

Engaging People with Lived Experience of Opioid Use

by

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Abstract

This inquiry explored the research question: How can the Fort St John Community Action Team (CAT) create a safe environment to ensure peer input? The Northern Health Authority acted as a partner in this research. This inquiry was grounded in community-based action research and action research engagement methodology. Following Royal Roads University Research Ethics Board (REB) approval and the Northern Health Authority Research Ethics and Operational approval, eight people with lived experience (peers) over the age of nineteen, within the community of Fort St John, were recruited to participate in journey mapping sessions and semi-structured interviews. In addition, eight members of the Community Action Team (CAT) participated in a focus group. Findings in this inquiry include information related to the barriers peers experience accessing services within the community, the importance of supportive services within the community, the importance of foundational relationships between community professionals and peers, and the importance of using a variety of engagement methods to gather input from peers. This inquiry adhered to the Royal Roads University and Northern Health Research Ethics policies.

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Executive Summary

This inquiry explored the perspective of people with lived experience of opioid use (peers) in providing their input to organizations seeking to improve safety and reduce deaths as a result of the opioid crisis in the province of British Columbia. This research was conducted in partnership with Northern Health and the Community Action Team (CAT) in Fort St John, B.C. Specifically, the research question was how can the CAT create a safe environment to ensure peer input? Related sub questions were:

- What barriers exist in the current system that impact the participation of peers?
- What change can occur at a community level to increase safety for peers to provide input?

A review of the literature related to working with vulnerable populations and the principles of harm reduction supported the research design. Prior to data collection, ethical approval was obtained through the Royal Roads University Research Ethics Board (REB) and ethical and operational approval was obtained from the Northern Health research ethics committee. Using community-based action research and the action research engagement model (ARE), data were gathered from adults with experience of opioid use within the last year and residing within the community of Fort St John using journey mapping and semi-structured interviews. A focus group was also held with community professionals.

Data were analyzed using thematic analysis which involved the identification and grouping of data into themes (Braune & Clarke, 2008). Using the verbatim data from research participants as the foundation research findings were developed. Research findings include information

related to the importance of relationships between service recipients and professionals, the need for supportive services, barriers in the current system of services within the community and peer supported ways of engaging. Research conclusions highlighted four conclusions: peers are interested in engaging with professionals; engagement can take many different forms; negative interactions between peers and professionals continue to persist within the community of Fort St John; and organizations lack adequate resources to action their commitment to engage service recipients.

Recommendations were developed based on the findings and conclusions supported by a review of literature related to the topic of engagement. There are four recommendations from this inquiry: that the findings, conclusions and recommendations of this inquiry are shared with the Fort St John CAT team and any peer serving agencies with the community; that the CAT support engagement sessions with peers using a variety of methods; that the ability to improve the capacity of community organizations to develop feedback systems with service recipients be explored; and finally, that the CAT encourage training and resources for professionals to increase their capacity to develop respectful relationships with peers.

The recommendations will be considered as the Fort St John CAT continues to develop work plans and increase the input of peers in their ongoing work to increase safety for those using substances within the community.

Chapter One: Focus and Framing

Numerous communities across the province of British Columbia are experiencing an opioid crisis, primarily driven not just by an increase in the amount of fentanyl in the community but an increase in the amount of fentanyl contained in other illicit drugs (BC Center for Disease Control, 2017). This has resulted in a staggering increase in the number of overdose and poisoning deaths across the province, as well as nationally and internationally (Hartney, 2018). The government of British Columbia has been working with numerous stakeholders to create plans to reduce the number of opioid related deaths, including the creation of naloxone take home kits and related training for both opioid users and others who have consistent contact with opioid users, media campaigns focused on destigmatizing drug users, and the provision of grants for the creation of Community Action Teams (CAT) (Overdose prevention and response in B.C., n.d.). CATs were created across the province in communities where overdose data has identified the most urgent need, and are focused on local coordination and communication to create a response to the needs of those most at risk of overdose within the community (Overdose prevention and response in B.C., n.d.).

The community of Fort St John received a grant for a CAT. This team consists of representatives from several different agencies within the community, such as physicians, Royal Canadian Mounted Police (RCMP), Ministry of Children and Family Development (MCFD), First Nations Health Authority, Northern Health administration, ambulance, fire fighters, non-profit social service agencies, and Indigenous community agencies. The focus of the team is to

create an interagency plan to reduce the number of opioid related crises, specifically overdoses and deaths, within the community.

As a member of the CAT, and an employee with the MCFD, I have witnessed the devastating impacts of the opioid crisis in the community of Fort St John. This action research engagement project focuses on one aspect of this inter-agency CAT system, the inclusion of input from people with lived experience of opioid use (in this context referred to as “peers”). For any plan to reduce the number of opioid related deaths and overdose, input from peers is crucial. Without this input, the plan would lack crucial information related to the actual experience of those impacted by this crisis. However, the current state of the community agency system in Fort St John contains barriers that impact the ability for input from this population. This research will explore this system and identify what strategies could be utilized to increase peer input.

Specifically, the research question is: How can the CAT create a safe environment to ensure peer input? Related sub-questions are:

- What barriers exist in the current system that impact the participation of peers?
- What change can occur at a community level to increase safety for peers to provide input?

Significance of the inquiry

On April 14, 2016, Dr. Perry Kendall, British Columbia’s public health officer, declared a public health emergency after a significant increase in drug related overdoses and deaths (Baker, 2016). This declaration allowed the province to exercise emergency powers, notably, it permitted an increased ability for health officers to share information related to overdoses in a real time fashion allowing responses to be tailored to crisis situations (Baker, 2016). Since that

time, efforts to reduce the impact of this public health emergency have been underway throughout the province of B.C. One strategy has been the development of Community Action Teams (CATs) in communities where the number of overdoses and deaths has been significant. The provincial government provided funding for these identified communities through grants (Magione, 2019).

Fort St John, B.C. was identified as a community with a significant number of overdose events and deaths (Overdose Prevention and Response in B.C., n.d.). Following this identification, a small number of community stakeholders came together to complete a grant application to secure funding to create a local CAT. The initial Fort St John CAT grant application was completed without the engagement of peers, as the deadline for application did not allow for this engagement. As the CAT expanded from a steering committee to full membership, it became evident that no member of the group had a clear idea on how to engage with peers and obtain their input for the ongoing work for the team. Addressing this gap is the focus of this research inquiry.

The focus of this inquiry is based on the premise that the end users of any system change need to be included in the planning or the system change will not be based on a full understanding of the system (Stroh, 2015). Members of the CAT are identified both through their professional roles and their commitment to making change. The CAT has been meeting for nearly a year and members have engaged in activities aimed at reducing the number of opioid related crises. However, representatives of the team work for a variety of organizations that are often in conflict with peers, including the RCMP and the MCFD. Although members of the CAT have witnessed the devastating impact of the opiate crisis on families through their professional

roles, many have not endured an addiction issue themselves. In addition, members of the CAT typically experience the health and social service agencies as professionals and not service recipients. Through the ongoing work of the CAT, a few peers have begun participating in initiatives and meetings, but this remains a small number of the overall peer population. Expanding the mechanisms for engaging peers and ensuring that peers are not simply attending CAT meetings but are fully able to participate is the focus of this research.

This action research project is specifically focused on understanding the current system within the community, identifying what barriers currently exist, identifying actions that could make a change to increase the safety of peers in providing their information to the community members, and providing this information back to the CAT. The CAT will then have recommendations to inform how to improve the engagement of peers in their ongoing work. This engagement will allow the focus of the system change to be based on the users of the system.

Organizational Context and Systems Analysis

The Fort St. John CAT is a community-based group, comprised of stakeholders from numerous agencies within the community and focused on creating strategies to address the opioid crisis using existing community resources. The mandate of this group includes education, awareness and partnerships, intervention planning and exploring treatment, recovery and after care in Fort St. John, and strengthening the collaboration of team members (Personal communication, CAT Steering Committee, March 2019). The CAT is, by its very nature, focused on creating change. The mandate and responsibilities are focused on changing how the system responds to substance use and are based on a harm reduction model of intervention. The CAT

members are taking on this work in addition to any other work tasks they are responsible for and have demonstrated, through their continued participation, their commitment to this change.

Funding for this group was provided by the Community Crisis Innovation Fund, a fund created by the provincial government and managed through the Ministry of Mental Health and Addictions (Overdose Prevention and Response in B.C., n.d.). Membership of the Fort St. John CAT consists of community stakeholders working to support overdose response. As per the CAT terms of reference, attached as Appendix A, the membership list is regularly reviewed and updated as organizations express interest in joining; all members are expected to attend monthly meetings where actions are reviewed and members are able to provide input into planning activities focused on reaching the goal of reducing the number of opioid related overdoses and deaths. Eight members of the CAT have an additional role as members of the steering committee; this committee oversees the groups' adherence to stated goals, monitors the allocated funding, creates agendas for the monthly meetings and reports back to the Ministry of Mental Health and Addictions on these items.

A key responsibility of the CAT, as outlined in the terms of reference, is to support the overdose response by coordinating with Northern Health's Regional Response committee. Together these two groups have a mandate that focuses on: the ongoing provision of harm reduction supplies including Naloxone and related training; promoting diversity of community based overdose prevention programs and services; strengthening the identification of individuals at risk; increasing capacity for connection to support services; support strategies to increase social stabilization and recovery; enhancing cultural safety and humility; addressing stigma and

discrimination; and increasing peer empowerment. The responsibility to increase peer empowerment is the focus of this research.

The CAT team meets as a broader group monthly to review the progress towards goals and create plans for any next steps. Many CAT members are also members of work groups – four different groups assigned specific tasks to be completed as part of the broader group goals. For example, one group was responsible for the creation of two videos that will be released in the community reviewing the opioid crisis in Fort St John and where community members can find support. CAT members self-select to be part of a working group and report their progress back to the larger membership at the monthly meetings. A small number of peers have participated in monthly meetings and working groups.

As described above, the inclusion of peer engagement and input has been identified as a key goal of the CAT. However, throughout the work in the first year, the engagement of peers has been difficult. The CAT membership, particularly the steering committee, has expressed concern that without the engagement of peers, any strategies that are developed will not lead to the desired system change. Part of the difficulty in this work has been the absence of information on how to engage peers in a meaningful way. Although some peers have begun attending meetings and working groups, the number remains low. The CAT is invested in increasing peer engagement but is struggling to know how best to engage with peers and create an environment that allows for peers to provide their input, and hence, this is the focus of this research. Given the power differences that are believed to exist between peers and members of the CAT, and the numerous systems the CAT represents within the community, the steering committee believes that an analysis of the barriers that exist in this system will assist in understanding how best to

increase peer engagement. This project will seek to identify the differences between the current reality and the vision the CAT seeks to reach (Stroh, 2015).

Although the opioid crisis is provincial, and is part of a national and international problem, this project will focus specifically on the engagement between the Fort St John CAT, its member organizations and peers currently residing within the community. This narrowing of scope will permit any recommendations to be specific to the responsibilities of the Fort St John CAT and allow any actions to be used as leverage to improve peer engagement in this community.

Overview of the Thesis

This thesis will provide an in-depth summary of this action research engagement project. Chapter Two will include a review of literature relevant to the research; topics include harm reduction, engagement with vulnerable populations, and client feedback mechanisms. Chapter Three will provide information outlining the methodology and data collection methods that were used, along with information about the project participants and any ethical implications. Chapter Four will provide the findings, conclusions and recommendations from the research. The final chapter, Chapter Five, will discuss the implications from the research for the organization and the next steps that could be taken by the organization to move this research from information to action.

Chapter Two: Literature Review

Contained in this research are three primary areas that require further exploration of literature. Investigation of previous efforts to engage vulnerable populations and harm reduction will be key to this research. To inform the recommendations, a review of existing literature related to organizational use of client feedback was critical. All three topics are discussed below.

Engaging with Vulnerable Populations

Conducting research with vulnerable populations poses challenges of access and confidentiality for researchers. A review of relevant literature has guided the development of this research project by providing information to assist in research design and the management of ethical considerations. This literature review focuses on definitions previously used in research that are relevant to this project, strategies that have been used to engage hard to reach populations, and methods that have demonstrated some success for researchers in gathering information.

Conducting research with vulnerable populations brings some significant challenges for researchers, most notably researcher access to participants and difficulty discussing sensitive subjects (Atkinson & Flint, 2001; Borek, Allison & Caceres, 2010; Hartney, Orford, Dalton, Ferrins-Brown, Kerr & Maslin, 2003; Munteanu, Molyneaux & O'Donnell, 2014; Shghaghi, Bhopal & Sheikh, 2011; Sydor, 2013). A review of relevant literature has brought forward three primary terms related to the research being conducted in this project: *hard to reach*, *hidden*, and *sensitive topics*. According to Sydor (2013), although the terms *hidden* and *hard to reach* are sometimes used interchangeably, the notable difference is that *hard to reach* implies a population

that is difficult for researchers to access, while *hidden* describes a population that has no established boundary making its size difficult to know. Sensitive topics are topics that many would prefer not to discuss publicly, such as substance use, usually for fear of risks associated with disclosure (Sydor, 2013). In this research project, the population I am seeking to engage is considered *hidden* and *hard to reach*, and the topic being examined is *sensitive*.

The importance of engaging populations most impacted by decisions has been recognized by many organizations. Despite this understanding, strategies that have demonstrated positive practices are dispersed throughout literature. While many articles discuss strategies that were used in that specific research, stand alone research providing best practices generally are difficult to locate (Stark-Cutler, Schnirer, & Dare, 2017). Stark-Cutler et al. (2017) point to Community Based Research (CBR) “where partners build capacity in the community while collaboratively studying relevant issues with an aim of social change” as a method of inquiry that builds trust and relationships with hidden or vulnerable populations (p. 602). CBR is an approach that is aimed towards building partnerships to resolve challenges and acknowledges the expertise of researchers and participants, allowing marginalized populations to have equal input into research outputs (Israel, Schulz, Parker, & Becker, 1998; Stark-Cutler et al., 2017). Seven specific clusters of considerations were identified by Stark-Cutler et al. (2017) as paramount to engaging with vulnerable populations: ethical practices, participant support, social accountability, community involvement, language competence, financial compensation and project management. This research project is based in CBR and considers the elements above in the process of conducting this research.

Examining specific methods of data collection that have been successful with this population has identified that the specific method is not the crucial variable, the principles that support the methods are more significant. Basing research methods in ethical practice and addressing participation barriers are crucial to engaging population who would otherwise not participate in research (Isreal et al., 2011; Stark-Cutler et al., 2017; Sydor, 2013). Based in the principles of CBR, researchers need to build authentic partnerships with participants while acknowledging the inequalities between themselves and participants (Isreal et al., 2011; Stark-Cutler et al., 2017). Building authentic and respectful relationships is often based on small changes to research that demonstrate respect for participants such as: flexible scheduling, fair remuneration, collecting data in places participants feel comfortable, and removing participation costs (Isreal et al., 2011; Stark-Cutler et al., 2017). These seemingly minor considerations demonstrate a researcher's understanding of the circumstances of participants and supports the creation of trusting relationships and collaboration (Isreal et al., 2011; Stark-Cutler et al., 2017).

This research proposal has been created with a focus on the past successes of researchers in engaging *hidden* and *hard to reach* populations and seeking to discuss sensitive topics.

Harm Reduction

Since the CAT has been created as a harm reduction initiative to address the harmful effects of opioid use in the community of Fort St John, including overdose and death, it is important to understand what harm reduction is. Harm reduction is an approach focused on reducing the harm associated with drug use (Anderson & Nutter, 1975; Cheung, 2000; Paulus & Halliday, 1967; Pauly, Goldstone, McCall, Gold, & Payne, 2007; Epele & Pecheny, 2007). Harm

reduction emerged in the 1980's, largely due to the AIDS epidemic and a related desire to reduce the transmission of the disease, with a foundation built on public health strategies of pragmatism, humanistic values, focus on harms, and balancing costs and benefits (Cheung, 2000; Pauly et al., 2007; Epele et al., 2007). There is a continuum of theory related to managing drug use; one end of the continuum is represented by those asserting that abstinence is the appropriate strategy while the other end of the continuum is asserting the liberation perspective that all drugs should be decriminalized and managed publicly (Cheung, 2000). Harm reduction sits in the middle of this continuum focusing on increasing drug use safety practices rather than eliminating all drug use (Hathaway, 2001). Harm reduction models are strategies based on a value neutral approach to drug use that is intended to influence drug policy and practice (Pauly, 2008). The overall philosophy of harm reduction has been implemented in varying ways throughout the world, often at least partially based on interrelated factors including political climate, financial implications, and social acceptance (Hedrich, Pirona & Wiessing, 2008). It is beyond the scope of this inquiry to provide an extensive review of global perspectives on harm reduction, given this project is based in British Columbia, the focus will be on harm reduction within this province. In British Columbia, harm reduction is described as an approach that focuses on keeping people safe and reducing risk related to high risk behaviours, while understanding that the high risk behaviour may continue despite the risks (Ministry of Health & Ministry of Children and Family Development, 2010).

Some well known examples of harm reduction practices in Canada are needle exchange programs, safe injection sites and opioid agonist therapy (Anderson & Nutter, 1975; Fischer, Rehm, & Blitz-Miller, 2000; Kent, 1996; Hathaway & Tousaw, 2008; Paulus & Halliday, 1967).

Vancouver, British Columbia opened the world's first methadone maintenance treatment program in when it opened in 1959 (Paulus & Halliday, 1967). Research into these methods of harm reduction have consistently demonstrated that these practices have reduced the harmful impacts of drug use on users (Fischer et al., 2000; Kent, 1996; Hathaway & Tousaw, 2008). Despite these improved outcomes, there continues to be opposition to harm reduction as a model of managing the impacts of drug use.

A continuing argument against harm reduction is that assisting people to reduce the harm they experience resulting from drug use supports their ongoing use rather than supporting them to stop using drugs (Hathaway, 2001; Kent, 1996). Safe injection sites and the provision of clean needles are also seen as having the potential of encouraging intravenous drug use as a preferred method of use (Hathaway, 2001; Kent, 1996). Despite ongoing studies of the efficacy of these interventions in reducing harm to drug users, and therefore reducing the impact on the public health system, some critics still contend that all approaches to managing the use of drugs should be based on abstinence and enforcement.

Critics of the harm reduction model also point to practical and ideological problems related to the harm reduction model (Hathaway, 2001). Hathaway asserted that "harm reduction in Canada has been officially espoused at times yet seldom adhered to in principle" (2001, p. 126). Critics point to the fact that harm reduction policies remain silent on addressing predominant themes around drug use allowing proponents of abstinence and libertarians to continue their discussions without entering the conversation (Hathaway, 2001; Hathaway & Tousaw, 2008). This is seen as discrediting the foundation of harm reduction in human rights values as no action is taken to influence the prevailing stigma and discrimination experienced by

drug users (Hathaway, 2001; Hathaway et al., 2008). Some critics of harm reduction also contend that harm reduction strategies do not go far enough to address underlying social issues related to drug use and what is needed is a mobilization of resources in social science to reduce the social suffering related to drug use (Rhodes, 2008; Pauly, 2008). Some examples of social suffering include reduced access to medical care and ongoing stigmatism. According to Hathaway, adhering to the philosophy of harm reduction requires a paradigm shift away from the idealism of abstinence and the belief that those that use drugs need to face the consequences of their behaviour (2001). The continued emphasis of criminal enforcement of drug use and related offences is clearly in opposition to Canada's focus on harm reduction.

Despite the objections and criticisms of the harm reduction model as a mechanism of addressing challenges for drug users, B.C. continues to rely on harm reduction strategies. The website, Overdose Prevention and Response in B.C., outlines a number of strategies the government has created in its attempts to reduce opioid deaths and overdoses in the province and an examination of the information provided identifies harm reduction as the primary foundation for strategies (<https://www2.gov.bc.ca/gov/content/overdose>).

Feedback and Engagement

A key part of this research project is increasing the engagement of peers. To understand both the value and potential methods of engagement, it is important to explore why and how this peer engagement is critical to planning. In addition, this understanding will guide the development of recommendations. This section will begin with a review of the benefits of client feedback in the field of psychology, followed by a review of the reasons for public participation

and the mechanisms that are used by organizations. The risks and challenges associated with public engagement will follow. This section will conclude with a review of the methods that are appropriate for the engagement of peers.

The value of using client feedback to improve outcomes is well documented in the field of psychology. A client's perspective on the helping relationship between them and their clinician has been shown to be a better predictor of therapy outcomes than the clinician's own perspective (Reese, Norsworthy & Rowlands, 2009; Sapyta, Riemer & Bickman, 2005; Shaw & Murray, 2014). Lambert and Shimoka (2011) asserted that the rationale for seeking feedback from clients is based on common sense, that if therapists seek to understand the clients' perspective on what is working and what is not working, and adjust their clinical approach accordingly, it is natural to assume that client responsiveness to intervention would improve. According to Shaw & Murray (2014), questions related to the relationship between the client and the therapist, including measures such as empathy, can only be answered by the client as it is the client's perspective on the therapeutic alliance that impacts client outcomes. In other words, it is the client's experience of the clinical relationship that matters, not the therapist's perspective on how well they are demonstrating skills such as empathy. The benefits of formal feedback systems have also been shown to be superior to informal check-ins by a therapist (Reese et al., 2009; Shaw & Murray, 2014). Engaging in formal feedback with clients has not only been shown to support therapists to adjust their approach but the very act of requesting feedback has been shown to demonstrate a therapist's intention to develop collaborative relationships which has in turn strengthened the therapeutic alliance (Reese et al., 2009; Shaw & Murray, 2014). The importance of feedback measures above relates to one on one relationships. For an understanding

of engaging larger groups in feedback, I looked to public participation in governing organizations.

In public affairs, such as policy settings, a trend to increase public participation in decision making has been taking hold (Rowe & Frewer, 2019). Rowe and Frewer (2019) define public participation as “the practice of involving members of the public in the agenda-setting, decision-making, and policy-forming activities of organizations/institutions responsible for policy development” (p. 253). According to Arnstein, the purpose of citizen participation is to encourage the input of the ‘have-nots’ in planning for social reform based on the sharing of resources in an affluent society (2019). Engaging in public engagement is believed to put governing bodies in closer touch with the citizens, ensuring that decisions are based on the needs of the citizens (Rowe & Frewer, 2019; Wollum, 2011). The importance of having feedback in therapeutic relationships and the understanding that public participation in decision making brings governing bodies in closer alignment with citizens supports the importance of engaging system users in decisions related to service delivery. Further understanding of effective methods of engagement are necessary to ensure that efforts are well spent and obtain the desired outputs.

Different methods have been used to engage populations in decision making. Rowe and Frewer (2019) proposed three categories of public participation: public communication, public consultation and public participation. The different categories are differentiated by the flow of information that occurs in a participation method: communication involves information being provided to the public with no desire to obtain public feedback or input; consultation is when information is provided by the public to the governing body at the request of the information receiver; participation involves the exchange of information between the public and the

governing body and involves some kind of dialogue and negotiation (Rowe & Fraser, 2019). At times, all three of these categories have been used to assure citizens that public input was being sought when, in fact, communication and consultation have been described as ‘tokenism’ and methods of placation (Arnstein, 2019). Although all these mechanisms have a place in sharing and obtaining information, engagement of participants in decision making falls into the third category of participation.

There is an almost overwhelming number of identified ways to seek feedback and support participative engagement, ranging from broad concepts to structured procedures. Rowe and Frewer (2019), in reviewing literature related to participation mechanisms, identified over 100 mechanisms represented in the literature in the United Kingdom and United States. They also noted that many of the mechanisms, when described, were the same processes with different names or, in some cases, the same name was used for different mechanisms (Rowe & Frewer, 2019). Despite this rather large and confusing list of methods, primary variables have been associated with maximizing the amount of relevant information from participants in engagement: a representative base of participants, leadership support, transparent and ongoing communication, active facilitation and open response formats (Rowe & Frewer, 2019; Wollom, 2011). The type of engagement has not been shown to have as much influence on the effectiveness of an engagement session as the variables associated with maximizing the amount of relevant participant information.

There are risks and considerations associated with public engagement. Public engagement approaches that maximize relevant input by ensuring appropriate representation include: having an active facilitator, commitment to ongoing, transparent communication and

offering open response formats. However, these are time consuming and can require skills that organizations may not have readily available. For example, if an engagement is well attended, well facilitated and responses are provided in an open format, such as a focus group dialogue, the data must then be analyzed and interpreted. Following this, information about the outcome of the session will need to be communicated to participants, as well as those in the organization who have a role in decision making. Although some organizations may have employees who can carry out these roles embedded in their system, it is more likely that they will not. As a result, organizations would be seeking to pay for professionals with these skills from an outside agency or have an internal employee take on this task with limited, if any, training in this type of work. This support within an organization requires funding and the investment of leadership in the value of the potential input from service users.

Literature supports the value of engaging with clients or service users in processes that provide opportunities for feedback and engagement in decision making. The information gleaned from participative sessions allows decisions makers to adjust their approach to better meet the needs of service recipients. It is important that this type of engagement is truly participatory, which requires resources to ensure processes are created to maximize the sharing of relevant information and the ongoing communication of outcomes.

Chapter 3 Methodology

This research is an action research project, using the action research engagement model (ARE) and community-based action research (CBR). This chapter will describe these methodologies, outline the data collection methods that were utilized, and provide an overview of the project participants. Following this information is a detailed description of how the research was conducted, along with information related to data analysis and validity. This chapter concludes with a review of the ethical considerations that were inherent in this research.

Methodology

Action research is a “set of collaborative ways of conducting social research that simultaneously satisfies rigorous scientific requirements and promotes democratic social change” (Greenwood & Levin, 2007, p. 1). This research methodology is seen across many fields and theoretical frameworks but to be action research there are three primary requirements the research must contain: action, research and participation (Greenwood & Levin, 2007). Action research is reflective and cyclical by nature, progressing through recurring cycles of reflection and action (Dickens & Watkins, 1999). Kurt Lewin, often referenced as the pioneer of action research, described action research as an iterative process whereby research leads to action and action leads to evaluation and further research, with each cycle consisting of stages of planning, action and fact-finding about the results of the action (Bernard, 2004). The cycles of action research can be repeated, as needed, until a topic is exhausted. Many forms of action research exist, tackling topics from many areas of interest. For this research, CBR methodology was used, as it has a focus on the involvement of community members in the inquiry.

As the title implies, CBR focuses on research and action that involves community members. The involvement of community members is an equal partnership where researchers and community members collaborate to conduct the research and use the research to create action (Wallerstein & Duran, 2003). Nicolaidis and Raymaker (2015) outlined four properties of CBR: a focus on community, equal partnerships, research for action and an ongoing commitment to the principles of CBR.

CBR begins by engaging and acknowledging the community, as the community is the basis for all further research. For this research project, the community was defined as Fort St John community members over the age of 19 who, within the last year, had used opioids. Building on the acknowledgement of the community, equitable partnerships between researchers and participants were developed. In CBR, the term equitable means that “equal weight and consideration is given to the contributions of both the community and academic partners, but the nature of those contributions covers different areas” of expertise (Nicolaidis & Raymaker, 2015, p. 170). For example, researchers are typically responsible for planning the research and ensuring the methods and ethical considerations are appropriate while community members are responsible for ensuring that needs of the community remain a primary consideration. In this project, I designed the research questions and methods, and participants were given latitude to make decisions about what event they wanted to discuss. For example, journey mapping sessions were held with participants. The journey map consisted of four lanes: what the participant was thinking, what they were feeling, what was helpful or would have been helpful and what was not helpful. Participants were asked to map any event in their lives where they encountered social or health agencies within the community of Fort St John. This allowed me to collect information on

similar topics from each participant, and participants were encouraged to share an event that had meaning for them.

As research progresses, it is crucial in CBR to keep a focus on managing power, discourse and reflection by ensuring communication is done in the language of the community, ensuring all community members can communicate in ways that favour their personal strengths (Nicolaidis & Raymaker, 2015). All methods with participants started with a review of their consent to participate and ability to withdraw from the research. Data collection was completed from an empathic and non-judgemental framework. Although cues and questions were used, the methods involved listening and repeating information given by participants only for clarity, allowing participants to share their experiences without judgement. In the journey mapping sessions, notes were taken on a white board to capture each participant's information and participants were asked to review this for any errors or omissions at the end of the session. Non-judgmental data collection was a key foundation for building trusting dialogues with participants.

As with all forms of action research, CBR is focused on action as an outcome of research. The engagement with participants in this research was based on questions related to how to change the system to increase peer engagement. Recommendations from this research are based on the information gathered from participants and are focused on taking action to adjust the system of care in Fort St John. This type of action is consistent with a methodology of CBR. This research project, although based in the methodology of CBR, focused on the first phase of action research: planning. For this, the ARE model was used.

The ARE model is focused on this first planning stage of action research and outlines a method for completing planning through a cycle typical of action research (Rowe, Graf, Agger-

Gupta, Piggot-Irvine, & Harris, 2013). The cycles in the ARE model include focus and framing, stakeholder engaged inquiry, reflection on action, evaluation of action and engage forward, and finally, recontextualize and reconstruct (Rowe et al., 2013).

The first stage of the ARE model, focus and framing, requires the researcher to understand the organizational context and the topic of concern to be examined (Rowe et al., 2013). For this project, I spent time reviewing CAT documents, including the terms of reference and membership list. In addition, I conducted literature reviews to support the development of this research project.

In the second stage of ARE method, stakeholders are engaged in inquiry methods and data related to the topic of concern is collected (Rowe et al., 2013). In this inquiry, discussions with members of the CAT steering committee were held to discuss the data collection and recruitment methods. In addition, these discussions helped clarify the research questions the CAT was seeking to explore.

The third stage, reflection on action, requires the data to be examined to “identify overarching themes and sub themes, and to assess the implications of what has been learnt” (Rowe et al., 2013, p. 26). A report that outlines the engaged inquiry process and conclusions, along with a review of relevant literature, is often created in the reflection on action stage (Rowe et al., 2013). This thesis report outlines what was learned, including themes and sub themes, and including conclusions and recommendations that outline the implications of what was learned.

Stage four of the ARE model, the evaluation of action and engage forward, “involves a group of decision makers engaged in further dialogue and deliberation on the outcomes of Stage three” (Rowe et al., 2013, p. 27). This stage is focused on evaluating potential action strategies

and their implementation with a goal of creating an action plan (Rowe et al., 2013). The final stage of the ARE model, recontextualize and reconstruct, involves the move of the action plan, or change initiative, from the inquiry group to the organizational unit who has the authority to implement the recommendations (Rowe et al., 2010). This research project progressed through the ARE model, beginning with focusing on understanding the topic of concern, proceeding to data collection from community stakeholders, followed by a review and analysis of the data, an evaluation of the data and recommendations by the CAT steering committee, and concluding with a transition of the research recommendations to the CAT team for implementation.

Specific information outlining the collection of data and study conduct are included in the sections below.

Data Collection Methods

This research project used three data collection methods: journey mapping, semi-structured interviewing and a focus group. All three of these methods are qualitative methods of data collection. Peer participants engaged in journey mapping sessions and semi-structured interviews; the CAT steering committee participated in a focus group.

Journey mapping is a relatively new method for data collection and allows researchers to create a visual representation of a participant's interactions with an experience and helps to tell stories about individuals' actions, feelings, perceptions and frame of mind (Hanington, Bruce, & Martin, 2012). Data for journey maps can be obtained through a variety of methods, including through in person contact or through methods such as surveys where information is obtained and then mapped by an organization or researcher. Journey maps allow themes to emerge by

examining common user pressure points and allows a variety of perspectives to be mapped against an experience (More than metrics, 2017). Following journey mapping, peer participants will engage in semi-structured interviews. Journey mapping was chosen as the first method of engagement as this method was largely led by participants and allowed the researcher to develop the foundation for a relationship with participants. This foundation, along with the information provided by participants, supported the development of questions used in the semi-structured interviews.

According to Kvale, interviews are a form of conversation and “through conversations we get to know about other people, get to learn about their experiences, feelings and hopes” (2007, p. 19). This research project is specifically focused on understanding the perspective of peers, and interviews allowed for an open dialogue to gather all facets of participant experiences. The interviews were semi-structured. Semi-structured interviews allow for a conversation that follows the information provided by the participant, while allowing the researcher to ask some focused questions specific to the research question (Kvale, 2007). Semi-structured interviews combine aspects of an open conversation and a more formal list of questions such as in a survey. The use of semi-structured interviews allowed the researcher to ask questions relevant to the research question but also allowed participants the ability to expand the information they provided based on what they felt the researcher needed to know. This enabled a fulsome gathering of peer experiences.

In the interests of understanding the gap between the system recipients (peers) and the professional organizations, data needed to be collected from the professional organizations. For this group, the CAT steering committee participated in a data collection through a focus group.

Focus groups are a research technique where data is collected from a group of individuals on a specific topic related to the researcher's questions (Morgan, 1996). The goal of a focus group is to understand the attitude and beliefs of a group of people who share a connection to the topic that is being examined (Greenbaum, 2000). The focus group discussion is led by the researcher who acts as moderator and moves the group through pre-determined questions. In this research, a focus group was chosen as the data collection method for this group of participants given their common role as professionals within the helping profession in the community of Fort St John and their professional focus on the CAT goals. Participants brought perspectives from a variety of different agencies in Fort St John but had a connection to the topic begin explored.

These data collection methods enabled the researcher to gather information through a variety of methods, allowing for a fulsome understanding of the participants views on the research topic.

Project participants

In this research project, two groups of project participants were utilized. People with lived experience of opioid use (peers) participated in two data collection methods (journey mapping and semi-structured interviews) and members of the CAT steering committee participated in a focus group.

Peer project participants were adults in the community of Fort St John who self identified as individuals who are currently or have recently been using opioids (within the last twelve months). A letter was circulated with a local agency that has daily contact with peers, the Women's Resource Center, and via email to a local peer group, the Northern Sun Helpers. The

first ten participants who met the research criteria were chosen to participate in the research. In the group there were eight women and two men, and all identified as Indigenous (although this was not a criterion for participation). This research was focused on understanding the lived experience of opioid users in Fort St John and how this might impact their ability to provide their input to the CAT. Given this focus, it was imperative that participants have this lived experience, and have experienced this lifestyle in a recent period to ensure their input was valid in the current system context. In addition, participants were living in the community of Fort St John as the CAT only has authority to action changes within this community. All participants met with the researcher to determine their eligibility to participate, as well as to review the purpose of the research, prior to any data collection sessions.

The number of adult opioid users in Fort St John is not currently known. Given the scope of the project and the one on one nature of data collection, recruitment was set at a maximum of ten participants. Since two methods of data collection were being utilized with peers and the volume of data per participant was anticipated to be extensive, ten participants ensured that data analysis was manageable within the time frames of this research. Data from professionals were collected after data collection with peers was complete.

The CAT steering committee is comprised of representatives of organizations with a keen interest in the CAT mandate. The number of CAT steering committee members fluctuates as members join or leave the group. These committee members are responsible for guiding the work done through the CAT, including the goal of increasing the engagement of peers. This group was defined prior to the conduct of this research and all members of the steering committee were invited to participate in a focus group. At the time of the focus group, there were

eight steering committee members and seven participated in the focus group. The participants represented a variety of community organizations including Northern Health Authority, First Nations Health Authority, Community Social Service agencies, and the parent of a peer (not a peer that participated in the research), allowing for information to be collected from a variety of perspectives.

There were no exclusion criteria based on race, gender, or culture, however, minors were not included in this research study. Although the input from minors would be valuable, it is outside the scope of this research given that the perspective of youth would likely be an entirely different research topic.

Study Conduct

Following Royal Roads University Research Ethics Board (REB) and Northern Health Research Ethics and operational approvals, participant recruitment began through letters of invitation (Appendix B). These letters were circulated in two ways: the letter was emailed to the Northern Sun Helpers (a peer group in Fort St John) and hard copies were left at the Women's Resource Center, a local agency that provides support to the community. Potential participants contacted the researcher and set a time to meet. This first meeting was brief and was focused on reviewing the research project, confirming that the potential participants met the parameters of the study, reviewing the letter of introduction (Appendix C), the methods that would be used in the research, peer compensation for participating and consent forms (Appendix D). The use of letters for participant recruitment allowed participants to be approached by individuals they have pre-existing relationships with or anonymously but did not provide the researcher with their

information unless they were interested in participating. The reverse was also true; those that circulated the letters were not provided with information regarding who became a participant.

Following the initial introduction meeting, journey mapping sessions were set up with participants. Of the ten initial participants, eight attended for journey mapping sessions. All journey mapping sessions and interviews occurred in a private meeting room with a private entrance, allowing participants to attend sessions with anonymity. All sessions were audio recorded. The journey mapping sessions began with a brief discussion about the participants' contact with health or service agencies in the community of Fort St John. This allowed the participants to identify a period that they were interested in discussing using a journey map.

Although all participants identified their own experience to discuss, the four metrics for each journey map were the same: feeling, thinking, what was helpful, and what was not helpful. An example of a blank journey map is included as Appendix E. Participants identified the first touch point to begin the journey map and proceeded to describe their experiences to the researcher using the four metrics. This activity was recorded on a whiteboard with the participant providing information and the researcher capturing the information on the journey map. The use of a whiteboard allowed for any corrections to be made easily as the session proceeded. At the end of each session the journey map was reviewed from beginning to end with the participant to identify any missed information or information that required correction. At the end of sessions, all participants were reminded that the researcher had access to a counsellor, and they could participate in a counselling debrief session free of charge; however, no participants accepted this offer.

Following the completion of the journey mapping session, a time was arranged for the completion of the semi-structured interviews. Of the eight participants that attended for journey mapping sessions, five also participated in semi-structured interviews. The interviews occurred in the same location as the journey maps and were audio recorded. Prior to commencing interviews or audio recording, consent to participate, the right to withdraw, and the availability of a counselor were reviewed with participants. These semi-structured interviews were guided by questions related to peer engagement with the CAT; however, peers often shared information related to their thoughts on improving services within the community. The interview schedule has been included as Appendix F. Although the interview questions were few, in most interviews the questions were repeated to refocus the interview. After data collection from peers was complete, the focus group with the CAT steering committee was organized.

The invitation to a focus group was sent via email to the CAT steering committee. All eight steering committee members were invited to participate, and all but one accepted the invitation. Consent forms were reviewed and signed at the beginning of the session, and a copy has been included as Appendix G. The intention of the focus group was to hear from professionals in the community about their perception of the engagement of peers within their organization, from a leadership perspective and from a community perspective. Focus group questions are included as Appendix H. With the permission of participants, the focus group was audio recorded.

All audio recordings were transcribed with the use of a transcriptionist. Following data analysis, a meeting with the CAT steering committee was held to finalize recommendations that will be taken to the whole CAT team for consideration and implementation.

Data Analysis and Validity

Thematic analysis was used for data analysis in this research. Thematic analysis is a foundational method for qualitative analysis that involves locating and grouping themes within the data, focusing on patterns that emerge through analysis (Braun & Clarke, 2006). To begin, all data were transcribed and reviewed by the researcher. After transcription, codes were extracted from the data. Codes were then organized into themes. According to Braun and Clarke (2006), “a theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set” (p. 10). Data analysis through thematic analysis required returning to the data set frequently to ensure accuracy. Frequent reviews of the data in its entirety ensured that the context of participant statements was not lost.

In this inquiry, data were collected through three methods: journey mapping, semi-structure interviews and a focus group. This collection of information through differing methods allowed for data triangulation, the use of multiple sources of information rather than the reliance on one source (Axinn & Pearce, 2006).

In this inquiry, the findings and conclusions were derived directly from the verbatim accounts of participants. Patterns in response also allowed for validity, meaning that more than one participant provided similar information on topics.

Ethical implications

The research adhered to the Tri-Council Policy statement for the Ethical Conduct for Research Involving Humans (TCPS2) (2018). Three primary principles of this policy are respect

for persons, concern for welfare and justice. All three of the primary principles focus on valuing people and their contributions to research while respecting their human rights to make informed decisions about their participation. In this research project, participants were considered vulnerable. TCPS2 (2018) describes vulnerable or marginalized populations as any population that has limited access to “social goods such as rights, opportunities and power” (p. 8).

Participants in this research had used opioids in the previous twelve months, making them part of a group who often faces marginalization through inequitable access to rights, opportunities and power. This vulnerability was considered throughout the research, specifics are outlined below by examining each of the core principles of ethical conduct for research involving humans: respect for persons, concern for welfare and justice.

Respect for persons includes the right for people to make informed decisions without coercion or fear of reprisal (TCPS2, 2018). Given the vulnerability of the participants in this research, it was imperative to ensure consent was informed and reviewed regularly, along with the right for participants to end their consent and withdraw their information from the research. At the first meeting with participants, prior to any data collection, I reviewed the introduction and information letters with participants, highlighting their right to withdraw from the research without penalty. After this introductory meeting, appointments were set with participants to conduct journey mapping. This allowed participants time to consider their decision prior to engaging in any data collection. At the start of the first session of data collection, participants were asked if they had any questions from the introductory meeting; these questions were answered and consent forms were reviewed and signed by all participants, including the consent for their sessions to be recorded. Each session of data collection began with a review of

participant consent and the right to withdraw information with no negative impacts. This ongoing review allowed participants the opportunity to reinforce or change this decision.

Concern for welfare includes the consideration for participant health in all aspects of their life (TCPS2, 2018). In this research, the two primary considerations related to concern for welfare were support for emotional health and privacy.

Participants were asked to discuss aspects of their life related to their use of opioids and their contact with health or social service agencies within the community. Supporting participants following these discussions was imperative to maintaining their emotional health. All participants were informed that a counselor was available to them, following the session, if they desired a debrief session. This counselling support was available free of charge to all participants and its availability was reviewed at the beginning and end of sessions. No participants requested this service.

Given the personal nature of the data collected and the vulnerability of the population, participant privacy was a primary consideration throughout the research. From participant recruitment through to publication of this thesis, participant privacy was considered, and steps were taken to reduce any chance of information being available or accessible to anyone other than the researcher. Recruitment was completed through letters. Those distributing the letters had information about potential participants' use of opioids, but the letter asked the participant to contact the researcher directly, ensuring that potential participants did not have to tell anyone other than the researcher about their interest. In addition, the researcher did not know who received the letters, ensuring that only those that wanted to participate became known to the researcher. This first step in recruitment established confidentiality for participants.

All sessions were held in a private room with a private entrance and bathroom. Sessions began with a review of participant consent and ability to withdraw their information. All information collected through this project was maintained in locked storage. Electronic records and recordings were stored on devices with passcodes or stored in locked cabinets. All paper records were stored in a locked cabinet. Participants were informed, through their consent form, of how the information would be used and that any information used would be anonymized. The practices to support each participant's emotional wellness and privacy were key considerations in ensuring the welfare of all participants was supported.

Justice is described by the TCPS2 as ensuring that research is conducted in a way that supports fairness and equity (2018). Considering fairness and equity includes the consideration of participant vulnerability, along with recruitment methods that support the inclusion of participants (TCPS2, 2018). Recruitment for this research was conducted randomly within the population of adults who used opioids, and there were no exclusion criteria based on race, gender, disability, or culture. The vulnerability of the participant population was considered throughout the research project by ensuring participant's anonymity and supporting any negative impacts to participants' emotional health.

Given the vulnerability of the participants' population in this research, planning for ethical research was imperative to reducing any potential negative outcomes as a result of participation.

Proposed outputs

The recommendations from this research will be implemented by CAT in Fort St John, in addition to completing my course requirements for my Master of Arts in Leadership. These research findings will be first brought to the CAT steering committee for the finalization of recommendations. In addition to finalizing the recommendations this meeting will include a discussion regarding how this information will be provided to the larger CAT team at a monthly meeting.

Although not finalized, it is anticipated that the presentation will include a collated version of the journey maps that were created with participants to augment the presentation with a visual graphic of the current system from the perspective of users (Samson, Granath, & Alger, 2017; Howard, 2014). The presentation will be followed by a facilitated discussion focused on examining how the findings can be actioned through interagency change. The meeting with the larger CAT community will focus on bringing the research recommendations into action steps and having members of the CAT identify which tasks they are able to commit to within their organizations. In the past, the CAT has created working groups, that include peers, to action plans within the community. It is anticipated that the recommendations will be added to existing working groups or that a working group will be created to action the recommendations of this research.

Contribution and application

This research will present the CAT with strategies to fully gather the input from peers to inform the broader goal of the team in reducing opioid deaths. In addition, it is our goal to share our findings related to the successes and failures of engaging this vulnerable population with

others working to reduce the impact of the opioid crisis in their communities. The information gathered, although specific to peers, will help inform others seeking to engage with vulnerable communities on the effectiveness of the methods utilized.

This research will add to the literature currently available on the topic of engagement with vulnerable populations to action system change that includes input from system users.

Chapter 4: Inquiry Project Findings and Conclusions

This chapter is divided into three sections: the study findings, the study conclusions and the scope and limitations of this research project. The study findings will describe the findings that emerged through qualitative thematic data analysis. Following this, the conclusions section will discuss the conclusions that were drawn from the analysis. Finally, this chapter will outline the scope of the research project and its limitations. The focus of this chapter is to answer the inquiry question: How can the CAT create a safe environment to ensure peer input? And the related sub-questions:

- What barriers exist in the current system that impact the participation of peers?
- What change can occur at a community level to increase safety for peers to provide input?

Study Findings

As outlined earlier, data were gathered through journey mapping and semi-structured interviews with peers, and a focus group with community professionals. These findings are drawn from all three data collection methods. A graphic has been created to present a collation of the journey map data and has been included as Appendix I.

Data analysis revealed four themes:

1. Foundation relationships.
2. Supportive services.
3. Barriers to service access.
4. Considerations for engaging with peers.

Finding One: Foundational relationships. During journey mapping sessions, many peer participants spoke about the importance of relationships in their lives, both personal and professional. Peers spoke of relationships as the foundation for their safety and the key foundation required if they were seeking to begin recovery. This finding includes information related to actions that negatively impact relationship building and maintenance, actions that support the development of respectful and trusting relationships and the importance of these relationships for peer input.

Negative interactions with professionals

Peers who engaged in journey mapping quickly identified actions taken by professionals that negatively impacted their relationships with professionals. These included being ignored, having their concerns dismissed, cancelling programs or appointments, and not taking time to explain things. According to one peer, “I was angry. I felt ignored and neglected” (Participant 7). Participant 1 described their experience as follows:

I was just like oh help me. Like I’m in pain and like it took forever for them to like help me go to the washroom, get me a pan, or you know the chair with the butt. It took them forever to do that. They treat you like you’re a piece of dirt, when you go there, and I don’t like it because you had a few, and I think because I’m native. So, I don’t like that part (Participant 1).

The dismissive approach to helping peers when they attend for other medical issues reduces their desire to approach the health community for any support. When seeking help with their addiction specifically, one peer described their experience:

They just didn't care. It was just horrible. I mean, that was the feeling of doubtful and horrifying... like just because it made me feel because I was an addict asking for help, that was the reason why they didn't want to help me. Cause oh, this is just someone that just wants to use our drugs to get high again. And I didn't want to. I wanted to get clean (Participant 2).

While continuing to seek help, the same peer waited three weeks for an appointment. When they arrived, they were emotional and crying. They stated "I was begging for help. She [the professional] got up and left the room" (Participant 2). This peer tried for weeks to seek support through different avenues and faced barriers in each attempt. This ultimately led to their relapse. In another case, a peer participant described their desire to stop taking methadone and switch to suboxone. They shared their goal with the prescribing physician, who did not agree with them. After the physician continued to ignore their request, they took drastic action that led to significant illness.

When I actually had to do the process myself, because he wouldn't listen. So, I had to not take my Methadone for 48 hours. I was in a lot of distress. I had to go there in my pyjamas crying for him to be like. Ok we have no other choice, but to put you on suboxone (Participant 5).

The examples from participants outline situations where they sought support at a crisis point and were met with disrespectful and unsupportive professionals. Peers reported feeling that their negative treatment was based in stigma, cultural discrimination or both. In journey mapping sessions peers described feeling scared at the early part of their journey and reaching out for help involved vulnerability, and their experiences outline some experiences where they were not only

not supported but treated with disrespect. It is easy to imagine that these negative encounters impact any relationship development between peers and community professionals.

The impact of respectful relationships

Peers described actions taken by professionals that lead to the development of respectful relationships, which included listening, being friendly, showing compassion and empathy, and being accessible. For peers, professionals taking the time to hear their story and their needs were often described as the foundation for a relationship. Three peers described relationships with professionals that were developed while they were accessing services at drop-in centers, needle exchange centers, or safe injection sites in communities other than Fort St John. According to these peers, the professionals took the time to listen, which supported the feeling of compassion and empathy. When these peers were wanting to seek services to address their addictions, they sought out these professionals for support and guidance on potential next steps.

They were with the needle exchange, but they were more than that. They had like this tiny little room like this. That's where you would go and exchange needles. They would have like clothes, but they would give you like sandwiches, and they would talk to you like, one on one. They wouldn't look down on you. Or degrade you for being a user, and addict. They treated you the exact same as they would everybody else. Like they inspired me to want (Participant 2).

The relationships peers had developed with helpers in their lives became the key support in their journey to address their addiction.

I was telling her I was just in a really shitty place. I just couldn't seem to stay sober off anything. Cause I don't just use opiates right. Like I do cocaine and basically whatever.

Yeah I was missing ... appointments. I was missing things I was supposed to do. And I just kind of let her know, why that was. Was because of everything I lost. I'd yell from the loss. I was basically admitting. That's when I knew I was having problems and I couldn't really do anything about it. You know as much as I didn't used to like her. Kind of realized at some point that I could talk to her (Participant 4).

Peers described the foundation of respectful relationships as the key contributor to their ongoing involvement with any service or group in the community. It seems common sense to imagine that a negative interaction would reduce the chances that any service user would return to an agency or professional, but peer input signifies that the impact is greater than simply avoiding negative encounters. A relationship based on dignity and respect often became the foundation of support peers needed when they sought support.

Finding Two: Supportive services. In journey mapping sessions and interviews, peer research participants discussed how their use of opioids is only one part of their life, and that their access to supports to address issues such as homelessness, employment, nutrition, health services, healthy activities, and financial supports are imperative to their ongoing wellness. In focus group dialogue, community professionals described challenges supporting clients within the constraints of contracts provided deliverables that don not address the broad reaching challenges clients can face.

Accessing support services for housing and disability

Peers described difficulty knowing how to access services such as disability payments, income assistance, and housing. Support to navigate these systems was described by peers as crucial in any journey they described as successful.

[She] got me a place as soon as I got back...I was scared actually coming back. Cause I was like, ok, I have nowhere to live. I'm super nervous, what if I have to go back to the shelter... [She] helps everyone more than she needs to (Participant 2).

Another participant discussed their move back to Fort St John and challenges finding housing and getting disability payments.

I was on welfare when I first got here. So I was staying with my family, but then I got approved for disability. Which was a huge help as well. And [she] was super helpful...she helped with everything when I needed help, like with forms to fill out. She went with us to the place...she went with us to the doctor. Cause he was doing it wrong...she was like, this is what needs to be done...it took me a year because my doctor kept doing it wrong (Participant 5).

In both cases above, peers were early in their journey of sobriety and this support was key in maintaining their sobriety. Other peers described situations where their inability to access services resulted in relapse. One peer described attending day treatment and residing in low barrier housing.

The only reason why I failed actually, I'm not going to say any names but it was a worker at the Sally Ann (Shelter). I was paying rent, and I was in the little barrier. But I was still kicked out, from basically the people on the shelter side. I was still kicked out. I get a bag lunch. I get toast in the morning. And I wouldn't even be allowed there for supper.

That's what kind of screwed that up (Participant 3).

Losing housing, and the support that go with low barrier housing, while in a day treatment program derailed this peer's journey to sobriety. According to the peer, this was the

closest to sobriety they had ever come. Another peer described seeking services to maintain sobriety.

There was no consistency. You only get to do so much, then you get to a point yes you can do this, and then it gets shut down. That's what they were doing...I got a new counsellor, I like this one, I can talk to this one. Two sessions and then I had to see a different one. I was like fuck that. I don't want to do that anymore...I relapsed big time. Then I ended up on the streets in Fort St John...Fuck em all. There is no point. Feel defeated...Yeah I gave in. I gave in to the streets (Participant 7).

The key support with navigating complex systems is often not available to peers. However, none of the community professionals were able to identify a service within the community that is tasked with supporting the navigation of these systems.

So for myself ... I don't know if there is an actual system in place that allows me to engage with people with lived experience, but there is NO system in place that says that I can't... Coming to me seeking help, whether that be for opioid use, to get off of it, to seek treatment, to understand better and how to navigate the system. So, I do a lot of that work... in one hand, it's like really great, but in the other hand it just creates more work for myself (Participant 13).

One focus group participant, from a community organization, described some challenges supporting peers in their journeys, stating, "The priorities [are] not matching the given space and time within the deliverables, to spend the human time. And the human time needs to be spent on it" (Participant 11).

Peers identified support for housing and disability as crucial to success in their lives and described the significant negative impact when they did not have access to these supports. In contrast, community agencies have no specific programs that navigate these complex systems although agencies do attempt to provide this support in addition to their other services when possible.

Community supports

Peers highlighted the importance of being engaged in activities such as volunteerism, employment or recreation. According to Participant 7, “This town is so fricken boring. If there was more to do I’m pretty sure people would get involved right...just something to get people to get together.” Participant 6 stated:

Stuff that would give them a hobby. Because I’ve been on the streets here for quite awhile. And I know that they are bored, they don’t have anything else to do but walk around and drink booze and do drugs. That’s how they live their life. They just walk from one area, walk down to another area. Drink, drink, and just walk around and do drugs and everything.

Peer participants who had lived in other communities identified the benefits of having drop-in centers or mobile supports where they were able to do a variety of things including laundry, taking showers, accessing food, talking to friends, and accessing counseling.

They had vans that went around with clean needles, condoms, cool person with lived experience, I think, that was like driving it and talking to them. They had, the working girls, could go in that van and be like ok, so I’m going to work today. I can send you,

they will text the licence plates and stuff. They had a drop in center...so you can go shower and clean up, and eat. And watch TV. That was really nice (Participant 5).

This support was focused on safety and health, rather than judgement. For example, texting a license plate refers to a safety strategy in sex work where the license plate of the client is sent to someone so that if the sex worker does not return or has any issues with the client, the client can be tracked.

Another peer advocated for a drop-in center after experiencing the benefits in another community. They stated:

I think they should have a drop-in center where they have pool tables, couch and chairs where you can just chill out. T.V. Right? Just where you can have showers...where you can drop in. You can sign up for a shower, you have to sign up to wash your clothes (Participant 7).

Working with peers to support their safety includes the understanding that their opioid use is not the only part of their lives that may require intervention or support, and that aspects of an individual's life are interwoven.

Finding Three: Barriers to service access. Although not a research question in this project, journey mapping sessions with participants highlighted barriers in the system of support in Fort St John. Physical location and a limited public transportation presented as barriers to service accessibility within the community. In addition, peers identified barriers related to waitlists for services.

Location of services

Within the community of Fort St John, accessibility to services was highlighted as a barrier. The public transportation services in Fort St John are provided by buses that run from approximately 6 am to 7 pm with no service on Sundays or statutory holidays. With limited funds, peers were often without access to a vehicle or able to purchase taxi services. According to one participant, some services in town have the means to support client transportation but do not often provide them. According to one peer, the Fort St John hospital has “tickets for a cab, for people, and like the transit bus. And they just tell you to make her walk. I hate that” (Participant 1). Peers identified this limited access to transportation, particularly in the northern winter months, as a barrier to accessing services and suggested that professionals leave their offices to meet with clients. “They should actually be getting out there more...all they do is sit in their damn offices. I think you should get some of the professional counsellors out there doing some street walking” (Participant 7). Participant 2 highlighted difficulty accessing Narcotics Anonymous, stating “I know a lot of moms who want to do NA but NA is at 8 o’clock at night. At the church and you’ve got a child...But the 8 o’clock at night and having no ride sucks”.

This difficulty navigating between locations in Fort St John presents as a barrier for peers seeking services.

Waitlists and access to services

In addition to accessibility barriers, peers identified waitlists as a concern when attempting to access services. Peers highlighted waitlists as a barrier in accessing many different programs including treatment, detox, community addiction services, psychiatry, and mental health services. Peers provided numerous examples of their experience with waitlists.

I tried to [get help] but there was none. I would call mental health. We actually called the BC Health people and tried to ask. This was when I tried to get clean when I first came up here. Everyone. Even the BC Health system. They told me, keep using, keep using. And I was kind of shocked. Cause I'm like I'm an addict who wants to get clean, but there was NO help for me (Participant 2).

Peers discussed their concerns that waitlists for services have a significant impact on accessing services, as those seeking to address any addiction issue need support quickly.

Participant 5 described their concern about peers waiting for treatment:

Sometimes it takes awhile to get them out. And by then it's really hard for an addict to wait four days, to go to treatment. I wish there was a way they could just move that along for them. Because, yeah it happened to me a few times too. I need treatment I'm going to die, and they'll be like. Ok, just wait four days, and someone will call you. And I'm like. Yeah, that'll happen. One time in particular that I remember like, now we've lost her, because like, that desire to do that, doesn't stay forever.

The barriers of accessibility to services and the waitlists that are often in place present clear obstacles for peers in locating support.

Finding Four: Considerations for engaging peers. Peer interviews highlighted the varied ways input can be sought from peers, and the lack of formal systems in community agencies for seeking client input were highlighted in the community professionals focus group. Service providers identified that their organizations generally had leaders who see the value in client feedback and input, but no formal mechanisms exist for gathering this information. In

addition, peers provided some suggestions for how to recruit and engage participants within the community.

Methods to engage

When asked about their desire to provide feedback to professionals planning for peer safety in the community, all peers stated that they would be interested in providing their perspective. In fact, all peer participants shared a desire to provide information that could be used to increase safety for themselves and other peers. One peer stated, “the whole point of everything is to help people...it makes me feel like it’s helping. You know, it is motivating me, maybe makes me feel inspired” (Participant 4). There were significant differences in how peers felt they could provide this information.

Two peer participants stated that they had no issue attending a large community meeting as a peer representative. Participant 6 stated, “for me, it’s ok. I don’t mind [but] I think most people like confidentiality”. Peers identified concerns about providing their input in a large group setting for the following reasons: anxiety in large groups, a lack of anonymity and previous negative interactions with professionals in the group. One peer stated:

There is a lot of us that don’t have voices so. Just doing sessions like this (one on one). Making them feel more accepted and more involved. A lot of people have a hard time talking to authority figures right. Due to being jail...negative pasts... schooling and stuff. You know with the residential schools. A lot of people have a lot of hatred, anger and animosity toward people like that. People in authority (Participant 7).

It is difficult to imagine sitting in a large group setting and feeling that your input is valid when others in the same group represent authority figures that you typically avoid. This power

imbalance presents as a key issue in obtaining input from peers in the setting professionals typically utilize, such as large meetings.

One participant identified a lack of confidentiality as a barrier to participating in a large group:

I don't know if you really can have confidentiality in that. Like you know, I guess the big thing would be, you know, not a whole bunch of people hearing about it. Maybe just the ones that really need to (Participant 4).

This highlights a peer's right to privacy and outlines the need for professionals to ensure that information sharing upholds confidentiality. Peers sharing information related to their substance use are no different than most people, they desire some ability to decide who is entitled to their information and for what purpose.

Small groups may support information sharing in a less risky environment. For example, Participant 6 stated:

Maybe a smaller group would be better, and then their input could go forward, and they wouldn't have to be part. Cause people are intimidated by authority so. I don't want to be around authority or whatever – just avoid it.

A significant risk of missing information from relevant peers exists if input from peers is only sought through large meetings.

Participant 1 identified written material as a method for peers to provide input stating “I don't know, I am not very comfortable with that (large group setting). Sometimes I can but then I'm shy...stuff I wrote down. Like write what I think down.” Participant 5 stated that of key

importance is that professionals listen, stating “Listen, because they don’t know what we’ve been through. So listening would be great. And just, that’s it”.

Peers identified one on one conversations, small facilitated groups and written material as ways to gather input while providing anonymity and safety. This information highlights a need for choices for peers related to how they engage with professionals seeking input.

Recruitment

Peers also highlighted that recruiting participants could involve hanging up flyers inviting them to meet with people and ensuring that this is done through community agencies they are already attending. It was noted that word of mouth is a powerful recruitment tool in a small community such as Fort St John. Participant 4 suggested, “Put out a poster or an ad. Maybe mention something on social media. You know just kind of putting it out there. Like that how groups start right?” Another participant stated:

Put up pamphlets at the Friendship society...just say if you are an addict, or have been a drug user in the past, this study is for you...a lot of people go to the Friendship center every morning. You could also put a couple flyers at the Women’s Resource, and also at the shelter. And even the employment agency (Participant 6).

In this research, peers were paid \$25 per one hour session, which is an amount recommended through the Compassion, Engagement and Inclusion group of B.C. This group is a collaborative partnership focused on supporting peer engagement in harm reduction initiatives within the province. In interviews, peers were asked about peer payment and if being compensated for their time supported engagement. Peers confirmed that payment for their time in engagement sessions would increase engagement. According to Participant 4:

I'd say for most people, it's probably important. Street people per se, you know, they can always use the money. And it's just...you give something, you get something. I think it helps to be honest. Lots of people could use a few extra bucks, right.

Peers identified ways to support peer engagement through recruitment in locations they are attending and financially compensating them for their participation.

Current agency feedback or engagement systems

For community professionals, the value of engagement was identified and supported through their organizations and leadership. However, actual mechanisms to complete engagement were almost entirely lacking. As a result, the methods of engagement were informal and largely based on each professionals' own desire to obtain feedback. Community professionals stated that "we don't have structures to do that, we don't have the finances to do it" (Participant 14) and often referred to time constraints and skill sets as barriers to engagement.

We don't have good ways of either proactively or real time or planning purposes of getting a group together and having that conversation. And there really isn't. The leader would also need to feel comfortable doing that and would also need to have time to do that. So, we would just really need to structure things differently (Participant 12).

Despite the challenges identified by the community professionals, the desire to engage peers was clear. Professionals identified their agencies support engagement with all of those seeking services, and the opportunity the opioid crisis has brought to examine work in addiction services.

There is this giant you know huge opportunity to really create space so that we can hear the other side of things. Where it's not just like us telling people how they should be

helped. It's about people who need the help telling us how they want to be helped
(Participant 13).

Generally, peers stated that they are willing to provide input if the method of collection provides safety through confidentiality and allows for varied methods to provide input. Community professionals highlighted the desire to seek and use feedback from peers but identified challenges in completing this.

Study Conclusions

Building on the findings there are four conclusions from this inquiry:

1. Peers are interested in engaging with professionals.
2. Engagement can take many different forms.
3. Negative interactions between peers and community professionals persist in the community of Fort St John.
4. Organizations lack resources to adequately action their commitment to client engagement.

This section will expand on each conclusion.

Conclusion One: Peers are interested in engaging with professionals.

All peer participants highlighted their desire to speak to community professionals about their needs and to provide some perspective on how things are working within the community, stating that the focus is about helping people. To maximize peer engagement, it is imperative that barriers to engagement are addressed. Since peers are wanting to provide information, and

professionals understand the value of seeking their input, it can be concluded that this is a shared value that can be built on.

Throughout data collection, peer participants highlighted barriers to their participation in community services. Consideration of these barriers is important to avoid duplicating similar barriers in engagement sessions. Specifically, accessibility and communication relate to engagement methods. Peer participants discussed the need for professionals to attend in locations where peers are, rather than anticipate that peers will be able to make their way to a different location. Also highlighted was the tendency for community professionals to rely on phone communication, or other methods involving technology, and the difficulty that peers may have in accessing the required technology to engage.

As described by Stark-Cutler et al. (2007), the principles of ethical practice and addressing participant barriers are the most important variables in conducting data collection. Stark-Cutler et al. (2017) highlighted the need for professionals to consider flexibility, fair remuneration, seeking data in locations peers feel comfortable and ensuring there is no cost (financial or otherwise) for participation. To address these potential barriers, it is important to consider the location of any in-person events and how recruitment and ongoing communication can be managed without relying on technology. Any in-person engagement sessions should be held in locations that peers are accessing and that if this is not possible, transportation arrangements will need to be considered.

Conclusion Two: Engagement can take many different forms. Information gathering can be done in multiple formats and data highlighted the need for different methods to be used to address issues of confidentiality and personal preference. The purpose of seeking client feedback

and input is to encourage service users in planning, by bringing those offering services a clearer picture of the issue they are working to address (Rowe & Frewer, 2019). In this case, peer input is crucial to planning for safety within the community. Efforts to make change without involving the participation of the impacted population often fail to reach their desired outcomes as plans are built on incomplete information. Seeking input from service users is a key component of systems change. Moving to systems thinking can increase the likelihood that people's action can be mutually supportive (Stroh, 2015). Seeking input from peers respectfully will support the creation of relationships, allowing all players in this system to reflect on their own role in the system and any system improvement (Stroh, 2015). Undertaking peer engagement activities requires the above understanding of the value of seeking input from service users to effect change.

Data supports the use of varied methods to increase peer comfort and their ability to provide input. Specifically, peers identified one on one, small group sessions and written input as ways to ensure different peer perspectives are obtained. In reviewing data collection methods, Rowe & Frewer (2019) identified over 100 mechanisms represented in research within the United Kingdom and United States, highlighting that the CAT has innumerable options for engagement sessions with peers. Using a variety of methods will expand the input of peers beyond those who are comfortable engaging in large discussions or meetings.

Conclusion Three: Negative interactions between peers and community professionals persist in the community of Fort St John.

Data highlighted the need for respectful relationships as the foundation for all work with peers. Peers highlighted empathy, time to listen and accessibility as key measures of a respectful

relationship. Although it seems intuitive that respect is a key component for the development of relationships, the findings highlight negative interactions with community professionals within the community of Fort St John. The negative interactions peers described were not isolated to one group of community professionals but rather existed across many different interactions with many different professionals. This supports the conclusion that work continues to be needed within the community to understand the importance of building relationships as a foundation for work with service users.

Conclusion Four: Organizations lack resources to action their commitment to client engagement.

Despite organizations identifying the importance of engagement with clients, most organizations have limited resources to conduct this work within the community of Fort St John. Community professionals identified the lack of staff or funding to complete engagement sessions or create feedback loops. In addition, there is no formal structure within most organizations to review and make changes based on any engagement or feedback that might be obtained.

Engagement activities require resources. To ensure engagement is not only well attended and relevant but can be integrated into system improvement, time must be allotted to the engagement process. Gathering input from peers and failing to integrate that feedback to inform change makes any engagement a token activity (Rowe & Fraser, 2019; Woolum, 2011).

Scope and Limitations of the Inquiry

This research set out to determine how peers can be more engaged in the CAT in Fort St John. As with all research projects, this project had a specific scope and inherent limitations. In

this section the scope of the project will be reviewed, including a discussion of the project limitations.

The scope of this research was specific to adults within the community of Fort St John and limited to ten peer participants. Although the total number of opioid users within the community is unknown, the participation was a small percentage of the believed overall population. The representation did include those who used opioids obtained through a medical prescription, those who used opioids infrequently, and those who used them frequently. All participants identified experiencing negative health and social effects related to their opioid use, placing them in the chronic dependent category of the spectrum of psychoactive substance use described in *Healthy Minds, Healthy People* (Ministry of Health and Ministry of Children and Family Development, 2010). It's important to note that the focus of this project is not on formal diagnosis of substance use disorders as outlined in the DSM 5. There were significant differences in the daily life of peer participants: employment status, housing stability, and family composition varied considerably. This variety in the peer participants group allowed for a broad understanding of perspectives. However, the data are also limited by restriction to the community of Fort St John and adults. The data do not necessarily represent the peer population in a different location and there are no data to determine the views of youth.

Although not a requirement for participation, all peer participants identified as Indigenous. There was great variability in identified Indigenous ancestry and geographical distance between Fort St John and the participants' traditional territory. Although not the focus of this inquiry, when asked about the use of culture to address social issues, no participants identified feeling that this would be useful.

Data collection highlighted peer concerns related to the services provided within the community of Fort St John. Finding three outlines these data as it was provided by peers. This information, while valuable, was not the focus of this research project. Exploring this specific topic further could provide valuable information for service providers on how services could be improved or better aligned to meet the needs of service users.

Chapter Summary

In this chapter the data collected through journey mapping sessions, interviews and a focus group were outlined as they related to the inquiry questions and sub-questions. The findings were described and supported through the data provided by research participants. Following a review of the findings was a summary of the inquiry conclusions drawn directly from the findings and supported by the literature reviewed in chapter 2. Finally, this chapter reviewed the inquiry's scope and limitations. The following chapter will outline the inquiry recommendations, the implications for the CAT in Fort St John and some recommendations for future inquiry.

Chapter 5: Inquiry Implications

This chapter will outline the recommendations of this inquiry, followed by an overview of the implications of this inquiry for the Fort St John CAT. A section of any implications for future inquiry follows. A summary of this thesis will conclude this chapter.

Study Recommendations

Created directly from the inquiry findings and conclusions, there are three recommendations as an outcome of this research. As an action research project, these recommendations outline actions that can be taken by the Fort St John CAT to increase the engagement of peers in the work of the CAT within the community. This section will review the inquiry recommendations, linking them to the inquiry questions:

How can the CAT create a safe environment to ensure peer input?

- What barriers exist in the current system that impact the participation of peers?
- What change can occur at a community level to increase safety for peers to provide input?

The inquiry recommendations are as follows:

1. Present the findings, conclusions and recommendations of this inquiry to the Fort St John CAT. Following this presentation, engage in presentations of this information to peer serving agencies within the community.
2. Facilitate peer engagement sessions using a variety of methods to collect information, ensuring that sessions are held in places peers frequent and involving those professionals with pre-established relationships.

3. Explore the ability to improve the capacity of community organizations to develop feedback mechanisms.
4. Encourage ongoing training and resources for community professionals to increase their capacity to develop respectful relationships with peers.

Recommendation One: Present the findings, conclusions and recommendations of this inquiry to the Fort St John CAT. Following this presentation, engage in presentations of this information to peer serving agencies within the community.

As outlined earlier, the Fort St John CAT has a wide variety of stakeholders representing many agencies within the community and all members have a connection to work with peers. The data collected through this inquiry provides information that could be helpful to every agency in their interactions with peers. In addition, this information can be used to guide to work of the CAT and sharing this foundational information will help create a shared understanding for ongoing work together.

The agencies represented at the CAT vary from small organizations to large government organizations, making one system of engagement for all agencies inappropriate. Sharing the findings, conclusions, and recommendations will allow each agency to use this information to review their service with peers and provide information related to how they may increase their engagement with service recipients.

Following the presentation at the CAT, the information included in this project should be distributed from the group representatives to any interested agency. The CAT members are representatives from community agencies and expanding information sharing to the broader

community of professionals will allow a broad community understanding of the current barriers within the system of support for peers. Providing the perspective of peers to those providing support services will allow community professionals to consider the value of seeking peer input specifically related to their services.

Recommendation Two: Facilitate peer engagement sessions using a variety of methods to collect information, ensuring that sessions are held in places peers frequent and involving those professionals with pre-established relationships.

This inquiry's conclusions highlight the importance of conducting a varied method of engagement with peers. Engaging people with drug use experience is necessary to ensure interventions and harm reduction services are relevant and acceptable (BC Center for Disease Control, 2019). The CAT exists to reduce to number of opioid related overdoses and deaths within the community and to improve the efficacy of this work, the input of peers is imperative.

Building on pre-established relationships between the peer community and professionals, engagement sessions should be organized to obtain fulsome information from peers. A variety of methods and locations should be used and CAT members can assist in the facilitation of these sessions, drawing on their own strengths and experience. Sessions need to focus on dialogue – the sharing of information from participants to the CAT and the CAT to the participants (Rowe & Fraser, 2019). The B.C. Center for Disease control (2019) warns that peers are underutilized when they are asked only to share information with no ongoing engagement, leading to a tokenism rather than engagement.

As outlined by Rowe and Fraser (2019), there is an overwhelming number of ways to seek feedback and support participative engagement and the specific method of engagement is not as important as the underlying foundation. To best support engagement methods, the foundation for engagement needs to be focused on broad peer representation, having open and transparent communication and having open response formats (Rowe & Fraser, 2019).

The key to engagement with peers is hosting a variety of events that allow for open response formats in locations that are familiar to peers, while ensuring ongoing and transparent information sharing.

Recommendation Three: Explore the ability to improve the capacity of community organizations to develop feedback mechanisms.

The CAT has broad overarching goals, but also the potential to create changes that have a lasting impact. The information gathered through this inquiry highlighted a lack of resources within community organizations to create forms of client feedback that could be used to strengthen services. As a result, most organizations have limited information related to what is working and what is not working in their services.

The CAT is uniquely positioned as the mandate and membership are broad and can be designed to meet the specific needs of the Fort St John community. As many organizations are represented as part of the CAT, and many representatives are leaders within their organizations, the CAT is positioned to offer supports to interested community agencies to review their services. Support could include financial support from the CAT funding to support peer engagement through supplies and payment, and the use of others in CAT membership to assist in

visioning and implementing engagement sessions within an organization. Additionally, reporting these activities back to CAT membership would allow for learning to occur throughout the team. The work of the CAT is specific to the opioid crisis but requesting feedback on one area of service is likely to lead to information about many services within an organization and within the community.

Supporting agencies to create and implement feedback systems would give the agencies needed resources to establish these systems, creating a path for ongoing feedback cycles. This action can allow agencies to establish a system they are able to maintain, leading to a long-term engagement mechanism to inform service changes.

Recommendation Four: Encourage ongoing training and resources for community professionals to increase their capacity to develop respectful relationships with peers.

Negative interactions between peers and community professionals persist within the community of Fort St John, and the impact of these negative interactions resonates through the system of support within the community. Although the underlying reasons for these negative interactions were not the focus of this inquiry, there are numerous resources that can be assessed to strengthen the work of practitioners with peers.

The Ministry of Health has a framework describing patient-centered care (Ministry of Health, 2015). Patient-centered care is described as placing the patient in partnership with health professionals by ensuring patients have control over their own health decisions and are provided information to make informed decisions (Ministry of Health, 2015). In addition, the Ministry of Children and Family Development and Ministry of Health offer culturally relevant training

through an online course entitled San'yas Indigenous cultural safety training (Provincial Health Services Authority in B.C., n.d.). This training provides historical information related to Indigenous peoples and the impacts of this history of colonization on with a goal of creating a climate of understanding to ensure safe and equitable treatment of Indigenous peoples (Provincial Health Services Authority in B.C., n.d.). The Ministry of Mental Health and Substance Use has a trauma informed practice guide that describes strategies for moving trauma informed principles into practice by professionals (BC Centre of Excellence for Women's Health/BC Ministry of Health, 2013). This resource includes examples of how trauma informed practice has been implemented in a variety of different client serving settings along with information explaining trauma and a checklist for organizations to use to guide changes within their practice (BC Centre of Excellence for Women's Health/BC Ministry of Health, 2013). Although these resources have been created through these specific ministries, they are public documents available to all organizations for review.

A review by members of the CAT of resources available in their organizations, along with a review of the documents described above, is likely to provide a plethora of information to create consistent training for community professionals within the community of Fort St John. Many resources exist for specific groups of professionals. An example is the recent publication entitled "Engagement with physicians to enhance cultural safety in primary care for people who use substances", a resource that provides practice guidelines specifically designed for primary care physicians (Hartney, 2019). These resources exist at the present time and can be utilized to strengthen the practice of professionals within the community of Fort St John. Strengthening

patient-centered care within the community and increasing trauma informed practice will strengthen relationships between community professionals and peers.

Organizational Implications

As a member of the CAT, my involvement with the organization and partner were ongoing throughout this project. I was able to provide real time updates on the progress of the research and utilize the support of other CAT members in some research activities, such as recruitment.

The CAT is at the beginning of their second year of work within the community and continues with the mandate to develop partnerships to provide focused action-oriented strategies tailored to community needs that will support addressing the overdose crisis (Personal communication, CAT steering committee, Sept 2019). The recommendations fit well with the ongoing work of the CAT and will continue to develop a foundation for ongoing work within the community.

A specific consideration for the CAT is the adoption of a patient-centered approach to their work. A patient-centered approach aligns with the mandate of the CAT and could provide a lens for all the work the CAT is championing within the community. The focus of a patient-centered approach is to “deliver health care as a service built around the individual, not the provider and administrator” (Ministry of Health, 2015). This aligns perfectly with the CAT mandate that includes the empowerment of peers and the strengthening of a collaborative environment within the community (Appendix A). The adoption of a patient-centered framework could provide a framework for decision making and priority setting for the CAT, with the engagement of peers supporting the patient perspective in planning.

With a patient-centered framework guiding the work of the CAT, the consideration of trauma informed work with peers naturally follows. Trauma informed practice supports the understanding that many individuals seeking support have symptoms related to trauma and that professionals need to consider ways to avoid triggering service users. In addition, informed practice outlines ways to engage with clients to address their trauma and support them from a whole person perspective.

The data within this inquiry will be presented to the CAT team consideration and implementation planning. As the CAT continues to develop and implement strategies, the recommendations in this research will continue to act as a guide. The recommendation specific to peer engagement can become the foundation for developing long term peer engagement within the community.

As the CAT is comprised of numerous community agencies there is potential that agencies within the community could use the research to begin engagement with service users for their organizations. This would allow the perspective of service users to become embedded in the work of service agencies with the community, increasing the likelihood of services that support the needs of peers.

Creating an overall framework for the work of the CAT based in a patient-centered framework and utilizing a trauma informed approach will create a change throughout the system of care with the community of Fort St John. Increasing the engagement of peers while strengthening the work of community professionals has the capacity to create a system that is able to obtain input from system users and adjust the system accordingly. This system change

will take time and the CAT has the representatives to create, monitor and adjust the system change.

Implications for Future Inquiry

This inquiry sought to understand the experiences of peers within the community of Fort St John in providing feedback to community professionals and build further engagement methods based on the input from peers along with relevant literature. Two primary areas of potential further inquiry were identified through this inquiry: the system of support within the community of Fort St John and negative interactions between peers and community professionals.

Through data collection peers described their interactions with services within the community of Fort St John. They discussed issues with waitlists, services that are difficult to access and a lack of outreach services. This information was not the focus of this inquiry but could be the focus of a future inquiry. The experience of peers accessing services is a key consideration in planning to support them within the community. Peers expressed interest in providing information to professionals and gathering data related to their experience within the system would be invaluable to planning for system improvements.

It is clear through this inquiry that negative interactions persist between peers and professionals within the community of Fort St John. This inquiry highlighted the experience of peers with a variety of different service providers. However, understanding the underlying reasons for these negative interactions is outside the scope of this inquiry. The importance of relationships with peers was highlighted within this inquiry, with a focus on peer experiences. Understanding the perspective of service providers would allow targeted strategies to be

developed that could change the way service providers develop relationships. A change in this dynamic could lead to improved outcomes for peers within the community and a strengthening of the overall system of support.

Further inquiry into the two areas would allow a more fulsome understanding of the systems that exist within the community of Fort St John, allowing the creation of system change based on accurate information informed by those working within the system.

Thesis summary

This final chapter presented the recommendations from this inquiry, followed by a discussion of the implications for the CAT and any future inquiry.

Above all, this thesis focused on the engagement of peers in planning measures to reduce the number of opioid overdoses and deaths within the community of Fort St John, B.C. Through one on one journey mapping sessions and semi-structured interviews with peers, the perspective of peers within the community were heard and included in this thesis. A focus group with community professionals provided information related to peer engagement within peer serving agencies within the community of Fort St John. Gathering data from these two groups provided a more fulsome understanding of the system within the community.

Overall themes were built from data and described in chapter four. These findings were used to build conclusions and recommendations. These recommendations have been provided to the Fort St John CAT for implementation in their ongoing work within the community of Fort St John. The recommendations are actions that can be taken to create change, change that is built on the engagement of peers.

The opioid crisis in British Columbia is ongoing and at the point of this writing has been ongoing for nearly four years since the public health emergency was declared. Efforts continue throughout the province to reduce the deaths related to this public health emergency. It is my hope that the information gathered within this thesis can be used to further engage the peer community and strengthen the work of professionals with this vulnerable population.

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Appendix A

Community Action Team (Fort St. John) – Terms of Reference**Purpose**

The Community Action Team is responsible for encouraging the coordination and communication of overdose response within the municipality of Fort St John. This includes the following:

- Education, awareness and partnerships
- Intervention planning
- Exploring treatment, recovery and after care in Fort St John
- Strengthening the collaboration of the Fort St John community Action Team

Membership

Membership consists of an multi-disciplinary team who represents community stakeholders supporting the overdose response. Membership is regularly reviewed & reassessed by the Community Action Team. Members are expected to regularly attend meetings or send a designate when unavailable.

The Fort St John's Community Action Team is comprised of the following representatives:

- City of Fort St John
- BC Ambulance
- RCMP
- Front-line Community Agencies including:
 - Fort St John Women's Resource Centre
 - Salvation Army
 - Employment Connections
 - Community Bridge
 - Positive Living North
 - United Way
 - Community Development Institute (UNBC)
 - Fort St John Healthy Living Coalition
- First Nations Health Authority
- NP Division of Family Practice
- Indigenous/FN communities including:

- Treaty 8 Tribal Association
- Halfway River First Nations
- Blueberry First Nations
- Doig River First Nations
- Fort St John Metis Society
- Peers and Families with lived experience
- FSJ Mental Health & Addictions Advisory Committee
- Government Agencies including:
 - BC Ministry of Children and Families
 - Northern Health
 - School District 60
 - Northern Lights College
 - Community Corrections – Adult & Youth

Responsibilities

The Community Action Team is responsible for supporting the Overdose Response by coordinating with the Northern Health's Regional Response Committee to:

- Ensure optimal naloxone supplies and the necessary community-level infrastructure to ensure access
- Promote a diversity of community-level overdose prevention programs and services tailored to population/community needs
- Strengthen and support surveillance, analytics and referral systems that identify individuals at risk within communities and increase the capacity for follow-up connection to treatment and recovery programs
- Ensure low-barrier access to oral and injectable agonist therapies and comprehensive treatment approaches
- Promoting strategies for an empowering environment
- Social stabilization and recovery
- Peer empowerment and employment
- Cultural safety and humility
- Addressing stigma, discrimination and human rights
- Members of the Community Action Team are expected to:
 - Promote a culture of collaboration

- Regularly attend meetings or appoint a knowledgeable designate when unable

Chairperson

- Ensure effective facilitation of meetings
- Monitor meeting attendance
- Provide action plan status reports to the Regional Response Committee
- Communicate barriers encountered to the Regional Response Committee

Meeting Agenda and Minutes

- Meeting agenda and previous minutes will be developed and distributed within 10 days of each meeting
- Northern Health staff will take minutes of meetings and distribute as well as sending out invites to CAT meetings
- Community Action members are encouraged to advise co-chairs of agenda items before the meeting

Meeting Frequency

- The Community Action Team shall meet every month

Review of Terms of Reference: Terms of Reference will be reviewed every six months.

Appendix B

Letter of Invitation

To whom it may concern,

I would like to invite you to be part of a research project that I am conducting. This project is part of the requirement for my Master of Arts Degree in Leadership, at Royal Roads University. This project has been approved by Northern Health and I have been given permission to contact potential participants by providing this letter. for this purpose.

The purpose of my research is to understand the barriers that exist for people with lived experience of drug use in providing input to community stakeholder groups. A local Community Action Team has been created to address the number of overdoses and deaths because of the opioid crisis. Your input for this group valuable and I is seeking your perspective on how to best gather your perspective.

This phase of my research project will consist of a one on one interview and participation in a one on one mapping session. Both meetings should take approximately one hour and can be arranged at your convenience.

You are not required to participate in this research project. If you do choose to participate, you are free to withdraw without prejudice. Your data can no longer be withdrawn once the data has been grouped together and anonymized as I will no longer be able to identify your specific information.

Please feel free to contact me at any time should you have additional questions regarding the project and its outcomes.

If you would like to participate in my research project, please contact me at:

Name: Chrystal Ragan

Sincerely,

Chrystal Ragan

Appendix C

Letter of introduction

My name is Chrystal Ragan and this research project is part of the requirement for a Master of Arts in Leadership program at Royal Roads University. My credentials with Royal Roads University can be established by contacting Dr. Catherine Etmanski, Director, School of Leadership Studies.

Purpose of the study

The community action team is tasked with creating a plan to reduce the number of opioid related crises in the community of Fort St John and is made up of several community stakeholders. The input from people with lived experience is crucial to the planning process and this research is focused on identifying how input can be safely provided by participants to this broader team.

Your participation and how information will be collected

The research will consist of one on one interviews between participants and researcher. It is anticipated that each participant will be interviewed for approximately one hour. In addition, I will hold one on one mapping sessions to allow me to understand your experience of the current system of information gathering and how it could be improved. The mapping experience will take approximately one hour.

The anticipated questions include: what are your thoughts on providing input to a community action team? Is there anything that concerns you about providing information to this group? What could be done to make it easier for you to contribute?

Benefits and risks to participation

As participants in this research you will have the opportunity to inform community stakeholders on what needs to be done to ensure your perspective can be part of community planning to reduce the number of opioid related crises in the community of Fort St John.

The benefits of your involvement can have far reaching impacts for the engagement of specific populations in planning that has a direct impact on their lives.

Sharing personal information can create a variety of different emotional responses for participants. Although I will do my best to ensure you have access to appropriate support services, there is a risk that your participation will result in unexpected emotional reactions.

Real or Perceived Conflict of Interest

My employment is within the Ministry of Children and Family Development. My research partner, Connie Cunningham, is employed with Northern Health as the Regional Substance use lead. Information gathered in this research will not be used in our professional roles, except in circumstances required by law and outlined in the consent to participate form. I disclose this information here so that you can make a fully informed decision on whether to participate in this study.

Confidentiality, security of data, and retention period

I will work to protect your privacy throughout this study. All information I collect will be maintained in confidence with hard copies (e.g., consent forms) stored in a locked filing cabinet. Electronic data (such as transcripts or audio files) will be stored on a password protected computer on my home computer or in a locked box. Interviews will be audio recorded and transcribed and summarized in anonymous format in the body of the final report. At no time will any specific comments be attributed to any individual unless specific agreement has been obtained beforehand. All documentation will be kept strictly confidential. Following the defense of my thesis, and by September 30, 2019, all raw data will be destroyed.

There are specific circumstances where I am required by law to disclose information you provide me. There are: information that a child or children may be at risk of harm as described by the Child, Family and Community Services act or information that you are at risk of suicide or homicide. Information of this nature will be reported to the appropriate authorities.

Sharing results

In addition to submitting my final report to Royal Roads University in partial fulfillment for a Master of Arts in Leadership, I will also be sharing my research findings with the Fort St John community action team. No information provided will contain participants specific information but will contain recommendations from the participants and researcher that are determined through the research. A copy of the information provided will be made available to any interested participant.

Procedure for withdrawing from the study

You can revoke your consent to participate in the study and any data you have provided will be destroyed upon your withdrawal. However, following the gathering of data from all participants the data will be anonymized (contain no identifying personal information) and consent can no longer be withdrawn as I will be unable to determine the origin of specific data. To withdraw, please contact me to advise of your decision.

You are not required to participate in this research project. If you are interested in participating, please contact me.

Please keep a copy of this information letter for your records.

Chrystal Ragan

Appendix D

Consent to Participate

By signing this form, you agree that you are over the age of 19 and have read the information letter for this study. Your signature states that you are giving your voluntary and informed consent to participate in this project and have data I contribute used in the final report and any other knowledge outputs (articles, conference presentations, newsletters, etc.).

I consent to the audio recording of the interviews and mapping sessions.

I consent to quotations and excerpts expressed by me through the interviews or mapping session be included in this study, provided that my identity is not disclosed

I consent to the material I have contributed to and/or generated thorough my participation in the mapping session to be used in this study

Name: (Please Print): _____

Signed: _____

Date: _____

Appendix E

Journey Map example

Feeling						
Thinking						
What was helpful or would have been helpful?						
What was not helpful?						

Appendix F

Interview Schedule

Review consent, ability to withdraw, access to counselling following session

Describe CAT team including membership and purpose.

What would you need to share information with that kind of a group?

Any other concerns that you have about being part of a big group?

What should we do to find people interested in participating?

How important do you think payment is?

Anything else you think would be important for people to consider?

Appendix G

Focus Group Consent Form

By signing this form, you agree that you are over the age of 19 and have read the information letter for this study. Your signature states that you are giving your voluntary and informed consent to participate in this project and have data I contribute used in the final report and any other knowledge outputs (articles, conference presentations, newsletters, etc.).

I have read or been described the information presented in the information letter about the project

YES NO

I have had the opportunity to ask questions about my involvement in this project and to receive additional details I requested. YES NO

I consent to the material I have contributed to and/or generated thorough my participation in the mapping session to be used in this study YES NO

I consent to quotations and excerpts expressed by me through the interviews or mapping session be included in this study, provided that my identity is not disclosed YES NO

I understand that if I agree to participate in this project, I may withdraw from the project at any time up until the report completion, with no consequences of any kind. YES NO

I have been given a copy of this form. YES NO

I agree to the focus group being recorded. YES NO

Follow-up information can be sent to me at the following email or mailing address:

I would like to receive a copy of the final report: YES NO

Signature (or note of verbal consent): _____

Name of Participant (Printed): _____

Date: _____

Appendix H

Focus Group Questions

June 3, 2019

1. What systems currently exist within your organization to engage people with lived experience of opiate use (peers)?

2. Thinking about your organization today, from your perspective:
 - a. What are the strengths of your organizations' engagement with peers?
 - b. What are the challenges of your organizations' engagement with peers?
 - c. What are the opportunities within your organization related to the engagement of peers?

3. Thinking of the leadership within your organization, and their philosophy related to engagement with peers, from your perspective:
 - a. What are the strengths of your organizations' leadership related to engagement with peers?
 - b. What are the challenges of your organizations' leadership related to engagement with peers?
 - c. What are the opportunities within your organizations' leadership related to engagement with peers?

4. Thinking about the future of the community of Fort St John, from your perspective:
 - a. What are the strengths of the communities' engagement with peers?
 - b. What are the challenges of the communities' engagement with peers?
 - c. What are the opportunities within the community to strengthen the communities' engagement with peers?

5. Do you have any other additional comments?

Appendix I

