Priority setting for the overdose crisis: challenges and opportunities for peer engagement in British Columbia

by

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Abstract

In recent years, decision-makers in BC have engaged people who use(d) drugs (PWUD) and the general public for their input on strategic directions regarding the overdose crisis. Given the oft-politicized nature of substance use, it is important for the response to centre around people with lived experience and to be grounded by the best available evidence. By engaging PWUD or “peers” as essential partners, the resulting policies and services may better reflect the community’s needs. Meaningful engagement can be challenging due to stigma and a multitude of systemic barriers. Special considerations must be taken to ensure participatory processes are inclusive and ethical.

BC’s worsening overdose crisis demands that we reevaluate our drug policies and spending priorities across health and other social sectors. PWUD have identified several key priority areas, including expansion of harm reduction, controlled pharmaceutical prescribing, and drug decriminalization, some of which have ignited considerable debate among stakeholders.

Keywords: substance use and addictions; people who use drugs; public engagement; stakeholder engagement; healthcare priority setting; health policy

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List of Acronyms

BC	British Columbia
BCCDC	British Columbia Centre for Disease Control
BCCSU	British Columbia Centre on Substance Use
COVID-19	Coronavirus disease 2019
DTES	Vancouver's Downtown Eastside neighbourhood
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IAP2	International Association for Public Participation
MMHA	BC Ministry of Mental Health and Addictions
OAT	Opioid Agonist Treatment
OERC	Overdose Emergency Response Centre
PAR	Participatory Action Research
PBMA	Program Budgeting and Marginal Analysis
PWUD	People who use(d) drugs
SFU	Simon Fraser University
VCH	Vancouver Coastal Health Authority
2GS	Second Generation Strategy

Chapter 1. Introduction & Background

Priority setting for the overdose crisis

Every public health system around the world faces difficult decisions on how and where to distribute funding, personnel, attention, and implementation efforts. Implicitly or explicitly, these decisions signal the degree of urgency and importance with which particular issues are viewed. In April 2016, British Columbia responded to the rapidly rising number of deaths and poisonings from illicit drugs by declaring a public health emergency[1].

The Ministry of Mental Health and Addictions (MMHA), the first of its kind in Canada[2], was created as part of BC's overdose response. As part of its mandate, the MMHA created service plans, a long-term roadmap, and strategic directions to transform the existing system of addictions care in the province[2]. In 2017, the BC government allocated an additional $322 million over three years to carry out the most urgent parts of the response as follows[1]:

1. Saving lives through Take-Home Naloxone distribution, expansion of supervised consumption sites, increased drug-checking services, Good Samaritan legislation, and enhanced data collection[3].

2. Ending stigma against PWUD through targeted public awareness campaigns and further training and education for care providers.

3. Building an evidence-based network of treatment and recovery services through improved opioid agonist treatment (OAT) retention, innovative pilot programs[1], integrated services[4], peer training[5], and emphasizing trauma-informed and culturally appropriate care.

Although many deaths have been averted by these combined efforts[6], many more lives continue to be lost at an unprecedented rate[3]. An emergency of this magnitude demands an equally unprecedented mobilization of resources and attention towards preventing overdoses and resolving root problems, many of which extend far beyond the health system[5,7]. Among the public health community, there is a widespread recognition that criminalization of drug use not only fails to reduce drug use, but also exposes PWUD to increased health risks and extreme societal harms[3,8]. The criminalization of drugs and PWUD must give way to public health approaches to substance use and addiction that are informed by scientific evidence and lived experience. This shift warrants a carefully planned reallocation of resources, budgets, and priorities towards interventions that will advance health equity for PWUD.

At the time of writing, British Columbia is facing dual public health emergencies: the global coronavirus pandemic (causing COVID-19), and the worsening overdose crisis stemming from a poisoned and unpredictable illicit drug supply. May and June 2020 have been the two deadliest months for fatal overdoses ever recorded in the province[9]. Widespread border closures around the world have created massive disruptions in the global production and distribution chains for illegal drugs[10]. These downstream consequences combine with local factors in BC to cause drug shortages and a concentration of harms due to adulteration and fentanyl toxicity[11,12]. Additionally, infection control measures such as self-isolation and reduced operating capacity across harm reduction services may also have contributed to this surge in overdoses[11,13].

During these uncertain times, there is an opportunity for decision-makers to re-evaluate their approach to substance use and addictions. This rare convergence of external and sociopolitical factors could form a policy window[14] to enable novel and previously untenable policies and interventions to be considered and evaluated. One such proposal garnering recent attention is the provision of a legal, regulated supply of pharmaceutical alternatives[11,15,16], a concept commonly referred to as “safe(r) supply”. This terminology reflects the contrast between pharmaceuticals of known composition and those of unknown origin and potency which are commonly found in the illicit supply. At this moment, marginalized voices and movements have a renewed opportunity to influence the kind of drug (and broader social) policies that will emerge in the post-COVID-19 world. With the continued support of cross-sectoral leaders, COVID-19 could usher in some long-awaited and permanent changes to BC’s overdose response.

Public engagement in priority setting and decision-making

Governments, policymakers, and healthcare organizations are increasingly striving for greater public involvement in their planning and decision-making[17]. Well-designed stakeholder engagement processes are thought to embody the ideals of democracy and shared decision-making while simultaneously increasing the quality, relevance, responsiveness, and inclusivity of the resulting programs[18]. As far as health equity is concerned, the process by which decisions are made can be just important as the outcomes themselves[19]. The International Association for Public Participation (IAP2) describes a spectrum of activities that institutions can adopt for the purpose of public engagement, each with varying commitments and intensities[20]. At the lowest end, institutions will simply inform the public of their pre-determined decisions. Moving up the spectrum, organizations may consult, involve, or collaborate with the public to guide and shape policy solutions. At the highest end, institutions empower the public as equal partners, pledging to support and implement the participants' final decisions[20].

Public initiatives can fall short of their expected results when important factors are poorly understood or overlooked during any stage of development or implementation. It is therefore customary to consult with a wide range of stakeholders while intentionally placing extra emphasis on targeted groups of knowledge-holders[18]. Stakeholder engagement can vary in scope and length of commitment across different audiences, taking the form of public comment periods, public hearings, online questionnaires, town halls, roundtable discussions, and involvement on advisory boards and steering committees. Public engagement has the potential to be mutually beneficial for participants when they are granted a certain degree of autonomy and shared decision-making power[19]. For people "who are affected by and want to change the existing system"[21], these avenues are invaluable methods for bringing concerns and policy ideas to the table. Free and open dialogue is critical in situations where stakeholders hold competing interests, or when deeply entrenched paradigms are being challenged by new and controversial ideas. Robust public engagement can also act as a means for amplifying under-represented voices[18], especially if the group's priorities have been repeatedly negated or invalidated in the past.

History of PWUD's involvement in priority setting

PWUD or peers are key stakeholders who can shape, inform, and lead aspects of BC's overdose response. These communities have a long history of self-advocacy and organizing, particularly in Vancouver's Downtown Eastside (DTES) neighbourhood[22,23]. Much of their activism was born out of the HIV/AIDS crisis, which disproportionately affected many of the same stigmatized and marginalized communities who are now at greatest risk of overdose[24]. When governments and health authorities were slow to act on HIV and the various waves of drug epidemics, activists began implementing needle exchanges, operating overdose prevention sites, and exchanging knowledge on protecting their communities[25–27]. These practices, collectively known as harm reduction, aim to minimize the "negative health, social, and legal impacts" associated with drug use in the surrounding risk environment[28]. Harm reduction principles also seek to uphold the rights of PWUD by pushing back against social exclusion and discrimination. Over the years, peers have coalesced around the phrase "nothing about us without us"[22]. This guiding principle is a demand and an expectation for direct involvement in policies that impact their health and safety.

In a report to the MMHA titled "It's Our Lives", a broad coalition of PWUD and allies detailed their analysis of the healthcare system's shortcomings and presented their priorities for moving forward[21]. Notably, these community members do "not [feel] adequately supported" by existing engagement efforts, nor are they afforded sufficient opportunities to meaningfully collaborate with health authorities to craft programs and policies[21]. There is a willingness and urgency for peers to have greater involvement in priority setting and planning in all matters that affect their lives[29]. Despite BC having declared the overdose epidemic a public health emergency, PWUD continue to struggle for recognition, policy changes, and resources for the implementation of recommendations. PWUD and allies have also noted the clear discrepancy between the province's COVID-19 messaging (with definitive orders, a swift mobilization of resources, and near-daily press conferences) and the messaging surrounding the overdose crisis[30].

Objective of this Capstone report

This capstone is a critical literature review aimed at synthesizing the current body of knowledge on peer engagement in priority setting for substance use and addiction services in BC amidst an evolving overdose crisis. I will discuss some of the major challenges involving peer engagement by health authorities and government organizations. I will then present a critique of past priority setting activities and offer suggestions on how PWUD can be more meaningfully involved in decision-making and policymaking moving forward. Though this paper focuses specifically on PWUD, many concepts can apply to other marginalized communities whose voices have been sidelined and overlooked by people in positions of power.

Chapter 2. Methods

Focused Literature Review

The literature search for this capstone paper was conducted primarily through PubMed, Google Scholar, and the Google search engine, focusing on articles published between 2005-2020. Boolean search terms included a combination of one or more of the following: peer engagement, stakeholder engagement, engag*, participat*, public participation, people who use drugs, PWUD, people who use substances, people with lived experience, communit*. Other search terms included decision-making, resource allocation, priority setting, health service delivery, drug policy, public health emergency, drug poisoning, opioid*, drug use, overdose crisis. To narrow the scope of the paper, I focused on British Columbia, giving particular attention to organizations in the Downtown Eastside of Vancouver and the surrounding geography; this area has both been the epicenter of Western Canada's overdose crisis, but is also a space of tremendous resilience and activism[23,31,32]. Vancouver Coastal Health (VCH) is the health authority that governs health care in this region. Region-specific search terms included Vancouver, DTES, Second Generation Strategy, VCH, BC, MMHA, BCCDC, BCCSU, OERC. Deeper searches were then conducted by examining the Similar Articles section as well as reference lists within articles of interest.

The peer engagement work discussed in this paper was primarily conducted by local and provincial organizations and peer-led networks. These included publications from health authorities, university research organizations, advocacy groups, and governmental bodies. There is also a growing body of peer-reviewed publications looking at healthcare priority setting and various forms of stakeholder engagement. To flesh out the context and public health implications of this work, I consulted grey literature produced by community organizations, including those led by people with lived/living experience of drug use, and those who work focuses on the legal system and broader issues of social justice. This grey literature included position papers, special reports, and news articles. Articles that were focused on clinical decision-making and public engagement in setting research priorities were excluded from this review.

This capstone is the culmination of two years of graduate studies at Simon Fraser University (SFU), integrating concepts from public policy, health promotion, healthcare priority setting/resource allocation, and public health ethics. My interpretation of the literature is guided by a conceptual framework which includes elements of participatory action research (PAR) and systems-based thinking. Authentic peer engagement is consistent with the philosophy of PAR, a mode of inquiry based upon the ideas of democracy and liberation of communities through empowerment and collaborative social change[33]. Systems-based thinking and implementation science approaches are necessary to facilitate the uptake of recommendations produced by community-based research in their appropriate local contexts, considering the vast connections between institutions, politics, incentive structures, and paradigms (i.e. deeply held beliefs about drug use, poverty, and law enforcement) and the potential barriers they pose[34]. My practicum placement at the BC Centre on Substance Use (BCCSU) provided real-world insights into the ways academic research institutions collaborate with PWUD, health authorities, and the provincial government to tackle various aspects of the overdose crisis. Finally, this literature review is also informed by my work as an outreach volunteer in the DTES, where I informally spoke with peers, nurses, clinic support workers, and staff in community centres and housing non-profits about their experiences receiving and delivering services. I found community engagement and intersectoral collaboration to be two of the major through lines embedded across all my learning experiences.

In Chapter 3, I discuss best practices for engaging PWUD and provide an overview of the major challenges related to the work of peer engagement – both for community members themselves, and for people conducting the work. In Chapter 4, I discuss commonly identified priority areas, criticisms of past consultations, opportunities for PWUD to shape future drug policy, arguments for and against public involvement, and the need for peer engagement beyond health authorities.

Chapter 3. Working with PWUD

Best practices for engaging PWUD

The promotion and normalization of meaningful peer engagement within health authorities and governments can create positive environments that not only increase the uptake of recommendations made by PWUD, but also builds capacity among all parties. The recent development of best practice guidelines for engagement of PWUD[19] and renewed commitments from health authorities signal a shift towards honouring the principle of "nothing about us without us,"[22,29]. All health practitioners involved in peer engagement should ideally have received training in trauma-informed practice, cultural safety, the philosophy of harm reduction, and the history of drug policy in their local context[19]. Additionally, they must recognize that PWUD can have a wide range of perspectives and experiences depending on their intersecting identities and past histories[19]. Careful and targeted recruitment of peers may be warranted to ensure adequate representation on any given matter. Prior to the start of any engagement initiative, peers should be made aware of the logistics of their involvement, including their expected role, the names of other participants, and the types of support they will receive[19]. Organizations wishing to do this type of work must honour equity and accountability throughout the process by consciously anticipating and mitigating power imbalances.

In BC, provincial organizations with a primary or significant focus on substance use and addiction have collaborated with PWUD as partners. The BC Centre on Substance Use (BCCSU) and BC Centre for Disease Control (BCCDC) hold regular meetings with advocacy organizations and have taken great care to avoid tokenism by sharing decision-making power and yielding space for peer-led dialogue and critique[29]. Their governance frameworks ensure that PWUD and their allies can continue advancing their community's interests through direct lines of communication with the MMHA and various health authorities. However, there are still barriers to operationalizing these practices more widely.

Challenges with engaging PWUD

Societal discrimination & barriers

BC's overdose crisis takes place against the backdrop of an unpredictable and toxic street drug supply, with approximately three-quarters of overdose deaths involving illicit fentanyl, according to the most recent BC Coroners report for 2020[9]. Any individual exposed to the illicit drug market faces life-or-death scenarios which are further compounded by the continued criminalization of PWUD and rampant economic instability among many in these communities. Peers commonly experience intense social stigmatization[21,29,35] and structural vulnerabilities[36–38] as they simultaneously struggle for survival and advocate for themselves and for their communities. Through the nature of their public participation, it may be necessary for peers to disclose highly sensitive and potentially stigmatizing information, such as their HIV status or their lived experiences of sex work, homelessness, or trauma[29]. Consequently, certain groups such as Indigenous people, women, sex workers, and victims of gender-based violence may be less likely to have their unique and diverse challenges represented in the discourse[19,39]. A number of logistical barriers may prevent peers from effectively participating in engagement activities. These can include ongoing mental health concerns, unmet medical needs, language barriers, homelessness, travel restrictions, financial constraints, and incarceration[22,29].

Governments and other organizations must also be cognizant of the personal and psychological risks that individuals may experience as a result of their participation[40]. While it is one thing to live these experiences, it is another to openly share deeply personal and potentially traumatic stories in front of strangers in an unfamiliar setting. With regards to sustainability, peers, particularly well-known community leaders, may experience burnout as a result of involvement in multiple committees, advisory boards, community organizations, and other projects[40]. Organizations have a role in addressing these concerns and barriers to ensure that peer engagement processes are inclusive and safe for PWUD[22]. Specific outreach strategies may be needed to empower under-represented communities and assist them with the necessary training prior to their participation. Through the provision of appropriate resources and financial support, governments can bolster the strength and capacity of PWUD and peer-led organizations to further engage in policy development[29,41].

Mistrust of health authorities and institutions

One of the greatest difficulties of peer engagement is overcoming the skepticism and mistrust that peers may hold towards institutions. Among peers, there is a widespread belief that lengthy public engagement periods can be deployed to block or delay initiatives[40], as provincial governments in Alberta and Ontario have done regarding funding for overdose prevention sites[42,43]. Individuals who have been negatively impacted or harmed by their interactions with health organizations or governments may be hesitant to work with the system, especially if those agencies have limited resources and capacity to properly support them[19]. Recent work from the BCCDC revealed that health authorities and organizations across BC differ widely in their experience with engaging PWUD, manifesting in notable differences in word choice, comfort levels, and ability to smoothly moderate these interactions[19]. Peers living in rural and remote areas of BC reported experiencing overt discrimination from service providers, and therefore "could not conceive" of health authorities asking for their opinions[19]. Consequently, some PWUD may prefer contributing to peer-led organizations or other types of grassroots activism instead of working within the confines of health authorities. The pressure to work with health authorities may also push highly capable individuals towards accepting pre-defined agendas, and away from the pursuit of the more "radical" and transformative policy ideas championed by peer-led organizations[24]. In partnering with people with lived experience, health authorities should allow these communities to determine how best to approach and involve their members[19]. Strong commitments from leadership are key to creating the conditions for effective peer engagement to occur. By necessity, it also requires public health practitioners to understand their employers can often be the same institutions that are complicit in historic and ongoing discrimination[19,31,41,44].

Peers have also expressed frustration towards researchers and organizations whose practices have the potential to "exploit, exhaust, and extract" from marginalized communities, offering little in return[40]. Negative experiences can erode the trust of the community, leaving behind a shaky foundation for future attempts at engagement[45]. A number of recent consultations and reallocation decisions have undermined the DTES community's self-identified priorities and initiatives by claiming they did not meet certain "outsider-created expectations" or mandates[40]. Under VCH's Second Generation Strategy (2GS), a multi-year overhaul of healthcare delivery in the DTES, several programs that were meeting unique community needs suddenly lost their funding,

leaving clients and program directors with little recourse[46,47]. After decades of operation, the DTES Drug Users Resource Centre (Portland Hotel Society)[48], Positive Outlook (Vancouver Native Health Society)[49,50], and ARA Mental Health[47] ceased operations as the 2GS eliminated their funding. Although their services were shifted to new providers, many feared that the social bonds and relationships forged from years of experience would be lost during the transition[48]. Further criticisms and a deeper discussion of the restructuring of healthcare service delivery in the DTES follows in Chapter 4.

Power differentials

As peers participate in community consultations, advisory panels, and committees in greater numbers, organizations must be increasingly mindful of the inherent power differentials and dynamics that exist between the people in the room[33]. Many peers have experienced dehumanizing instances of elitism and contempt from their past interactions with academic researchers and clinicians[29,40]. This inequality can be even more pronounced where peers work with institutional representatives and healthcare providers who hold divergent views over which policies and programs to pursue. For instance, peers on the province's Overdose Emergency Response Centre (OERC) committee witnessed important debates on the expansion of methadone and prescription heroin programs grinding to a stop due to opposition from members who may have their own political and financial interests[30]. These are not isolated incidents, but evidence of a broader system of bureaucratic gridlock which demonstrates a continued consolidation of decision-making power and a stunning lack of humility when working with PWUD.

The tension between on-the-ground experience and professional expertise touches on deeper issues of epistemology: what kinds of knowledge are considered valid[33], and whose views are weighted more heavily in decision-making? There is a pervasive belief that the information produced by peer networks and families is less credible or rigorous compared to recommendations coming from healthcare professionals and academics[19,29]. Although decision-makers may be subject matter experts on certain aspects of substance use and addiction, PWUD hold equally valuable expertise on their lives and the situations in their communities. By acknowledging the existence of these tensions, health authorities and other institutions can mitigate some of the challenges associated with top-down approaches to healthcare priority setting, especially as it pertains to situations involving a degree of subjectivity or lack of a solid evidence base.

Towards more meaningful engagement

Prior to the start of the engagement process, all participants should be made aware of the scope of the discussions and what their role(s) will entail. These important conversations are vital for setting expectations and accountability for what the consultations hope to achieve. As the project wraps up, deliberate actions must take place to avoid the sense of loss that can occur after its conclusion. At a minimum, knowledge dissemination activities such as follow-up feedback sessions, plain language summaries, and draft policy or program proposals should be brought back to the stakeholders[40]. For priority setting, efforts should be made to highlight areas of consensus, meaningfully discuss disagreements, and fully rationalize the inputs and thought processes that went into the final decisions. Lastly, stakeholder engagement processes should conclude with clear and concrete action items assigned to specific parties, with a special consideration for those requiring cross-jurisdictional collaboration for implementation. It is important for participants to leave with a sense of direction and purpose; it can be devastating when it feels as though nothing has meaningfully changed after the expenditure of so much time and emotional labour.

Given all of public health's missteps and failures to properly engage PWUD in decision-making, it is understandable why peers may be hesitant to work with health authorities. Taken together, these structural challenges and fragile alliances pose major barriers to widespread peer engagement in the healthcare system[44]. With this in mind, certain considerations throughout the planning, engagement, and reporting stages can help health authorities support meaningful engagement of peers as partners and start to heal past harms[19,45]. Many of these suggestions can be found in documents such as the Research 101 Manifesto[40] and the BCCDC's guide to Peer Engagement Principles[19]. Agencies are urged to make their engagement processes fully accessible to community members and to deepen their commitments to foster impactful collaborations with communities[22,45]. This could include liaising with multiple advocacy organizations, showing flexibility in meeting formats and locations, assisting with transportation, and providing training, honoraria, and medical support for the duration of the activity[22]. Peers should also receive fair compensation for their knowledge, time, and other expenses incurred through their participation[19]. The issue of payment should be discussed upfront, not merely as an afterthought.

In searching the literature on peer involvement in priority setting and policymaking, Ti et al. and others have noted that the number of documents appearing in peer-reviewed journals only represents a small fraction of the total work being done in this area[24,29]. Contributions made by drug user-led organizations and peers have been poorly documented and undervalued over the years[51]. Additionally, grey literature such as government consultations are rarely indexed on these standard academic sites, creating some challenges when searching. Ti et al. suggest increasing our efforts as public health researchers and practitioners to critically assess and amplify the work of advocacy groups and other non-academic sources to expand its visibility[29]. They also encourage organizations to assist communities in capturing their rich body of knowledge in a manner that meets traditional markers of quality vis-à-vis study design, bias, and internal and external validity, potentially furthering the chances of citation. Institutions could also consider publicly sharing their experiences and lessons from their peer engagement processes to inform others who wish to take on this type of work[19,45]. These steps can start to dismantle existing hierarchies, strengthen partnerships, and set new standards moving forward.

Chapter 4. Priority setting activities involving PWUD

Commonly identified priorities

Over the years, PWUD and their family members have participated in numerous peer engagement initiatives throughout BC and Canada[4,7,21,41,44,52–54], many of which converged on a similar set of themes and priorities which are listed below in Table 1. These consultations have been instrumental in helping health authorities identify service gaps, implementation issues, and policy weaknesses. In BC, roundtable dialogues between the MMHA and stakeholders (including people with lived experience[41]) resulted in the formation of a roadmap which outlines the province's priority actions for the next ten years[2]. Participants around the province emphasized the need for intersectoral coordination in order to address the health-related aspects of the overdose crisis and the underlying socio-structural determinants that create conditions of vulnerability in the first place[52]. Notably, one of the action items is the establishment of a Provincial Peer Network, intended to help organizations build capacity to further support the involvement of peers in decision-making[2].

While health authorities have made multiple commitments and investments in various harm reduction and treatment services across the province, their efforts have tended to focus on short and medium-term interventions[1,2,52]. Meanwhile, other priorities have languished. Peers have long felt that the province went after the uncontroversial "easy wins" (such as drug checking) instead of pursuing the boldest actions that start to address root causes[30].

Table 1: Common priority areas and actions for BC's overdose response

• Create and fund a comprehensive public health-based safe(r) supply* program
• Integrate and coordinate care between service providers (including data sharing)
• Improve access, quality, and retention along the full range of evidence-based treatment options for substance use disorders, including specialist-led OAT approaches
• Increase capacity to train professionals who care for people with substance use disorders, chronic pain, and mental health disorders
• Enhance access to culturally safe and effective care, with particular attention to Indigenous health and wellness
• Ensure PWUD and their families are involved in all matters of policy and program development
• Decriminalize all illicit drugs, PWUD, and people who sell drugs
• Expand funding for harm reduction services, particularly in shelters, correctional facilities, mobile sites
• Increase oversight and regulation of drug recovery centres
• Plan for evaluation and adapt/adjust resource allocation based on local needs
• Improve education, anti-stigma, and harm reduction campaigns for children/youth and the general public

*refers to a reliable, legal, and/or regulated supply of unadulterated, pharmaceutical-grade substances[55]. This broad term currently encompasses multiple strategies, dispensing models (differing degrees of clinical or peer supervision) and purposes (e.g. for maintenance/substitution treatment, for pandemic prescribing).

Notably, we have yet to see significant progress on two major fronts: the decriminalization of personal use of regulated substances[3,5,56] and the widespread expansion of a safer pharmaceutical drug supply. These potentially transformative approaches to the overdose response will require a substantial shift in attitudes across sectors and governing bodies to achieve full and stable implementation. At the time of writing, the federal government has firmly indicated that it will not commit to drug decriminalization beyond actions directly linked to cannabis legalization[57]. For people on the ground, there is a recognition that they cannot wait for top-down action from Ottawa. As the Minister of Mental Health and Addictions continues to push these priorities forward to the federal government, BC's Provincial Health Officer recommends urgent action at the provincial level to decriminalize personal possession of controlled substances, presenting two mechanisms under the Police Act for consideration[3]. This is a position garnering support from a wide range of bodies, including the Canadian Association of Chiefs of Police[58] and the Canadian Public Health Association[59], among others[5,21,60]. It remains to be seen if the BC government will make the move.

With the skyrocketing prevalence of overdoses involving fentanyl[9], the provision of pharmaceutical alternatives has become ever more urgent. This approach, too, has strong support from VCH's chief medical health officer, subject experts, the City of Vancouver, and numerous elected officials[5,61–65]. BC currently faces issues in the scale-up and accessibility of safe(r) supply, particularly outside of urban centres and small pilot programs[62]. The availability of specialist-led OAT options including injectable diacetylmorphine (heroin) and hydromorphone tends to concentrate in larger cities, leaving PWUD in rural and remote areas with differential access to the full range of addiction treatment[52,62]. The newly-released guidelines for the prescription of pharmacotherapy options for the duration of the COVID-19/overdose crisis may prove to be an inflection point[15], and is certainly a positive step. However, the roll-out has been bumpy, with many prescribers hesitating on this novel course of action, citing the fear of liability and the lack of a clear body of supporting evidence[66,67]. Further studies of BC's pandemic prescribing practices can help shed light on the experiences of care providers and PWUD, providing valuable feedback to inform future models and guidelines for safe(r) supply.

Criticisms of past consultation efforts

Opaque decision-making processes

A BCCDC study examining peer engagement in policy and program planning around the world concluded that the majority of efforts thus far have been largely tokenistic and symbolic[29], characterized by a lack of true decision-making power despite being at the table. This appears to be a common challenge when there are large power differentials between decision-makers and other stakeholders[33].

In highly bureaucratic settings such as health authorities, it remains unclear how participants' inputs are integrated with other factors such as scientific evidence, public opinion, special interests, and political feasibility[17,68,69]. It is also unclear how health authorities and governments handle recommendations they deem to be too radical or that stray too far from existing approaches. This lack of clarity stands in stark contrast to one of the public engagement principles, transparency, in which decision-makers provide "honest and forthcoming explanations for processes and outcomes"[19]. Organizations should be able to defend their decisions and provide rationales and responses to any issues that were raised. Without these post-consultation communication efforts, decision-making processes can feel opaque and one-sided. As a result, participants may lose confidence in the process, thereby increasing their likelihood of dissatisfaction with the outcomes of the consultation[70].

In BC, many peers believe that decision-makers have repeatedly capitulated to pressure from other stakeholders by adopting positions that do not accurately affirm the priorities of PWUD[40,41,71]. On other policy matters, the diversity of voices pushing in different directions has often led to stalemates and inaction[30], with no mechanism to work through areas of disagreement as overdoses continue to rise. In these complex circumstances, there is a need for deliberative methods and informed debate to resolve moral conflict; peer perspectives can be used to complement the medical and technical aspects of difficult decision-making[69]. However, we must also acknowledge that organizations often have to rely on incomplete data to make decisions. In the absence of clear scientific consensus for newer interventions and concepts, communities can collectively help to shape research and clinical agendas, slowly and methodically building a body of evidence, as was done for North America's first supervised injection facility, Insite[72].

VCH's Second Generation Strategy in the DTES

Vancouver Coastal Health (VCH) openly acknowledges their shortcomings when it comes to serving and supporting the residents of the DTES neighbourhood[73]. The health authority has specifically expressed a desire to rebuild trust through meaningful public engagement that goes beyond "talk for talk's sake"[73]. VCH's five-year project to restructure health care delivery in the DTES, termed the Second Generation Strategy (2GS), was built upon multiple layers of extensive public engagement with peers, staff, clients, and the broader community[4]. In its final design, many of the priorities identified by peers and family groups were implemented at the centre of the strategy[4]. Some of the much-welcomed changes include increased service hours, coordinated/integrated care models, rapid access to OAT, and efforts to improve health outcome reporting.

However, the 2GS is not without controversy. Peers have criticized some of the new service providers for having little to no experience working with PWUD[48]. Key community leaders have expressed concern that certain aspects of the program design do not align with recommendations brought forward by people with lived experience[47]. Instead of acknowledging and honouring the socio-structural determinants of health, the 2GS appears to rely on an increasingly clinical model and a limited view of health. This is evidenced by the defunding of prevention and tertiary care services that do not have a clear and direct clinical mandate[47]. VCH's focus on medical and psychiatric programs came at the expense of other services which had the ancillary effect of building community and offering social supports. VCH has also leaned towards improvements in clinical accountability at the expense of trauma-informed practices, the latter of which would allow for patient anonymity and access regardless of prior clinic registration[47]. Some peers and health professionals are concerned that overly formalized medical and institutional approaches will drive people away and discourage connection to care. Furthermore, it appears that the 2GS does not sufficiently address issues of intersectionality, specifically for women in the DTES. Although the concerns raised by women and women-serving agencies were discussed at length in the workshops and commissioned reports, they were not prioritized in the final design of the 2GS[39].

The missing discussions on resources

Priority setting activities, roundtable discussions, and other public engagement efforts have led to the development of dozens of action items directed at various levels of government. However, these consultations are rarely (if ever) accompanied by a discussion on the resources required to implement each item[52]. Among health authorities and local service delivery partners, it is unclear how the priorities will be acted upon, and in what order. Without detailed information on budget impact, resource implications, and timelines, these priority setting exercises alone are insufficient to serve as implementation guides.

Opportunities for PWUD to shape future spending priorities

BC's 10-year roadmap explicitly mentions the need to shift funding priorities from downstream services to upstream initiatives such as health promotion, early intervention, and support for people in recovery[2]. VCH also acknowledges the need for more active discussion on how to manage their budgets for addiction treatment, primary care, and mental health services for the DTES community[73]. The time frame, rationale, and overall operationalization of these potential funding shifts are unclear at this time. However, the dual COVID-19 pandemic and overdose crisis could act as an impetus to start having these serious discussions.

Healthcare priority setting requires decision-makers to allocate resources among competing services, patient groups, or types of care[68]. Health authorities will often rely on historic patterns and political mandates to determine how their resources are divided[68,74]. However, it is unlikely that these tactics will produce optimal service delivery and care, especially under constantly evolving circumstances[74]. Program Budgeting and Marginal Analysis (PBMA) is a formal priority setting approach that combines elements of health economics, stakeholder engagement, and deliberative debate to make recommendations based on highly specific and locally relevant criteria. PBMA has been used by BC health authorities (including VCH) and healthcare organizations around the world to structure and guide their investment, disinvestment, and restructuring initiatives[75,76]. At the heart of the PBMA approach is the advisory panel, typically made up of physicians, allied health professionals, health economists, program managers, and occasionally, lay persons[74]. The planned and intentional inclusion of PWUD on these

expert advisory panels could represent a powerful opportunity to take part in the decision-making processes.

For instance, the panel could be tasked with examining the health authority's budget for harm reduction upon receiving a substantial funding increase. As advisory panel members, PWUD would have a hand in crafting the criteria (e.g. client experience, unmet need, equity) and weighting scheme that will be used to weigh all investment and disinvestment options. In the next step, PWUD and other panelists would compile and identify specific areas for service growth (e.g. a new supervised inhalation site), cutbacks (e.g. reduced hours of service), or elimination. Finally, the options would be scored and ranked based on the earlier criteria, with final recommendations presented to senior leadership. Given that resources spent towards one initiative necessarily means that the same money cannot go elsewhere, it is important for BC to be making efforts to fund the right mix of services. The PBMA approach could assist health authorities to maximize funding for high priority interventions that have the highest impact for their local communities.

Addressing arguments against public (peer) participation in decision-making

While many communities, scholars, and governments push for greater public involvement of key stakeholders in decision-making, others are not sold on the merits of public participation. Bruni et al. believe that these "perceived" barriers to participation do not stand to scrutiny, and have provided compelling counter-arguments to each objection[70]. Firstly, opponents of public involvement say that lay citizens do not possess the scientific or medical expertise to contribute in a significant way[70]. This is a misunderstanding of the public's role; they are there to provide expertise from the point of view of community members and patients in the healthcare system. While lay participants may not be equipped to engage on highly technical aspects, they can speak to their community's values and concerns, and ask valuable questions about equity, implementation, and downstream impacts[69]. Secondly, it is argued that the lay public cannot understand the complexities of the decision-making processes[70]. In fact, there may be many interested parties who are not afforded adequate training or opportunities to contribute fully. Decision-makers can employ a range of engagement activities across the IAP2 spectrum to match the comfort levels of participants. Thirdly, opponents argue

that lay citizens are biased, and therefore cannot be objective[70]. Bruni et al. assert that there is no evidence that lay persons are more biased than any other individuals at the decision-making table; they believe community members are there to help make difficult decisions and participate in good faith discussions as best they can[70]. The fourth argument warns that public engagement will lengthen consultation periods[70]. Some initiatives such as the inclusion of peers on advisory panels are time neutral. In other cases, resources spent towards gathering robust community feedback and considering broader impacts could pay off in the form of better policies, minimizing the potential objections and criticism that could result from a rushed consultation[70]. Lastly, opponents question the value of hearing from lay participants, given that we cannot generalize their experiences to the whole population[70]. This argument is a partial truth: while an individual may represent a small constituency, they certainly do not speak for all members of their community. Greater representation may be needed to capture a full range of experiences, especially among groups with intersecting vulnerabilities.

Need for peer engagement beyond health authorities

By now, it is clear that the health of PWUD is intimately linked with factors outside of the healthcare system, such as housing, employment, income assistance, and the criminal justice system[16]. Structural barriers and deep-seated stigma across institutional policies and practices continue to impede access to health services, putting individuals at higher risk of overdosing and dying preventable deaths[35,36,44,52,77]. As these various agencies conduct their own discussions around reform, they could look towards the health care system for guidance on how to meaningfully engage PWUD in these processes. Furthermore, if there is to be a substantial movement of funds among or between these systems, priority setting processes must be employed to ensure that resources are distributed with as much transparency and equity as possible.

Chapter 5. Conclusion

As BC enters the fourth year of its overdose crisis, the active participation of peers in the reimagining of healthcare planning, priority setting, and policymaking has become ever more urgent. This situation demands a deep understanding of local risk environments and accurate information on the immediate and long-term health needs of PWUD across the province. As health authorities and governments partner with peers in these communities, there are ethical and logistical considerations they can make to ensure that PWUD and facilitators are properly supported in their work. Although PWUD have participated in numerous consultations by health authorities and governments in the past, this engagement has largely been symbolic. There is continued evidence that their top priorities are not being adopted and implemented. Repeated demands for a safe(r) supply of pharmaceutical alternatives and the decriminalization of illicit drugs have largely been met with resistance, devolving into arguments over federal/provincial jurisdiction. However, COVID-19 could be an inflection point for the BC government and health authorities to critically re-examine their past decisions and take bold steps to prevent further overdose deaths, as they have done for the coronavirus pandemic.

Despite education campaigns, strong evidence for harm reduction strategies, and news coverage of the staggering death statistics, the overdose response continues to be undermined by societal discrimination and the criminalization of PWUD. Because of the multi-faceted nature of the overdose crisis, solutions must also involve sweeping reforms to address housing, over-incarceration, poverty, and the far-reaching aftershocks of colonial dispossession among Indigenous people. As COVID-19 and the overdose crisis intersect with the growing racial justice movements, the public is starting to see that so-called “vulnerable” groups are not inherently more susceptible to illness or addiction. In fact, these vulnerabilities and poor health outcomes stem from decades of neglect, systemic racism across institutions, and deliberate policies designed to dehumanize and remove their agency. The future of BC’s overdose response will require robust evaluations of current policies, new investments, and potential resource reallocations into solutions that effectively meet the needs of communities. Though this will undoubtedly continue to be an uphill battle, the current sociopolitical environment may possess enough momentum to finally move the needle on some of these issues.

Chapter 6. Critical Reflection

As we move through the world, we are shaped by our upbringing, our changing environments, the people that we meet, and the ideas we encounter. From the beginning of my graduate studies, FHS emphasized reflexivity as a crucial aspect of public health scholarship and practice. On the surface, reflexivity involves identifying the myriad ways that our assumptions and preconceived notions can affect our thoughts and actions. This is especially salient for practitioners who work with communities and people who have vastly different backgrounds and life experiences from their own. Though I have chosen to study substance use, addiction, and drug policy, I am an outsider in many ways. First and foremost, I personally do not have lived experience of drug use, nor has anyone in my immediate circle been impacted by the overdose crisis. Nonetheless, this issue weighs heavily on my heart and mind. Because I do not have strong personal ties to this community, it becomes even more critical for me to thoroughly and honestly interrogate how my own beliefs are influenced by the broader society's beliefs around addiction and people who use illicit substances. PWUD remain a highly stigmatized and marginalized group who are often spoken about in terms of their deficits. Much of this victim-blaming, pity, sympathy, shock, or downright hostility is driven by moralistic judgement and a belief that "illegal" and "criminal" behaviour should be met with consequences. Though I do not share these views, I acknowledge that other people in the population do, and that some of those individuals hold positions of great power and influence in government. If we are to overcome political and ideological roadblocks to achieve healthy public policy, we public health practitioners must provide the best possible evidence and messaging to bring others to our side.

In order to unpack and better understand the overdose crisis, I had to acknowledge and build competencies[78] around some of my knowledge gaps, namely in political science/public policy (PH2), and social sciences (CC5). I gained an understanding of how neoliberal policies, colonial violence against Indigenous people, the criminalization of drug use, and the carceral state disproportionately affect people of colour and people who are poor and underhoused; this is an unsettling reality for many people living in the DTES. Gentrification and the systematic dismantling of social safety nets fractured communities and further exacerbated health inequities among these populations. I also developed competencies in gender, culture, and social location (CC11) through applying

and tailoring concepts of community engagement and empowerment for PWUD in healthcare priority setting. To situate the discussion in its proper context, it was also necessary for me to expand my understanding of the inner workings of our provincial health system (CC12), specifically around community consultation, partnerships, and governance. It was also helpful to understand how health institutions consider metrics such as accessibility, health outcomes, and costs in decision-making processes. This capstone also briefly touches on secondary competencies including systems thinking (CC10), and partnerships & collaboration (CC6).

Throughout my studies, I encountered some uncomfortable truths about the ways public health and medicine have largely failed PWUD, particularly people of colour. Although there are undoubtedly some meaningful efforts to improve the situation on the ground, our institutions as a whole continue to victimize and harm peers through inaction and delays, all the while espousing values such as dignity, equity, and self-determination. In this space, I oscillate between believing in pragmatism (i.e., steady incremental changes at the margins) and wishing we could tear down the entire system and start over. Even if the arc of the moral universe bends towards justice, countless lives will be lost in the process. We cannot allow ourselves to become numb to these preventable tragedies. We each have our own sphere of influence, and every conversation is an opportunity to challenge toxic ideologies and slowly work towards a society based on person-centric, harm reductionist, intersectional, and anti-oppressive worldviews.

In completing my degree, I join a community of public health practitioners who aim to use their voice and position of privilege to advance health equity for PWUD in BC and beyond. As a new graduate, I understand that one's education and academic titles alone are not sufficient to create trust and respect between individuals. In seeking meaningful and participatory community-based engagement, one must come from a place of deep humility and a willingness to listen and absorb what is being said. Finally, I must recognize the people and organizations who have been fighting the racist, violent, classist drug war for decades before me. I have, and will continue to look towards anti-poverty activists, peer-led groups, researchers, journalists, and health professionals who speak truth to power. As I endeavour to move from knowledge to action and non-performative allyship, I hope to build upon the incredible work they have done.

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