinical care, policies, and education, with the aim of achieving optimal health outcomes for people, communities, and the health-care system. This Guideline is to be used by nurses and health workers who work in SIS with people who inject drugs.

In November 2016, RNAO convened a panel comprised of individuals with expertise in harm reduction and substance use service delivery. The RNAO expert panel included individuals with lived experience and those who held clinical, leadership, education, and research positions in a range of health-care organizations, practice areas, and academic settings. These experts work with people who inject drugs who are receiving services and supports in a wide range of health-care settings (e.g., SIS, community health centres, harm reduction programs, public health, and primary health care) or represent other sectors (such as post-secondary institutions and professional unions).

To determine the purpose and scope of this Guideline, the RNAO Best Practice Guideline Development Team conducted the following steps:

1. A guideline search and gap analysis.
2. Twelve key informant interviews.
3. Two virtual focus groups with experts in the field in Edmonton, Ottawa, Toronto, and Vancouver, including front-line health workers, administrators, researchers, and individuals with lived experience.

Analysis of these activities directed the RNAO Best Practice Guideline Development Team to develop a guideline for nurses, health workers, and decision-makers on the most effective approaches for SIS delivery to people who inject drugs. SIS should (a) promote person engagement, (b) support positive health outcomes and health equity^G, and (c) reduce harms associated with injection drug use.

The main outcome of this Guideline is to promote health equity for people who inject drugs through harm reduction, culturally safe, and trauma-informed practices and policies in SIS.

The recommendations apply to nurses and health workers providing SIS. However, as people who inject drugs access services and supports in other health and social service settings, this Guideline is a critical resource for all sectors.

Types of Recommendations

Recommendations are provided at three levels.

- Practice recommendations^G are primarily intended for nurses who provide direct services and supports to people who inject drugs in SIS, as well as other health workers who collaborate with nurses to provide comprehensive care. These recommendations outline how to engage people who inject drugs and maintain trusting and respectful relationships that are grounded in harm reduction, cultural safety, and trauma-informed practice.
- Education recommendations^G are directed at those responsible for educating health workers, such as educators, quality improvement teams, managers, administrators, and academic and professional institutions. These recommendations outline core training strategies required for entry-level or pre-licensure curricula, continuing education, and professional development. The focus is nurses and other members of the health-care team.

- Organization and system policy recommendations^G apply to managers, administrators, and policy-makers responsible for developing policy or securing the supports required within SIS for implementing best practices.

For optimal effectiveness, recommendations in these three areas should be implemented together.

Discussion of Evidence

The Discussion of Evidence that follows each recommendation has four main sections. The “Evidence Summary” outlines the supporting research from the systematic review^G that directly relates to the recommendation statement. “Practice Notes” highlights pragmatic information for health workers and may include supportive evidence from other sources (e.g., other guidelines or the expert panel). “Benefits and Harms” inform aspects of care that promotes or deters from the person’s health and well-being. “Values and Preferences” denotes the prioritization of approaches that facilitate health equity and the importance of consideration for desired care.

Content for “Benefits and Harms” and “Values and Preferences” may or may not include research from the systematic review. When applicable, the RNAO expert panel contributed to these areas.

Concepts Used in This Guideline

Health workers: defined as “all people engaged in actions whose primary intent is to enhance health” (1). This includes both regulated health professions (e.g., registered nurses^G, physicians, and social workers) and unregulated health workers (e.g., peer workers^G, mental health workers, harm reduction workers, drug counselors, and outreach workers).

Drugs: defined as the psychoactive substances that people accessing SIS may inject. This commonly includes, but is not limited to (a) opioids (e.g., illicit drugs, such as heroin, and prescription medications, such as oxycodone, hydrocodone, morphine, and fentanyl), and (b) stimulants (e.g., illicit drugs, such as cocaine, methamphetamine, and MDMA, and prescription medications, such as amphetamines and methylphenidate).

People who inject drugs: specifically refers to people who inject drugs. When the discussion of evidence includes research that studied a broad group of individuals using drugs (including some who are not necessarily injecting drug users), the term “people who use drugs” will instead be used.

RNAO Guidelines and Resources That Align with This Guideline

Other RNAO guidelines and evidence-based resources may support implementation of this Guideline. See [Appendix B](#) for RNAO guidelines and other resources on the following related topics:

- engaging clients who use substances;
- implementation science^G, implementation frameworks, and resources;
- intra-professional collaboration;
- interprofessional collaboration; and
- person-and family-centred care.

For more information on the development process, systematic review, and search strategy for this Guideline please see [Appendices C and D](#).

Supporting Guidelines from Other Organizations

See [Appendix D](#) for high-quality guidelines on the following topics:

- prevention and testing of viral hepatitis B and C for people who inject drugs;
- harm reduction programming for people who use drugs and are at risk for HIV, hepatitis C, and other harms;
- community management of opioid overdose; and
- needle and syringe programs.

Topics Outside of the Guideline Scope

In Ontario, SIS is a rapidly evolving area that provides support to a clinically complex population. This Guideline may not address all relevant content. As SIS expands and changes, RNAO will develop resources and tools to support clinical practice and other pertinent areas.

The following are conditions and topics *not* covered within the scope of this Guideline:

- clinical interventions, including the prevention, assessment, and management of drug overdose, skin and soft tissue infections, and other viral and bacterial infections;
- drug treatment services and supports;
- opioid agonist treatment;
- supervised services for smoking drugs;
- guidance on establishing local need for SIS and obtaining community support; and
- regulatory considerations, service models, or human resource models.

See [Appendix E](#) for resources on topics outside of the scope of this Guideline.

Priority Populations

Unless specified, the recommendations in this Guideline generally apply to all people who inject drugs. The RNAO expert panel, however, identified sub-populations of people who inject drugs who have unique circumstances, experiences, and health inequities^G that need to be considered when providing support and services. These groups include:

- Indigenous^G people;
- lesbian, gay, bisexual, transgendered, queer, two-spirit, and intersex (LGBTQ2I) people;
- women; and
- pregnant persons.

It is imperative that nurses, health workers, and system leaders understand the historical and current systemic factors that contribute to the unique needs of these populations. See [Appendix F](#) for further resources on these priority populations.

Interpretation of Evidence

Levels of evidence are assigned to each study to denote the research design. Higher levels of evidence indicate that fewer potential sources of bias influenced the research findings eliminating alternative explanations of the phenomena of interest. Levels of evidence do not reflect the quality of individual studies or reviews.

In some cases, guideline recommendations are assigned more than one level of evidence. This reflects inclusion of multiple studies to support the recommendation. For transparency, the level of evidence for each component of the recommendation statement is identified in the discussion of evidence.

Table 1: Levels of Evidence

LEVEL	SOURCE OF EVIDENCE
Ia	Evidence obtained from meta-analysis ^G or systematic reviews of randomized controlled trials ^G , and/or synthesis of multiple studies primarily of quantitative research.
Ib	Evidence obtained from at least one randomized controlled trial.
IIa	Evidence obtained from at least one well-designed controlled study ^G without randomization.
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study ^G without randomization.
III	Synthesis of multiple studies, primarily of qualitative research ^G .
IV	Evidence obtained from well-designed non-experimental observational studies, such as analytical studies ^G , descriptive studies ^G , and/or qualitative studies.
V	Evidence obtained from expert opinion, committee reports, or clinical experiences of respected authorities.

Adapted by the RNAO Best Practice Guideline Development Team from: Scottish Intercollegiate Guidelines Network. SIGN 50: a guideline developer's handbook. Edinburgh: Scottish Intercollegiate Guidelines Network; 2011; and Pati D. A framework for evaluating evidence in evidence-based design. Health Environments Research and Design Journal. 2011;21(3):105–12.

Quality of Evidence

The quality of each study or review was determined using critical appraisal tools. Quality was ranked as high, moderate, or low and cited in the discussion of evidence. The validated and published quality appraisal tools included The Critical Appraisal Skills Program for primary studies, AMSTAR for systematic reviews and others to judge methodological strength of the studies. The quality rating was calculated by converting the score on the appraisal tool into a percentage. When other guidelines informed the recommendation and discussion of evidence, the AGREE II instrument was used to determine the quality rating. **Tables 2** and **3** highlight the quality scores required to achieve a high, moderate, or low quality rating.

Table 2: Quality Rating for Studies Using Critical Appraisal Tools

QUALITY SCORE ON APPRAISAL TOOLS	OVERALL QUALITY RATING
Greater than, or equal to, a converted score of 82.5%	High
A converted score of 62.5–82.4%	Moderate
Less than, or equal to, a converted score of 62.4%	Low

Table 3: Quality Rating for Guidelines Using the AGREE II Tool

QUALITY SCORE ON THE AGREE II	OVERALL QUALITY RATING
A score of 6 or 7 on the overall guideline quality	High
A score of 5 on the overall guideline quality	Moderate
A score of less than 4 on the overall guideline quality	Low (Not used to support recommendations)

For detailed explanation of the systematic review process and quality appraisal, see [Appendix D](#).

Summary of Recommendations

PRACTICE RECOMMENDATIONS		LEVEL OF EVIDENCE
<p>Research Question #1: How do health workers provide trauma-informed and culturally safe harm reduction care to people who are injecting drugs or accessing services in SIS facilities?</p>		
1.0 Practice	<p>Recommendation 1.1: Develop trusting relationships based on respect and a non-judgmental approach at every encounter with people who inject drugs to support continued engagement.</p>	IV
	<p>Recommendation 1.2: Use reflective practice to recognize and acknowledge health inequities that result from past and ongoing experiences of trauma, marginalization, and stigma experienced by people who inject drugs.</p>	IV
	<p>Recommendation 1.3: Promote and engage in shared decision-making with people who inject drugs at every encounter and intervention to minimize discrimination and stigma.</p>	IV



EDUCATION RECOMMENDATIONS		LEVEL OF EVIDENCE
<p>Research Question #2: What are effective educational strategies to increase the knowledge, attitudes, and skill that health workers need to work with people who inject drugs or access services in SIS facilities?</p>		
2.0 Education	<p>Recommendation 2.1: Design educational programs that incorporate multiple teaching methods and strategies (in-person or technology-enabled) for health workers and students to increase knowledge, skill, confidence, and improve attitudes required to provide high-quality care to people who use drugs.</p>	Ib, IIb, and IV
	<p>Recommendation 2.2: Incorporate people with lived experience and practice experts in the delivery of educational programs for health workers and students to increase knowledge and confidence, and improve attitudes required to provide high-quality care to people who use drugs.</p>	IIb and IV
	<p>Recommendation 2.3: Modify the format and structure of educational programs for health workers to support effective learning by focusing on</p> <ul style="list-style-type: none"> ■ location of training, ■ resources required for training, ■ frequency and longevity of training, and ■ method of delivery. 	Ib, IIb, and IV

ORGANIZATION AND SYSTEM POLICY RECOMMENDATIONS		LEVEL OF EVIDENCE
<p>Research Question #3: What organizational and health system policies are required to support health workers in providing high-quality care in SIS facilities?</p>		
<p>3.0 Organization and system policy</p>	<p>Recommendation 3.1: Integrate peer workers into the programming of supervised injection services by</p> <ul style="list-style-type: none"> ■ increasing access to peer workers as a vital resource for people who inject drugs, and ■ including peer workers in organizational decision-making processes 	<p>IV</p>
	<p>Recommendation 3.2: Integrate comprehensive services into the programming of supervised injection services to ensure that people who inject drugs have access to</p> <ul style="list-style-type: none"> ■ testing and counselling for blood-borne infections, ■ primary care providers, ■ mental health clinicians, and ■ housing and social services. 	<p>Ib and IV</p>
	<p>Recommendation 3.3: Embed harm reduction programs that include supervised injection services into existing health and social settings to improve retention in care and reduce adverse health outcomes among people who inject drugs.</p>	<p>IV</p>
	<p>Recommendation 3.4: Align the location, physical space, and operating hours of facilities to the needs of the local population, and make operational improvements and structural redesign (as needed) to decrease barriers for access to supervised injections services for people who inject drugs.</p>	<p>IV</p>
	<p>Recommendation 3.5: Advocate for legislation and regulations to support ethical policies and procedures that increase access to and utilization of supervised injection services for</p> <ul style="list-style-type: none"> ■ people who require assisted injection support, and ■ youth who inject drugs. 	<p>IV</p>

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Declarations of competing interests that might be construed as constituting an actual, potential, or apparent conflict were made by all members of the RNAO expert panel, and members were asked to update their disclosures throughout the guideline development process. Information was requested about financial, intellectual, personal, and other interests and documented for future reference. No limiting conflicts were identified. Details regarding disclosures are available at [RNAO.ca/bpg/supervised-injection-services](https://rnao.ca/bpg/supervised-injection-services).

Stakeholder Acknowledgment

As a component of the guideline development process, feedback was obtained from participants across a wide range of health-care organizations, practice areas, and sectors. Participants include nurses, health workers, people with lived experience, knowledgeable administrators, and funders of health-care services. Stakeholders representing diverse perspectives also were solicited* for their feedback. RNAO wishes to acknowledge the following individuals for their contribution in reviewing this Guideline.

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*Stakeholder reviewers for RNAO BPGs are identified in two ways. First, stakeholders are recruited through a public call issued on the RNAO website ([RNAO.ca/bpg/get-involved/stakeholder](https://rnao.ca/bpg/get-involved/stakeholder)). Second, individuals and organizations with expertise in the guideline topic area are identified by the RNAO Best Practice Guideline Development Team and the expert panel, and are directly invited to participate in the review.

Stakeholder reviewers are individuals with subject matter expertise in the guideline topic or those who may be affected by the implementation of the guideline. Reviewers may be nurses, health workers, administrators, researchers, educators, nursing students, or persons and family. RNAO aims to solicit stakeholder expertise and perspectives representing diverse health-care sectors, roles within nursing and other professions (e.g., clinical practice, research, education, or policy), and geographic locations.

Reviewers are asked to read a full draft of the guideline and to participate in the review prior to its publication. Stakeholder feedback is submitted online by completing a survey questionnaire. The stakeholders are asked the following questions about each recommendation:

- Is this recommendation clear?
- Do you agree with this recommendation?
- Is the discussion of evidence thorough and does the evidence support the recommendation?

Public Advisors are reviewers who have lived experience. They participate in focus groups and interviews facilitated by RNAO expert panel members to provide feedback on the guideline. Public Advisors are asked the following questions about each recommendation:

- Do you agree with this recommendation?
- Will this recommendation meet your needs?

All reviewers have the opportunity to include comments and feedback for each section of the guideline. Reviewer submissions are compiled and feedback is summarized by the RNAO Best Practice Guideline Development Team. Together with the expert panel, RNAO reviews and considers all feedback and, if necessary, modifies the guideline content and recommendations prior to publication to address the feedback received.

Stakeholder reviewers have given consent to the publication of their names and relevant information in this Guideline. Public Advisors review and sign a consent form prior to participating in focus groups or interviews, indicating whether they want to be acknowledged as an individual or group (such as a patient advisory council) or if they wish to remain anonymous.



Background Context

What is SIS?

SIS are a health-care setting where people can inject drugs under the supervision of trained health workers (4). This harm reduction service provides sterile injection supplies, drug preparation materials, overdose prevention and intervention, education, primary care, psychiatric and counselling services, and referrals to drug treatment, housing, and other health and social services.

The primary goal of SIS is to improve the physical and mental well-being of people who inject drugs. SIS aims to reduce the spread of infectious diseases (such as HIV and hepatitis), the number and case fatality of drug overdoses, and incidents of community issues or health risks (such as public drug use or discarded needles). SIS also facilitates contact with other health and social services (5).

Countries around the world have implemented SIS, such as Australia, Denmark, Germany, Luxembourg, the Netherlands, Norway, Spain, and Switzerland (6). Internationally, SIS may be referred to as “supervised injection facilities,” “safer injection sites,” “drug/supervised consumption rooms,” or “supervised injecting centers.” Different SIS models exist, such as stand-alone models (e.g., Insite in Vancouver), integrated models (e.g., Dr. Peter Centre in Vancouver), embedded models (e.g., in-hospital SIS in Lariboisière Hospital in Paris), mobile outreach models (e.g., L’Anonyme in Montréal), and women-only models (e.g., SisterSpace in Vancouver) (7).

The Role of Nurses in SIS

Nurses working within SIS provide vital health and social services and are ideally positioned to engage with people who inject drugs, particularly those at high risk for injection-related harm (e.g., females and people requiring assisted injection) (8). The care provided is within the registered nurse’s scope of practice and aligns with the Canadian Nurses Association Code of Ethics (6, 9). The Code of Ethics involves:

- providing safe, compassionate, competent, and ethical care;
- promoting health and well-being;
- promoting and respecting informed decision making;
- preserving dignity;
- maintaining privacy and confidentiality;
- promoting justice; and
- being accountable (10).

Engaging people who inject drugs, establishing a rapport with them, and maintaining relationships over time are foundational to nursing practice in SIS and are the focus of the practice recommendations in this Guideline.

Nurses are integral to the effective and safe delivery of SIS. They require advanced foundational (e.g., harm reduction, culturally safe, and trauma-informed practices) and clinical preparation to manage the complex and rapidly changing needs of people who inject drugs. Nurses employed in SIS should have specific knowledge, skill, and expertise to provide effective and safe support and services to people who inject drugs (see “Practice Notes” in **Recommendation 2.1** for a list of knowledge and skills applicable to nurses in SIS).

The role of nurses in SIS encompasses a holistic approach and may include (but is not limited to) the following responsibilities and activities:

- providing safer injection education;
- monitoring for and managing unsafe injection practices;
- monitoring for signs of drug overdose or anaphylaxis;
- intervening in emergency situations;
- assessing and managing skin and soft tissue infections (e.g., abscesses and cellulitis);
- providing testing and counselling for blood-borne infectious diseases (e.g., HIV and hepatitis B and C);
- administering immunizations;
- supporting health promotion;
- providing education related to the prevention of skin and soft tissue infections and blood-borne infections;
- developing community partnerships and referring clients to relevant health and social services if requested (e.g., drug treatment services, primary care services, specialists, hospitals, housing, and income and food support);
- helping navigate institutional systems like the health-care or justice systems;
- being accountable; and
- providing emotional support and counselling (8–12).

See [Appendices D](#) and [E](#) for other guidelines and resources relevant to clinical practice in SIS.

Positive Outcomes of SIS

International peer-reviewed research has demonstrated the benefits of SIS for both people who inject drugs and the broader community. SIS has achieved the following:

- increasing access to nursing, medical, and social services;
- reducing drug-related morbidity and mortality;
- reducing HIV and hepatitis C risk behaviours;
- reducing the prevalence and harms of bacterial infections;
- providing safer injection education and a subsequent increase in safer injecting practices;
- increasing uptake of drug treatment and use of detoxification services;
- attracting and retaining a high risk population of people who inject drugs;
- providing a safer alternative to public and private injection settings (including protection from violence and theft, and helping reduce arrest or criminal prosecution);
- reducing initiation into injection drug use;
- reducing community drug use;
- reducing drug-related crime;
- reducing public disorder and public injecting behaviour, and increasing public safety; and
- providing cost savings due to reductions in disease, overdose deaths, and need for emergency medical services(13–15).

Challenges in SIS Implementation

The implementation of SIS faces a number of challenges, including operational design, service delivery models, and exclusionary policies that reject or obstruct sub-groups of people who inject drugs from accessing services. Some key implementation considerations that require careful deliberation include the following:

- how to determine location and capacity of the facility (e.g., how many injection booths will be provided);
- what operating hours should the facility offer (e.g., limited hours/days or open 24 hours per day, seven days a week);
- how will the facility provide services to youth, pregnant persons, and people who require assisted injection;
- how will the facility provide services to people who need to split or share drugs with others; and
- will funding include ongoing distribution of optimal harm reduction supplies (e.g., drug analysis service and high-quality injection equipment) (13, 15).

Health Inequities among People Who Inject Drugs and Their Root Causes

Health Complications Associated with Injection Drug Use

Injection drug use is associated with high mortality compared to that of the general population. Major causes of death for people who inject drugs are related to drug overdose and AIDS-related mortality (16). Other health-related harms associated with injection drug use include high prevalence of hepatitis C (17–19), injection site infections and injuries (such as bacterial skin and soft tissue infections and chronic wounds) (20–22), and an increased risk of tuberculosis (23).

Root Causes of Health Consequences

The consequences associated with drug use must be addressed concurrently with the social determinants of health^G that influence health equity and well-being, such as homelessness, poverty, unemployment, and lack of social support (24, 25). These determinants are further impacted by stigma towards people who inject drugs and drug policies that rely on criminalization and punishment to manage drug use. These negative attitudes and prejudiced approaches exacerbate the health inequities that people who inject drugs may already experience due to their social circumstances (24).

Globally, current drug policies contribute to poor health outcomes for people who inject drugs because drug prohibition regulations can impede their access to health care and harm reduction services (26, 27). These barriers to access put people who inject drugs at risk for violence, communicable-disease transmission (such as HIV and viral hepatitis), and overdose-related morbidity and mortality (19, 24, 26, 28, 29). Enforcement of drug laws in some countries has also led to targeting and incarceration of certain racial and ethnic populations, further exacerbating the health inequities they experience (26, 30). An example of this is Indigenous people in Canada, who have been gravely impacted by Canada's history of colonization and ongoing systemic racism, resulting in personal and intergenerational trauma that increases their risk of drug use and the health consequences associated with injection drug use. In British Columbia, for instance, Indigenous people and their communities are disproportionately affected by the opioid public health crisis compared to other populations who use opioids (31). The unfair distribution of the social determinants of health and the systematic discrimination allowed by current drug policy has serious negative implications for individuals, families, and communities.

SIS as an Approach to Addressing Health Inequities

Drug criminalization policies that negate public health and human rights considerations increase the health risks of people who inject drugs and their communities by undermining harm reduction and creating stigma (29). SIS must move beyond a narrow focus on harms directly related to drugs and drug use to address the social determinants of health inequities^G and associated health policies (26, 27, 30). SIS clinical and organizational approaches that are based on harm reduction, cultural safety, and trauma-informed practice can promote health equity (32).

Table 4 supplies more information on the principles associated with harm reduction, cultural safety, and trauma-informed practice. **Figure 1** provides a visual representation of these approaches and principles within the context of SIS.



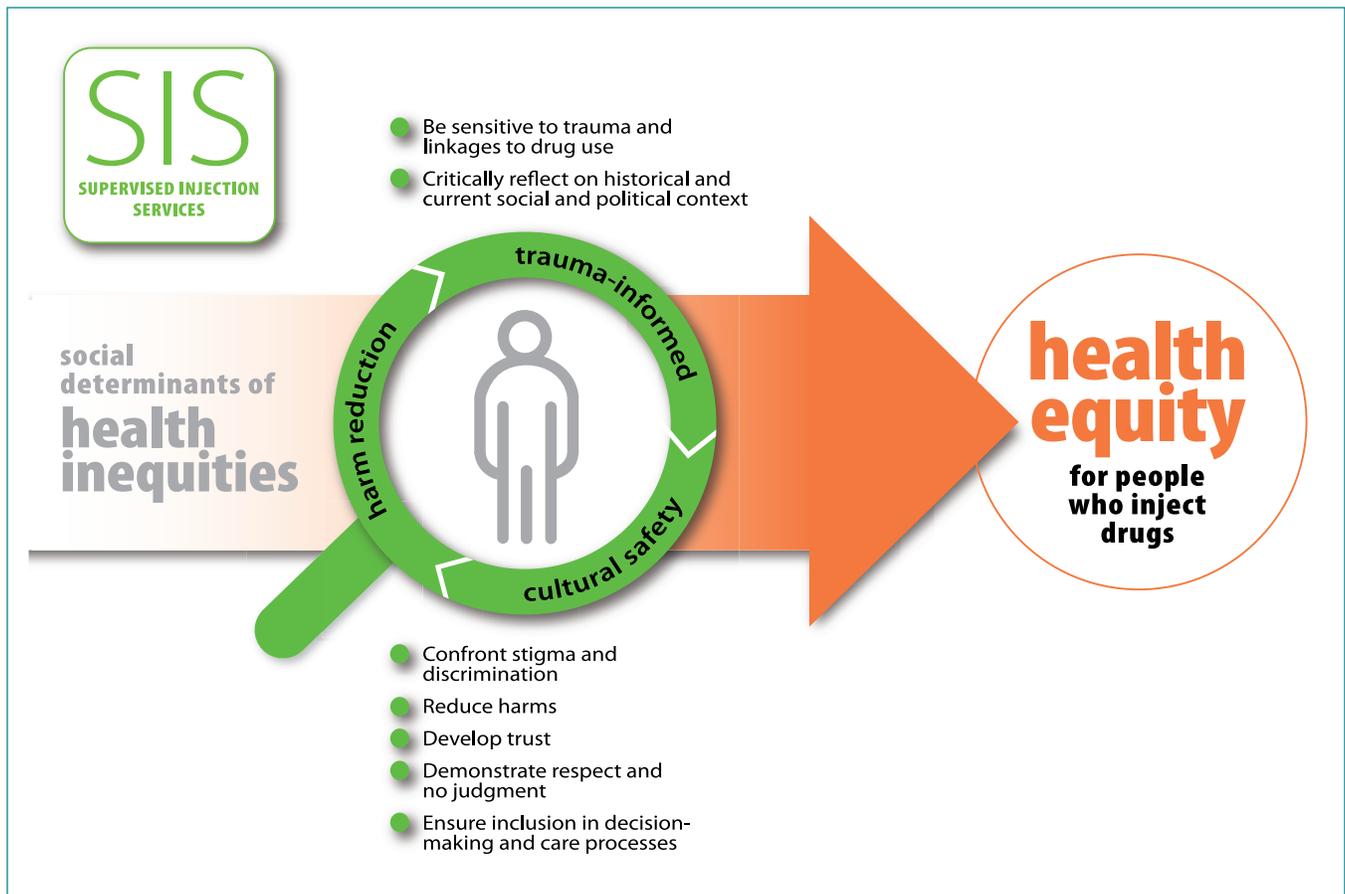
Table 4: Key Approaches to Promote Health Equity

APPROACH	DESCRIPTION
Cultural safety (33, 34)	<ul style="list-style-type: none"> ■ Cultural safety in the context of this Guideline refers to providing culturally safe care for all people who inject drugs in SIS. ■ It requires nurses and other health workers to undertake a process of self-reflection on their own history, cultural identity, and privilege, and that they recognize the impact that their personal experiences have on their beliefs, attitudes, and practice. ■ It also involves recognizing imbalances of power and shifting that power from health workers to people who inject drugs. <p>Five elements of providing culturally safe care to people who inject drugs:</p> <ol style="list-style-type: none"> 1. Promote engagement and participation of people who inject drugs in care. 2. Recognize that health status and drug use is influenced by the criminalization of drug use. 3. Consider how past and current histories of trauma, marginalization, and stigma affect how people who inject drugs engage with the health system. 4. Build positive, trust-based relationships with people who inject drugs. 5. Develop a culture of respect and safety within the health-care environment that supports culturally safe care.
Harm reduction (35, 36)	<ul style="list-style-type: none"> ■ Harm reduction involves taking action through policy and programming to reduce the physical and psychological health harms or risks associated with drug use. ■ Its approaches are evidence-based and cost-effective. ■ Harm reduction does not require abstinence from drugs, nor does it preclude people who inject drugs from choosing abstinence. ■ It involves regarding people who inject drugs with dignity and respect. ■ It also promotes responses to drug use that protect human rights. ■ It utilizes non-judgmental approaches. ■ Harm reduction has the potential to reach highly marginalized people who inject drugs. ■ It seeks to foster connection to other health (e.g., primary care), social (e.g., housing), and drug treatment services (e.g., detoxification services), if requested by people who inject drugs. ■ It challenges laws and policies that contribute to drug-related health harms. ■ It involves people who inject drugs in policy and programming decisions that affect them.

APPROACH	DESCRIPTION
<p>Trauma-informed practice (37, 38)</p>	<ul style="list-style-type: none"> ■ Trauma-informed practice requires an understanding of, and responsiveness to, the impact that trauma has on the health and drug use of people who inject drugs (e.g., a history of early physical or psychological trauma, physical and/or sexual abuse, abandonment, and co-morbidity involving mental illness and drug use). ■ It emphasizes choice, control, and safety. ■ It does not focus on treatment for trauma or require disclosure of trauma. ■ It ensures that care is provided in a manner that does not further traumatize people who inject drugs.



Figure 1: Approaches to Promoting Health Equity in SIS



Source: Developed by the RNAO Guideline Development Team in collaboration with the RNAO expert panel.

Figure 1 shows the process for improving health equity for people who inject drugs in SIS (moving from left to right). The far left column represents the inequities people experience as a result of the social determinants of health (see **Root Causes of Health Consequences**). The middle column outlines key principles grounded in harm reduction, cultural safety, and trauma-informed practice (see detailed description in **Table 4**). The principles support person engagement and promote the establishment of trusting and inclusive relationships. When nurses, health workers, and decision-makers utilize these principles in clinical and organizational approaches, it addresses health equity for people who inject drugs (circle on far right).

RECOMMENDATIONS

Practice Recommendations

RESEARCH QUESTION #1:

How do health workers provide trauma-informed and culturally safe harm reduction care to people who are injecting drugs or accessing services in SIS facilities?

RECOMMENDATION 1.1:

Develop trusting relationships based on respect and a non-judgmental approach at every encounter with people who inject drugs to support continued engagement.

Level of Evidence for Summary: IV

Quality of Evidence for Summary: High = 2; Moderate = 5

Discussion of Evidence:

Evidence Summary

Research evidence indicates that trusting relationships are fundamental to the delivery of effective health services for people who inject drugs. Demonstrating respect and non-judgmental acceptance of people who inject drugs is essential when building trusting therapeutic relationships (39–42). As a person receiving care at a Canadian supervised injection service stated, “there is no judgment there . . . I’m not judged or mocked for what I am . . . they [the nurses] help us to build character” (41).

Establishing trust is a continuous process that may require multiple encounters with people who inject drugs and ongoing demonstration of respect and non-judgment on the part of health workers (39, 43). Building trust is a mutual process wherein people who inject drugs feel safe to invest in relationships with health workers who are trustworthy and trusting of people who inject drugs (40).

Developing trusting relationships is important with all people who inject drugs, but special consideration should be given to engaging women who use drugs, as they often are highly vulnerable and have limited access to services. Family physicians and midwives attempting to engage women who use drugs are more able to establish trust if the women feel genuinely respected and not judged during the care encounter (44, 45).

Practice Notes

Examples of behaviours that demonstrate trusting, respectful, and non-judgmental approaches towards people who inject drugs include the following:

- determining readiness, reading cues, and refraining from “pushing too hard” for the person to make changes;
- having people set their own priorities rather than following an agenda driven by health workers;
- being humble, patient, and sympathetic;
- listening actively, inquiring about the well-being of people, or offering practical support;
- using “eliciting” styles of communication, such as asking open-ended questions;

- spending time with people and being open and honest regarding health-care matters;
- having an appreciation of social stigmatization, including negative experiences and mistrust based on past encounters that people have had with the health and social systems; and
- acknowledging that drug-related harm is driven by social and structural inequities (e.g., social determinants of health inequities) (34, 39, 40, 44–48).

Benefits and Harms

The health and social benefits of trusting relationships for people who inject drugs include the following:

- improved health outcomes;
- prevention and treatment of drug overdoses;
- referral and increased access to health and social services and drug treatment programs;
- increased self-esteem, hope, and motivation to seek support;
- feeling supported, important, understood, welcome, comfortable, safe, and valued (34, 39–43, 47, 48).

When people who inject drugs do not have a trusting relationship with health workers, the following harms can occur:

- avoiding or delaying seeking support and services;
- withdrawing from services before the health issue has been addressed;
- not being open to sharing about their lives;
- feeling stigmatized and discriminated against;
- feeling excluded, judged, labeled, and “under surveillance”; and
- feeling a loss of power and control (34, 39, 40, 43).

Values and Preferences

The RNAO expert panel attributed high value to ensuring that people who inject drugs feel respected and accepted within all encounters at health and social settings. This therapeutic and supportive relationship dynamic facilitates their return to SIS for ongoing care, and it may prevent negative health outcomes.

Additional Resources

RESOURCE	DESCRIPTION
<p>British Columbia Centre for Disease Control. Respectful language and stigma regarding people who use substances [Internet]. Vancouver (BC): British Columbia Centre for Disease Control; 2017. Available from: http://www.bccdc.ca/resource-gallery/Documents/respectful-language-and-stigma-final_244.pdf</p>	<ul style="list-style-type: none"> ■ Provides an overview of what stigma is and how it influences health. ■ Provides recommendations on language that reduces stigma around drug use.
<p>Canadian Medical Association. CMA code of ethics (update 2004) [Internet]. Ottawa (ON): Canadian Medical Association. Available from: https://www.cma.ca/En/Pages/code-of-ethics.aspx</p>	<ul style="list-style-type: none"> ■ Provides an ethical guide for Canadian physicians, including residents and medical students. ■ Based on the fundamental principles and values of medical ethics, such as compassion, beneficence, non-maleficence, respect for persons, justice, and accountability.
<p>Canadian Nurses Association. Code of ethics for registered nurses [Internet]. Ottawa (ON): Canadian Nurses Association; 2017. Available from: https://cna-aiic.ca/en/on-the-issues/best-nursing/nursing-ethics</p>	<ul style="list-style-type: none"> ■ Outlines the specific values and ethical responsibilities expected of nurses in Canada. ■ Addresses how nurses can address social inequities as part of ethical practice.
<p>Canadian Nurses Association. Therapeutic nurse–client relationship [Internet]. Rev. ed. Toronto (ON): College of Nurses of Ontario; 2006. Available from: http://www.cno.org/en/learn-about-standards-guidelines/educational-tools/learning-modules/therapeutic-nurse-client-relationship/</p>	<ul style="list-style-type: none"> ■ Includes four standard statements with indicators that describe the ways in which a nurse is accountable in the nurse–client relationship. ■ Describes the five components of the nurse–client relationship: trust, respect, professional intimacy, empathy, and power.
<p>Registered Nurses' Association of Ontario. Establishing therapeutic relationships. Toronto (ON): Registered Nurses' Association of Ontario; 2006. Available from: http://rnao.ca/bpg/guidelines/establishing-therapeutic-relationships</p>	<ul style="list-style-type: none"> ■ Provides resources necessary for the support of evidence-based nursing practice in the area of establishing therapeutic relationships.

RECOMMENDATION 1.2:

Use reflective practice to recognize and acknowledge health inequities that result from past and ongoing experiences of trauma, marginalization, and stigma experienced by people who inject drugs.

Level of Evidence for Summary: IV

Quality of Evidence for Summary: High = 2; Moderate = 2; Low = 1

Discussion of Evidence:**Evidence Summary**

Research demonstrates that people who inject drugs are likely to have experienced multiple and continuing forms of trauma from childhood to adulthood through a variety of contexts and offenders and on multiple levels. Living with these adversities can contribute to drug use as a means of coping (42, 49). Health-care experiences among people who inject drugs may involve feeling unsafe to engage with health workers due to stigmatizing systems that criminalize drug use (45, 50). People who inject drugs have expressed fear that they will be ignored or seen as undeserving of care, which can contribute to decisions to delay care and withdraw from services (34, 50).

Reflecting on past and ongoing trauma, marginalization, and stigma experienced by people who inject drugs enables health workers to recognize and acknowledge the conditions surrounding drug use and health inequities. People's decisions and actions—including drug use—are influenced by external determinants, such as social, political, and economic factors. This perspective puts people's behaviour into context and recognizes that choices and decisions are influenced by life circumstances rather than an individual flaw (50).

Practice Notes

Reflective practice can be better understood within the concepts of critical inquiry and cultural safety. Critical inquiry provides a method for health workers to reflect on their actions when providing care to people who inject drugs. It is defined by the College of Nurses of Ontario as “a process of purposive thinking and reflective reasoning where practitioners examine ideas, assumptions, principles, conclusions, beliefs, and actions in the context of nursing practice” (51). Applying the concept of cultural safety takes critical inquiry a step further by requiring nurses to reflect on “issues of racialization, institutionalized discrimination, culturalism, and health and health-care inequities” (51). Thus, cultural safety is particularly relevant in the provision of nursing care for people who inject drugs who are experiencing health inequities (34).

Examples of behaviours that demonstrate reflective practice in the provision of care for people who inject drugs include the following:

- Taking into account the impact of trauma on the lives, development, and drug use of people. This does not necessarily require disclosure of trauma.
- Understanding the broader social circumstances that impact drug use or the social determinants of drug use.

- Shifting perspective regarding drug use and people who inject drugs to include consideration for stigma and societal circumstances that contribute to the harms of drug use.
- Recognizing that people's health, health care, priorities, and experiences are influenced by history and policies that criminalize drug use.
- Considering past histories of trauma, violence, and stigma, as doing so may help health workers engage with people who inject drugs.
- Critically reflecting on how drug use is framed in health care and impacts on interactions with people who inject drugs (34, 49, 50).

Benefits and Harms

See **Recommendation 1.1** for the applicable health- and social-related benefits and harms. The research suggests that benefits and harms associated with this recommendation are consistent with those outlined in **Recommendation 1.1**.

Values and Preferences

The evidence indicates that people who inject drugs prefer that health workers utilize trauma-informed practices (see **Table 4**) rather than implementing trauma-specific interventions⁶ (49). Trauma-specific interventions should be initiated when a need is indicated through shared decision-making. The RNAO expert panel attributed high value to health workers regularly conducting reflective practice.

Additional Resources

RESOURCES ON CULTURAL SAFETY	DESCRIPTION
Canadian Association of Nurses in AIDS Care. Position statement: cultural safety for First Nations, Inuit and Métis people [Internet]. Regina (SK): Canadian Association of Nurses in AIDS Care; 2000. Available from: http://canac.org/about-us/position-statements/	<ul style="list-style-type: none"> ■ Outlines culturally safe nursing in the context of HIV and AIDS, and key position statements with respect to working with Indigenous people living with HIV and AIDS.
Pauly B, McCall J, Parker J, et al. Creating culturally safe care in hospital settings for people who use(d) illicit drugs. Centre for Addictions Research of BC [Internet]. 2013;11:1–6. Available from: https://www.researchgate.net/publication/289250069_Creating_Culturally_Safe_Care_in_Hospital_Settings_for_People_who_Used_Drugs	<ul style="list-style-type: none"> ■ Highlights five elements of culturally safe care to guide nursing practice for people who use drugs.
Thunderbird Partnership Foundation. A cultural safety toolkit for mental health and addiction workers in-service with First Nations people [Internet]. Bothwell (ON): Thunderbird Partnership Foundation; 2013. Available from: http://thunderbirdpf.org/nnapf-document-library/	<ul style="list-style-type: none"> ■ Contains exercises to promote critical reflection and cultural safety.

RESOURCES ON THE IMPACT OF CRIMINALIZATION AND DRUG POLICY	DESCRIPTION
<p>Boyd S. Lecture: An illustrated history of Canadian drug policy and prohibition [Video]. Vancouver (BC): [publisher unknown]; 2015. Available from: https://youtu.be/3tF2gp2QgF0</p>	<ul style="list-style-type: none"> ■ Provides an overview of Canadian drug policy and prohibition over a century.
<p>Dodd Z. The drug war reading list: recommended texts on race, class, gender and the war on drugs [Internet]. [place unknown: publisher unknown]; 2016. Available from: https://drive.google.com/file/d/0B9UC2Cb0oww2QkQxV1lnSHU4MXc/view</p>	<ul style="list-style-type: none"> ■ Provides a list of books to assist with understanding the war on drugs, harm reduction, and the impacts of drug policy. ■ Highlights how race, class, and gender impact personal experiences.
<p>International Network of People Who Use Drugs. Drug user peace initiative: stigmatizing people who use drugs [Internet]. London (ON): International Network of People Who Use Drugs; 2014. Available from: http://www.druguserpeaceinitiative.org/dupidocuments/DUPI-Stigmatising People who Use Drugs.pdf</p>	<ul style="list-style-type: none"> ■ Provides an overview of how criminalization leads to stigma, the ways in which people who inject drugs are stigmatized, and the impacts of stigma.
<p>Levy J. The harms of drug use: criminalization, misinformation, and stigma [Internet]. London (ON): [publisher unknown; date unknown]. Available from: http://www.inpud.net/The Harms of Drug Use JayLevy2014 INPUD YouthRISE.pdf</p>	<ul style="list-style-type: none"> ■ Explains how drug laws and policies—along with social constructions and stigma—are responsible for increasing the harms of drug use.
RESOURCES ON TRAUMA-INFORMED PRACTICE	DESCRIPTION
<p>Aguiar W, Halseth R. Aboriginal peoples and historic trauma: the processes of intergenerational transmission [Internet]. Prince George (BC): National Collaborating Centre for Aboriginal Health; 2015. Available from: https://www.ccnsa-nccah.ca/495/Aboriginal Peoples and Historic Trauma The process of intergenerational transmission.nccah?id=142</p>	<ul style="list-style-type: none"> ■ Provides an overview of trauma, how it is defined, and how it must be conceptualized within the context of Indigenous people in Canada. ■ Examines the psychological, physiological, and social processes by which trauma can be transmitted.

RESOURCES ON TRAUMA-INFORMED PRACTICE	DESCRIPTION
<p>Arthur E, Seymour A, Dartnall M, et al. Trauma-informed practice guide [Internet]. Vancouver (BC): BC Centre of Excellence for Women's Health; 2013. Available from: https://bccewh.bc.ca/2014/02/trauma-informed-practice-guide/</p>	<ul style="list-style-type: none"> ■ Provides feasible strategies for health workers and system planners for supporting the application of trauma-informed principles in practice and policy.
<p>BC Centre for Excellence for Women's Health. Trauma-informed practice resources [Internet]. Vancouver (BC): BC Centre for Excellence for Women's Health; 2017. Available from: http://bccewh.bc.ca/2017/03/trauma-informed-practice-resources/</p>	<ul style="list-style-type: none"> ■ Provides a selection of resources and curricula related to trauma-informed practice.
<p>Jean Tweed Centre. Trauma matters: guidelines for trauma-informed practices. Toronto (ON): Jean Tweed Centre; 2013. Available from: http://www.addictionsandmentalhealthontario.ca/research-and-tools/trauma-matters-guidelines-for-trauma-informed-practices-in-womens-substance-use-services</p>	<ul style="list-style-type: none"> ■ Presents fundamental information about trauma-informed and evidence-informed practices for organizations to provide substance use services for women.
RESOURCES ON SOCIAL DETERMINANTS OF HEALTH	DESCRIPTION
<p>Registered Nurses' Association of Ontario. Nursing towards equity: applying the social determinants of health in practice [Internet]. Toronto (ON): Registered Nurses' Association of Ontario; 2014. Available from: http://rnao.ca/bpg/courses/nursing-towards-equity-applying-social-determinants-health-practice</p>	<ul style="list-style-type: none"> ■ Provides an overview on how to screen and intervene with people at risk for poverty, integrate social determinants of health theory into organizational practices, and implement methods to apply health equity concepts into advocacy and political action to create change.

See **Appendix F** for additional resources on sub-populations of people who inject drugs that the RNAO expert panel has identified as priority populations for the purposes of this Guideline.

RECOMMENDATION 1.3:

Promote and engage in shared decision-making with people who inject drugs at every encounter and intervention to minimize discrimination and stigma.

Level of Evidence for Summary: IV

Quality of Evidence: High = 1; Moderate = 5

Discussion of Evidence:**Evidence Summary**

Promoting and engaging in shared decision-making with people who inject drugs supports an equitable distribution of power and respect during the provision of care. Unequal power relations contribute to discrimination and stigma associated with drug use, negatively impacting interactions with health workers and affecting health consequences (52). For example, perceived discrimination and stigma by health workers may discourage people who inject drugs from seeking treatment for hepatitis C virus (HCV), or may result in risky injection practices (40, 53). Health workers need to be aware that people who inject drugs may have a heightened sensitivity to discrimination and stigma. There is potential for misinterpretation of their actions, particularly among people who inject drugs with past negative experiences (40, 53). It is the responsibility of health workers to utilize approaches that convey respect to support ongoing engagement in the service. Shared decision-making is recommended at the practice level during the provision of care and at the organizational level during the planning, development, and delivery of services (see **Recommendation 3.1**) (45, 50, 54).

Practice Notes

Shared decision-making promotes a collaborative relationship in which the person is an expert in their health and well-being (55). It requires health workers to act as coaches who provide education and counselling on service and treatment options. Shared decision-making redistributes power and demonstrates respect for the ability of people who inject drugs to make their own decisions and set their own health priorities (55).

Examples of behaviours that demonstrate shared decision-making with people who inject drugs include the following:

- being sensitive to interpersonal dynamics and adapting one's interactional style (as needed);
- supporting people to set their own health priorities;
- respecting people's knowledge of their bodies and health;
- supporting people's personal agency; and
- fostering the engagement and participation of people who inject drugs in shaping the care they and their peers receive (45, 52).

Benefits and Harms

The benefits of shared decision-making for people who inject drugs include the following:

- feeling recognized and acknowledged as a human being,
- enjoying productive and satisfying interactions with health workers,
- experiencing enhanced health and well-being,

- possessing a sense of ownership in their own care, and
- developing increased personal capacity (50, 53, 54).

The harms of a paternalistic or traditional model of care for people who inject drugs include the following:

- feeling powerless, marginalized, and discriminated against;
- feeling judged as “drug addicts”;
- seeing the health-care system as an unsafe institution that is prone to negative and moralizing judgments;
- not being listened to regarding their knowledge of their bodies and health; and
- experiencing the perpetuation of internalized oppression and trauma (50, 53, 54).

Values and Preferences

The RNAO expert panel attributed high value to embedding the person as the expert in their own care and supporting shared decision-making. This improves health equity by mitigating stigma and reducing discrimination.

Additional Resources

SHARED DECISION-MAKING TOOLS AND RESOURCES	DESCRIPTION
Fraser Health. Engaging in overdose prevention conversations [Internet]. Surrey (BC): Fraser Health; 2017. Available from: http://www.fraserhealth.ca/media/Engaging-in-OD-Conversations.pdf	<ul style="list-style-type: none"> ■ Overview of the core elements that support good engagement in overdose prevention conversations.
Ottawa Personal Decision Guides [Internet]. Ottawa (ON): Ottawa Hospital Research Institute; 2015. Co-published by the University of Ottawa. Available from: https://decisionaid.ohri.ca/decguide.html	<ul style="list-style-type: none"> ■ An approach to support people to identify their decision-making needs, plan next steps, track their progress, and share their views about the decision.
Ottawa decision support tutorial [Internet]. Ottawa (ON): Ottawa Hospital Research Institute; 2015. Co-published by the University of Ottawa. Available from: https://decisionaid.ohri.ca/	<ul style="list-style-type: none"> ■ Designed to help health workers develop their knowledge and skills to support decision making.
SHARE Approach Workshop [Internet]. Rockville (MD): Agency for Healthcare Research and Quality; 2014. Available from: https://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/workshop/index.html	<ul style="list-style-type: none"> ■ A curriculum to support the training of health workers on how to engage patients in their health-care decision making.
The SHARE Approach: A Model for Shared Decision Making—Fact Sheet [Internet]. Rockville (MD): Agency for Healthcare Research and Quality; 2016. Available from: https://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/tools/sharefactsheet/index.html	<ul style="list-style-type: none"> ■ A five-step process for shared decision-making that includes exploring and comparing the benefits, harms, and risks of each option through meaningful dialogue about what matters most to the person.

Education Recommendations

RESEARCH QUESTION #2:

What are effective educational strategies to increase the knowledge, attitudes, and skill that health workers need to work with people who inject drugs or access services in SIS facilities?

RECOMMENDATION 2.1:

Design educational programs that incorporate multiple teaching methods and strategies (in-person or technology-enabled) for health workers and students to increase knowledge, skill, confidence, and improve attitudes required to provide high-quality care to people who use drugs.

Level of Evidence for Summary: Ib, IIb, and IV

Quality of Evidence for Summary: High = 1; Moderate = 6

Discussion of Evidence:

Evidence Summary

Organizations and academic institutions should develop educational programs and curricula (in-person or technology-enabled) that include a combination of didactic and participatory strategies to support health workers and students in providing high-quality care to people who inject drugs. Research indicates that multiple and blended approaches to training effectively increase the knowledge, skill, and confidence required to work with people who inject drugs (50, 53, 54, 56–59). Other positive outcomes include improving the attitudes of health workers and students towards people who inject drugs, including pregnant persons and youth (60–62). Specific skill sets and knowledge include improving communication skills (62), understanding gender differences in treatment (60), managing opioid overdose and administering naloxone (56), engaging youth (61), understanding key practice areas in mental health (58), learning motivational interviewing skills (59), and using the Screening, Brief Intervention, and Referral to Treatment (SBIRT) tool (57).

Examples of evidence-based teaching strategies include lectures, presentations (PowerPoint or multimedia), role-playing, case studies, demonstrations (live or on video), coaching and feedback, and peer group discussions.

Practice Notes

The RNAO Guideline Development Lead conducted key informant interviews and focus group sessions with experts in harm reduction and SIS and people with lived experience. Participants indicated that nurses and health workers in SIS require specific knowledge, skills, and expertise. Participants recommended the following list of key areas and required skills to support delivery of care to people who inject drugs:

- safe injection assessment, monitoring, techniques, and teaching;
- overdose prevention, monitoring, and management;
- prevention, assessment, and management of wounds related to injection use;

- assessment and management of mental health issues;
- harm reduction;
- crisis intervention (e.g., techniques for de-escalating behaviour);
- motivational interviewing;
- knowledge of drugs (e.g., types of drugs, how they are used, their effects and ingredients, and how they should be prepared for injection);
- assessment and management of withdrawal;
- pharmacological and psychosocial drug treatment approaches;
- testing and counselling for infections associated with injection use (e.g., HIV, HCV, and other sexually transmitted infections);
- knowledge of appropriate referrals to health and social services that support people who inject drugs;
- knowledge of diverse cultural and holistic healing traditions; and
- knowledge of the unique needs of Indigenous people, LGBTQ2I, youth, women, and pregnant persons.

See [Appendices D, E, and F](#) and [Recommendation 3.5](#) for further resources on the above areas and skills.

Benefits and Harms

Organizations and academic institutions need to incorporate multiple teaching methods and strategies to improve the knowledge and skills of students and health workers when caring for people who inject drugs. Building and enhancing expertise specific to people who inject drugs may improve benefits and minimize harms in the provision of care.

Values and Preferences

The RNAO expert panel attributed high value to educational methods and strategies that effectively increase knowledge and skill as described in the practice notes.



Additional Resources

RESOURCES TO SUPPORT LEARNING	DESCRIPTION
<p>Registered Nurses' Association of Ontario. Nurse educator mental health and addiction resource: integrating mental health and addiction into the undergraduate nursing curriculum [Internet]. Toronto (ON): Registered Nurses' Association of Ontario; 2017. Available from: http://rnao.ca/bpg/initiatives/mhai/mhar</p>	<ul style="list-style-type: none"> ■ Supports educators to integrate mental health and addiction knowledge and skills into the undergraduate nursing curriculum. ■ Based on the Canadian Association of Schools of Nursing (CASN) and the Canadian Federation of Mental Health Nurses (CFMHN) Entry-to-Practice Mental Health and Addiction Competencies for Undergraduate Nursing Education in Canada (2015) and supporting research.
<p>Registered Nurses' Association of Ontario. Practice education in nursing [Internet]. Toronto (ON): Registered Nurses' Association of Ontario; 2016. Available from: http://rnao.ca/bpg/guidelines/practice-education-nursing</p>	<ul style="list-style-type: none"> ■ Provides evidence-based recommendations that promote and sustain the undergraduate nursing student's application of knowledge to practice in a variety of clinical learning environments. ■ The guideline is framed within the system of interaction among educational institutions, service agencies, and policy-makers, with specific recommendations for each entity.

RECOMMENDATIONS

RECOMMENDATION 2.2:

Partner with people with lived experience and practice experts in the delivery of educational programs for health workers and students to increase knowledge and confidence, and improve attitudes required to provide high-quality care to people who use drugs.

Level of Evidence for Summary: IIb and IV

Quality of Evidence for Summary: Moderate = 5

Discussion of Evidence:**Evidence Summary**

Organizations and academic institutions should partner in the delivery of educational programs and curricula, both with people who inject drugs from diverse backgrounds and with practice experts. Doing so will support health workers and students in providing high-quality care to people who inject drugs; the involvement of both practice experts and people with lived experience in teaching, feedback, consultation, and guidance also strengthens knowledge translation. This integrated approach—combined with multiple educational methods and strategies—has been shown to increase the knowledge and confidence required to work with people who inject drugs and to improve the attitudes of health workers and students (60, 61, 63–65).

This approach has positively affected the use of harm reduction as a pragmatic strategy for addressing drug use (65). Learners have increased their knowledge and confidence in the areas of substance use disorder issues (63), treatment methodologies (60), and youth mental health and mental illness (61).

Practice Notes

Examples of educational strategies include the following:

- question and answer sessions with a panel of people with lived experience;
- presentations and lectures from people with lived experience or from practice experts;
- training sessions led by people with lived experience;
- attendance at support groups for people who use drugs and visiting treatment facilities where people are receiving services and supports;
- student placements in community-based harm reduction services or agencies; and
- feedback, guidance, role modeling, and coaching from practice experts during skill acquisition (61, 65–70).

See [Appendix G](#) for a list of Canadian peer-run support organizations led by people who use drugs that may be able to provide experiential knowledge and educational support.

Benefits and Harms

The opportunity to learn from people with lived experience and practice experts promotes the development of advanced knowledge and competency. It has the potential to change negative attitudes that perpetuate damaging stigma and discrimination towards people who inject drugs, but the benefits also extend to people who inject drugs, because they are recognized for their leadership, resilience, and influence to enact change.

People who inject drugs are at risk for stigmatization, disrespect and judgments during training sessions when engaging with learners that may be inexperienced at applying the principles of harm reduction, cultural safety, and trauma-informed practices. The unique needs of priority populations (such as Indigenous people) need to be considered in the context of including them in educational programs in order to prevent any potential harm associated with interacting with learners.

Values and Preferences

Health workers prefer multiple educational methods and strategies that are provided by qualified and experienced people (69, 71). The RNAO expert panel attributed high value to people who inject drugs informing the design and plan of educational programs, and to avoid the tokenistic inclusion of people who inject drugs.

Additional Resources

DOCUMENTARIES TO SUPPORT LEARNING	DESCRIPTION
Gibson H. The stairs [motion picture]. [Toronto (ON)]: Midnight Lamp Films; 2016.	<ul style="list-style-type: none"> Examines the lives of people who use drugs in Toronto's Regent Park and challenges the prejudice and preconceived notions about addiction.
Naylor L. The fix [motion picture]. [Brooklyn (NY)]: By The By Productions; 2014.	<ul style="list-style-type: none"> Portrays life after heroin addiction.
Wild N, Bevel up [motion picture]. Gold F, Maginley J, Carson B, et al., producers. [Vancouver (BC)]: BC Centre for Disease Control; 2007. Co-published by National Film Board of Canada.	<ul style="list-style-type: none"> Depicts the experience of health workers who provide care to people who use drugs in Vancouver's Downtown Eastside.

RECOMMENDATION 2.3:

Modify the format and structure of educational programs for health workers to support effective learning by focusing on

- location of training,
- resources required for training,
- frequency and longevity of training, and
- method of delivery.

Level of Evidence for Summary: Ib, IIb, and IV

Quality of Evidence for Summary: High = 1; Moderate = 3; Low = 3

Discussion of Evidence:**Evidence Summary**

Educators within health-care organizations should consider the format and structure of continuing education and professional development programs for health workers to ensure that the location, resources, frequency, and method of delivery supports knowledge development. Educational programs that address these format and structure considerations are effective in facilitating the implementation of evidence-based practice (69, 71–73), increasing knowledge (74), and engaging learners (75, 76).

Practice Notes

Examples of format and structure considerations for educational programs targeted towards health workers include the following:

- accessible education sessions, when possible (preferably where health workers provide service);
- appropriate and adequate resources to facilitate implementation of evidence-based practice;
- protected time for health workers to attend education sessions;
- ongoing education sessions and follow-up support to ensure maintenance of evidence-based practices; and
- face-to-face educational sessions (when possible) in order to increase engagement and peer learning (69, 71–76).

Benefits and Harms

The benefit of implementing this recommendation is that conditions are established to enable health workers to provide evidence-based SIS to people who inject drugs. It also ensures the overall effectiveness of the program.

Values and Preferences

Health workers value high-quality education programs, ready access to useful implementation resources, and organizational support for professional development and evidence-based practice (74).

Organization and System Policy Recommendations

RESEARCH QUESTION #3:

What organizational and health system policies are required to support health workers in providing high-quality care in SIS facilities?

RECOMMENDATION 3.1:

Integrate peer workers into the programming of supervised injection services by

- increasing access to peer workers as a vital resource for people who inject drugs, and
- including peer workers in organizational decision-making processes.

Level of Evidence for Summary: IV

Quality of Evidence for Summary: High = 3; Moderate = 4

Discussion of Evidence:

Evidence Summary

Peer workers should be present, visible, and available in SIS to facilitate access to peer support for people who inject drugs. Examples of peer worker roles in harm reduction services include the following:

- harm reduction education;
- direct harm reduction and health services; and
- support, counselling, outreach, and referrals.

Peer workers also participate in research studies and advisory committees, and they should significantly contribute to SIS operational decision-making processes (e.g., consultative processes or advisory structures) in order to improve service quality and engage people who inject drugs. For more information, see “**Additional Resources**” at the end of this recommendation.

People who inject drugs are more likely to demonstrate a willingness to receive services from peer workers (e.g., HIV counselling and testing) (77, 78). Improvements have been observed in people who inject drugs when peer workers are integrated in harm reduction services, drug treatment centres, primary care clinics, and community programs. Specifically, education and assistance from peer workers has been valuable in providing information on infections, safer injection practices, and the correct preparation of various drugs (79). The non-judgmental communication and expert knowledge offered by peer workers can be a resource for overcoming barriers to health care that arise due to mistrust and fear of stigma (80), and people who inject drugs may experience psychological benefits when they have access to peer workers, including improved mental health and well-being (81).

The involvement of peer workers in operational decision making fosters relationships based on mutual respect and decreases stigma towards people who inject drugs (54). Peer workers have invaluable insights on operations related to their lived experience with drug-using risk environments. People who use drugs can offer in-depth advice regarding how a harm reduction service should be designed (82).

Practice Notes

Examples of organizational strategies to facilitate effective integration of peer worker roles in harm reduction initiatives include the following:

- ensuring the direct participation as outreach workers of people who inject drugs;
- establishing meaningful peer involvement in the governance and management of the program;
- using flexible, accessible, and culturally relevant programming;
- developing programming grounded in the lived experience of people who inject drugs that recognizes the importance of peer influence and networks;
- providing training consistent with practices for other health workers; and
- addressing barriers to participation by people who inject drugs by addressing broader social determinants of health (83).

This recommendation is supported by two high-quality guidelines from other organizations (84, 85). Areas of consistency between these guidelines include peer worker involvement in the development and delivery of harm reduction services and access to peer interventions and supports (84, 85).

Benefits and Harms

Meaningfully integrating peer workers in SIS promotes respect and decreases stigma, thus improving health equity for both peer workers and those accessing SIS.

Peer workers are at risk for harm (e.g., psychological distress) if requisite supports are not provided to manage any issues associated with their involvement in SIS.

Values and Preferences

The RNAO expert panel attributed high value to ensuring that peer workers are the first point of contact for people who inject drugs in SIS, and that they receive the same support and benefits as paid employees.

Additional Resources

RESOURCE	DESCRIPTION
<p>Baker D, Belle-Isle L, de Kiewit A, et al. Peerology: a guide by and for people who use drugs on how to get involved [Internet]. Ottawa (ON): Canadian AIDS Society; 2015. Available from: http://librarypdf.catie.ca/PDF/ATI-20000s/26521E.pdf</p>	<ul style="list-style-type: none"> ■ Provides direction on how to include people who use drugs in decisions that affect their lives. It also supplies suggestions for building capacity to respond to the needs of people who use drugs.
<p>Balian R, White C. Harm reduction at work: a guide for organizations employing people who use drugs [Internet]. New York (NY): Open Society Foundations; 2010. Available from: https://www.opensocietyfoundations.org/sites/default/files/work-harmreduction-20110314.pdf</p>	<ul style="list-style-type: none"> ■ Provides practical guidance for addressing the challenges faced when hiring people who use drugs.
<p>Canadian HIV/AIDS Legal Network. Nothing about us without us. Greater, meaningful involvement of people who use illegal drugs: a public health, ethical, and human rights imperative [Internet]. Toronto (ON), Canadian HIV/AIDS Legal Network; 2005. Available from: http://www.catie.ca/en/resources/nothing-about-us-without-us-greater-meaningful-involvement-people-who-use-illegal-drugs-pu</p>	<ul style="list-style-type: none"> ■ Provides rationale for meaningful peer involvement in Canada’s response to HIV and AIDS, HCV, and injection drug use.
<p>Centre for Addiction and Mental Health. Peer positive toolkit: preparing organizations to better engage people with lived experience through equitable processes [Internet]. Toronto (ON): Centre for Addiction and Mental Health; [date unknown]. Available from: http://www.peerpositive.ca/resources/</p>	<ul style="list-style-type: none"> ■ Prepares organizations to shift their culture, values, and practices by engaging people with lived experience in order to meet the needs of the populations served.
<p>Greer AG, Amlani AA, Buxton JA, et al. Peer engagement best practices: a guide for health authorities and other providers [Internet]. Vancouver (BC): BC Centre for Disease Control; 2016. Available from: http://www.bccdc.ca/resource-gallery/Documents/PEEP%20Best%20Practice%20Guidelines.pdf</p>	<ul style="list-style-type: none"> ■ Provides guidance on how to engage peers to ensure that harm reduction services meet the needs of the populations served.

RECOMMENDATIONS

RESOURCE	DESCRIPTION
<p>Marshall Z, Dechman MK, Minichiello A, et al. Peering into the literature: a systematic review of the roles of people who inject drugs in harm reduction initiatives. <i>Drug Alcohol Depend.</i> 2015;151:1–14.</p>	<ul style="list-style-type: none"> ■ Describes the roles of people who inject drugs in harm reduction initiatives, how programs are organized, and the obstacles and facilitators to engaging people with lived experience in harm reduction programs. ■ Figure 2 (on page 5 of this article) provides a summary of peer worker roles in harm reduction initiatives.
<p>Toronto Harm Reduction Task Force. Information guide for peer workers and agencies [Internet]. 2nd ed. Toronto (ON): Toronto Harm Reduction Task Force; 2013. Available from: http://canadianharmreduction.com/node/2208</p>	<ul style="list-style-type: none"> ■ Provides guidance for those entering into peer worker roles.
<p>United Nations Office on Drugs and Crime; International Network of People Who Use Drugs; UNAIDS, et al. Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical guidance for collaborative interventions [Internet]. Vienna (AT): United Nations Office on Drugs and Crime; 2017. Available from: http://www.inpud.net/en/iduit-implementing-comprehensive-hiv-and-hcv-programmes-people-who-inject-drugs</p>	<ul style="list-style-type: none"> ■ Contains practical recommendations on implementing HIV and HCV services in collaboration with people who inject drugs.
<p>University of Victoria Centre for Addictions Research. From one ally to another: practice guidelines to better include people who use drugs at your decision-making tables [Internet]. Victoria (BC): University of Victoria Centre for Addictions Research; 2016. Available from: https://www.uvic.ca/research/centres/carbc/assets/docs/bulletin-14-from-one-ally-to-another.pdf</p>	<ul style="list-style-type: none"> ■ Provides guidance on how better to include people who use drugs in decision making.

RECOMMENDATION 3.2:

Integrate comprehensive services into the programming of supervised injection services to ensure that people who inject drugs have access to

- testing and counselling for blood-borne infections,
- primary care providers,
- mental health clinicians, and
- housing and social services.

Level of Evidence for Summary: Ib and IV

Quality of Evidence for Summary: High = 2; Moderate = 9; Low = 2

Discussion of Evidence:**Evidence Summary**

Issues that impact the health and well-being of people who inject drugs include blood-borne infections (86–91), mental health conditions (92–94), and food insecurity and homelessness (46, 95–97).

Harm reduction programs that integrate comprehensive services have positive outcomes on health and well-being. Studies demonstrate that integrated services offer prevention, testing, counselling, and primary care for HIV and hepatitis B and C (87, 88, 90, 91). Acceptability of integrating rapid HIV and HCV tests into harm reduction programs has supported ease of testing and test interpretation (86). Primary care services that offer testing and counselling for blood-borne infections within a harm reduction framework such as SIS contribute to a safe, nonjudgmental environment for people who inject drugs. This fosters communication with health workers and increases the feasibility of testing and improving access to required services and supports (89, 91).

People who inject drugs who are experiencing mental health issues such as depression are at a greater risk of a non-fatal overdose (92). They also report increased barriers to accessing health and social services (93). Integrated mental health services and supports increase access to on-site counselling, link to resources within the community, and provide assistance with navigating the mental health system (92–94). Social inequities, such as food insecurity and homelessness, are associated with injection drug use and increase the risk for health-related harms and high-risk injection practices (such as sharing injection equipment) (95–97). One study has shown that embedding housing and nutrition services into SIS improved the overall health of people who inject drugs (46).

People who inject drugs often face barriers to health and social services, but SIS are ideally positioned to support their overall health and well-being. Evidence-based SIS create the conditions for health workers to establish and maintain trusting relationships that extend beyond the supervision and monitoring of drug use to include other important health and social services (see **Recommendation 1.1**).

Practice Notes

This recommendation is supported by two high-quality guidelines from other organizations (85, 98). Areas of consistency between guidelines include offering people who inject drugs the following:

- testing and counselling services for HIV and hepatitis B and C,
- primary care services,
- mental health services, and
- housing services within harm reduction services.

Benefits and Harms

Access to these health and social services in SIS may address the consequences of injection drug use and improve outcomes related to poverty, homelessness, and overall functioning (including physical and mental health).

There is a risk of harm to priority populations of people who inject drugs if the services offered are not relevant or effective for their specific health and social requirements (see [Appendix F](#)). For example, services offered to Indigenous peoples should be provided by an individual or organization that understands the needs of this population.

Values and Preferences

The RNAO expert panel attributed high value to ensuring that people who inject drugs have access to services that go beyond the provision of supervising injections. Other services that support their health and well-being include referrals to exercise programs (e.g., yoga and boxing programs for women with trauma), drug treatment services and counselling services (if desired).



Additional Resources

RECOMMENDATIONS

RESOURCE	DESCRIPTION
<p>Bayoumi AM, Strike C, Brandeau M, et al. Report of the Toronto and Ottawa supervised consumption assessment study [Internet]. Toronto (ON): St. Michael’s Hospital; 2012. Co-published by the Dalla Lana School of Public Health, University of Toronto. Available from: http://www.catie.ca/en/resources/report-toronto-and-ottawa-supervised-consumption-assessment-study-2012</p>	<ul style="list-style-type: none"> ■ Provides insight into what services are considered important by people who use drugs within a potential supervised consumption facility (see Section 4.1. “Supervised Consumption Facility Service Considerations”)
<p>International Drug Policy Consortium with Canadian HIV/AIDS Legal Network. Drug consumption rooms: evidence and practice [Internet]. Toronto (ON): Canadian HIV/AIDS Legal Network; 2012. Available from: http://www.aidslaw.ca/site/drug-consumption-rooms-evidence-and-practice/?lang=en</p>	<ul style="list-style-type: none"> ■ Provides an overview of drug consumption rooms in different countries and the types of health and social services offered in each facility.
<p>Strike C, Leonard L, Millson M, et al. Ontario needle exchange programs: best practice recommendations [Internet]. Toronto (ON): Needle Exchange Coordinating Committee; 2006. Available from: http://www.ohrdp.ca/wp-content/uploads/pdf/Best_Practices_Report.pdf</p>	<ul style="list-style-type: none"> ■ Provides best practice recommendations for needle exchange programs in communities throughout Ontario. ■ Includes a section on addressing the health and social service needs of people who inject drugs.

RECOMMENDATION 3.3:

Embed harm reduction programs that include supervised injection services into existing health and social settings to improve retention in care and reduce adverse health outcomes among people who inject drugs.

Level of Evidence for Summary: IV

Quality of Evidence for Summary: High = 1; Moderate = 2

Discussion of Evidence:**Evidence Summary**

This recommendation focuses on expanding and embedding SIS into existing health and social services. When combined with **Recommendation 3.2**, both recommendations support service delivery models that promote both health equity for people who inject drugs and the principles of health promotion, improved access to care, and system integration.

Studies have demonstrated that people who inject drugs believe hospital-based harm reduction interventions promote patient-centred care by prioritizing care retention and risk reduction, increasing responsiveness to individualized health needs, reducing adverse health outcomes, and fostering culturally safe care (99). The willingness of people who inject drugs to access in-hospital SIS improves their ability to remain in hospital, allows them to use drugs under the supervision of health workers, and reduces stress associated with being forced to leave the hospital for using drugs (100). For example, a Canadian HIV resident care facility embedded harm reduction services by incorporating SIS into existing programming, thus improving access and equity. This approach mitigated the impact of homelessness and food insecurity for people who inject drugs living with HIV; it also improved HIV treatment outcomes and increased access to antiretroviral therapy, increasing survival (46).

Practice Notes

Before integrating SIS, it is imperative that the principles of harm reduction, cultural safety, and trauma-informed practice are incorporated into policies and practices in health-care settings that people who inject drugs have traditionally found to be judgmental and stigmatizing (such as hospitals). For example, the operationalization of embedding SIS into hospital settings may require specialized programs (in-patient and ambulatory) that use harm reduction and non-discriminatory approaches to create safe spaces for people who inject drugs (99).

Benefits and Harms

The following benefits are realized when SIS are embedded into existing health settings:

- prioritizes and improves care retention;
- ensures that continued drug use does not interfere with service access;
- increases responsiveness to subjective health needs (e.g., it acknowledges pain and withdrawal symptoms and other health-care needs, and it ensures that those needs are prioritized over drug abstinence);
- promotes culturally safe care;

- enables people who inject drugs to enact harm reduction by facilitating access to supports (e.g., supervision and injection equipment) that are critical to minimizing HIV and overdose risks;
- promotes non-judgmental interactions and refocuses attention on personhood;
- fosters an atmosphere that supports drug use discussions without fear of punitive action and increases open dialogue with health workers; and
- fosters a welcoming environment (46, 99, 100).

Values and Preferences

The RNAO expert panel attributed high value on organizational support for harm reduction programs in health and social settings to facilitate equitable access to necessary services that support health and well-being. Other settings for further consideration include shelters and other housing services.

Additional Resources

RESOURCE	DESCRIPTION
British Columbia Centre on Substance Use. Supervised consumption services operational guidance [Internet]. Vancouver (BC): British Columbia Centre on Substance Use; 2017. Available from: http://towardtheheart.com/assets/uploads/1504645603Pzi0GGINlhYQ7LMcrhsGZC7wRMWDbliYzsrHX2G.pdf	<ul style="list-style-type: none"> ■ “Appendix I” provides examples of embedded supervised consumption services.
DeBeck K, Kerr T. The use of knowledge translation and legal proceedings to support evidence-based drug policy in Canada: opportunities and ongoing challenges. <i>Open Medicine</i> [Internet]. 2010;4(3):E167. Available from: https://open.library.ubc.ca/cIRcle/collections/facultyresearchandpublications/52383/items/1.0339967	<ul style="list-style-type: none"> ■ Provides an overview of two key strategies to shift drug policy toward an evidence-based approach and maintain the operation of a SIS. ■ Offers lessons for the implementation of evidence-based approaches in other controversial areas of public policy.
Glaser W, Petch J, Tierney M. Hospital policies put the lives of people who inject drugs at risk, say experts. <i>Healthy Debate Articles</i> [Internet]. 21 July 2016. [place, publisher, date unknown]. Available from: http://healthydebate.ca/2016/07/topic/harm-reduction-hospitals-injection-opioids	<ul style="list-style-type: none"> ■ Discusses how current hospital policies put people who inject drugs at risk. ■ Provides an overview of what harm reduction could look like for people who inject drugs when admitted to an inpatient setting.

RECOMMENDATION 3.4:

Align the location, physical space, and operating hours of facilities to the needs of the local population, and make operational improvements and structural redesign (as needed) to decrease barriers for access to supervised injections services for people who inject drugs.

Level of Evidence for Summary: IV

Quality of Evidence for Summary: Moderate = 7

Discussion of Evidence:**Evidence Summary**

People who inject drugs may experience barriers to accessing SIS because they live in rural environments where SIS do not exist (101, 102), the SIS location is unsafe or too far for travel (103, 104), or there are long wait times or inconvenient and limited hours of operation (105–107).

Inequitable Access in Remote and Rural Communities

Within rural communities, there are challenges accessing harm reduction services and supports due to travel distance and limited awareness regarding harm reduction programs. Information regarding safe use practices and other health-related needs—such as food, clothing, and social supports—are often inadequate (102). Barriers to health-care services for people who inject drugs living in rural environments include shortages of health workers who are specialized in mental health and substance use, limited access to current technology for connecting to specialized services, financial barriers, and stigma (101).

Facility Proximity and the Safety of the Surrounding Environment

People who inject drugs may have limited access to harm reduction services and supports due to seasonality, inclement weather and travel distance between their residence and the facility. Research indicates that service usage is lower in the winter than it is in the spring (103). The drug use practices of sub-groups of people who inject drugs (such as women) and how those practices impact health and access to harm reduction services requires consideration when choosing a location for SIS. For instance, the spaces occupied by women who inject drugs are often restricted because women may avoid areas where they have experienced violence. Some women and marginalized men have reported avoiding a particular SIS due to past experiences of violence in or near the facility's physical location (104).

Operational Challenges

Examples of significant operational barriers include restrictions in physical space and hours of operation (105). Research indicates that long wait times and specific hours of operation (i.e., not being a 24-hour service) impact access and use of the facility (106, 107).

Practice Notes

Examples of decreasing barriers to SIS access for people who inject drugs include the following:

- establishing facilities in rural and non-urban environments based on feasibility studies and assessment of regional resources and supports;
- improving the proximity of SIS facilities for people who inject drugs (e.g., establishing a number of smaller SIS sites throughout the area);
- establishing facilities in safer environments for people who inject drugs who are at risk for violence (e.g., integrating SIS services into shelters or supportive housing for women who inject drugs);
- increasing physical space within existing facilities (e.g., expanding the number of injection spaces available at an existing SIS); and
- expanding the hours of operation at existing SIS (101–108).

Benefits and Harms

The benefit of having more space or using specific approaches for different populations (including women who inject drugs) within SIS increases equitable access in rural and urban communities. Consideration regarding location, capacity, safety, and hours of operation is critical to achieving better health outcomes and minimizing harms (such as injecting at other venues, where there is an elevated risk of overdose and reduced potential for assistance).

There is potential harm for people who inject drugs if there has not been a considerable assessment of the diverse needs of people who inject drugs in the region (such as rural Indigenous people) and the resources available in a region (including access to nurses with specialized knowledge and skills), or if there had not been careful planning around the implementation of a new SIS or the expansion of an existing one.

Values and Preferences

The RNAO expert panel attributed high value to addressing common operational and structural challenges indicated by health workers and people who inject drugs. Addressing these challenges has the potential to improve health equity for the diverse range of people who inject drugs if it results in appropriate action.

Additional Resources

RESOURCE	DESCRIPTION
<p>Bayoumi AM, Strike C, Brandeau M, et al. Report of the Toronto and Ottawa supervised consumption assessment study [Internet]. Toronto (ON): St. Michael's Hospital; 2012. Co-published by the Dalla Lana School of Public Health, University of Toronto. Available from: http://www.catie.ca/en/resources/report-toronto-and-ottawa-supervised-consumption-assessment-study-2012</p>	<ul style="list-style-type: none"> ■ Provides insight on what design considerations people who use drugs feel are important in a supervised consumption facility (see Section 4.2. "Supervised Consumption Facility Design Considerations").
<p>Berryman A. The merits of supervised injection facilities: a case for Sudbury and Northern Ontario. Thunder Bay (ON): Northern Policy Institute; 2016. Available from: http://www.northernpolicy.ca/supervisedinjectionfacility</p>	<ul style="list-style-type: none"> ■ Provides an example of how to conduct a feasibility study for SIS in a particular community.
<p>Hardill K. Below the radar: an exploration of substance use in rural Ontario [Internet]. Bancroft, (ON): Bancroft Harm Reduction; 2011. Available from: http://www.canadianharmreduction.com/node/2308</p>	<ul style="list-style-type: none"> ■ Study provides a deeper understanding of the nature and context of substance use in rural Ontario.
<p>Ontario HIV Treatment Network. The Ontario supervised injection services feasibility study [Internet]. Toronto (ON): Ontario HIV Treatment Network; 2017. Available from: http://www.ohtn.on.ca/oisis/</p>	<ul style="list-style-type: none"> ■ Provides an example of how to conduct a feasibility study for SIS in a particular community.

RECOMMENDATION 3.5:

Advocate for legislation and regulations to support ethical policies and procedures that increase access to and utilization of supervised injection services for

- people who require assisted injection support; and
- youth who inject drugs.

Level of Evidence for Summary: IV

Quality of Evidence for Summary: High = 1; Moderate = 4

Discussion of Evidence:**Evidence Summary**

Ethical examination is required of policies and procedures that restrict access to SIS based on age or prohibit assisted injection. Changes are urgently needed to accommodate a wider range of people who inject drugs and to minimize structural vulnerabilities to drug-related harm. Specifically, modernization of legislation and regulations governing the operations and standards of SIS are essential to accommodate youth who inject drugs and people who require assisted injection support.

Assisted Injections

Legal models regulating SIS operations may create barriers that constrain facility usage and produce inequities in access to harm reduction services (109). People who inject drugs who require help injecting have identified that regulations prohibiting assisted injection from a nurse were a barrier to using SIS (107). Highly vulnerable populations, including women and people living with disabilities, are disproportionately represented among those who require help injecting. Prohibition of assisted injection unintentionally reinforces the marginalization of women within the population of people who inject drugs (109). When health workers are unable to support the self-injection process through education, people who inject drugs seek support outside of SIS, which puts them at risk. For example, assisted injection services provided by health workers may reduce or eliminate injections in dangerous environments (such as injecting in local alleys) (106).

Youth and Injection Drug Use

Studies on youth who inject drugs have demonstrated significant barriers to accessing life-saving harm reduction services due to age restrictions and parental consent requirements (110). Other barriers include lack of knowledge of services and the presence of older people who use drugs at harm reduction services, which may make youth uncomfortable. Harm reduction and HIV programs should attempt to reach young people and include comprehensive services such as linking youth to the housing, education, and employment sectors (110).

Research has shown a lack of consensus on specific age thresholds for SIS, but consistent agreement regarding the exclusion of youth from existing services and prominent concerns for safety are evident (111). Thus, ethical and evidence-based policy regarding age specific access must be considered by SIS to benefit youth and mitigate health inequities.

Practice Notes

Offering harm reduction services to youth who inject drugs and developing policies for this population is supported by a high-quality guideline from another organization (98). It is important to note that SIS facilities that lower the age limit for receiving services also create resources and supports specifically geared towards the unique needs of youth.

Benefits and Harms

Providing services to youth who inject drugs and other people who require assisted injection support improves equitable access to care.

There is a potential for harm if the unique needs of youth are not considered in the programming of services and supports. It also is important to recognize and consider the complex ethical issues that nurses and health workers may face when they are expected to participate in assisted injection; doing so will help to mitigate those issues prior to implementing a new policy.

Values and Preferences

The RNAO expert panel attributed high value to addressing these two specific sub-groups to ensure they have access to SIS. In addition, the panel values operational procedures that facilitate equal access and service for Indigenous peoples, LGBTQ2I people, and pregnant persons who inject drugs.



Additional Resources

RESOURCE	DESCRIPTION
<p>Barnaby L, Erickson PG, Fidler T, et al. Drugs, homelessness & health: homeless youth speak out about harm reduction. The Shout Clinic harm reduction report [Internet]. Toronto (ON): The Shout Clinic; 2010. Available from: http://www.wellesleyinstitute.com/wp-content/uploads/2010/02/homelessyouthspeakout_shoutclinic2010_v2.pdf</p>	<ul style="list-style-type: none"> ■ Presents the results of a harm reduction needs assessment survey among homeless youth in Toronto, identifies barriers to appropriate health services, and makes recommendations for better programs.
<p>Bayoumi AM, Strike C, Brandeau M, et al. Report of the Toronto and Ottawa supervised consumption assessment study [Internet]. Toronto (ON): St. Michael's Hospital; 2012. Co-published by the Dalla Lana School of Public Health, University of Toronto. Available from: http://www.catie.ca/en/resources/report-toronto-and-ottawa-supervised-consumption-assessment-study-2012</p>	<ul style="list-style-type: none"> ■ Reports the views of stakeholders and people who use drugs on operating rules of supervised consumption facilities (see Section 4.3. "Supervised Consumption Facility Rules").
<p>Gagnon M. It's time to allow assisted injection in supervised injection sites. CMAJ [Internet]. 2017;189(34):E1083–4. Available from: http://www.cmaj.ca/content/189/34/E1083.extract</p>	<ul style="list-style-type: none"> ■ A commentary on how assisted injection is necessary to ensure equitable access to supervised injection sites based on an individual's needs, not their capacity to inject.
<p>Lorpenda K, Veronese V. Step-by-step toolkit: preparing for work with children and young people who inject drugs [Internet]. London (UK): Harm Reduction International; 2015. Co-published by Youth Rise; International HIV/AIDS Alliance. Available from: https://www.hri.global/files/2015/11/06/WEB2_Step_by_step_tool1.pdf</p>	<ul style="list-style-type: none"> ■ Provides a process that may quickly be implemented to prepare health workers to engage with children and young people under 18 years of age. The toolkit is intended for harm reduction service providers with limited experience working with children and young people who inject drugs.
<p>Pearshouse R, Elliott R. A helping hand: legal issues related to assisted injection at supervised injection facilities [Internet]. Toronto (ON): HIV/AIDS Legal Network; 2007. Available from: http://www.aidslaw.ca/site/a-helping-hand-legal-issues-related-to-assisted-injection-at-supervised-injection-facilities-3/?lang=en</p>	<ul style="list-style-type: none"> ■ Considers prohibition on assisted injection from a Canadian Charter of Rights and Freedoms perspective and suggests that the ban may be discriminatory and negatively impact the right to life, liberty, and security of the person.

RESOURCE	DESCRIPTION
<p>Registered Nurses' Association of Ontario. eLearn: engaging youth who use substances [Internet]. Toronto (ON): Registered Nurses' Association of Ontario; [date unknown]. Available from: http://rnao.ca/bpg/courses/engaging-youth-who-use-substances</p>	<ul style="list-style-type: none"> ■ Discusses youth and trends regarding substance abuse.



Research Gaps and Future Implications

The RNAO Best Practice Guideline Development Team and expert panel identified priority areas for future research (outlined in **Table 5**). Studies conducted in these areas would provide further evidence to support high-quality and equitable services and supports for people who inject drugs. The list is not exhaustive; other areas of research may be required.

Table 5: Priority Research Areas for Each Research Question

RESEARCH QUESTION	PRIORITY RESEARCH AREA
Research Question #1	<ul style="list-style-type: none"> ■ Nursing-sensitive outcomes on the care of people who inject drugs in SIS. ■ Studies on the effectiveness of nursing interventions for people who inject drugs in SIS. ■ Studies on the meaning of cultural safety for people who inject drugs in the context of SIS.
Research Question #2	<ul style="list-style-type: none"> ■ Longitudinal studies on the knowledge, skill, confidence, and attitudes of health workers and students following education sessions.
Research Question #3	<ul style="list-style-type: none"> ■ Comparison studies on the effectiveness of different SIS models. ■ Specific guidance on appropriate policies and procedures for youth who inject drugs, pregnant persons, and people who inject drugs who require assisted injection. ■ Studies on integrated models of service delivery that include priority populations (such as Indigenous people).
Evaluation (see Table 6)	<ul style="list-style-type: none"> ■ Development of reliable and valid instruments that capture indicators related to SIS. ■ Development of public data repositories for provincial and national data collection of outcomes relevant to SIS.

Implementation Strategies

Implementing guidelines at the point of care is multi-faceted and challenging. It takes more than awareness and distribution of guidelines for practice to change: guidelines must be adapted for each practice setting in a systematic and participatory way to ensure that recommendations fit the local context (112). The 2012 RNAO *Toolkit: Implementation of Best Practice Guidelines* provides an evidence-informed process for doing this. It can be downloaded at www.RNAO.ca/bpg/resources/toolkit-implementation-best-practice-guidelines-second-edition.

The *Toolkit* is based on emerging evidence that successful uptake of best practices in health care is more likely when the following occur:

- leaders at all levels are committed to supporting guideline implementation;
- guidelines are selected for implementation through a systematic, participatory process;
- stakeholders for whom the guidelines are relevant are identified and engaged in the implementation;
- environmental readiness for implementing guidelines is assessed;
- the guideline is tailored to the local context;
- barriers and facilitators to using the guideline are assessed and addressed;
- interventions to promote use of the guideline are selected;
- use of the guideline is systematically monitored and sustained;
- evaluation of the guideline's impact is embedded in the process; and
- there are adequate resources to complete all aspects of the implementation.

The *Toolkit* uses the “Knowledge-to-Action” framework (113) to demonstrate the process steps required for knowledge inquiry and synthesis (see **Figure 2**). It also guides the adaptation of the new knowledge to the local context and implementation. This framework suggests identifying and using knowledge tools (such as guidelines) to identify gaps and begin the process of tailoring the new knowledge to local settings.

RNAO is committed to widespread deployment and implementation of our BPGs. We use a coordinated approach to dissemination, incorporating a variety of strategies, including the following:

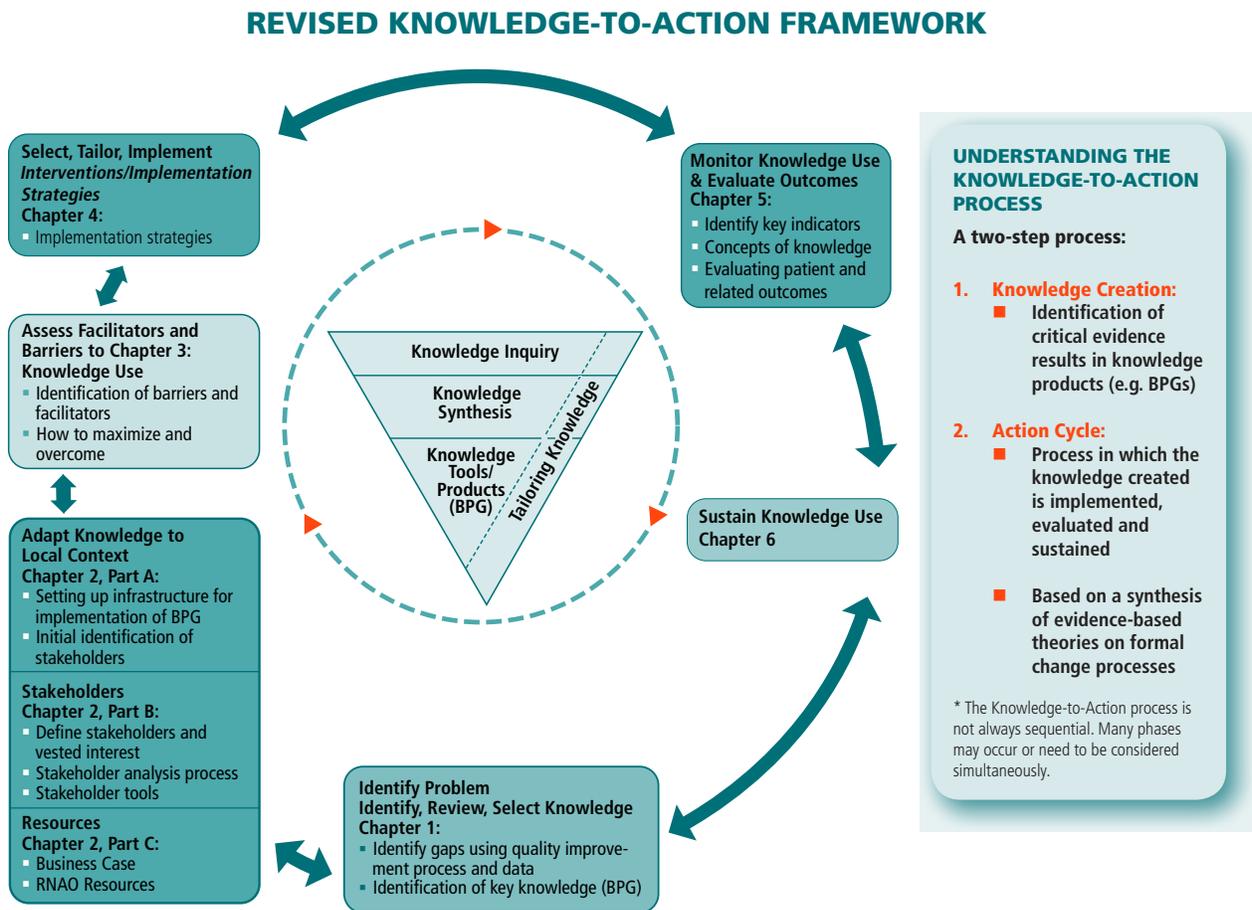
1. The Nursing Best Practice Champion Network[®], which develops the capacity of individual nurses to foster awareness, engagement, and adoption of BPGs.
2. Nursing order sets[®], which provide clear, concise, and actionable intervention statements derived from the practice recommendations of clinical BPGs that can be readily embedded within electronic medical records, but which may also be used in paper-based or hybrid environments.
3. The Best Practice Spotlight Organization[®] (BPSO[®]) designation, which supports implementation at the organization and system levels. BPSOs focus on developing evidence-based cultures with the specific mandate to implement, evaluate, and sustain multiple RNAO BPGs.

In addition, we offer annual capacity-building learning institutes on specific BPGs and their implementation.

Information about our implementation strategies can be found at:

- RNAO Best Practice Champions Network®: RNAO.ca/bpg/get-involved/champions
- RNAO Nursing Order Sets: RNAO.ca/bpg/initiatives/nursing-order-sets
- RNAO BPSO®: RNAO.ca/bpg/bpso
- RNAO capacity-building learning institutes and other professional development opportunities: RNAO.ca/events

Figure 2: Knowledge-to-Action Framework



Source: Adapted by the RNAO expert panel from: Straus S, Tetroe J, Graham ID, editors. Knowledge translation in health care. Oxford (UK): Wiley-Blackwell; 2009.

Guideline Evaluation

Table 6 provides potential evaluation measures to assess overall guideline success. It is important to evaluate evidence-based practice changes when implementing a guideline. Select the measures most relevant to the practice setting. There are no data repositories available for SIS in Ontario and Canada; the following measures will support quality improvement and evaluation. The instruments listed are used to collect the data for the measures.

Table 6: Evaluation Measures for Overall Guideline Success

EVALUATION MEASURES	INSTRUMENTS
<ul style="list-style-type: none"> ■ Percentage of population who inject drugs ■ Percentage of youth who inject drugs 	TPH ¹
<ul style="list-style-type: none"> ■ Number of SIS visits <ul style="list-style-type: none"> □ New clients □ Existing clients ■ Number of injections at site ■ Number of safe injection kits distributed and collected ■ Number of opioid reversal agents distributed (e.g., naloxone or others) ■ Number of overdose events treated successfully 	TPH TPH TPH TPH
<ul style="list-style-type: none"> ■ Incidence of HIV and hepatitis B and C infections ■ Incidence of fatal and non-fatal overdoses ■ Incidence of soft tissue injuries (such as abscesses and other skin- or vein-related problems) ■ Infection related hospital admissions <ul style="list-style-type: none"> □ Incidence of endocarditis (e.g., rheumatic heart disease or myocardial infarction) □ Incidence of cellulites □ Incidence of other infections 	TPH, PHAC ² , PHO ³ TPH TPH
<ul style="list-style-type: none"> ■ Local city drug-related crime rate (point in time) ■ Number of persons congregating around SIS (point-in-time survey) ■ Public acceptance 	TPH TPH TPH

¹ TPH (Toronto Public Health)

² PHAC (Public Health Agency of Canada)

³ PHO (Public Health Ontario)

Other RNAO resources for the evaluation and monitoring of BPGs:

- Nursing Quality Indicators for Reporting and Evaluation[®] (NQuIRE[®]) is a unique nursing data system housed in the International Affairs and Best Practice Guideline Centre that allows BPSOs[®] to measure the impact of BPG implementation by BPSOs worldwide. The NQuIRE data system collects, compares, and reports data on guideline-based nursing-sensitive process and outcome indicators. The international NQuIRE data system was launched in August 2012 to (1) create and sustain evidence-based practice cultures, (2) optimize patient safety, (3) improve patient outcomes, and (4) engage staff in identifying relationships between practice and outcomes to advance quality and advocate for resources and policy that support best practice changes (114). Please visit [RNAO.ca/bpg/initiatives/nquire](https://rnao.ca/bpg/initiatives/nquire) for more information.
- Nursing order sets embedded within electronic medical records provide a mechanism for electronic data capture of process indicators. The ability to link structure and process indicators with specific client outcome indicators aids in determining the impact of BPG implementation on specific client health outcomes. Please visit [RNAO.ca/ehealth/nursingordersets](https://rnao.ca/ehealth/nursingordersets) for more information.



Process for Update and Review of the Guideline

RNAO commits to updating its BPGs as follows:

1. Each BPG is reviewed by the RNAO Best Practice Guideline Development Team every five years following publication.
2. RNAO International Affairs and Best Practice Guideline Centre staff regularly monitor for new research studies and other relevant literature in the field.
3. Based on that monitoring, staff may recommend an earlier revision period for a particular BPG. Appropriate consultation with members of the original expert panel and other specialists and experts in the field will help inform the decision to review and revise the BPG earlier than planned.
4. Three months prior to the review milestone, the Best Practice Guideline Development Team commences planning of the review by doing the following:
 - a. Inviting specialists in the field to participate on the expert panel. The panel is comprised of individuals with expertise and/or lived experience in the topic area.
 - b. Compiling feedback received and questions encountered during the implementation, including comments and experiences of BPSOs[®] and other implementation sites regarding their experiences.
 - c. Conducting a gap analysis to explore other relevant guidelines in the field and to refine the purpose and scope.
 - d. Developing a detailed work plan with target dates and deliverables for developing a next edition of the BPG.
5. New or next editions of BPGs will be disseminated based on established structures and processes.



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Appendix A: Glossary of Terms

Analytical studies: Analytical studies test hypotheses about exposure–outcome relationships. Investigators do not assign an intervention, exposure, or treatment, but they do measure the association between exposure and outcome over time using a comparison group (115). Analytical study designs include case-control studies and cohort studies.

See *case-control study* and *cohort study*

Case-control study: A study that compares people with a specific disease or outcome of interest (cases) to people from the same population without that disease or outcome (controls) (116).

Cohort study: A study in which a defined group of people (the cohort) is followed over time, either prospectively or retrospectively (116).

Consensus: A process used to reach an agreement among a group or panel during a Delphi or modified Delphi technique (117). A consensus of 70% agreement from all RNAO expert panel members was needed for the recommendations in this Guideline.

See *modified Delphi technique*

Controlled study: A clinical trial in which the investigator assigns an intervention, exposure, or treatment to participants who are not randomly allocated to the experimental and comparison or control group (116).

Cross-sectional study: A study measuring the distribution of some characteristic(s) in a population at a particular point in time (also called a survey) (116).

Descriptive studies: A study that generates a hypothesis and describes characteristics of a sample of individuals at one point in time. The investigators do not assign an intervention, exposure, or treatment to test a hypothesis, but merely describe the who, where, or when in relation to an outcome (115, 116). Descriptive study designs include cross-sectional studies.

See *cross-sectional study*

Education recommendation: Statement of educational requirements and educational approaches and strategies for the introduction, implementation, and sustainability of the BPG.

Health equity: “Health equity means that all people can reach their full health potential and should not be disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, social class, socioeconomic status, or other socially determined circumstance” (119).

Equity in health “involves the fair distribution of resources needed for health, fair access to the opportunities available, and fairness in the support offered to the people when ill” (120).

Health inequities: “Health inequities refer to those health inequalities [that] are avoidable or remediable differences in health among populations or groups defined socially, economically, demographically, or geographically” (118).

Health workers: “All people engaged in actions whose primary intent is to enhance health” (1).

Implementation science: Methods to promote the systematic uptake of proven clinical treatments, practices, and organizational and management interventions into routine practice, and to improve health (123).

Indigenous: Refers to “individuals and collectives who consider themselves as being related to and/or having historical continuity with ‘First Peoples,’ whose civilizations in what is now known as Canada, the United States, the Americas, the Pacific Islands, New Zealand, Australia, Asia, and Africa predate those of subsequent invading or colonizing populations” (121).

Exceptions to the use of this terminology occur in literature (e.g., studies and reports) that use alternative terms. For example, Statistics Canada uses the term “Aboriginal,” which includes First Nations, Inuit, and Métis people (122).

Meta-analysis: A systematic review of randomized controlled trials that uses statistical methods to analyze and summarize the results of the included studies (116).

Modified Delphi technique: The modified Delphi technique is a process whereby the initial recommendations, which were formulated to answer the research questions, are carefully created before being provided to the panel for a consensus-seeking process (117).

A modified Delphi technique was used during the development process for this Guideline. While the identity of the RNAO expert panel members was not concealed, their individual responses to the survey questionnaires were concealed from the other members of the group.

Nursing: “Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups, and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled, and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles” (124).

Nursing order set: A group of evidence-based interventions specific to the domain of nursing. Nursing order sets are ordered independently by nurses (i.e., without a physician’s signature) to standardize the care provided for a specific clinical condition or situation. Nursing order sets are derived from the practice recommendations within a guideline.

Organization and system policy recommendation: Statement of conditions required for a practice setting that enable the successful implementation of the BPG. The conditions for success are largely the responsibility of the organization.

Peer workers: A peer worker is a person who has similar lived experiences as those utilizing supervised injection services (SIS). A peer has valuable insider knowledge and expertise that can improve services for people who inject drugs and bring credibility and trust to SIS (125).

Peer positions within harm reduction organizations may be referred to by role function, such as “outreach worker,” “program assistant,” “harm reduction program worker,” “needle exchange worker,” “project associate,” or “workers with lived experience” (126).

Practice recommendation: Statement of best practice directed at nurses and health workers that enables the successful implementation of the BPG.

Qualitative research: An approach to research that seeks to convey how human behaviour and experiences can be explained within the context of social structures, using an interactive and subjective approach to investigate and describe phenomena (127).

Quasi-experimental study: Quasi-experimental studies are those that estimate causal effects by observing the exposure of interest, but the experiments are not directly controlled by the researcher and lack randomization (128).

Randomized controlled trials: An experiment in which the investigator assigns one or more interventions to participants who are randomly allocated to either the experimental group (receives intervention) and the comparison (conventional treatment) or control group (no intervention or placebo) (116).

Registered nurses: Registered nurses are “self-regulated health-care professionals who work autonomously and in collaboration with others to enable individuals, families, groups, communities, and populations to achieve their optimal levels of health. At all stages of life, in situations of health, illness, injury, and disability, [registered nurses] deliver direct health-care services, coordinate care, and support clients in managing their own health. [Registered nurses] contribute to the health-care system through their leadership across a wide range of settings in practice, education, administration, research, and policy” (129).

Social determinants of health: The social determinants of health are “the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries” (130).

Social determinants of health inequities: “The underlying social structures and processes that systematically assign people to different social positions and distribute the social determinants of health unequally in society” (131).

Systematic review: A comprehensive review of the literature that uses clearly formulated questions and systematic and explicit methods to identify, select, and critically appraise relevant research. A systematic review collects and analyzes data from the included studies and presents them, sometimes using statistical methods (116).

See *meta-analysis*

Trauma-specific interventions: Differentiated from “trauma-informed practice” (see **Table 4**). Trauma-specific interventions directly address the need for healing from traumatic life experiences and facilitate trauma recovery through counselling and other clinical interventions (132).

Validity: The degree to which a measurement is likely to be true and free of bias (116).



Appendix B: RNAO Guidelines and Resources That Align with This Guideline

The following are topics that align with *Implementing Supervised Injection Services*, with suggested RNAO guidelines and resources from other organizations.

TOPIC	RESOURCE(S)
Engaging clients who use substances	<ul style="list-style-type: none"> Registered Nurses' Association of Ontario. Engaging clients who use substances. Toronto (ON): Registered Nurses' Association of Ontario; 2015. Available from: http://rnao.ca/bpg/guidelines/engaging-clients-who-use-substances
Implementation science, implementation frameworks, and resources	<ul style="list-style-type: none"> Registered Nurses' Association of Ontario. Toolkit: implementation of best practice guidelines. 2nd ed. Toronto (ON): Registered Nurses' Association of Ontario; 2012. Available from: http://rnao.ca/bpg/resources/toolkit-implementation-best-practice-guidelines-second-edition The National Implementation Research Network's Active Implementation Hub [Internet]. [place unknown]: AI Hub; 2013–2017. Available from: http://implementation.fpg.unc.edu/ Canadian Patient Safety Institute. Improvement frameworks getting started kit [Internet]. [place unknown]: Safer Healthcare Now!; 2015. Available from: http://www.patientsafetyinstitute.ca/en/toolsResources/ImprovementFramework/Pages/default.aspx Dissemination & Implementation Models in Health Research & Practice [Internet]. [place unknown]: The Center for Research in Implementation Science and Prevention; [date unknown]. Available from: http://dissemination-implementation.org/content/resources.aspx
Interprofessional collaboration	<ul style="list-style-type: none"> Registered Nurses' Association of Ontario. Developing and sustaining interprofessional health care: optimizing patients/clients, organizational, and system outcomes. Toronto (ON): Registered Nurses' Association of Ontario; 2013. Available from: http://rnao.ca/bpg/guidelines/interprofessional-team-work-healthcare
Intra-professional collaboration	<ul style="list-style-type: none"> Registered Nurses' Association of Ontario. Intra-professional collaborative practice among nurses. Toronto (ON): Registered Nurses' Association of Ontario; 2016. http://rnao.ca/bpg/guidelines/intra-professional-collaborative-practice-among-nurses
Person-and family-centred care	<ul style="list-style-type: none"> Registered Nurses' Association of Ontario. Person-and family-centred care. Toronto (ON): Registered Nurses' Association of Ontario; 2015. Available from: http://rnao.ca/bpg/guidelines/person-and-family-centred-care mumsDU [Internet]. [place, publisher, date unknown]. Available from: http://www.mumsdu.com/ <ul style="list-style-type: none"> A coalition of Canadian mothers and fathers who have lost sons and daughters to a drug overdose and other drug-related harms. From Grief to Action [Internet]. Vancouver (BC): From Grief to Action: When Addition Hits Home; [date unknown]. Available from: https://www.fromgriefftoaction.com/ <ul style="list-style-type: none"> A volunteer-based not-for-profit that provides a voice and support network for families and friends affected by drug use.

Appendix C: Guideline Development Process

RNAO is committed to ensuring that every BPG is based on the best available evidence. To meet international standards, a monitoring and revision process has been established that occurs for each guideline every five years. For this Guideline, RNAO assembled a panel of experts who represent a range of sectors and practice areas (see **RNAO Expert Panel**). A systematic review of the evidence—based on the purpose and scope of this Guideline, and supported by the three research questions listed below—was conducted to capture relevant peer-reviewed literature published between January 2011 and April 2017.

The following research questions were established to guide the systematic review.

1. How do health workers provide trauma-informed and culturally safe harm reduction care to people who are injecting drugs or accessing services in SIS facilities?
2. What are effective educational strategies to increase the knowledge, attitudes, and skill that health workers need to work with people who inject drugs or access services in SIS facilities?
3. What organizational and health system policies are required to support health workers in providing high-quality care in SIS facilities?

The RNAO Best Practice Guideline Development Team and expert panel work to integrate the most current and best evidence, and to ensure the validity^G, appropriateness, and safety of the guideline recommendations with supporting evidence and expert panel consensus^G.

A modified Delphi technique^G was employed to obtain expert panel consensus on the recommendations in this Guideline.

Appendix D: Process for Systematic Review and Search Strategy

Guideline Review

The RNAO Best Practice Guideline Development Team searched an established list of websites for guidelines and other relevant content published between January 2011 and August 2016. The resulting list was compiled based on knowledge of evidence-based practice websites and recommendations from the literature. RNAO expert panel members also were asked to suggest additional guidelines (see **Figure 3**). Detailed information about the search strategy for existing guidelines, including the list of websites searched and the inclusion criteria used, is available at RNAO.ca.

The Guideline Development Lead and a nursing research associate appraised seven international guidelines using AGREE II (133). Guidelines with an overall score of four or below were considered low and were excluded. Guidelines with a score of five were considered moderate, and guidelines with a score of six or seven were considered high. The following six guidelines (rated moderate or high) were selected to inform the purpose and scope of this Guideline, as well as the discussions of evidence.

1. **National Institute for Health and Care Excellence. Hepatitis B and C testing: people at risk of infection. Manchester (UK): National Institute for Health and Care Excellence; 2012.** Available from: <https://www.nice.org.uk/guidance/ph43>
2. **National Institute for Health and Care Excellence. Needle and syringe programmes. Manchester (UK): National Institute for Health and Care Excellence; 2014.** Available from: <https://www.nice.org.uk/guidance/ph52>
3. **Strike C, Hopkins S, Watson TM, et al. 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: part 1. Toronto (ON): Working Group on Best Practice for Harm Reduction Programs in Canada; 2013.** Available from: <http://www.catie.ca/en/programming/best-practices-harm-reduction>
4. **Strike C, Watson TM, Gohil H, et al. 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: part 2. Toronto (ON): Working Group on Best Practice for Harm Reduction Programs in Canada; 2015.** Available from: <http://www.catie.ca/en/programming/best-practices-harm-reduction>
5. **World Health Organization. Guidance on prevention of viral hepatitis B and C among people who inject drugs. Geneva: World Health Organization; 2012.** Available from: <http://www.who.int/hiv/pub/guidelines/hepatitis/en/>
6. **World Health Organization. Community management of opioid overdose. Geneva: World Health Organization; 2014.** Available from: http://www.who.int/substance_abuse/publications/management_opioid_overdose/en/

Systematic Review

A comprehensive search strategy was developed by RNAO's research team and a health sciences librarian based on inclusion and exclusion criteria created with the RNAO expert panel. A search for relevant research studies only published in English between January 2011 and April 2017 was applied to the following databases: Cumulative Index to Nursing and Allied Health (CINAHL), MEDLINE, PsycINFO, and Embase. Expert panel members were asked to review their personal libraries for key studies not found through the above search strategies (see **Figures 4, 5, and 6**).

Detailed information on the search strategy for the systematic review, including the inclusion and exclusion criteria and search terms, is available at [RNAO.ca/bpg/supervised-injection-services](https://rnao.ca/bpg/supervised-injection-services).

Studies were independently assessed for relevance and eligibility by the Guideline Development Lead and a nursing research associate based on the inclusion and exclusion criteria. Any disagreements were resolved through tiebreaking by a second nursing research associate.

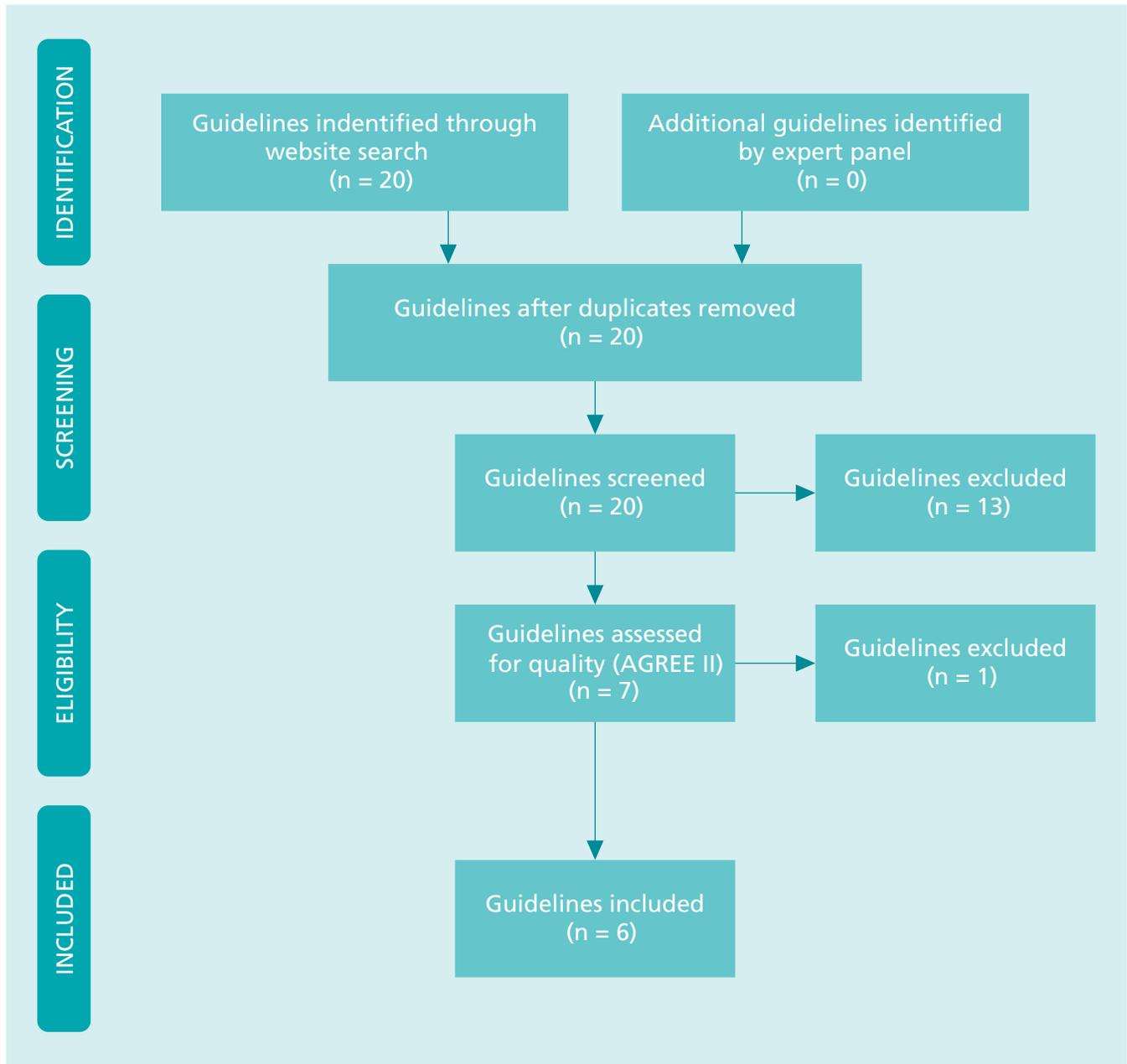
Quality appraisal scores for 25 studies (a random sample of 20 percent of the total studies eligible for data extraction and quality appraisal) were independently assessed by the Guideline Development Lead and a nursing research associate. Quality appraisal was assessed using CASP for primary studies, AMSTAR for systematic reviews, and RNAO's scoring system that rates studies as low, moderate, or high (see **Table 2**).

An acceptable inter-rater agreement (kappa statistic, $K=0.86$) was reached, which justified proceeding with quality appraisal and data extraction for the remaining studies. The remaining studies were divided equally for quality appraisal and data extraction (134). Research summaries of literature findings were completed and used to describe the results in narrative form. The comprehensive data tables and research summaries were provided to all expert panel members for review and discussion.

A complete bibliography of all full text reviews screened for inclusion is available at [RNAO.ca/bpg/supervised-injection-services](https://rnao.ca/bpg/supervised-injection-services).



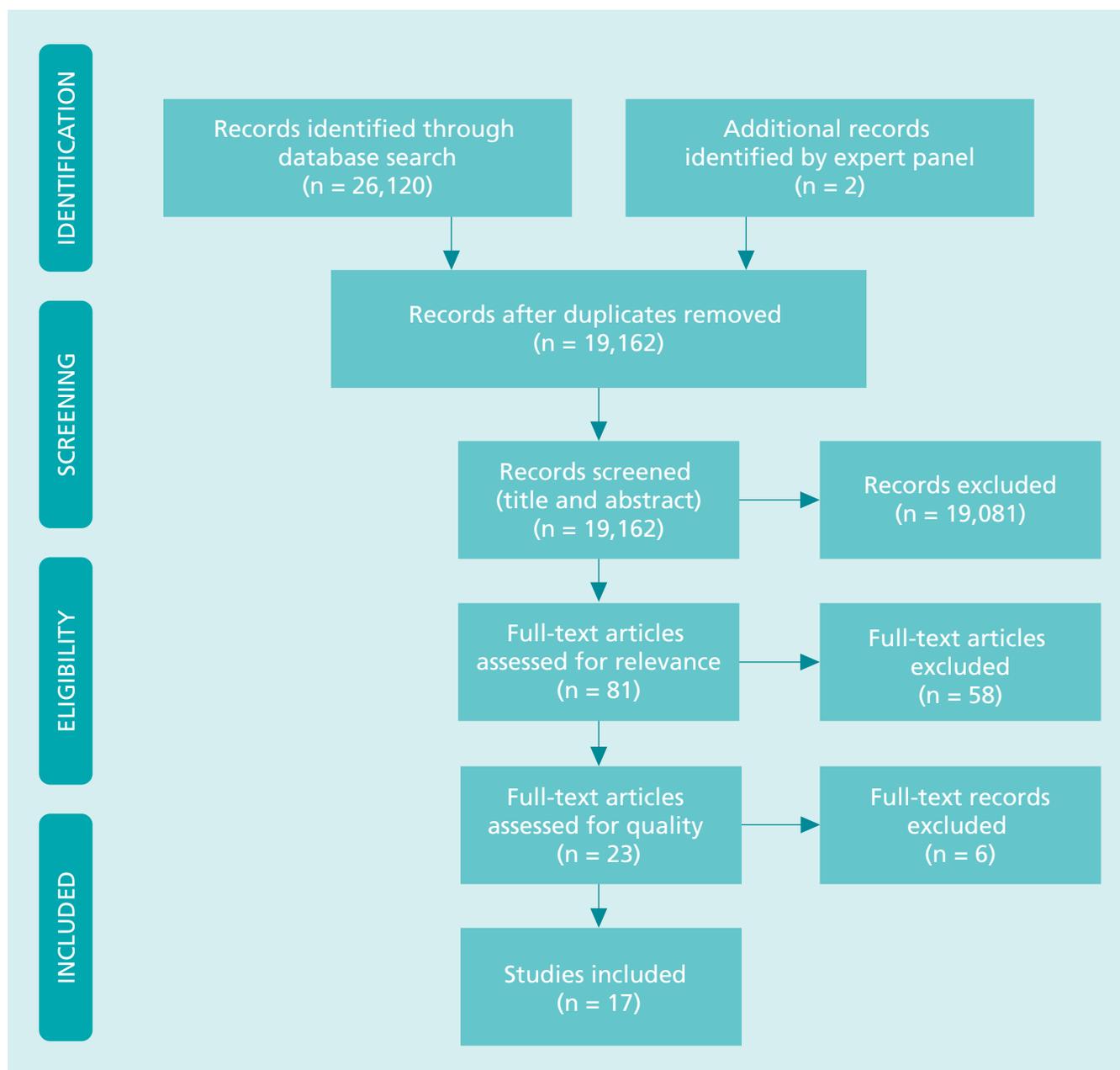
Figure 3: Guidelines Review Process Flow Diagram



Included guidelines had an overall AGREE II score of five or more (out of seven).

Source: Adapted by the RNAO expert panel from: Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *BMJ*. 2009;339:b2535. doi: 10.1136/bmj.b2535.

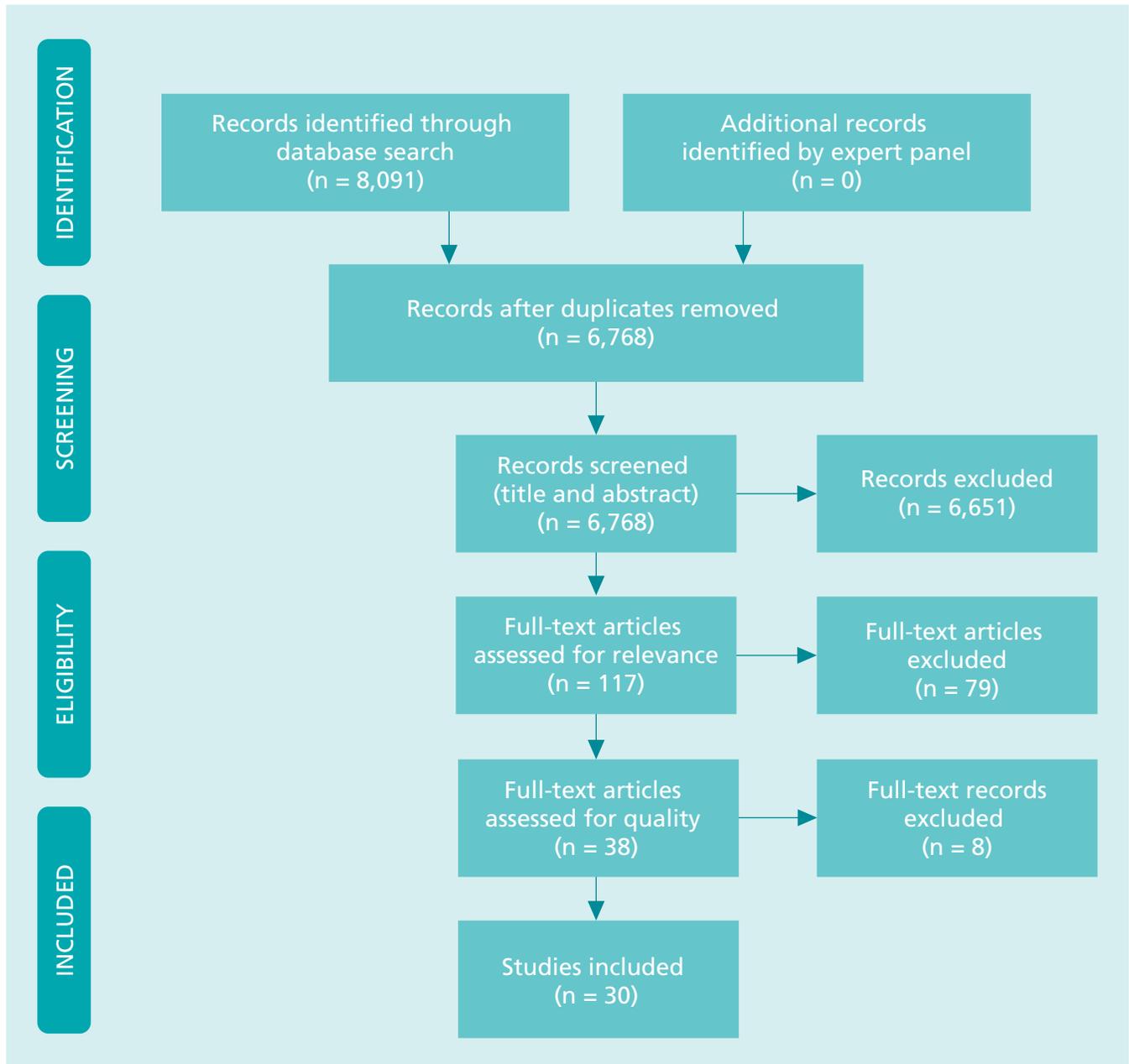
Figure 4: Question 1 Article Review Process Flow Diagram



Source: Adapted by the RNAO expert panel from: Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *BMJ*. 2009;339:b2535. doi: 10.1136/bmj.b2535.

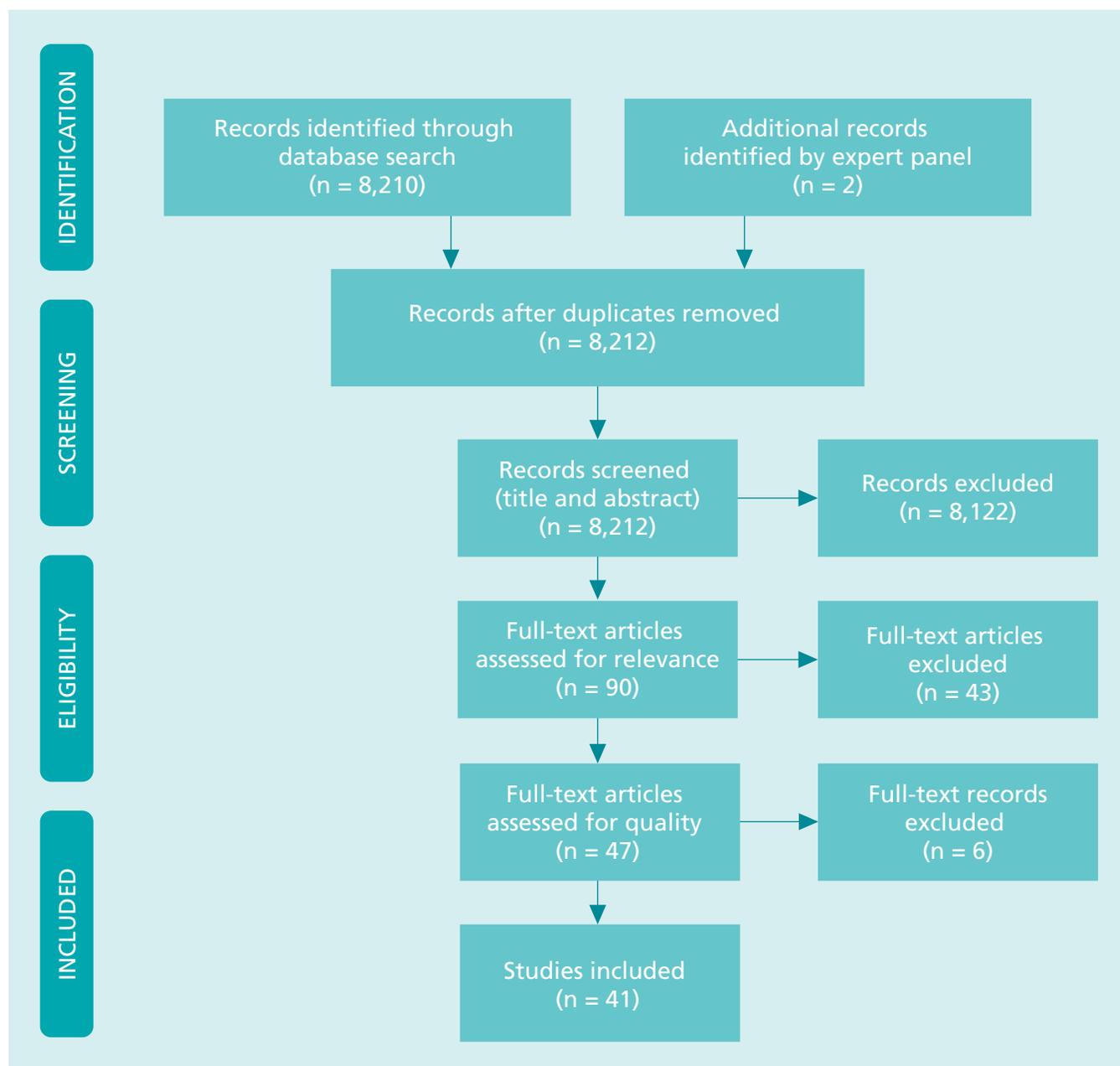
APPENDICES

Figure 5: Question 2 Article Review Process Flow Diagram



Source: Adapted by the RNAO expert panel from: Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *BMJ*. 2009;339:b2535. doi: 10.1136/bmj.b2535.

Figure 6: Question 3 Article Review Process Flow Diagram



Source: Adapted by the RNAO expert panel from: Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *BMJ*. 2009;339:b2535. doi: 10.1136/bmj.b2535.

APPENDICES

Appendix E: Additional Resources for SIS

The following table was compiled by the RNAO Best Practice Guideline Development Team and members of the expert panel with input from external stakeholder reviewers. These resources are relevant to the topic area but were identified as being outside of this Guideline's scope (see **Purpose and Scope**). They include resources on naloxone, drug treatment services and supports, wound care, drugs, and SIS implementation and operations. For high-quality guidelines on hepatitis B and C prevention and testing for people who inject drugs, community management of opioid overdose, and best practices for harm reduction programs and services, see **Appendix D**.

Links to websites are provided for information purposes only; RNAO is not responsible for the quality, accuracy, reliability, or currency of the information provided through these sources. Further, RNAO has not determined the extent to which these resources have been evaluated. Questions regarding these resources should be directed to the source.

RESOURCE	DESCRIPTION
NALOXONE	
British Columbia Centre for Disease Control. Decision support tool for administration of naloxone [Internet]. Vancouver (BC): British Columbia Centre for Disease Control; 2016. Available from: http://www.bccdc.ca/resource-gallery/Documents/Educational%20Materials/Epid/Other/NaloxoneDSTUseforRN.pdf	<ul style="list-style-type: none"> ■ A decision support tool for registered nurses who administer naloxone in the management of individuals suspected of, or those witnessed to have experienced, opioid overdose. ■ Provides an overview of <ul style="list-style-type: none"> □ clinical features of opioid overdose, □ assessment considerations, □ naloxone information, □ overdose management, □ follow-up care, and □ client education.
Get Naloxone Kits for Free [Internet]. Toronto (ON): Government of Ontario/Queen's Printer for Ontario; 2017. Available from: https://www.ontario.ca/page/get-naloxone-kits-free	<ul style="list-style-type: none"> ■ Provides an overview of naloxone and directions on where you can get a free naloxone kit.
DRUG TREATMENT SERVICES AND SUPPORTS	
About the Online Addiction Medicine Diploma [Internet]. Vancouver (BC): British Columbia Centre On Substance Use; [date unknown]. Available from: http://www.bccsu.ca/about-the-online-addiction-medicine-diploma/	<ul style="list-style-type: none"> ■ Intended for health-care professionals interested in learning more about providing care to patients with alcohol, tobacco, and opioid substance use disorders.

RESOURCE	DESCRIPTION
DRUG TREATMENT SERVICES AND SUPPORTS	
<p>British Columbia Centre on Substance Use. A guideline for the clinical management of opioid use disorder [Internet]. Vancouver (BC): British Columbia Centre on Substance Use; 2017. Available from: http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/bc_oud_guidelines.pdf</p>	<ul style="list-style-type: none"> ■ Provides recommendations for the full spectrum of medical and psychosocial interventions available to treat patients with opioid use disorder. ■ Intended for health-care professionals with and without specialized training in addiction medicine.
<p>British Columbia Centre on Substance Use. Guidance for injectable opioid agonist treatment for opioid use disorder [Internet]. Vancouver (BC): British Columbia Centre on Substance Use; 2017. Available from: http://www.bccsu.ca/wp-content/uploads/2017/10/BC-iOAT-Guidelines-10.2017.pdf</p>	<ul style="list-style-type: none"> ■ Provides an overview of the evidence on injectable opioid agonist treatment, potential models of care for this treatment, recommendations for clinical practice, and the necessary operational requirements.
<p>Canadian Centre on Substance Abuse and Addiction. Competencies for Canada's substance abuse workforce [Internet]. Ottawa (ON): Canadian Centre on Substance Abuse and Addiction; 2015. Available from: http://www.cclt.ca/Eng/topics/Workforce-Development/Workforce-Competencies/Pages/default.aspx</p>	<ul style="list-style-type: none"> ■ An evidence-informed framework that sets out the specific abilities required by the substance abuse treatment workforce to help individuals and organizations ensure consistently high-quality service and care.
<p>Centre for Addiction and Mental Health. Buprenorphine/naloxone for opioid dependence: clinical practice guideline [Internet]. Toronto (ON): Centre for Addiction and Mental Health; 2011. Available from: https://www.cpso.on.ca/uploadedFiles/policies/guidelines/office/buprenorphine_naloxone_gdlns2011.pdf</p>	<ul style="list-style-type: none"> ■ Provides clinical recommendations for the initiation, maintenance, and discontinuation of buprenorphine/naloxone maintenance treatment in the ambulatory treatment of adults and adolescents with opioid dependence in Ontario.
<p>National Collaborating Centre for Mental Health. Drug misuse: psychosocial interventions [Internet]. London (UK): British Psychological Society; 2008. Co-published by Royal College of Psychiatrists. Available from: https://www.nice.org.uk/guidance/cg51/evidence/drug-misuse-psychosocial-interventions-full-guideline-195261805</p>	<ul style="list-style-type: none"> ■ Provides guidance on psychosocial interventions for drug misuse and emphasizes the importance of the experience of care for people who misuse drugs and their carers.

RESOURCE	DESCRIPTION
DRUG TREATMENT SERVICES AND SUPPORTS	
National Collaborating Centre for Mental Health. Drug misuse: opioid detoxification [Internet]. London (UK): British Psychological Society; 2008. Co-published by Royal College of Psychiatrists. Available from: https://www.nice.org.uk/guidance/cg52/evidence/drug-misuse-opioid-detoxification-full-guideline-196515037	<ul style="list-style-type: none"> ■ Provides recommendations for opioid detoxification for drug misuse. ■ Covers the care provided by health-care professionals who have direct contact with, and make decisions concerning the care of, adults and young people who misuse drugs.
Registered Nurses' Association of Ontario. RNAO eLearn: engaging clients with substance use disorders [Internet]. Toronto (ON): Registered Nurses' Association of Ontario; [date unknown]. Available from: http://rnao.ca/bpg/courses/engaging-clients-substance-use-disorders	<ul style="list-style-type: none"> ■ Provides recommendations on how to support clients experiencing a substance use disorder.
RNAO Addictions eLearn Series [Internet]. Toronto (ON): Registered Nurses' Association of Ontario; [date unknown]. Available from: http://rnao.ca/bpg/courses/addictions-elearning-series	<ul style="list-style-type: none"> ■ A series on different factors involved in the care of people who use drugs, including principles of opioid addiction and treatment and harm reduction.
WOUND CARE	
Orsted HL, Keast DH, Forest-Lalande L, et al. Foundations of best practice for skin and wound management. Toronto (ON): Wounds Canada; 2017. Available from: https://www.woundscanada.ca/health-care-professional/resources-health-care-pros/12-healthcare-professional/110-supplements	<ul style="list-style-type: none"> ■ Provides evidence-based recommendations associated with the five steps in the wound prevention and management cycle. ■ Guides the clinician through a logical and systematic method for developing a customized plan for the prevention and management of wounds, from the initial assessment to a sustainable plan for patient self-management.
Powell G. Wound care for injecting drug users: part 1. Nursing Standard. 2011;25(46):51–60.	<ul style="list-style-type: none"> ■ Examines the issues experienced by injecting drug users and the overall management of people presenting with injection drug-related wounds.
Powell G. Wound care for injecting drug users: part 2. Nursing Standard. 2011;25(47):41–45.	<ul style="list-style-type: none"> ■ Provides nurses with practical guidance on the assessment and management of leg ulcers, including compression therapy.

RESOURCE	DESCRIPTION
DRUGS	
<p>Insite. Insite 2010 Cookbook. 2010 (updated 2018). 16 p. Available from: RNAO.ca/bpg/supervised-injection-services</p>	<ul style="list-style-type: none"> ■ Provides information on commonly injected drugs, the supplies required to inject them, and the methods for their preparation.
<p>Sunshine Coast Health Centre. Drugs of abuse: an identification guide [Internet]. Powell River (BC): Sunshine Coast Health Centre; 2015. Available from: https://www.sunshinecoasthealthcentre.ca/pdf/SCHC_DIGuide2016_web.pdf</p>	<ul style="list-style-type: none"> ■ Provides information on the properties and effects of commonly used drugs.
SIS IMPLEMENTATION AND OPERATIONS	
<p>British Columbia Centre on Substance Use. Supervised consumption services: operational guidance [Internet]. Vancouver (BC): British Columbia Centre on Substance Use; 2017. Available from: http://www.bccsu.ca/wp-content/uploads/2017/07/BC-SCS-Operational-Guidance.pdf</p>	<ul style="list-style-type: none"> ■ Provides guidance on establishing the need for SIS, determining the model of delivery, creating a staffing structure, and developing a minimum set of policies and procedures.
<p>The Dr. Peter Centre. Guidance on community consultation and engagement related to implementation of supervised consumption service [Internet]. Vancouver (BC): The Dr. Peter Centre; 2017. Available from: http://www.drpeter.org/media/Guidance%20on%20Community%20Consultation%20and%20Engagement%20Related%20to%20Implementat....pdf</p>	<ul style="list-style-type: none"> ■ Provides guidance around the community consultation and engagement processes related to implementing supervised consumption services (SCS).
<p>Toronto Drug Strategy. Supervised injection services toolkit [Internet]. Toronto (ON): Toronto Drug Strategy; 2013. Available from: https://www.toronto.ca/legdocs/mmis/2013/hl/bgrd/backgroundfile-59914.pdf</p>	<ul style="list-style-type: none"> ■ Provides information and resources to assist decision-makers, potential service providers, and other community stakeholders when considering whether to provide SIS in Toronto.

Appendix F: Additional Resources for Priority Populations

The RNAO expert panel identified sub-groups of people who inject drugs that have unique circumstances, experiences, and health inequities that need to be considered when providing care. The following list of resources is not an exhaustive list; rather, it is meant to direct nurses and other health workers to resources that may provide helpful background context and applicable information on Indigenous people, LGBTQ2I, women, and pregnant persons.

RESOURCE	DESCRIPTION
INDIGENOUS PEOPLE	
Allan B, Smylie J. First peoples, second class treatment: the role of racism in the health and well-being of Indigenous peoples in Canada [Internet]. Toronto (ON): Wellesley Institute; 2015. Available from: http://www.wellesleyinstitute.com/wp-content/uploads/2015/02/Summary-First-Peoples-Second-Class-Treatment-Final.pdf	<ul style="list-style-type: none"> Provides an overview of the historical and contemporary contexts of racism, and the ways in which racism is fundamentally responsible for the alarming disparities in health between Indigenous and non-Indigenous peoples.
Assembly of First Nations (AFN); National Native Addictions Partnership Foundation (NNAPF); Health Canada. Honoring our strengths: a renewed framework to address substance use issues among First Nations people in Canada [Internet]. Bothwell (ON): Thunderbird Partnership Foundation; 2011. Available from: http://thunderbirdpf.org/honouring-our-strengths-full-version-2/	<ul style="list-style-type: none"> Outlines a continuum of care in order to strengthen communities and support regional and national responses to substance use issues. This framework is intended to guide the design, coordination, and delivery of services at all levels of the system. It also provides guidance on an approach to community development that prioritizes mental health and well-being and relies upon community and cultural strengths.
Canadian Association of Schools of Nursing. Educating nurses to address socio-cultural, historical, and contextual determinants of health among Aboriginal peoples [Internet]. Ottawa (ON): Canadian Association of Schools of Nursing; 2013. Available from: http://www.casn.ca/2014/12/educating-nurses-address-socio-cultural-historical-contextual-determinants-health-among-aboriginal-peoples/	<ul style="list-style-type: none"> Identifies what nursing students need to learn in order to address socio-cultural, historical, and contextual determinants of health among Aboriginal peoples, and how educational programs can prepare them to do this.

RESOURCE	DESCRIPTION
INDIGENOUS PEOPLE	
<p>Greenwood M, de Leeuw S, Lindsay NM, et al., editors. <i>Determinants of Indigenous peoples' health in Canada: beyond the social</i>. Toronto (ON): Canadian Scholars' Press Inc.; 2015.</p>	<ul style="list-style-type: none"> ■ Broadens the social determinants of health framework to understand health inequality by exploring the ways that multiple health determinants beyond the social converge to impact the health status of Indigenous peoples in Canada.
<p>Ontario Indigenous Cultural Safety Training [Internet]. Toronto [ON]: Association of Ontario Health Centres; [date unknown]. Available from: https://www.aohc.org/Ontario-Indigenous-Cultural-Safety-Training</p>	<ul style="list-style-type: none"> ■ Provides an interactive and facilitated online training program for professionals working in the Ontario health system. ■ Addresses the need for increased Indigenous cultural safety within the system by bringing to light service provider biases and the legacies of colonization that continue to affect service accessibility and health outcomes for Indigenous people.
<p>Registered Nurses' Association of Ontario. RNAO eLearn: engaging Indigenous people who use substances [Internet]. Toronto (ON): Registered Nurses' Association of Ontario; [date unknown]. Available from: http://rnao.ca/bpg/courses/engaging-indigenous-people-who-use-substances</p>	<ul style="list-style-type: none"> ■ Discusses foundational concepts and evidence-based practices when working with Indigenous people who use substances.
<p>San'yas Indigenous Cultural Safety Training Program [Internet]. Vancouver (BC): Provincial Health Services Authority in BC; [date unknown]. Available from: http://www.sanyas.ca/home</p>	<ul style="list-style-type: none"> ■ Online training program designed to increase knowledge, enhance self-awareness, and strengthen the skills of those who work both directly and indirectly with Indigenous people.
<p>Thunderbird Partnership Foundation Document Library [Internet]. Bothwell (ON): Thunderbird Partnership Foundation; 2017. Available from: http://thunderbirdpf.org/nnapf-document-library/</p>	<ul style="list-style-type: none"> ■ A series of guidebooks and toolkits for health workers providing mental health and substance use services.

RESOURCE	DESCRIPTION
<p>LESBIAN, GAY, BISEXUAL, TRANSGENDERED, QUEER, TWO-SPIRIT, AND INTERSEX (LGBTQ2I) PEOPLE</p>	
<p>Barbara AM, Chaim G, Doctor F. Asking the right questions 2: talking with clients about sexual orientation and gender identity in mental health, counselling and addiction settings [Internet]. Toronto (ON): Centre for Addiction and Mental Health; 2004. Available from: https://www.dal.ca/content/dam/dalhousie/pdf/campuslife/student-services/healthandwellness/LGBTQ/asking_the_right_questions.pdf</p>	<ul style="list-style-type: none"> ■ Helps health workers create an environment where all clients feel comfortable talking about their sexual orientation and gender identity. ■ Includes interview and assessment tools.
<p>U.S. Department of Health and Human Services; Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment. A provider’s introduction to substance abuse treatment for lesbian, gay, bisexual, and transgender individuals [Internet]. Rev. ed. Rockville (MD): Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment; 2012. Available from: https://store.samhsa.gov/shin/content/SMA12-4104/SMA12-4104.pdf</p>	<ul style="list-style-type: none"> ■ Informs clinicians and administrators about substance use disorder treatment approaches that are sensitive to lesbian, gay, bisexual, and transgender (LGBT) people.

RESOURCE	DESCRIPTION
WOMEN/PREGNANT PERSONS	
<p>BC Centre of Excellence for Women’s Health. Mothering and substance use: approaches to prevention, harm reduction, and treatment [Internet]. Vancouver (BC): BC Centre of Excellence for Women’s Health; 2010. Available from: http://bcewh.bc.ca/wp-content/uploads/2012/05/2010_GenderingNatFrameworkMotheringandSubstanceUse.pdf</p>	<ul style="list-style-type: none"> ■ Addresses the needs of pregnant persons and mothers in substance use prevention, harm reduction, treatment, service system planning, and policy making.
<p>BC Centre of Excellence for Women’s Health. Trauma-informed online tool: coalescing on women and substance use linking research, practice and policy [Internet]. Vancouver (BC): BC Centre of Excellence for Women’s Health; 2011. Available from: http://www.coalescing-vc.org/virtualLearning/documents/trauma-informed-online-tool.pdf</p>	<ul style="list-style-type: none"> ■ Provides links to recommended readings, curricula and training resources, and web resources for (a) working with women, (b) understanding the connections between substance use, mental health, and trauma, and (c) developing trauma-informed practices and services.
<p>World Health Organization. Guidelines for the identification and management of substance use and substance use disorders in pregnancy [Internet]. Geneva: World Health Organization; 2014. Available from: http://www.who.int/substance_abuse/publications/pregnancy_guidelines/en/</p>	<ul style="list-style-type: none"> ■ Provides recommendations on the identification and management of substance use and substance use disorders for health-care services that assist pregnant persons, those who have recently had a child, those who use alcohol or drugs, or those who have a substance use disorder.

Appendix G: Canadian Peer-Run Organizations of People Who Use Drugs

- **AAWEAR:** Alberta Addicts Who Advocate and Educate Responsibly
- **AQPSUD:** Quebec Association for the Promotion of the Health of People Who Use Drugs
- **BCAPOM:** British Columbia Association for People on Methadone
- **BCYADWS:** BC/Yukon Association of Drug War Survivors
- **Boundary REDUN:** Rural Empowered Drug Users Network (BC)
- **CAPUD:** Canadian Association of People Who Use Drugs
- **DUAL** Ottawa: Drug Users Advocacy League (ON)
- **MANDU:** Manitoba Area Network of Drug Users
- **Méta d'Âme:** Association for People Using Opioids (QC)
- **ONPAHR:** Ottawa Network of People Acting for Harm Reduction (ON)
- **SOLID:** Society of Living Illicit Drug Users (BC)
- **TDUU:** Toronto Drug Users Union (ON)
- **UNDUN:** Unified Network of Drug Users Nationally
- **VANDU:** Vancouver Area Network of Drug Users (BC)
- **WAHRS:** Western Aboriginal Harm Reduction Society (BC)

Source: Canadian Association of People Who Use Drugs. Collective voices, effecting change: final report of national meeting of peer-run organizations of people who use drugs. Victoria (BC): Centre for Addictions Research of British Columbia; 2014.

Endorsements



8 January 2018

Doris Grinspun, RN, MSN, PhD, LLD(hon), O.ONT
 Chief Executive Officer
 Registered Nurses' Association of Ontario
 158 Pearl Street, Toronto, Ontario M5H 1L3

Dear Doris,

On behalf of the Sigma Theta Tau International (Sigma) Honor Society of Nursing, we are pleased to endorse the Registered Nurses' Association of Ontario's (RNAO) best practice guideline *Implementing Supervised Injection Services*. We commend RNAO on this very important work to enhance the leadership capacity of nurses and other health work to effectively promote health equity for people who inject drugs through harm reduction, trauma-informed, and culturally safe practices in supervised injection services.

As you know, Sigma is dedicated to advancing world health and celebrating nursing excellence in scholarship, leadership, and service. With more than 135,000 active members from over 90 countries, we promote programs and services that focus on education, leadership, career development, evidence-based nursing, research, and scholarship.

We are confident that RNAO's *Implementing Supervised Injection Services* BPG will enable nurses at all levels to deliver evidence-based, person-centred care to people across all sectors, nationally and internationally.

Thank you for your leadership in developing this impressive work.

Sincerely,

A handwritten signature in black ink that reads "Beth Baldwin Tigges".

Beth Baldwin Tigges, PhD, RN, PNP, BC
 2017-2019 President

A handwritten signature in black ink that reads "Elizabeth A. Madigan".

Elizabeth A. Madigan, PhD, RN, FAAN
 Chief Executive Officer

SigmaNursing.org

550 W. North Street, Indianapolis, IN 46202



CANADIAN INDIGENOUS NURSES ASSOCIATION

50 Driveway, Ottawa, Ontario K2P 1E2

Tel.: (613) 724-4677 • Toll Free: 1-866-724-3049 • Fax: (613) 724-4718 • Website: www.indigenousnurses.ca

18 January 2018

Doris Grinspun, RN, MSN, PhD, LLD(hon), O.ONT
Chief Executive Officer
Registered Nurses Association of Ontario (RNAO)
158 Pearl Street, Toronto, Ontario M5H 1L3

Dear Doris,

On behalf of the *Canadian Indigenous Nurses Association (CINA)*, we are pleased to provide project specific endorsement to the Registered Nurses' Association of Ontario's (RNAO) Best Practice Guideline *Implementing Supervised Injection Services*. We commend RNAO on this very important work to enhance the leadership capacity of nurses and other health work to effectively promote health equity for people who inject drugs through harm reduction, trauma-informed, and culturally safe practices in supervised injection services.

As you know, the mission of the *Canadian Indigenous Nurses Association* is to improve the health of Indigenous people by supporting all Indigenous Nurses and by promoting the development and the practice of Indigenous Health Nursing. CINA continues to pursue meaningful engagement in activities related to recruitment and retention, research and education, member support, and consultation. We look forward to receiving several hard copies (6) of the final product.

We are confident that the collaboration with RNAO's *Implementing Supervised Injection Services* BPG will enable nurses at all levels to deliver evidence-based, person-centred care to people across all sectors, regardless of residency.

This project is a measure of the power we each hold to enrich our communities!

Yours truly,

Marilee A. Nowgesic
Executive Director,
Canadian Indigenous Nurses Association of Canada (CINA)

cc. Lea Bill, RN BScN, President
Canadian Indigenous Nurses Association of Canada (CINA)

The Canadian Harm Reduction Network

Reducing Drug-Related Harm Across Canada

January 19, 2018

Doris Grinspun, RN, MSN, PhD, LLD(hon), O.ONT
 Chief Executive Officer
 Registered Nurses' Association of Ontario (RNAO)
 158 Pearl Street, Toronto, Ontario M5H 1L3

Dear Doris,

On behalf of the Canadian Harm Reduction Network (CHRN), I am pleased to endorse the Registered Nurses' Association of Ontario's (RNAO) best practice guideline Implementing Supervised Injection Services. I commend RNAO on this very important work to enhance the leadership capacity of nurses and other health work to effectively promote health equity for people who inject drugs through harm reduction, trauma-informed, and culturally safe practices in supervised injection services.

As you know, the CHRN is the virtual meeting place for individuals and organizations dedicated to reducing the social, health and economic harms associated with drugs and drug policies. We have over 1,000 members, and a list of over 50,000 email addresses, approximately 75% of which are in Canada. We post two to four mailings per month.

I am confident that RNAO's Implementing Supervised Injection Services BPG will enable nurses at all levels to deliver evidence-based, person-centred care to people across all sectors, nationally and internationally.

Congratulations on this excellent work!

Regards,



Walter Cavalieri, Director

666 Spadina Avenue
 Suite 1904
 Toronto, Ontario M5S 2H8
 Email: noharm@canadianharmreduction.com
 Phone: 416 - 928 - 0279
 Web Page: <http://www.canadianharmreduction.com>



January 19, 2018

Dr. Doris Grinspun, Chief Executive Officer
Registered Nurses' Association of Ontario
158 Pearl Street
Toronto, Ontario
Canada M5H 1L3

Dear Dr. Grinspun,

The Canadian Nurses Association is pleased to endorse the Registered Nurses' Association of Ontario's best practice guideline *Implementing Supervised Injection Services*. The social and health care issues addressed in this guideline tackle a challenging and growing public health problem confronting the public, governments, health systems and many nurses every day, so it is especially timely and important.

This best practice guideline will be helpful to nurses working across many sectors within Canada and beyond. It offers practical recommendations for a comprehensive approach to implementing supervised injection sites, including harm reduction, trauma-informed care, and cultural safety. The recommendations are sound and are informed by evidence developed by a broad cross section of scientists and other experts.

As you know, the Canadian Nurses Association is the professional voice of Canadian nursing on the global stage. In all our leadership work in Canada and internationally, we strive to advance nursing excellence and positive health outcomes in the public interest. The Registered Nurses Association of Ontario's new guideline takes into consideration the Canadian Nurses Association *Code of Ethics for Registered Nurses* and our discussion paper, *Harm Reduction & Illicit Substance Use: Implications for Nursing*, both published in 2017 – and it is well aligned with our own work in this complex area of public policy and nursing practice.

The *Implementing Supervised Injection Services* best practice guideline will boost the ability of nurses to deliver more effective care to patients, families and communities that are facing the thorny challenge of finding safe care related to injected drugs. We commend the Registered Nurses' Association of Ontario team on this very important work; it brings light to an important public health problem and promotes a harm-reduction and trauma-informed approach to delivering equitable and culturally safe supervised injection services. Congratulations on this excellent work.

Kind regards,

A handwritten signature in black ink, appearing to read "BShellian".

Barb Shellian, President



**CANADIAN
PUBLIC HEALTH
ASSOCIATION** **ASSOCIATION
CANADIENNE DE
SANTÉ PUBLIQUE**

7 February 2018

Dr. Doris Grinspun
Chief Executive Officer
Registered Nurses' Association of Ontario
158 Pearl Street
Toronto, Ontario
M5H 1L3

Dear Dr. Grinspun:

On behalf of the Canadian Public Health Association (CPHA), I am pleased to endorse the Registered Nurses' Association of Ontario's (RNAO) best practice guideline *Implementing Supervised Injection Services*. I commend RNAO on this important work to enhance the leadership capacity of nurses and other health workers to effectively promote health equity for people who inject drugs through harm reduction, trauma-informed, and culturally-safe practices in supervised injection services.

CPHA is the independent voice for public health in Canada with links to the international community. As the only Canadian non-governmental organization focused exclusively on public health, we are uniquely positioned to advise decision-makers about public health system reform and to guide initiatives to help safeguard the personal and community health of Canadians and people around the world. We are a national, independent, not-for-profit, voluntary association. Our members believe in universal and equitable access to the basic conditions which are necessary to achieve health for all.

I am confident that RNAO's *Implementing Supervised Injection Services* best practice guideline will help enable nurses deliver evidence-based, person-centred care.

Sincerely,

Ian Culbert
Executive Director

cpha.ca

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