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Commentary

# Developing national best practice recommendations for harm reduction programmes: Lessons learned from a community-based project

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ABSTRACT

Through promotion of consistent, evidence-based policy and practice, best practice recommendations can improve service delivery. Nationally relevant best practice recommendations, including guidance for programmes that provide service to people who use drugs, are often created and disseminated by government departments or other national organisations. However, funding priorities do not always align with stakeholder- and community-identified needs for such recommendations, particularly in the case of harm reduction. We achieved success in developing and widely disseminating best practice documents for Canadian harm reduction programmes by bringing together a multi-stakeholder, cross-regional team of people with relevant and diverse experience and expertise. In this commentary, we summarise key elements of our experience to contribute to the literature more detailed and transparent dialogue about team processes that hold much promise for developing best practice resources. We describe our project's community-based principles and process of working together (e.g., regularly scheduled teleconferences to overcome geographic distance and facilitate engagement), and integrate post-project insights shared by our team members. Although we missed some opportunities for power-sharing with our community partners, overall team members expressed that the project offered them valuable opportunities to learn from each other. We aim to provide practical considerations for researchers, other stakeholders, and community members who are planning or already engaged in a process of developing best practice recommendations for programmes and interventions that address drug use.



Detailed dialogue about the development of evidence-based best practice recommendations for health-related and prevention programmes, including documents designed for programmes that provide service to people who use drugs (see Burrows (2006); National Institute for Health and Care Excellence [NICE] (2014); NYC Department of Health and Mental Hygiene (2009); Strike et al. (2011); World Health Organization (2007, 2009)), is largely absent from the published literature. In particular, the degree of community involvement in the development of best practice resources designed for interventions that address drug use is unclear, despite the recognised importance of such involvement (see Jürgens (2008); Schiffer (2011)). In this commentary, we reflect on our own experience of developing national-level best practice recommendations for harm reduction programmes (primarily, needle and syringe programmes) that provide service to people who inject and/or use drugs in other ways. We achieved unprecedented reach with these best practice recommendations, and share our case example from Canada to produce some practical considerations and advice that will benefit international researchers, other stakeholders, and community members interested or

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already engaged in a process of developing similar recommendations. We hope to motivate greater sharing of such team experiences and processes because best practice recommendations promote consistent, evidence-based policy and practice, and can, in turn, improve programmes delivery and address health service disparities that impact marginalised populations.

According to a group convened by the European Monitoring Centre for Drugs and Drug Addiction, "best practice"—in this context, applicable to drug demand reduction interventions—means "the best application of available evidence to current activities in the drugs field" (Ferri & Bo, 2013; p. 332). Nationally relevant health-related best practice recommendations are often created and disseminated by government departments or other national organisations. Notable examples related to drug use include guidelines for methadone maintenance treatment and concurrent mental health and substance use disorders developed by Health Canada (2002a, 2002b) and guidance for needle and syringe programmes produced by NICE (2014) in the United Kingdom. Unfortunately, production of such documents may not be a priority for governments and other organisations, especially if the subject area is not seen as within the scope of their work or is regarded as controversial, as is often the case with harm reduction programmes. A major challenge, particularly when the topic area may not be regarded as a current priority, is securing the funding and resources needed to convene a dedicated team that will complete the literature searches and retrieval, evidence syntheses, recommendation development, and eventual dissemination of best practice guidance to a wide audience of service providers and users. We confronted these issues as we began, back in 2009, to bring together a national team to complete a narrative synthesis (e.g., Popay et al., 2006) of evidence derived from research on programmes that serve people who use drugs. Our overarching goals were to develop comprehensive best practice recommendations that address multiple facets of harm reduction programming and disseminate this guidance to applicable programmes across Canada. Despite a stakeholder- and community-identified need, as we note below, for such recommendations, to the best of our knowledge, at the time we started our project the Canadian federal government had shown no intention of preparing or funding best practice guidelines for harm reduction programmes. We initiated and completed our project under an "anti-drug" federal policy climate; that is, in 2007, the former Conservative government launched a National Anti-Drug Strategy that omitted harm reduction as a pillar (DeBeck, Wood, Montaner, & Kerr, 2009). Indeed, securing funding for our project was a time-consuming effort, especially given the competitiveness of national research grant competitions. We sought funding from several sources and eventually secured funding from two, including a competition for HIV-related community-based research (CBR) projects hosted by the federal health research funding body.

Next, we describe our project in more detail and integrate post-project insights shared by team members. As we neared project completion in August 2015, we invited all team members—including those who had only been able to participate for short periods and/or were no longer participating—to attend via teleconference an audio-recorded group "debriefing" session that was moderated by an external evaluator. We hoped that by informally collecting this "data", we would capture valuable, transferable team member insights about the process they were a part of to develop best practice recommendations and any resulting personal and organisational capacity building.

## National team formation and principles

Prior to our project, like many other international jurisdictions (see Stone (2014)), Canada lacked national-level policies and best practice recommendations for harm reduction programmes, although provincial-level recommendations had been developed for two provinces, Ontario (Strike et al., 2006) and British Columbia (Buxton et al., 2008; Chandler, 2008). In 2009, meetings with key stakeholders from across Canada were held to discuss harm reduction programming priorities. Attendees, along with others recruited from varied groups across the country who were known to possess relevant expertise, joined together to meet an objective that arose from these meetings—a call for the development of national best practice recommendations. This multi-stakeholder best practice team, comprised of anglophone and francophone partners, included: people with lived experience of drug use, including a representative from a well-established user-led organisation; managers and workers at harm reduction programmes in each region of the country, most of whom had previous research-team experience; the manager of a provincial harm reduction supply programme; a consultant with a provincial health ministry; a manager at a national organisation that specialises in HIV/hepatitis C treatment and prevention knowledge translation; and researchers with years' worth of experience investigating the epidemiology of drug use in Canada, harm reduction programmes, blood-borne and other infections, and other relevant topics.

Our best practices project unfolded over the course of four years and two major phases, using a CBR approach that entailed a "long-term process and commitment" (Arroyo-Johnson et al., 2015) whereby all team members contributed to project design and implementation. Consensus was a central feature to our project's terms of reference as we were mindful that in CBR there are often power imbalances between researchers and community members that can render it difficult to incorporate community perspectives (e.g., Banks et al., 2013; Foster et al., 2012; Ross et al., 2010); we thus aimed to achieve team consensus on all project decisions. Also as a team, we agreed on the topics to be covered in the best practice documents (please see Table 1 for chapter topics found in Strike et al. (2013, 2015)); each team member was charged with soliciting input from their regional stakeholders and to report on what content was deemed to be essential for inclusion. The project was also designed to include learning opportunities for the staff and students who reviewed literature and initially drafted best practice recommendations for feedback from the full team, following a core principle of CBR to promote "a co-learning and empowering process" (Israel, Schulz, Parker, & Becker, 1998).

## Project building and maintenance

Geographic dispersion of researchers and stakeholders can lead to high costs—especially for CBR projects that would benefit from having close or face-to-face interaction among team members—as well as logistical (e.g., travel and time-zone differences) and engagement challenges (Foster et al., 2012; Isler et al., 2015). Funding is again a key issue, as funders do not always provide enough resources for large teams to meet in person. Given that we faced such a constraint yet wanted all team members to be actively included in all stages of the project, we had to find a cost-effective way to engage a national team; these were our reasons for choosing teleconferences as our primary method of communication and tool to work collaboratively on best practice development. We met by teleconferences to discuss each chapter and evidence summary as they were drafted, giving team members multiple opportunities to report on their feedback (either on the calls and/or over email), with emphasis on the wording, consistency, and usefulness of the drafted best practice recommendations.

While teleconference meetings might intuitively seem impersonal or limited, in our case service providers and other team members found that our model was well-coordinated, efficient,