Key Messages Report
Harm Reduction Symposium
Sponsored by
The Canadian AIDS Society and the Canadian Harm Reduction Network

March 30, 31and April 1, 2007
Winnipeg, Manitoba

I. Introduction

From March 30 to April 1, 2007, the Canadian Aids Society (CAS) and the Canadian Harm Reduction Network (CHRN) jointly hosted a national symposium on harm reduction. This symposium was one of the keydeliverables of a larger project funded by the Drug Strategy Community Initiatives Fund[1]; the project's objectives are: (a) to identify and document effective and innovative harm reduction programs and practices, and (b) to disseminate this information in order to enable organizations across the country to draw on each other's experiences and successes.

As for symposium itself, in addition to providing an opportunity for much needed networking, its objectives were to:

(1) showcase and document innovative and effective harm reduction programs and practices in selected cities and examine how they are integrated in the full spectrum of treatment, prevention and enforcement activities;

(2) identify how the information garnered in this project would be most usefully delivered to people who are currently offering harm reduction programs or who wish to develop harm reduction programs in their community **,** and identify how to best evaluate these resources.

II. Agenda

The agenda for this symposium was as follows:

Day 1: Friday, March 30, 2007 (16:00 to 18:00)
I. Opening
1. Welcome and Purpose of the Symposium (Lynne Belle-Isle, CAS and Walter Cavalieri, CHRN)
2. Review of process & agenda (facilitator)
3. Participant Introductions

II. Launching Discussion (exchange of information on the overall scene in the participating cities/regions as it pertains to drug use and to the challenges of harm reduction)

Day 2, March 31, 2007 (8:30-16:30)

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[1] Production of this report has been made possible through a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

III. Showcasing innovative practices (presentations by different agencies from the participating city on their harm reduction practices and programs).

IV. Drawing Conclusions and Identifying Lessons Learned

<u>Day 3: Sunday, April 1, 2007 (8:30 – 12:00)</u>

V. Identification of Most Useful Resources for Practitioners

VI. Next Steps and Closing Remarks (Walter Cavalieri /Lynne Belle-Isle)

III. In Attendance

Some twenty-five participants from seven provinces and one territory attended this symposium; they primarily represented organizations engaged in harm reduction in medium-sized centres cross the country. The meeting was facilitated by Lise Pigeon of *Lise Pigeon & Associates*. A complete list of participants is attached as Annex A.

IV. Key Messages

Day 1: March 30, 2007

I. Opening

Lynne Belle-Isle (CAS) and Walter Cavalieri (CHRN) welcomed participants and thanked them for taking their personal time during a weekend to attend this symposium.

Walter Cavalieri provided background information on the project and explained how the idea grew from a half-day session on the future of harm reduction held a few years ago during which attendees emphasized the need for networking and learning from their peers across the country.

Mr Cavalieri explained the process that the CHRN and CAS used to obtain funding from the Drug Strategy Community Initiatives Fund and how the project was launched. He mentioned that this was an action-based research project that hopefully will give strength, hope and support to all those in the harm reduction arena.

Ms. Belle-Isle stated that, very deliberately, the focus of the project was on small to medium-sized centres (as opposed to Vancouver, Toronto and Montreal), so that those engaged in harm reduction in smaller centres could exchange ideas and strategies that would have more transportability and applicability in their communities. The hosts also explained that following the symposium, the next major activity to be undertaken as part of this project will be the holding of focus groups across the country with users in order to get their perspectives on harm reduction programs; this is planned for the summer of 2007.

Mr. Cavalieri introduced Lisa Fleishmann, a documentary photographer, whose role was to visually document the symposium and put a human face on harm reduction.

Participants introduced themselves by providing a few details on their background and the perspective they brought to the symposium.

II. Launching Discussion

This "warm up" discussion allowed participants to exchange views on the overall scene in their city/region as it pertains to drug use and drugs of choice, and to share views on the major challenges experienced by the harm reduction community.

The following presents the key messages emerging from the plenary discussion.

1. Trends identified with regard to drug use included:
   - From coast to coast, the one common drug seems to be cocaine. Crack is also very significant.
   - Increasingly, people are unwillingly ingesting crystal meth (which increases addictiveness) because more and more, it seems to be laced into several other substances (for example, in ecstasy, marijuana). Heroin is also being cross-cut into other drugs as well.
   - Diversion of medications is on the rise. For example, the opening of the casino in Thunder Bay coincided with a dramatic increase of diverted medication.
   - More and more, people are starting to use drugs at a younger age; they are also by-passing softer drugs and going directly to injecting opiates, a trend that may result in more overdoses.
   - Use, abuse and mis-prescription of pharmaceuticals are on the rise and may soon become a huge problem; while this may reduce the spread of hep C and HIV/AIDS, it will result in very high rates of addiction. For example, an Ativan in some places is worth more than a few ounces of cannabis.

2. Some cities experience problems with law enforcement; for example, in Québec City, with the upcoming celebrations for the 400th anniversary, the city is getting a facelift and the "undesirables" are being driven underground. Thus, they are hard to reach and not getting the resources they need; they hide from the cops and their injecting and drug use becomes unsafe.

3. Aboriginal communities continue to be poorly served; methadone and needle exchange are unavailable on reserves. People are desperate for services, but in some locations, e.g., the Atlantic Region, they cannot be established or delivered because of resistance from chiefs and elders.

4. The geographical barriers that exist for rural and more isolated areas impact directly on those populations' access to services. Rural communities have no (or extremely limited) access to methadone and harm reduction. For example, there are only four pharmacies (all located in St. John's) that dispense methadone in the whole of Newfoundland.

5. There is a growing phenomenon in certain regions where seniors are being abused and victimized; people are moving in and using their homes as crack houses and are either purchasing or stealing their medications.

6. There is immense pressure on the people in the harm reduction agencies because of shifts in the political and social landscape, and because of built-in barriers; as a result, the clients are getting agitated and the workers are stressed out as they are unable to deliver services.
   - For example, in Victoria where the combination of poverty, homelessness and injection drug use is a major source of societal concern, there is political support for harm reduction but no funding. Public injection drug use is causing the most furor, but no money is going to detox and treatment. There is no investment in solutions.

- o In Newfoundland, the resources received are based on estimates of injection drug users, which in turn are based on a certain percentage of people living with hepatitis C; as a result, the number of estimated injection drug users is underestimated.

7. Cuts in services, barriers to service (which force people to adapt to the agencies rather than the agencies adapting to the people they serve), and insufficient services (including the refusal by many doctors to take on patients who consume drugs) are causing the greatest malaise. As a result, people are not accessing services, a situation that leads to increased cases of mental illness and a rash of pathologies like abscesses, necrotising faciatis, and probably of botulism as well. There are also inefficient services caused by the fact that agencies are forced into spending time feeding the bureaucratic machine rather than providing services.

8. The real problem is the voicelessness of the user population. Much of the harm reduction effort is cleaning up for bad decisions that could have been avoided if the drug users had a voice in the policies that are affecting them.

9. The medical profession is ill equipped to provide consistent and effective support; physicians are not educated with regard to problematic substance use. In addition:
   - o Confidentiality is not respected by some doctors who "black list" patients coming in with abscesses and some physicians share that information with others.
   - o The mindset around methadone results in an increase in the use of opiates; this is because to be on methadone, a patient has to follow complicated rules and the doctor has to make sure the patient is registered. However, it can be very easy to get prescriptions for opiates and no registration is required. Also, the regulations for methadone are inconsistent across the country and from one doctor to another.

10. The consequences of prohibition must be examined because its impacts on health are devastating.

11. Privatized methadone clinics (in Ontario) are probably the biggest threat to the drug using population.

12. Faced with contextual realities such as the changing political landscape and the economical impact of drugs both licit and illicit, the harm reduction community needs to take a strategic approach and build a business case for harm reduction; the community remains marginalized in part because it fails to take the bigger economic and political climate into consideration.

Day 2: March 31, 2007

III. Showcasing innovative practices

Almost all of day 2 was spent learning about the harm reduction programs and practices used in each of the participating cities. Participants were asked to cover the following themes/questions in their presentations:
- o Short description of their program or practice – what are its distinctive features?
- o How do people (users, practitioners) respond to it and feel about it?
- o What works best about it? Are there any evaluation results to be shared?
- o What hurdles/barriers needed to be overcome to launch and maintain the program? What/who made a difference in overcoming these barriers?
- o Whose support was needed in going forward? How was it obtained? What made a difference in getting "buy in" from the key players?

o   Who are the "heroes" / the real leaders in getting this program (or harm reduction in general) to happen? What makes them "heroes" and what we can learn from them?
o   What barriers are still preventing progress?
o   If one had to do it over again, what would be done differently?

Annexes II to XII present the speaking notes and/or the documentation provided electronically by each jurisdiction. Documents submitted in Pdf or Word Perfect were converted to Word; as a result, the original formatting of those documents may be slightly modified. With one exception, documents in Powerpoint have <u>not</u> been converted to Word because the photographs and other graphic features would have been lost. The Annexes (which are separate electronic documents) are as follows:

Annex II   Victoria, BC
Annex III   Nelson, BC
Annex IV   Whitehorse, YT
Annex V   Edmonton, AB
Annex VI   Winnipeg, MB
Annex VII   Thunder Bay, ON
Annex VIII Ottawa, ON
Annex IX   Abitibi-Témiscamingue, QC
Annex X   Québec, QC
Annex XI   Halifax, NS
Annex XII   St-John's NL

IV. Post Presentations Discussion: Drawing Conclusions and Identifying Lessons Learned

To wrap up a day of listening to each other presenting the most salient features of their respective programs, participants were invited to share in small groups what stood out for them in the different presentations they had heard. They were also asked what lessons/principles they drew from the description of everyone's experiences. Finally, they were asked what messages they would formulate to decision-makers (locally and at other levels as well) regarding sustainable community-based harm reduction practices and programs. The flip charts produced by the small groups in response to these questions are attached as <u>Annex XIII</u>.

The following captures the key messages emerging from the plenary discussion that followed the small group work.

1.   Some <u>general observations</u> resulting from the different presentations included:
   a)   Harm reduction practices across Canada are in different stages of evolution;
   b)   A diversity of solutions is required because evolving problems require evolving solutions;
   c)   Poverty and homelessness continue to be the biggest issues;
   d)   Health and mental health issues related to the problematic use of substances are not adequately addressed in most communities; much is left to be done;
   e)   There are many barriers to service because of rules and also because of the attitude of some providers who discriminate against people using drugs or against former users;
   f)   Research is required on many aspects of harm reduction; for example, harm reduction related to the use of solvents is one of these areas.

2.   <u>Lessons learned, reflections and guiding principles</u> included:

a) People in the harm reduction community must be more pro-active and less reactive; the community has been reactive because there has always been a lot of shame associated with the drug community, and with HIV and hep C.

b) Users must have more voice and there needs to be more recognition of their input; when the expertise of users and professionals comes together, better solutions emerge. However, in attempting to involve drug users in a meaningful way, it is important to ensure they are not being exploited.

c) To make progress, de-stigmatization must be a priority. De-stigmatization leads to access to services and to social inclusion. Some of the ways this can be done are: (i) including users in program development and governance, (ii) ensuring appropriate access to services, (iii) examining the impacts of gentrification[2] and capturing those forces in communities, and (iv) applying the fundamental principle of harm reduction which is to look at each person's gift & strengths, and build confidence & self-esteem.

3. The <u>vulnerability of programs</u> in all regions is a major concern; the current political climate creates much uncertainty. <u>Some of the ways to counteract this vulnerability and to strengthen the harm reduction community include</u> :
    a) Identifying allies, supporters and champions, and fostering a good relationship with them;

    b) Cultivating <u>new</u> champions, being creative in finding opportunities to generate interest and to educate;

    c) Developing broad-based coalitions for purposes of advocacy, learning, building capacity and humanizing the people who use drugs and those who work with them. This includes developing coalitions with members of the media so they are well informed and are there when needed.

    d) Developing a communication strategy for <u>all</u> audiences, i.e., all those in the "4F model" ; (in this model, the "<u>F</u>amily" refers to those working directly in the field, the "<u>F</u>riends" are those who support it from the outside, the "<u>F</u>oes" are those who openly oppose it, and the "<u>F</u>oreigners" are those who lack awareness, are neither "for nor against" but have the potential of going to one side or another depending on what they hear and how they are influenced).

    e) Building our own coalition (within the "family"); banding together to give ourselves more voice and to save us time and money. This would facilitate the sharing of information, knowledge, best practices and research, and would reduce the need for everyone to reinvent the wheel.

    f) Renewing how we (within the "family") think and the language we use around harm reduction. For example, when justifying services, we need to move from a language of "distribution" of services (e.g., distribution condoms for sex-trade workers, or marijuana for medical purposes or needles for IDUs) to a language of "contribution" -- i.e., we are not distributing marijuana; rather, we are contributing to the greater public health of the community by being a front line and service industry for the critically ill in our society; we

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[2] Gentryfication occurs when neighbourhoods that are normally associated with poverty and drug use and are being turned over into condos.

are also contributing scientifically to research and we challenging ideas that are not founded on evidence, and we are producing our own knowledge.

g) Developing a language and a set of messages to broaden and reframe the issue and making a business case for harm reduction; we need to be strategic in working with persons in positions of authority who have the power to make or break programs; we need to understand what their bottom line is and use a language that will resonate with them. It is important to include in the messaging, the notion that scientific studies definitely support the benefits of harm reduction.

h) Figuring out what we all agree to, what common principles and beliefs we all share, and developing a Substance Users' or Harm Reduction Bill of Rights which could be used as a litmus test to evaluate policies, laws, etc. (The Bill of Rights developed in Vancouver last year at the International Harm Reduction Conference could serve as a model.)

i) Creating a new set of indicators to convey to the public the positive impacts of harm reduction and documenting how harm reduction strategies have actually contributed to health. Then, disseminating that information widely to counteract the fact that the enforcement aspect of illicit drug use is very prevalent, a phenomenon that encourages the decision-makers to remain complacent about harm reduction.

j) Replacing the term harm reduction with a more positive expression, e.g., health promotion.

k) Developing creative strategies for getting corporate funding for the harm reduction community's programs (consider the MADD model for example).

6.   The key messages to be directed to decision makers include:
   a) The importance of humanizing both the debate and the solutions; this means (i) recognizing the human rights dimensions of the problem, (ii) making decisions based on evidence and on the recognition that health care is a fundamental right that must be extended to people who use drugs and (iii) making choices anchored in compassion.

   b) The biggest problem is the drug laws and their application. 20% of what the harm reduction community does has to do with problematic substance use while 80% is compensating for poor policy related to prohibition. To address this, the voice of drug users must be heard at all levels of decision-making.

   c) It is important to have a long term systems view of the issue and to understand the unintended consequences that certain decisions and interventions can generate; a broad spectrum of interventions must be adopted to respond to the very broad range of the problems related to the problematic use of substances.

   d) To make progress, money must be re-allocated from enforcement to harm reduction and treatment.

   e) Funding of front line organizations must be long term and the objective has to be to ensure the sustainability of the organizations and their programs; short term unsustainable projects can do more harm than good and divert resources away from core harm reduction work.

   f) The unique challenges of delivering harm reduction strategies in rural or remote areas as well as to Aboriginal communities must be recognized and addressed.

g) The paper burden imposed on small, understaffed and overworked organizations must be significantly reduced; meaningless reports, excessive demands and inflexible frameworks divert energy and time away from the delivery of services to those who need it most.

h) Governments must be held responsible for the health and welfare of the people who use drugs; failing that is nothing short of systemic genocide.

i) It is important to look at the health issues related to substance use; there are some 300,000 people with hepatitis C in Canada; 70%-90% of drug users have hepatitis B or C. This is a crisis and national recognition of this disease is urgent.

j) Endorsement and funding of a national awareness harm reduction strategy is required as is the recognition of a Users' Bill of Rights.

Day 3: April 1, 2007

V. Identification of Most Useful Resources for Practitioners

One of the key deliverables of the project for which CAS and CHRN received funding is the development (and/or acquisition) and dissemination of resources to enable front-line organizations across the country to learn from each other. The purpose of this agenda item was to consult participants on what information and resources they felt would be most meaningful to them.

Participants were first asked to brainstorm ideas in response to the following question: *"What information and tools, e.g., manuals –if they could be provided – would make your job easier and would help you be more effective? (This includes both the resources which could be produced or made available through CAS/CHRN, and the resources which must be advocated for.)"* The brainstorm generated a list of some sixty ideas which were regrouped into five categories. The complete list, in the participants' own words, is included as Annex XIV.

Participants were then asked to identify through a voting process of sorts, which ideas they felt the CAS and CHRN should act upon on a priority basis. Small groups were then invited to consider the outcomes of the brainstorming and the voting processes and to (1) make recommendations on what strategies and/or activities the CAS and CHRN should undertake, and (2) identify some of the desired results and impacts of these strategies. The flip charts produced by the small groups during this part of the meeting are attached as Annex XV.

The following which presents in an integrated manner the most significant needs identified by participants through the brainstorming and the recommendations with regard to those items which the breakout groups had time to discuss in more depth.

1. Developing and implementing a national strategy on harm reduction.

The need for a national strategy or framework on harm reduction received the greatest number of votes from participants. This speaks to the sense of isolation and fragmentation that experience many front line workers and practitioners across the country; it reflects their yearning to connect their small part to a bigger whole, and their need to know that governments at all levels, users and those supporting users, all have a common understanding of the issues and most importantly, share a common vision regarding solutions.

2. <u>Building Connections and Networks among Members of the Harm Reduction Community</u>

The harm reduction community is dispersed across Canada; its members want to know how and where to find each other, what practices and programs they are engaged in and how these are working out. The brainstorming identified the need for: (a) up to date lists of user groups across the country; (b) up to date lists of programs (with descriptions) & contacts in Canada; (c) an MMT directory; (d) the development of a national coalition (e) support from a group of members (good writers and thinkers) within this coalition who can produce letters and other materials that can be shared by all.

The breakout group examining this theme recommended the development of a National Directory of Harm Reduction Programs and Services in Canada including, but not limited to, user groups, NEPs, MMT and sex trade workers' organizations. Once the research is completed and the information is compiled, they recommended that the CAS/CHRN produce a web-based directory and make sure it is also available on CD Rom. They emphasized that because such lists need constant updating, a sustainability plan must also be in place.

The desired outcomes of this initiative include: (a) increased knowledge of programs and services, (b) improved communication between programs and services, (c) greater awareness of community resources and (d) an easier referral process.

3.   <u>Supporting the Unique Challenges Related to Serving Remote, Rural and Northern Communities</u>

Another item receiving a high number of votes is the need to support front line workers in rural and remote communities. Indeed, harm reduction workers who serve large territories are faced with unique challenges; for example, some workers require up to seven hours of driving to reach communities on the edges of their territory. There are other unique challenges related to serving small rural communities; for example, everyone knows everyone, a situation which makes confidentiality and privacy more difficult. Specifically, participants identified the need to (a) network with others who, like them, face the challenges of working in these conditions, and (b) share tools and ideas applicable to these unique circumstances.

4.   <u>Tools for Learning: Building the Research Base and Documenting/Disseminating Best Practices</u>

Participants yearn to enrich their knowledge base, integrate and apply the most meaningful and proven methods in their practice, and experiment with innovative & promising alternatives. To do this, they need access to learning tools of all kinds, e.g., workshops, web sites and manuals or compendiums of best practices. The breakout group made several recommendations related to this theme:

a. compiling a list of the best harm reduction practices internationally and doing so in a manner that situates Canada on the global harm reduction scene;
b. disseminating widely the "Nothing About Us Without Us" document and adopting a communication-based research paradigm;
c. delivering capacity-building/skill-building workshops for users to involve them in the research process;
d. ensuring accreditation for user involvement;

    e.   having easy access to research findings in layman's language and in different formats (e.g., print, online);

    f.   making accessible successful grant applications;

    g.   making resources available for proposal writing, and

    h.   compiling a list of research "allies".

5.   <u>Supporting the Front Line</u>

Limited resources and increased demand for services put an incredible strain on front-line workers whose workload is made even more complex and stressful with the added burden of administrative responsibilities, e.g., recruiting, training, managing finances and supplies, etc., and responding to the reporting requirements of funders. Burn out and exhaustion are not an uncommon phenomenon among service providers. Workers seek support on a personal level as well as ways to maximize their time dedicated to providing services and minimizing the time they put on matters that detract from their primary purpose.

From the brainstorming exercise, participants identified a number of ideas regarding the kind of tools that could be useful to them: (a) guidelines for starting a franchise, (b) standard letters on various recurring topics to avoid having to reinvent the wheel every time, (c) help with fund raising, (d) a consultation hot-line, (e) grief/loss support, (f) wellness promotion for frontline workers and (g) access to development, training and counseling specific to harm reduction.   The breakout group then identified three areas of focus which it recommends the CAS and CHRN attend to.

The first is <u>increasing the skill set of front line workers and improving the functioning of user groups</u>. To do this, the breakout group reiterated the need for user group engagement; participants recommended building on "Nothing About Us Without Us" and preparing a "how to" practical guide to cover issues such as (a) recruitment, (b) contracting, (c) cost – start up, (d) coming out (various size communities) and strategies for rural/small towns.

The second is related to <u>reducing burn out</u>. The breakout group recommended the establishment of a support link for front line workers, e.g., a hot line and a web page route/link on topics such as health, wellness, social loss, boundaries, supervision.

The third area of focus is related to <u>liaising with funders</u>. The group considered options for reducing the frustration and excessive energy spent on reporting while at the same time, using these reporting opportunities to improve the marketing of their program. They recommended that a strategy be developed to liaise with funders and respond to their expectations. While recognizing that there will be regional variations, they felt this will require defining more precisely what the issues are for both the funders and the funded. The group suggested building on the Alberta model as well as developing tips sheets on how to ensure reports are useful and help market programs.

6. <u>Educating Others/Advocacy/Media and Public Relations</u>

Front line workers know that their efforts could be more effective at all levels if the purpose, science, methods, benefits and results of harm reduction practices were better understood by decision-makers, by professionals in the fields of medicine, nursing, law, social work etc., by the media, by law enforcement and by the public in general. Increased understanding would raise the potential for synergy between these key players and the harm

reduction community and more importantly, would lead to better and more informed polic ies and practices.

Participants generated several ideas related to communicating with those who are external to the world of harm reduction; the two which received the most votes were (1) ensuring that harm reduction is part of the curricula in universities for doctors, nurses, social workers and others, and (2) establishing a think tank to build the business case/economic argument for harm reduction. Other vote -getting ideas included (3) the delivery of media training seminars, e.g., how to use non-stigmatizing language, (4) campaigns to educate people to care about addiction/mental health issues, and (5) the preparation of various written materials that the different agencies could adapt to their circumstances and use as required (e.g., position papers on key issues, media kits, and ready -made arguments re: harm reduction).

The breakout group assigned to this theme recommended the development of a Marketing Plan to make the case for harm reduction; this plan must cover the e conomic , social, and justice aspects of the issue. Specifically, the breakout group recommended that a think tank be put in place to develop the messages, and that experts (e.g., consumers, front line agencies, marketing and media & communication specialists) be used to ensure the messages are positioned and framed in a manner that will be heard by different audiences.

The desired result of this strategy is a communication plan for communities across Canada and the ex pected outcomes are (a) a shift in attitudes and awareness, (b) b etter harm reduction services integrated into health care and (c) a shift of funding from enforcement into health.

7.   Launch and Promote a National Harm Reduction Day

Several participants felt that one way to increase awareness and educate the public was to launch and promote a National Harm Reduction Day. This would also contribute to the development of a common discourse/language on harm reduction. A breakout group felt that such an activity -- which could be flexible and organization specific -- had the potential of raising multi-sectoral support for harm reduction; in addition, it could have the advantage of including everyone: medical officers, universities, jails, individuals.

The breakout group recommended that the date be set to coincide with the date prohibition was established so as to send the message that prohibition does not work. It also recommended that the most creative ideas for logos, emblems, activities etc., be used to draw attention to the day and to communicate the most critical messages.

8.   Develop a harm reduction professional ethics code

Although not discussed by any of the breakout groups, the need for a harm reduction professional code received a large number of votes from participants.

VI. Suggested Indicators for Project Evaluation

Participants were asked what indicators could be used to evaluate the project for which CAS and CHRN have received funding. Although there was no time to discuss these in depth, the group generated the following indicators:

The project will be successful if:

- Coalitions and connections have emerged and these have generated outputs;

- A number of finished products are delivered;

- These products are <u>accessible</u> (not only electronically), <u>disseminated,</u> <u>practical</u> and <u>usable</u> by front-line workers on a day -to-day basis and in the context of their realities as well as by a broad spectrum of users;

- The products are <u>adaptable</u> and can withstand the test of time and of changes on the political scene;

- The products are <u>sustainable</u>, i.e., they do not become obsolete as soon as they are produced.

VII. Quick evaluation of the meeting

<u>What went well:</u>

- the opportunity to network
- hearing from cities other than the big three
- got a lot done in a short time

<u>Things to think about next time:</u>
- make sure there is a next time!
- a longer time together to allow for spreading out the content

VIII. Closing Remarks (Lynne Belle-Isle and Walter Cavalieri)

Lynne and Walter thanked most sincerely the participants who took their weekend to come to this symposium and for giving it so much intensity, commitment and energy. They explained that a report on this symposium will be prepared and shared with all, along with the list of participants and their coordinates.

The next steps of this project include continuing the development of the web site as well as undertaking a series of focus groups across the country and incorporating the results of these in the products that will be produced at the end of the project. Lynne indicated that she will seek the assistance of those present to identify local participants for the focus groups to be held in their localities. Lynne also indicated that she is exploring with the Public Health Agency of Canada the possibility of joining forces with them and developing synergies that may result in another face-to-face meeting at the end of the project. She emphasized that talks are at a preliminary stage and that nothing has been decided on this yet.

Walter and Lynne thanked all those who supported them in making the meeting possible: the interpreters, the facilitator, the technical staff, the photographer and the hotel.

The meeting ended at noon on Sunday April 1.

Annex I
Participant List

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Annex XIII

**Flip charts produced in small groups during the
"Drawing Conclusion and Identifying Lessons Learned" Discussion**

Group 1:
- Pro-active vs. reactive ; ~~shame~~ empower
- Users can teach us how to help them – be their voice, give them confidence to have their own voice
- Be prepared
- Dispel public fears/stigma
- Go from language of distribution to language of contribution
- Need to be client driven vs. agency driven
- Need to educate the public on the benefits of harm reduction
- Need more national symposiums
- Why continually reinvent the wheel?
- Resourcefulness of harm reduction providers – (similar to users)
- Survival instinct exists among users
- Harm reduction leads to better all over health
- Scientific studies support the benefits of harm reduction

Messages to decision-makers
- Users/addicts are <u>people</u>
- All issues are human rights issues
- Laws should be based on evidence, human rights and compassion
- Propose a National Awareness HR Strategy
- Need national guidelines, best practices
- Drug Users' Bill of Rights

Group 2
- Different stages of evolution and practices of harm reduction across Canada
- Need to from coalitions on all levels
- Not much movement in recognition of health vs. legal concerns
- Lack of research and knowledge on solvents
- More recognition of "users" input and equal partnerships
- Strategy using negative press, i.e., drug strategy
- Expanding "ally base" and foresight in opposition
- Address frontline workers' well being; Users' Bill of Rights

Messages to decision makers:
- Sustainable funding
- Holding governments responsible for their lack of responsibility in health care and human rights and their role in HIV and hep C rates
- Access to research to incorporate into message

- Educate the public in costs, i.e., HIV meds vs. Safer Injection sites
- Incorporating harm reduction in the private sector, e.g., MADD example
- Corporate funding

Group 3
- National voice on harm reduction network
- Vulnerability of funding programs
- (Political program community) Champions/Allies
- Mobilization among people who use drugs/substances
- Person first
- Universality and equality of services
- People using drugs and substances need to be involved at all levels of organizations
- All inclusive self care based in harm reduction

Messages to decision-makers:
- Addiction programs not following harm reduction programs must change
- Government has responsibility to provide health and social services to all people
- Government inaction is genocide on people who use drugs in Canada
- Learn how to phrase what we do differently/use different language
- Need to sell in practical terms;
- Renew harm reduction message that has some national agreement
- Ensure funding for harm reduction programs goes to actual harm reduction programs
- More discussion/meetings with medium/small sized cities
- Need for discussion of rural harm reduction programs/strategies –they have unique issues
- Stronger ties to First Nations/Aboriginal; rural & urban & harm reduction

Group 4
- On the + side : support; resources
- On the – side: service instability: "hot", "sexy"
- Hard to sustain
- Push edge of envelope for harm reduction – e.g., running a brothel
- Inclusion of user group in programs and governance in society, access to services, de-stigmatize
- Importance of positive buzz; always build – ongoing informal education
- Hard to share information on an ongoing basis when in reality day-to-day of operations

Messages for decision-makers:
- Think long term re: consequences of actions, .e.g., enforcement may remover something, e.g., bikers) but something new will fill the void
- Think impact – shut down drug house means some people are homeless
- Harm reduction works; prohibition doesn't
- Project/limited funding for innovation limits impact; what is needed is ongoing quality programs
- Need flexible funding to do what is needed
- Reporting requirements are daunting

Group 5:

Lessons learned:

- Developing diverse relationships: respect, disagreement is OK, forward movement is essential (voice)
- Diversity of solutions for unique problems (evolving problems requires evolving solutions
- Develop broad based coalitions to humanize the streets/the client group and the issue in the eyes of Joe Blow conservative wanker
    - Educate, inform and engage ordinary people
    - Engage people who use, support them in getting them to speak – their words, experience are important to help make change. Users are fully people
- We need to be proactive in getting our message out in the media; identify allies in the media
- Poverty, homelessness are big issues
- Health, mental health not adequately addressed; services are not universal
- Barriers to service because of rules and also service providers' attitudes; discrimination against people using drugs and former users
- The biggest problem: the drug laws and their application

Messages to decision makers:

- Address poverty. There is no justification for it and homelessness in Canada.
- Money must be allocated for harm reduction and re-allocated from enforcement into treatment
- Core funding is essential
- Address discrimination based on source of income or class must be human rights protected
- Shift the bottom line argument re harm reduction to a humanitarian one
- Health care is a fundamental right which must be extended to all people who use drugs.

Needs Analysis, Part 1:
Brainstorming on Identification of Most Useful Resources for Practitioners

Participants were asked to brainstorm ideas in response to the following question: *"What information and tools(e.g., manuals) –if they could be provided – would make your job easier and would help you be more effective? (This includes both the resources which could be produced or made available through CAS/CHRN, and the resources which must be advocated for.)"* They were then asked to choose which ideas they felt the CAS and the CHRN should act upon on a priority basis.

The following lists the ideas generated by participants as they wrote them out on small sheets off paper which were then posted on flip charts. The ideas were then organized around five themes. The number in brackets next to the idea represents the number of votes which the group gave to the idea.

Theme 1: Building the Community, Networking, Staying Connected
1. Network and development of specific strategies for rural and northern communities (11)
2. Produce and up to date list of programs & contacts in Canada with descriptions (10)
3. MMT directory seamless continuum (6)
4. List of user groups across the country to form a national coalition of user groups (5)
5. The means to communicate messages – pro-active and responding on national basis - what/how? Establish a network of thinkers/writers to produce regular letters of/EDS (3)
6. Check list of qualities of HR (broad based list) (1)
7. List of harm reduction groups in Canada
8. Establish a national network of families/friends of people who use drugs – who are vocal/lobby – mon/pops who speak in support of HR
9. National HR specific contact, i.e., sex trade ...? – drug trend challenge
10. Quarterly magazine
11. HR online library and marketplace

Theme 2: Research/Best Practices
12. Manual on how service providers can best support or help start user groups without taking over or running them (12)
13. No research without users and recognition of users is published / Nothing about us without us (10)
14. Provide summary of current research finding (in lay terms) (9)
15. Global practices (utopian possibilities) (7)
16. A directory of programs that include info such as: details of proposal, funder, samples, whom to contact (2)
17. Harm reduction 101 workshop for organizations (1)
18. Harm reduction manual that can be adapted in other towns and cities
19. Examples of harm reduction interventions beyond drug use
20. On-line scrap book of success stories

Theme 3: Capacity Building/Supporting the Front Line

21. Support for rural and northern communities
22. Set standard re; how much accountability, planning we will provide and help each not drown in paper (10)
23. Support network for front line workers who burn out ; sustaining our energy (8)
24. Engage user groups into program development and implementation (6)
25. Franchise start up guidelines (1)
26. Social enterprise idea that can be shared across the country (1)
27. Maslow's hierarchy; find balance (1)
28. Annual award from workers/users to workers/users (1)
29. Mentorship and hero (1)
30. Lining provincial harm reduction networks to help others organize
31. Develop standard letter of support from NCHR
32. Set up consultation hot line
33. Promote health and wellness for the front line
34. Development, training and counseling specific to harm reduction
35. Help with fund raising
36. Grief/loss support
37. Accreditation harm reduction for programs that advertise harm reduction as part of program
38. Level playing field

Theme 4: Educating Others/Advocacy/Media and Public Relations

39. Professional development in universities, doctors, nurses, social workers etc. (12)
40. Establish a think tank to produce the business case/economic argument for H.R. (10)
41. Media training seminars, e.g., how to use non-stigmatizing language (5)
42. Mount a campaign to educate people to care about addiction/mental health issues; normalize/empathize, remove we/them attitude (5)
43. Organize, engage faith communities & ethicists (4)
44. Challenge politicians at all levels of government to support harm reduction principles – "challenge" those who don't (2)
45. Prepare position papers on key issues (2)
46. Develop a marketing plan (1)
47. Press release packages (1)
48. Prepare list of ready-made arguments re: harm reduction
49. *Developer outil de marketing*
50. Prepare a manual on how to engage the "foreigners"
51. Approach and network with the numerous e-health mags, publications and weekly e-letters
52. Create a mechanism for advocacy around harm reduction
53. Put in place a mobile advocacy group

Theme 5: Other

54. Develop and promote a national strategy on harm reduction (15)
55. Develop a harm reduction professional ethics code (10)
56. National harm reduction day/emblem/logo (8)
57. Harm reduction bill of rights (3)
58. Current on-line bad date list ?blogs; accessible by city
59. Promote drug related health promotion

Needs Analysis, Part 2:
Flip Charts (Verbatim) from Small Group Work on
Most Useful Resources for Practioners

Theme 1: Building the Community, Networking, Staying Connected
Directory (national) of Harm Reduction Programs and Services in Canada including but not limited to:
- o User groups
- o NEPs
- o MMT
- o Sex Trade Workers' Organization
- o Other

How?
- o Do research
- o Compile information
- o Produce directory that is web-based and available on CD Rom
- o Sustainability plan

Desired Impact
- o Increased knowledge of programs and services
- o Increase in Communication between programs and services
- o Greater awareness of community resources
- o Easier referral process

Theme 2: Research/Best Practices
- Dissemination of "Nothing About Us Without Us" document (CAMH/CARBC
- Critical communication-based research paradigm
- Capacity/skill-building workshops for users to involve them in the research process
- Insistence on accreditation for user involvement
- Accessibility of research findings –
  - o Language
  - o Format (print, online)
  - o Support/workshops for user group; networking
- Make accessible successful grant applications (*resources for proposal writing)
- Compile a list of research "allies"
- Compile a list of best harm reduction practices internationally (i.e., consciously situating Canada in the global harm reduction scene

Theme 3: Capacity Building/Supporting the Front Line
1. User group engagement
- Build on "nothing about us without us"
  - o How to; practical; could cover issues such as (a) recruitment, (b) contracting, (c) cost – start up, (d) coming out (various size communities) rural/small town strategies
- Expected results:
  - o increased skill set of front line facilitating

        o   better functioning user groups

2. Support link for front line workers
- Figure out how to start and sustain
  - Hot line
  - Web page route/link
- Topics: health, wellness, social loss, boundaries, supervision

Expected results:
  - Reduced burn out

3. How to liaise with funders and their expectations
- Issue definition – recognize regional variation
- Build on Alberta piece of wo rk
- Tips sheet on how to ensure reports are useful and market your program
- Expected results:
  - Increased marketing
  - Reduced burn out due to reporting

Theme 4: Educating Others/Advocacy/Media and Public Relations
The Weave Marketing Plan to Make the Case for HR
  - Economical
  - Social
  - Justice
- Action: organize think tank to develop messages
- Experts: consumers/Front line/Marketing/Communication/media
- Result: Communication plan for communities across Canada
- Outcomes:
  - Shift in attitudes and awareness
  - Better harm reduction services integrated into health
  - Shift of funding from enforcement into health

Theme 5: Other
National Harm Reduction Day/Emblem
- Date to coincide to date prohibition was established to send message: it did not work
- Leadership for protest on HR Day soon
- Information campaign; logo, ribbon, emblem
- Red, black, white, yellow to indicate "no borders to harm reduction"
- No ribbons, no wrist bands
- Polar bear, koala, skunk
- Helping Extend Lives of People (H.E.L.P.)

Impact:
- Common discourse/language
- Increased awareness
- Develop theme
- Educate – the day can happen everywhere
- Multi-sectoral support
- Flexible and organization specific

- Easy to include everyone: medical officers, universities, jails, individuals

Actions:

- Synchronize church bells, ambulances
- Promote user bill of rights
- Promote continuum: HR------------------Abstinence
- HR is HP
- Marketing mix – 1st annual
- Product: HR Day
- Pipeline: through networks
- Price: free package; time for event
- Production: CAS to develop packages and distribute