Responding to the Overdose Crisis in British Columbia

A Rapid Assessment of Frontline and Advocacy Organizations' Capacity- and Skills-Building Needs

Pacific AIDS Network

February 2017

Acknowledgements

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This report represents a compilation of facts and the opinions of frontline and advocacy organizations. The views and the opinions expressed in this report do not necessarily reflect the position of the Pacific AIDS Network, PAN member organizations, allied organizations, nor that of our funders and supporters.

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Background and summary

The Pacific AIDS Network's (PAN) Fall Conference is an annual opportunity to take a reading of the major issues facing our membership. On April 14, 2016, Dr. Perry Kendall, the Provincial Health Officer, declared a public health emergency under the *Public Health Act* as a result of the significant rise in opioid-related overdose deaths across British Columbia (BC) since the beginning of 2016. Because PAN's member agencies and partners have been on the frontlines of responding to, reversing, and managing grief and loss related to overdoses, substantial time was spent discussing the opioid crisis and national drug policy at the PAN Fall Conference in October 2016. The outcome of these conversations have been collated into a summary report.

Building on momentum from this conference and a strong desire for action that will support community-based organizations (CBOs) in the province, a conversation was initiated by the BC Centre for Disease Control (BCCDC) about how PAN can best support progress on this issue. This conversation put into motion the idea of conducting a rapid assessment with a number of key PAN members and stakeholders including a number of representatives from health authorities to determine key implementation activities, focusing on capacity- and skills-building, that would help to address the overdose crisis (OD) in BC. Respondents received an email invitation to participate in the rapid assessment. It is worth noting that most respondents promptly replied to the original invitation and were eager to make time in their busy schedules to

for these calls. The level of engagement in the rapid assessment demonstrates that frontline and advocacy organizations feel a strong need for capacity- and skills-building support in response to the OD crisis. Many organizations commented that PAN is well-positioned to provide resources that will be useful and suited to their organizations.

This report presents the results of this rapid assessment, which consisted of 20- to 30-minute telephone consultations conducted in January and February 2017 with 24 individuals across BC in 19 conversations (see 'Respondents and Regions' for more detailed information; some conversations were with two or more individuals at a time).

All respondents were asked five key questions:

1. What are the biggest issues your organization is facing in relation to the overdose crisis in BC?
2. What kinds of capacity-building and skills-building activities would best support your work?
3. What would your preference for delivery of these capacity- and skills-building activities? (webinar, face-to-face, telephone, written materials?)
4. Are there any capacity- or skills-building activities related to the overdose crisis already happening in your region or community?
5. Do you feel that there is a need for grief, vicarious trauma, compassion fatigue, burnout, loss, or trauma/crisis work in your organization or community and how can PAN best provide support?

Respondents' responses to the first four questions were diverse but clustered around similar needs related to supporting staff, clients, peers at the frontlines of the overdose crisis, as well as increased training opportunities, enhanced knowledge sharing, and increased funding. With regard to the fifth question, which inquires about the need for support related to grief, vicarious trauma, and compassion fatigue, all respondents answered with a firm and loud "yes."

Rapid assessment respondents by region

Region	Participants
Provincial/National	Caroline Brunt (Outreach Street Nurse, BC Centre for Disease Control) Sonya Ishiguro (Project Manager, Harm Reduction Program, BC Centre for Disease Control) DJ Larkin (Housing Campaigner, Pivot Legal Society) Jordan Westfall (President, Canadian Association of People Who Use Drugs)
Vancouver	Susan Alexman (Director of Programs, Portland Hotel Society) Miranda Compton (Manager of HIV Services, Vancouver Coastal Health) Coco Culbertson (Programs Manager, Portland Hotel Society) Sally Kupp (Harm Reduction and Prevention Clinical Educator, Vancouver Coastal Health) Shayne Williams (Executive Director, Lookout Society) Sara Young (Harm Reduction Coordinator, Vancouver Coastal Health)
Fraser	Kindra Breau (Program Director, Positive Living Fraser Valley) Erin Gibson (Regional Harm Reduction Coordinator, Fraser Health) Kari Hackett (Executive Director, Positive Living Fraser Valley)

	Ron Moloughney (President, Surrey Area Network of Substance Users) Shayne Williams (Executive Director, Lookout Society)
Island	Katrina Jensen (Executive Director, AIDS Vancouver Island) Griffin Russell (Regional Harm Reduction Coordinator, Island Health)
Interior	Jessica Bridgeman (Regional Harm Reduction Coordinator, Interior Health) Cheryl Dowden (Executive Director, ANKORS) Kate Fish (Regional Harm Reduction Coordinator, Interior Health) Kira Haug (Harm Reduction Coordinator, ASK Wellness) Clare MacDonald (Executive Director, Living Positive Resource Centre)
Northern	Linda Keefe (Nurse and Program Coordinator for AIDS Prevention Program and Needle Exchange, Northern Health) Reanne Sanford (Harm Reduction & Sexual Reproductive Health Regional Nursing Lead, Northern Health) Vanessa West (Executive Director, Positive Living North)

Frequency of key issues and needs

The table below describes the key issues and needs identified in the 19 conversations respondents (we spoke to 24 people but some conversations were with 2-3 respondents at a time). The two sections following this table describe these key issues and needs in more detail.

Key issue or need	# of times mentioned (out of 19)
Need for trauma and grief support or training for frontline staff	n=19
Need for effective debriefing training	n=16
Need for training related to drugs and the presentation of overdose	n=14
Limited funding resources	n=12
Need for cross-professional communication opportunities	n=10
Lack of support for peers and peer-based initiatives	n=9
Need for education about substitution therapy options and how to present these to clients	n=6
Need for drug policy changes and access to injectable alternatives	n=5
Opportunities to educate the broader community to reduce stigma	n=4

Need for improved access to abstinence-based treatment options	n=3
Need for strategies to manage client behaviour	n=2

What are the biggest issues organizations are facing in relation to the overdose crisis in BC?

At the staff level:

- Staff burnout related to the extraneous and emotionally taxing work of responding to overdoses. Most CBO staff members were hired for outreach or program delivery work. However, as the OD crisis has evolved, they have become de facto "first responders" to overdoses in and outside their organization without the professional training and supports provided to first responders such as paramedics, police, and clinicians. Staff members therefore, have found themselves in emergency, medical, and/or clinical-type situations without the training or skillset to cope. Staff have strong relationships with many of their clients and have taken up these roles with remarkable dedication (e.g. working overtime and while ill), fearful of deaths that might occur if they are not there to reverse overdoses. As one respondent stated, "We are holding it together with sticky gum and bobby pins."
- Managing poor client behaviour in BC's "new" Overdose Prevention Sites. Staff were initially relieved that they no longer had to keep check on how long someone spends in the bathroom while simultaneously managing front desk and other work. However, this relief was quickly replaced with a new source of stress when drug-dealing and other activities started occurring in the spaces. Staff require more behavioural intervention training if these sites will remain a part of their standard operations.
- Naloxone training has greatly improved since the fall of 2016. Now, there is a need for more training around stabilizing adrenaline response after a reversal and how to support individuals as they regain consciousness after experiencing an overdose.
- Staff are increasingly managing clients who look exclusively for fentanyl, stating that it lasts longer and is cheaper. One CBO staff member explained that many clients have been revived more than eight times and clients rely on each other to stay alive. This staff member explained how "not only did [fentanyl] come up and surprise everyone with the crisis, but through the crisis people built a tolerance or liking for synthetic opioids. So that's what they purchase [now]."

At the organizational level:

- For local businesses and community spaces participating in the BCCDC's facility overdose response program, there is a lack of knowledge around HIV and hepatitis C (HCV) and fear of contracting HIV and HCV by administering CPR and rescue breaths. If naloxone training is going to become a standard component of program delivery organizations need more resources to offer community members CPR training and education around HIV and HCV.
- Organizations feel as though they are being asked to provide more lifesaving services without receiving any additional funds to do such work. This sense of having to do more with less and less is especially true for organizations whose funding situation vis-à-vis the Public Health Agency of Canada (PHAC) is unclear post April 1, 2017. Frontline service organizations have strong relationships with the most marginalized groups being

affected by the overdose crisis and fear what will happen to their clients if and when they have to reduce their services as a result of funding cuts. As one Health Authority staff member stated, “we have a long history of asking non-profit and community organizations to bear the brunt of harm reduction activities and social care issues like addressing poverty and social isolation. So the chronic underfunding has put community organizations into a position where they are doing more than they are contracted to, with limited resources, and limited training.” Health Authority staff acknowledge that CBO staff hold relationships with the most vulnerable of folks who would otherwise be very difficult to reach.

- Positive attention from the local media about the great work organizations are doing related to the crisis increases the number of naloxone training and other service requests from the general public. While these services and trainings are absolutely necessary, they add additional pressures to managing organization resources.
- Organizations that have received more money to extend their hours are feeling a sense of pressure related to staffing.
- Staff members commented on the challenges of keeping up with changes in regulations related to dispensing naloxone and other ongoing changes. There was also a shared sense that naloxone has been a great tool but that “naloxone alone is not going to get us out of the crisis” so there is an institutional need to look at broader solutions that will be sustained over time.
- Senior-level CBO staff commented on being torn between meeting the needs of the community and the needs of the organization. The increased demand for services and changing policies and procedures both require attention and resources.

At the peer or client level:

- Peers are reversing overdoses among other peers outside of organizations and they witness and assist with peer overdoses when they are at an organization to receive services themselves. The trauma of these activities is magnified by the fact that many peers have lost friends and/or family members to the overdose crisis, so witnessing these events triggers further grief and loss. Staff at CBOs may not necessarily be trained to debrief and support peers who are experiencing these events and there is limited access to trauma services for peers.
- Two respondents who work closely with peer-based initiatives reported a lack of support from policy-makers at the local and federal level, with one respondent stating, “we see a lot of support for organizations but not for peer-led initiatives.” Peers have the knowledge, lived experience and interest in contributing to the development of meaningful and cost-effective harm reduction activities and policy strategies but often find themselves excluded from those conversations.
- Lack of access to abstinence-based treatment and maintenance (e.g. suboxone, methadone) treatment.

What kinds of capacity- & skills-building activities would best support the work of CBOs?

At the staff level:

- Practical training around the drugs people are taking, what staff can expect to observe when people take these different drugs, and signs of drug addiction and overdose. As one respondent explained, “you can draw on peers’ knowledge to explain to staff what

they experience in their own bodies when they use drugs and how to best support them through this." Similarly, another respondent mentioned the need to learn from peers what it feels like to overdose and to hear their perspective on what supports are necessary after people experience such a traumatic event.

- Access to Vikki Reynolds' training around burnout and trauma-informed practice (www.vikkireynolds.ca/). As one respondent stated, "[frontline CBO staff] are connecting with us and saying I don't know how much longer I can keep doing this, when members leave [our agency] I don't know if that's the last time I am going to see them... so the grief we are hearing is very profound."
- Training around managing stress and effective debriefing after critical incidents.
- CPR training, HIV and HCV education, and training around universal precautions.
- Access to counselling resources for family members supporting CBO staff, who often take this trauma home with them at the end of the day.
- Facilitated conversations (and training around how to facilitate conversations) to promote harm reduction, reduce stigma, and advocate for drug policy changes. As one respondent explained, "how, as a staff member at an organization, do I show up for the people that I serve, to have conversations about how the policies of the organization are harming people that we serve, and how are we dismantling the pieces of our organization that cause people harm, and how do we support people to do the same?"
- Knowledge exchange opportunities related to cutting edge programs and practices. Many CBO staff members stated that they wished to learn more about innovative programs and approaches being taken by their colleagues around the province and that they viewed PAN as a leader in facilitating these knowledge exchanges. A number of CBO and health authority staff suggested having monthly meetings via webinar or telephone to discuss what's happening in other agencies related to harm reduction, what strategies are working, and steps for reducing stigma and discrimination. Staff commented on a feeling of isolation and stated that opportunities to connect with colleagues doing similar work would promote knowledge sharing and improved service delivery across the province.
- Training or support developing interdisciplinary communities of practice to facilitate communication between CBO and health authority staff from across the province. Doing so would bring together the top-down and bottom-up approaches to managing this crisis that some people observed as not necessarily working together in the current context. As the respondent explained, for this suggestion to work "there has to be buy-in from all levels and people need to find time away from the urgent activities that they are already doing. It probably has to start with people in leadership positions being willing to create time and prioritize these activities."
- More education about substitution therapies and training on how to discuss substitution therapies with clients and members.
- Training around how to work with peers as partners in responding to the overdose crisis. As one CBO staff member explained, "There needs to be better education and support around working with and empowering peer [naloxone] distributors. We want to support meaningful involvement but at the same time we are working with people with limited capacity. Some training on how to help agencies and staff work in that peer system would be helpful. And of course there needs to be funding to support these activities, such as funding for peer stipends."

At the organizational level:

- Education and training around how to advocate for making medical spaces safer for the most vulnerable and marginalized individuals affected by the OD crisis.

- Education and training around how to identify and address pain medication dependency. Developing this competency is especially relevant to physician practice and therefore more in the realm of capacity- and skills-building at the level of the health authority.
- CBO staff want clearer guidelines about the difference between Overdose Prevention Sites and Supervised Consumption Sites to better manage their legal liability and moral ambiguity of working "on a fine line."
- A health authority staff member described the pressure of having to prioritize which organizations should receive overdose response training based on the number of overdoses occurring at or in proximity to the organization (e.g. outside the front door, in the alley, or parking lot). PAN could develop a tool to help assess an organization's level of need and could even provide some basic harm reduction for those organizations that are lower need.
- Establishing a wraparound service model that cascades after someone has experienced an overdose. A respondent likened the potential of this model to the intervention that happens when someone repeatedly seeks HIV testing: "when people are coming in repeatedly to get HIV testing, there's wraparound support to see why people are engaging in these risky behaviours and I think we need similar 'upstream intervention' to respond to [individuals who are frequently overdosing] in a way that's more proactive than frontline workers delivering these reversals. Frontline organizations are trying to be everything to everyone because people don't have anywhere else to go. So not just supporting workers but supporting the people."
- Training around trauma-informed care (TCI). A respondent suggested modifying the TCI practice guide developed on behalf of the BC Provincial Mental Health and Substance Use Planning Council.

At the peer or client level:

- Support for managing grief, loss and vicarious trauma.
- Training to respond to, reverse, and support individuals experience overdose and after they regain consciousness.
- There is a demand for basic leadership and organizing training for people who use drugs: how do you facilitate meetings, how do you get people to come to meetings, how do you secure organizational support, how do you find funding for your organizing, and so on.
- Not directly related to capacity- or skills-building, there needs to be increased advocacy and education related to removing police presence from 911 calls related to overdoses. Some peers and clients report being afraid to call 911 in cases of overdose, out of fear the police will arrive.

What are the most pressing capacity- & skills-building activities versus medium- or longer-term needs? What is the preference for how these activities should be delivered?

The table below summarizes the key capacity- and skills-building activities identified by respondents. The section following the table describes these activities in greater detail.

Need identified	Level of urgency	Preference for delivery
Support for grief, loss, and burnout	Immediate	In-person

Training on effective debriefing	Immediate	In-person or by webinar for those in remote areas
Establishing a community or communities of practice to exchange information and support	Immediate	Webinar or teleconference
Funding for ongoing naloxone and CPR training	Immediate	In-person (CPR) or by webinar (naloxone training)
Access to current guidelines on naloxone distribution and liability implications	Immediate	By email with opportunities for follow-up conference calls to ask questions
Guidelines on operating overdose prevention sites as compared to supervised consumption sites	Immediate	By email with opportunities for follow-up conference calls to ask questions
Public-facing education to reduce stigma and discrimination	Immediate to medium- and longer-term	In-person (at schools, organizations, etc) or by webinar/video training
Peer leadership training and support	Immediate to medium- and longer-term	In-person and by webinar/video training
Educational materials related to harm reduction	Immediate to medium- and longer-term	Digital and hard copies

As the table above demonstrates, most needs were identified as being immediate needs. There was a sense among CBO and health authority staff that action in response to the overdose crisis had already been delayed – at least 755 people across the province died of overdoses in 2016 before the first overdose prevention site opened in early December – so all current and potential activities are an attempt to 'catch up' on a need that has been present for some time.

An increased capacity to support staff members suffering from grief, loss, burnout, and vicarious trauma was defined as the most pressing need, as was funding to provide these services to individuals and their families. Respondents put forth excellent suggestions about the need to build debriefing skills as a team of colleagues: CBO staff explained how their staff members sometimes felt as though external counselling services did not understand the overdose crisis, so some felt that sessions with counsellors were spent explaining their work rather than receiving therapeutic benefits.

Respondents stated that activities related to "heart and mind" capacity- and skills-building ought to be delivered through in-person sessions. Providing a physical space where people could gather to discuss their experiences or seek respite was identified by at least two respondents as something they saw as having major success in their communities. As one respondent explained:

> *With capacity-building, you need to build a solid team and you support one another because you understand each other and the work. In our team of 10, we never once went to outside counselling because we supported one another and we had the team to debrief after incidents. Conversation is huge - non-profits, outreach workers - need time to debrief and support one another. If people choose to access external counsellors, you need counsellors that understand the complexity of this work and there's a lack of understanding about this work outside of the circles. Set aside time at the end of the day for tea, food, and conversation, because these activities will offer connection and that connection provides support. Each community should have a 'hub' - a hub of people who*

understand the complexity of communicating, connecting, and the complexities of this work. The hub should be consulted on what their needs are. The experts are the people on the ground: include us, communicate with us, and connect with us. Flatten the hierarchy and let's move forward. Let the on-the-ground outreach workers determine what the needs.

Establishing communities of practice to reduce the isolation of opioid-crisis related work was identified as an immediate need that would also reduce stress and increase resiliency. Respondents stated that it would be ideal to be able to meet in-person but recognized that geographic and time constraints made meeting via webinar or conference call more feasible.

CBO staff members identified an immediate need for education about substitution therapies and training on how to talk to individuals about these options. While CBO staff were grateful for naloxone and naloxone training, some viewed it as a reactive response rather than proactive response and wanted to support who weren't ready for abstinence-based treatments to make different decisions about their behaviour. A lack of training around supporting clients to access substitution therapy was viewed as a gap. The need for this education and training was identified as being especially important for interventions with individuals who are overdosing at CBOs multiple times per week and contributing to compassion fatigue for CBO staff and paramedics reversing these individuals. More broadly, this training could be developed and integrated as part of a wraparound care cascade for individuals who are being reversed from overdose multiple times per week. It was suggested that this training be delivered in-person or via online training modules.

Funding for ongoing naloxone and CPR training opportunities for CBO staff members and community groups were also discussed as immediate needs.

With regard to practical skills, respondents identified best practices and policy/guidelines related to overdose prevention site guidelines as an immediate need for CBO staff members. Relatedly, there is a need for policy guidelines for distributing and administering naloxone, including information about legal liability implications. These requests align with CBO staff members' general sense that the changes in policy, legal/liability issues and best practice are occurring so rapidly that it is difficult to keep up. Respondents suggested a mechanism for having best practices and policy and procedural changes delivered by email with follow-up conference calls or webinars that would provide CBO staff members with the opportunity to ask questions about how to roll out the changes. On the whole, this need and resulting suggestions highlight the need for increased province-wide communication about the steps being taken to address the overdose crisis.

CBO staff and advocacy groups commented that stigma is causing community backlash and making it difficult for several agencies to do their work in the community. Broad community-facing education was thus identified as an immediate but less pressing need that should include myth-busting around HIV and HCV transmission and dismantling the fear that touching someone in overdose can cause the responder to overdose.

All of these needs require increased funding and acknowledgement of the work being done by frontline organizations. As one health authority staff member stated:

The folks that really need these services are not engaged with the health authority staff but the CBOs are, so we are really relying on them to provide these services but this is all off the side of their desks and they aren't being compensated to do this work. They are responding to overdoses, reversing people, training people on naloxone but the

exposure to the traumatic event and the extra energy that goes into training people and saving people is not formally supported. And there is no process from the health authority to support them. The employees that do a lot of overdose response and who have lost clients to overdose don't have the same access to counselling services that employees at [the health authority] have. They aren't getting proper follow up and support after responding. So there is an increased workload that comes with overdose response. And one of the shelters up here invited a physician to do suboxone and methadone work in the shelter but they had to pull a frontline worker to support the urine testing, etc. So the low-barrier places that high risk people access aren't being supported to do this great and important work.

What capacity- and skills-building activities are already happening in communities? What resources are organizations and health authority members relying on?

At the staff level:

- Three out of the 19 conversations referred to accessing resources on *TowardTheHeart.com*. Documents about building resiliency, debriefing after overdose, and on trauma were listed as some of the most valuable resources on that site.
- Shannon Riley's overdose prevention room manual was described as really helpful by an organization that opened an overdose prevention site.
- Most respondents stated that the health authorities are doing a great job dispensing naloxone kits and providing overdose training, although one respondent noted some issues with naloxone kit distribution in Dawson Creek and other rural areas. Overall, CBO staff members are happy about the increased treatment options and facilities in certain regions. That said, there are still some concerns related to the abstinence-focus of these treatment opportunities and the lack of supportive housing for individuals when they exit treatment.

At the organizational level:

- Several CBO and health authority staff had formed or were forming interdisciplinary regional tables with frontline staff from CBOs, clinicians, law enforcement members and other key stakeholders. Respondents explained that these groups provide an opportunity to debrief, support one another, share knowledge and information, and give updates from a multidisciplinary perspective which is so important because things are changing so fast.
- Several CBOs had formed or were in the process of forming roundtables with other CBO staff members to support these organizations not only with naloxone training but also the opportunity to discuss and debrief the impact of the overdose crisis on staff and their clients and brainstorm how we could work in the existing context to reduce overdose.
- One organization is doing direct check-ins with the provincial health officer to stay abreast of policy and procedure changes.
- The City of Vancouver has been somewhat supportive in terms of transferring financial resources to CBOs in Vancouver.
- Several organizations have accessed training from Vikki Reynolds or the First Nations Health Authority's Compassion, Inclusion and Engagement (CIE) group and found this to be extremely helpful. The CIE focuses on reducing stigma and increasing compassion in service delivery, and seeks to bridge harm reduction champions with peers to help formulate the activities they could do together.

- The BCCDC is offering great training and support for the establishment of overdose prevention sites in Vancouver and Surrey.

In many cases, it sounded as though the CBO is the key resource to the community. Here are some of examples of how they are contributing to the overdose response:

- "We are doing a lot of training with individuals who are most likely to witness overdoses, including staff in the hospitality and service industry. Every major bar and nightclub in town has contacted us and requested training and so they now have trained staff on site at all times."
- One respondent discussed the value of the film *Bevel Up* and how if this film was digitized it could be used as an educational tool on how to connect and communicate with the most vulnerable community members.
- CBO staff members are delivering naloxone and overdose response training to various community groups, including staff in the hospitality and service industries.

What specific activities did respondents see as best-suited for PAN to deliver?

At a structural level:

- As a network rather than an agency, several respondents commented that PAN is in an ideal position to administer political pressure. Respondents indicated that PAN has the skills to advocate for a BC Substance Abuse policy, a BC Housing Strategy that offers addiction-based/supportive housing for people who aren't ready for abstinence-based treatment programs, and for increased awareness of the lack of mental health services and reasons why people are self-medicating.
- PAN could also be doing public education training around the opioid crisis: describing what does a day in the life of an unsupported addict look like and how much would it cost to provide housing and treatment as compared to the costs of unsupported addicts accessing police, ambulance and shelter services.

At an inter-organization and organizational level:

- Many respondents praised PAN's capacity-building and training, noting that PAN would do a great job at facilitating or moderating an interdisciplinary community of practice (CoP) focused on sharing best practices and emerging experiences related to the overdose crisis. Respondents suggested that this CoP could be offered as an online forum or monthly teleconference call.
- PAN ought to continue advocating for the meaningful inclusion and leadership of people with lived experience and people who use drugs (PWUD) at decision-making tables.
- PAN is well-respected in the community, is a great lead in supporting agencies and has experience facilitating CoP calls and groups, so it would be great if PAN could work to link diverse service providers in conversation.

At frontline level:

- As one respondent summarized, "if PAN offered support with grief or trauma work, we would take it in a second. I don't think that any agency would turn down that kind of support at this time." Another respondent suggested that PAN provide or host a one- or two-day workshop or training that examines trauma from a structural violence perspective workshops or training. This material could even be delivered through online access to webinars or resources that people can access on their own time or during staff meetings.

- PAN could build on *TowardTheHeart.com* resources on resiliency, to develop a resiliency and coping with grief toolkit for CBO staff. The toolkit could include readings, videos, and even a simple handbook with participatory exercises to help people put words to their emotions and experiences on this topic. PAN has a lot of great resources from the time of the HIV/AIDS epidemic that could be revised to support staff doing this challenging work.
- It would greatly reduce the human resources burden that organizations are currently facing if PAN could provide one or two days of basic harm reduction training to new staff members hired by CBOs on a monthly or semi-monthly basis. New staff members would still need to be oriented to the specific organization but some basic training would reduce the pressure on already-overworked staff to orient new employees. While it did not seem as though organizations have experienced a lot of employee turnover at the time of the rapid assessment calls, many respondents commented on the level of burnout and exhaustion staff were experiencing so it would be wise to plan for orienting new staff members should a significant need arise in the near future.
- PAN-led harm reduction education could include the creation of webinars and/or printed materials. Respondents suggested pamphlets or rack cards with basic harm reduction information as well as information about substitution therapies and HIV and HCV transmission. Part of this advocacy and development of a provincial educational strategy ought to include outreach to abstinence-based setting such as industrial camps where people might be penalized for even having naloxone on site. While CBOs are doing a great job at reaching out to at-risk individuals (even if they are doing it without much additional resources), there are still a lot of people using drugs alone in subsidized housing, private residences, and worksites.
- PAN's expertise working with peers could inform a training on peer trauma coping or even having peer-based guides to assist other peers in navigating the treatment system. Having peers who have experienced overdose support other peers connect community members and could be highly effective.
- It was suggested that PAN reach out to Moms United to End the War on Drugs to investigate a potential partnership.