Peer Engagement in Harm Reduction: Development, implementation, & evaluation of the Peer Engagement Best Practice Guidelines for BC Health Authorities

BC Centre for Disease Control
An agency of the Provincial Health Services Authority

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Presented on behalf of the Peer Engagement and Evaluation Project (PEEP) team:

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Today's presentation

1. Principles of peer engagement in harm reduction services and strategies
2. Who we are: the PEEP project
3. Why this is important now
4. The Peer Engagement Best Practice Guidelines for Health Authorities
5. Other tools and resources to support peer engagement
6. Discussion & moving forward

Harm reduction & peer engagement

- **"Peer"** is a person who both (1) has lived experience with substance use, and (2) incorporate that lived experience into their professional work.

- Peer **engagement** is the *meaningful participation of people with lived experience in program, policy, research, practice or care settings.*
  - Peer engagement is based in harm reduction principles
  - It ensures that people with lived experience of substance use routinely have a real voice in the creation of programs and policies designed to serve them.
  - It is informed by models of community and public engagement

Rationale for peer engagement

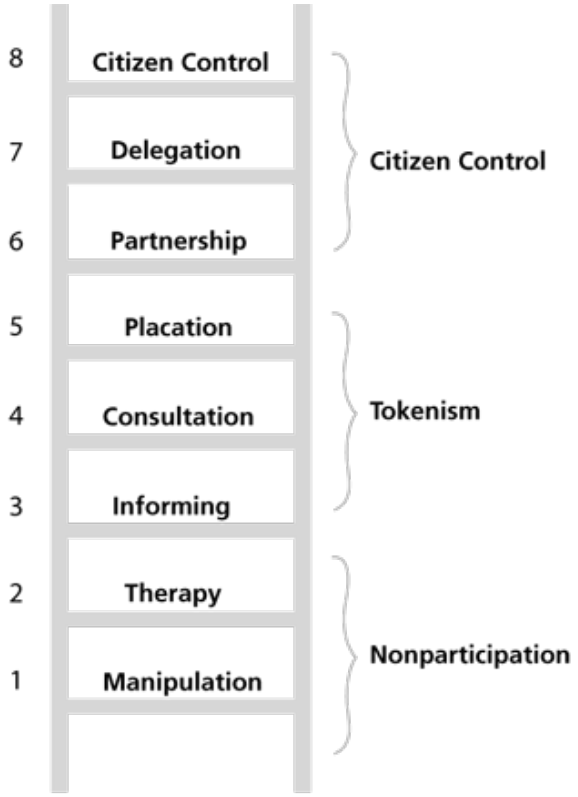
Peer engagement is meaningful participation of people with lived experience in program, policy and research settings.

- Peers are the experts
- One size does not fit all
- Capacity building

One size ≠ fit all

Peer engagement (PE)

- PE opportunities vary by length, depth, purpose, capacity, settings
- Meaningful participation
  - Sharing power at the table
  - Learn from each other
- Avoid tokenism
  - Moving away from ‘doing for’ to ‘doing with’, to coaching and mentoring



Arnstein’s Ladder (1969)
Degrees of Citizen Participation

Examples of Peer Engagement

- Designing harm reduction services for rural and remote regions
- Developing policies for substance use in primary care settings
- Creating an opioid substitution program that is designed by the patients themselves
- Asking and addressing issues that are meaningful and important to the community *first*
- Providing funds and resources to peers to open an Opioid Prevention Site (OPS)
- Take-home naloxone training hosted and delivered by peers

The birth of the Peer Engagement and Evaluation Project (PEEP)

- BC Harm Reduction Strategies and Services Committee
- Academic researchers from BCCDC, UVIC, UBC
- Health Authority harm reduction coordinators
- 5 peer research assistants and advisors in all regional Health Authorities; 2 new peer RAs
  - Lived experience → the experts

Peer Engagement and Evaluation Project

PEEP Goals:

1. Improve equity & access to harm reduction in BC
2. Enhance peer networks across BC
3. Use the Peer Engagement Best Practice Guidelines while building capacity among in our team and communities

PEEP's Progress

Year 1

- Visioning
- Recruiting and Training Peer Research Assistants
- 13 Focus Groups facilitated by peers in 5 Health Authorities

Year 2

- Data analysis and validation with team
- Training on Knowledge Translation
- Development of Best Practice Guidelines and Compassion-Inclusion tool

Year 3

- Implement and evaluate the BPGs
- Evaluation of PEEP
- Regional Convergences: delivering results and tools to communities

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PEEP Tools and Guidelines

1. Focus group results & Infographic
2. Compassionate Engagement Tool
3. Peer Engagement Best Practice Guidelines

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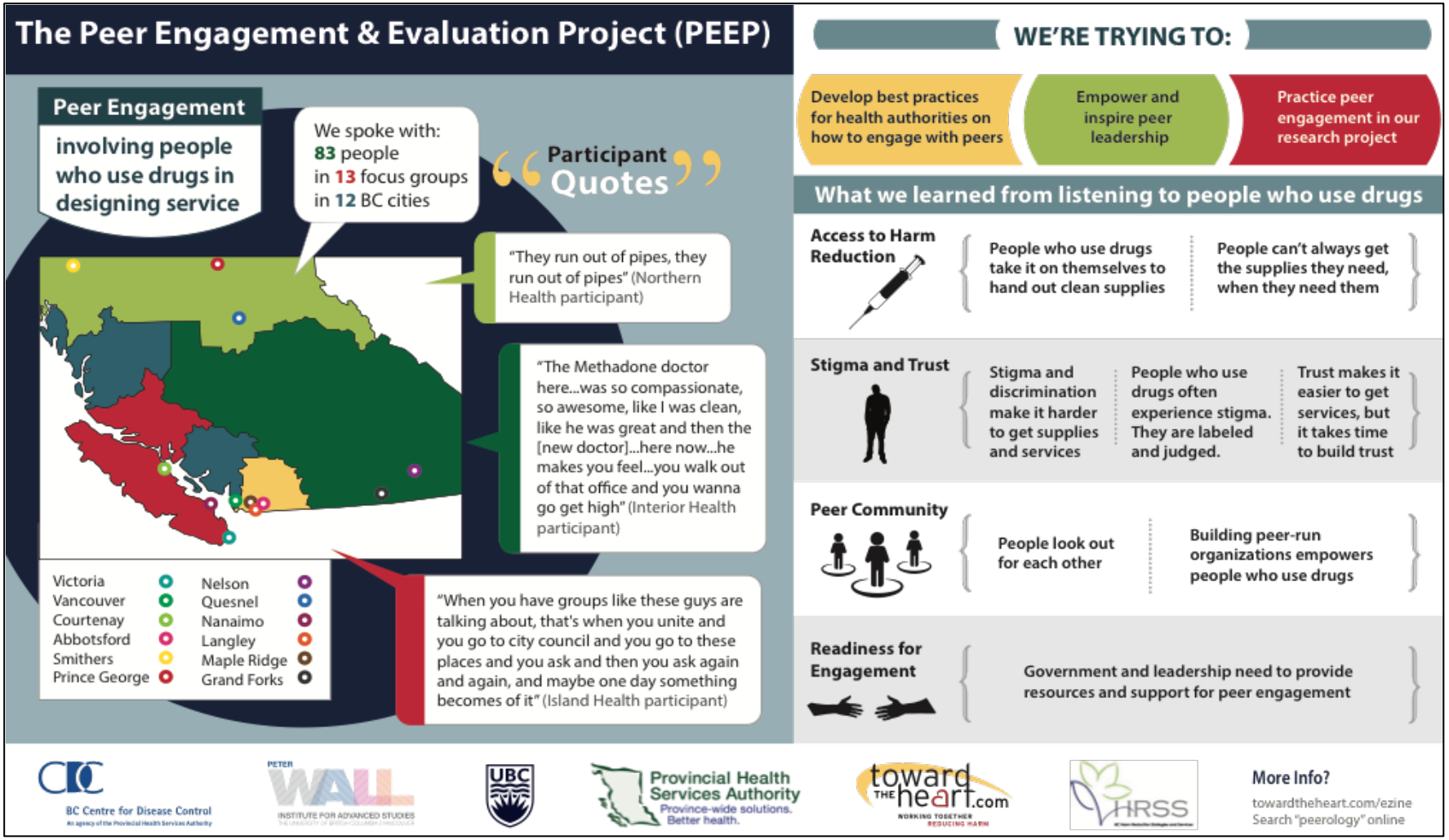
Infographic of Focus Group Findings



Compassionate Engagement Tool

Objectives

Communicate PEEP stigma and trust findings to stakeholders

- Engage stakeholders in experiential learning
- Increase awareness of stigma and its inadvertent consequences
- Facilitate collaborative efforts to reduce stigma against PWUD

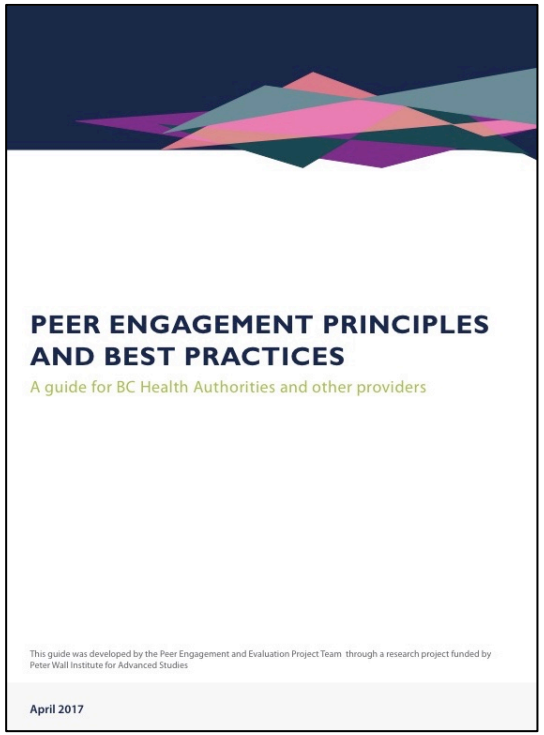
Stakeholders:

- People who use drugs
- Health Care Practitioners
- Service Providers
- Peer Research Assistants
- Public Health Leadership

Learning Module Components

1. Narrated photo series: case studies of participant experiences
2. Facilitated dialogue: Reflection on behaviours demonstrated
3. Theatre of the Oppressed: Re-enactment of scenario
4. Summary slides: Quotations on which case studies are based

Peer Engagement Best Practice Guidelines for BC Health Authorities

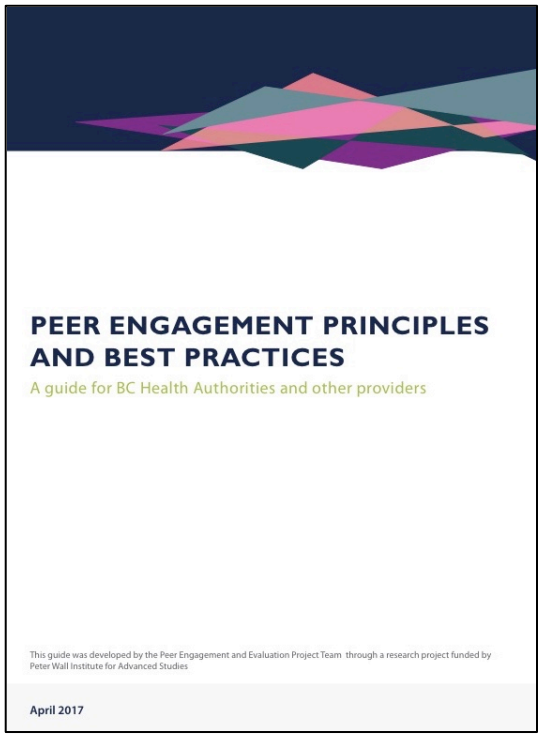


1. Principles (to support)
2. Practices (to do)

Do's and don'ts of engagement

A brief overview of things to consider:

- Meeting space (your turf or theirs?)
- Language used
- Compensation
- Privacy and confidentiality
- Travel and location
- Getting well, safely
- Barriers
- Training and a strengths based approach



Timely Opportunity for Peer Engagement

For interventions to the overdose crisis to be effective, they must be acceptable and accessible

Improvement and expansion of harm reduction:

- Facilitates engagement
- Connects people to health and substance use services (if needed)
- Combats stigma, which is fueling the overdose epidemic

Provincial support for Peer Engagement:

Health Officers' Council of BC Resolutions – October 2016

Resolution 145-03: Increasing compassion and inclusion in Harm Reduction services

Moved: Murray Fyfe, Seconded: Jane Buxton

Whereas: Harm reduction policies and programming, as outlined in the *BC Harm Reduction Strategies and Services Policy and Guidelines, December 2014* (*BCHRSSPG*) are evidence based, achieve positive population health outcomes, and integral to the health promotion, illness prevention, treatment and care continuum; and

Whereas: It is established that harm reduction services must be accessible, accommodating, affordable, acceptable and non-stigmatizing; and

Whereas: Clients continue to face stigma, restricted access, and experience interactions with health care staff and other community workers who have prejudices about people who use drugs;

Therefore be it resolved that:

That HOC takes the position health authorities and their contracted agencies support staff to engage people who use drugs with compassion and respect;

and be it further resolved that:

HOC takes the position that vulnerable and marginalized populations must be meaningfully engaged in the planning and provision of all harm reduction services that they may need to access. **All Carried**

- Pre-PEEP: Letters of support from all Health Authorities
- October 2016: Health Officers' Council of BC resolution
- April 2017: Endorsement from the Prevention and Health Promotion Policy Advisory Committee
- May 2017: Vancouver Island Geo 1 Directors Meeting

Moving forward

- Currently traveling to 10 towns/cities for presentations to Health Authorities service providers
  - Northern providers at 3 sites (n=24); Island 2 sites (n=30)
  - Interior, Fraser, and Vancouver sites TBD
- Evaluating the uptake of our tools and revising the BPGs
- PEEP's future plans with:
  - Peers:
    - Expand peer networks through grants and connections
    - PRAs engaging and getting involved locally
  - Service providers:
    - Develop capacity and engage more meaningfully using the BPGs
    - Reduce stigma through inclusive programs and services
    - Make peer engagement the norm across BC

In conclusion and challenges

- The challenge: Health Authority and other harm reduction staff have limited capacity to practice meaningful peer engagement.
- Tokenistic peer engagement may do more harm than good
- Support and resources to do meaningful peer engagement is needed on all levels of management and service

Acknowledgements & thanks

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- Paul Choisil

Other BC HRSS Committee

- Griffin Russell [Island]
- Janine Stevenson [First Nations]
- Kathleen Perkins [Ministry]
- Dr. Kenneth Tupper [Ministry]
- Reanne Sanders [Northern]
- Sara Young [Vancouver Coastal]
- Kate Fish & Jessica Bridgeman [Interior HA]
- Emily Ogborne-Hill
- Margot Kuo
- Monica Coll

Staff & clients at participating community sites