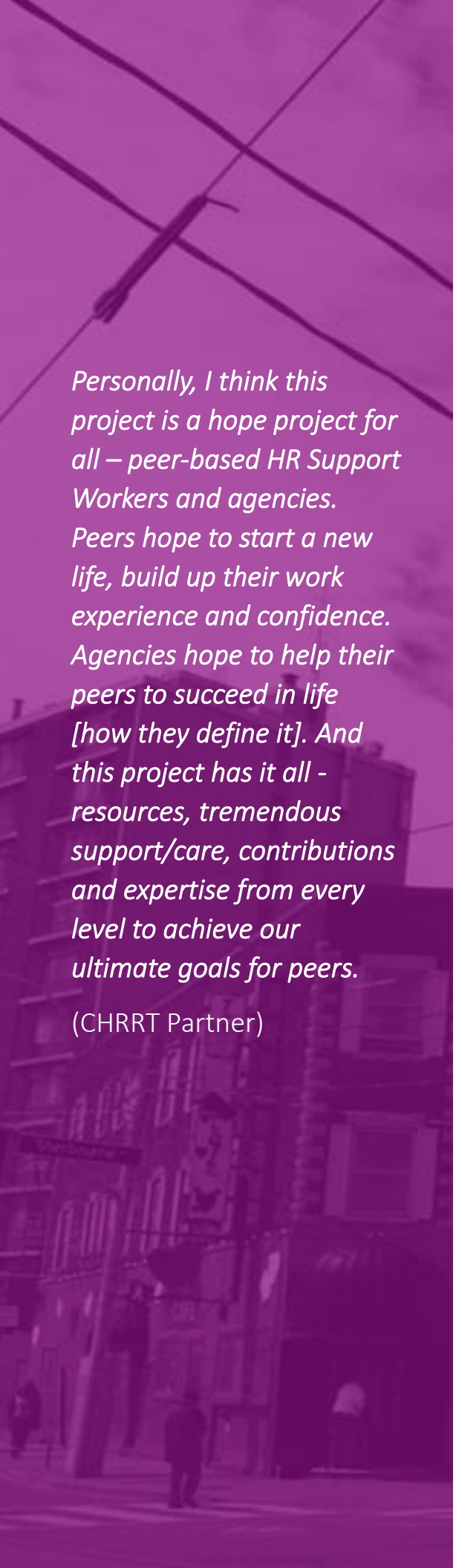

Personally, I think this project is a hope project for all – peer-based HR Support Workers and agencies. Peers hope to start a new life, build up their work experience and confidence. Agencies hope to help their peers to succeed in life [how they define it]. And this project has it all - resources, tremendous support/care, contributions and expertise from every level to achieve our ultimate goals for peers.

(CHRRT Partner)

SCALING UP HARM REDUCTION

FINDINGS ABOUT THE CHRRT MODEL

INTRODUCTION

In 2018, Street Health proposed piloting a new capacity building model designed to scale up the engagement of people with lived experience of substance use and poverty in community-based HR programming. The resulting Community Harm Reduction Response Teams (CHRRT) project was a three-year initiative (April 2018 to March 2021) funded by the Substance Use and Addictions Program (SUAP) of Health Canada as a response to the high numbers of overdoses and overdose-related deaths in Toronto neighbourhoods.

The project set out to explore how the mobilization of marginalized community members as Harm Reduction Support Workers (CHRRT HRSWs) might offer a promising means of promoting low-threshold community-led Harm Reduction (HR) services.

This approach is not new: Street Health and many other agencies have been engaging marginalized people who use substances in their community programming in Toronto for years, training and supporting them to be agents of Harm Reduction. The CHRRT research has affirmed that HRSWs greatly broaden program reach, offer potential to streamline referrals, and enhance the accessibility, relevance and quality of a broad range of programs and services.

The CHRRT model featured a central Coordinator to anchor the project and steward the HR vision, and to facilitate capacity building; and decentralized multi-site implementation by partner agencies. As anchor agency, Street Health convened a partnership of ten like-minded community organizations that made a commitment to support a collaborative training process and to engage HRSWs in their community services and programming.

The aim of the evaluation of the CHRRT project was to assess the model's effectiveness as a capacity-building strategy and as a way of promoting the broader engagement of marginalized communities in HR programming.

The COVID-19 pandemic side-swiped implementation of the pilot. In the first two years of implementation the model had revealed great promise: the project had rolled out as planned, and solid HRSW and operational capacity had been established. Outcomes were seriously set back by the impacts of COVID-19, and much of the progress has since been eroded. Luckily, however, sufficient data was collected from pre-COVID program activities throughout 2018-19 and from post-COVID partner activities to formulate an assessment of the model.

THE CHRRT MODEL

The CHRRT project has offered community members a rare chance to gain a toehold in a realistic and desirable occupation, while also providing community organizations with difficult to secure resources to extend their organizations' HR reach. The CHRRT model is comprised of the following program components:

1. An anchor organization (Street Health), provided ongoing leadership, coordination, centralized administration, and implementation support through a CHRRT team composed of a program Coordinator, trainer and Mentor.
2. A unique programming partnership of ten diverse community health and social service organizations came together to augment low-threshold HR services in their organizations. Creation of this community of practice/mutual exchange enhanced implementation capacity. It offered guidance and technical assistance for HR program implementation as required; and debriefing sessions facilitated by a clinical supervisor to support partner/supervisors in their efforts to integrate HRSWs into the community HR role.

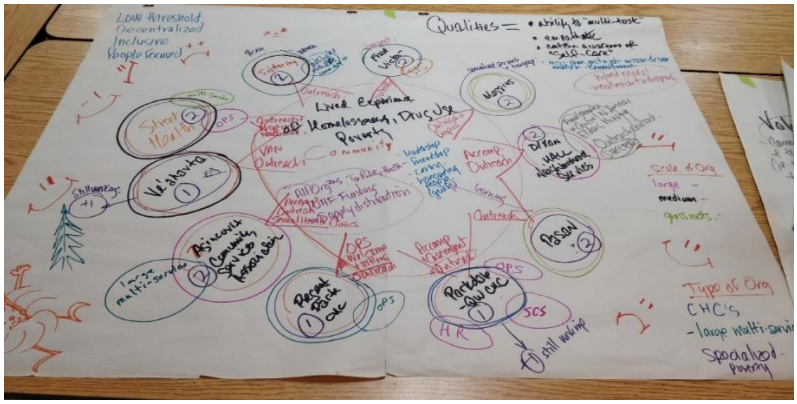

Figure 1: Community Researchers' Interpretation of the CHRRT Model

3. HRSW Capacity building was promoted centrally by the CHRRT team: intensive, paid, entry-level HR training and continuous learning with HRSWs, co-designed by the partners and delivered by community leaders with lived experience.
4. Marginalized people who use substances were hired as HRSWs through a decentralized process to fill low-threshold HR roles in the community (9 hours/week[1]). The HRSWs worked in teams of two and were managed, supported and mentored by partners at each of the ten partner organizations (referred to from here on in this paper as 'partner/supervisors')
5. The CHRRT team provided centralized, ongoing supports and services to sustain HRSWs' engagement in low-threshold HR activities:

a) CHRRT Mentor – a non-supervisory mentorship, counselling and support role;
b) Facilitation of group development – a network of mutual support; and
c) a 'response team' of networked HRSWs and community leaders.

6. A Program Resource Group was created: paid engagement of leaders from the community to guide and support learning and evaluation activities.
7. Stable three-year funding was provided for the life of the project.

[1] Wages varied between $17/hr. and $22/hr.; many organizations paid for work-related public transit costs; and all organizations offered paid sick leave.

CHRRT was designed to reach marginalized people (as HR workers and service users) who use substances, and who have experienced exclusion and oppression as a result of their intersecting identities. These may include: homeless people; newcomers; older adults; Black, Indigenous, and People of Colour (BIPOC) individuals; women; people with chronic physical and mental health conditions; members of the LGBTQ2S community; people who have HIV; and sex workers.

LEARNING ABOUT THE MODEL

- *"This is HR training is amazing! We never had this kind of training when I started my work in HR outreach. We just went out and got started. It was tough. We had to learn by trial and error." (CHRRT Partner)*

- The centralized anchor role was essential to maintaining the vision of the model and keeping the project on track.
- The partnership became an informal community of practice for the implementation of the model.
- HRSWs were well prepared to do entry level work.
- The transition to work in community HR requires intensive support and mentorship.
- The project offered an opportunity to engage HRSWs in new, more responsible roles.
- Mobilizing HRSWs as paid agents of low-threshold HR was a success.
- Partner/supervisors proactively nurtured HRSW learning and engagement.
- Trade Unions play an important role in ensuring that HRSW work finds a place in organizations.
- An investment in agile evaluation supported the model to develop and grow.
- CHRRT's centralized mentorship, supports and services took time to come to fruition and began to achieve their potential in the third year of operations.
- The funding was insufficient to support the partner/supervisor role and did not adequately reduce the precarity of HRSW work. The model could have benefitted from further funding and more delivery hours.

CONCLUSIONS

HRSWs are key assets in implementing low-threshold HR

The pilot proved that HRSWs can engage in low-threshold HR effectively when they receive appropriate ongoing training and support. Their lived experience and connections to community and street culture make

CHRRT partner agencies pursued different types of HR within a range of contexts and missions:

Large Community Health Centres:

1. *Parkdale Queen West Community Health Centre (P-QWCHC) – Systems Navigation*
2. *Regent Park Community Health Centre (RPCHC) – HR outreach and SIS support*

Large multi-service community agencies:

3. *Agincourt Community Services Association (ACSA) – outreach and drop-in sexual health clinics*
4. *Dixon Hall (DH) – housing HR, outreach and accompaniment*
5. *Fred Victor (FV) – HR outreach*
6. *Sistering – HR outreach*

Smaller, specialized social justice and community health organizations:

7. *Maggie's – HR outreach and drop-in*
8. *PASAN – HR outreach and drop-in*
9. *Street Health (lead agency) – HR outreach, drop-in and accompaniment*
10. *Ve'ahavta – HR outreach van*

What is a HR Support Worker (HRSW)?

The CHRRT delivery team made a decision to stop using the term 'peer worker' because it was seen to create the impression of a lowly, unqualified position. HR workers across Toronto work at a range of levels of technical expertise, pay and responsibility. The term 'peer' does not convey the skilled nature of their low-threshold Harm Reduction work.

CHRRT now uses the term 'Harm Reduction Support Worker (CHRRT HRSW)' to identify people with lived experience who are paid workers in a range of low-threshold Harm Reduction roles.

"We don't use the term 'peer' anymore because of stigma and discrimination. At one time, the word conveyed a specialization or expertise, but because of stigma the term is now often see as an inferior position and not legitimate within organizations, invoking controversy."

(CHRRT Partner)

them versatile and highly effective HR agents and advocates in a range of HR roles and responsibilities. They have also showed great flexibility in adapting their work to support community health measures during the COVID-19 pandemic.

At the same time, evidence demonstrated that it is very difficult to be an HRSW, just as it is not easy for organizations to implement and support the role effectively. Not everyone is suited: the role demands a sense of vocation combined with kindness, expertise, subtlety, deeply embedded HR values and great personal resilience. It also requires intensive ongoing support and mentorship.

This CHRRT model shows great promise for scaling up HR

The evidence reveals CHRRT's strong potential as a model for growing and supporting low-threshold HR practice at the community level. CHRRT made strides in piloting a collegial, community-led approach to build capacity for effective low-threshold Harm Reduction, and enhancing the credibility of an approach that draws on partners' strengths and expertise to build a common vision.

The CHRRT team's centralized capacity building effort was a key factor in the success of the model, offering flexible guidance, expertise and support to stakeholders, facilitating participatory, inclusive continuous learning and mentoring, and proactively promoting the retention of HRSWs. Centralization contributed to an effective, community-grounded approach to scaling up the practice.

The model itself emerged from community context and cannot be copied wholesale

The CHRRT model was intentionally adapted over time to fit the characteristics, needs and interests of stakeholders in Toronto neighbourhoods, and cannot be a 'cut and paste' into other communities. For agencies seeking to scale up capacity for low-threshold Harm Reduction in their neighbourhoods, emulation may be a better goal.

Yet as the research has demonstrated, there are important prerequisites to pursuing this model. Prospective lead organizations must already have made a significant prior investment in embedding HR practice into their work, building relationships with community leaders and people who use substances, and securing community collaboration.

CHRRT's intentional HRSW engagement and capacity building promotes community leadership and deepening HR roles along a continuum

HR workers require support and flexible, accommodating employment as they transition from early engagement as volunteers toward more responsible leadership positions. Movement along the continuum is not

"Harm Reduction work offers people a constructive and engaging, different pathway to change and self-care that builds on their lived experience and expertise."
(PRG interviewer)

guaranteed; it can be fast or it can take years. Each HRSW has their own pace of change and comfort levels as they move from accommodating employment to full-time HR practice (see Figure 1). In many respects, this is a continuum of intentionally cultivated empowerment: HR champions offer HRSWs opportunities to gain knowledge, expertise, confidence and competence as the responsibility of their role as HRSWs increases.

Figure 1 – A Continuum of Opportunity in HRSW Roles

Evolving roles	Volunteering	Community HR Work	Community leadership roles	Systems Navigation	Overdose Prevention Sites (OPS)	→	Full-Time Staff Roles in HR Work
HR Activities	Kit making, serving food, neighbourhood clean-up etc.	HR outreach and drop-in programs Handing out kits and supplies. Connecting to marginalized people in the community Naloxone distribution and training/education	Public speaking, peer training, Board membership, research, advisory work, policy	Individual support for socially isolated people - Peer counselling, accompaniment, access to entitlements and services, advocacy	'Peer supervision' of substance use	Transition to full-time professional HR role	Wide range of roles with higher levels of responsibility, supervision, accountability
Role requirements	-Ability to take some direction and work in a team environment	-Grueling, chaotic physical work -Commitment to the agency and themselves -Emotionally advanced relationship building -Practical knowledge in the use of Naloxone and ability to show people how to administer Naloxone -Making referrals	-Public speaking skills -Confidence -Training HR workers -Training Naloxone trainers -Understanding of community leadership -Offering community 'intelligence' e.g. re-toxic drug supply etc.	-Complex, self-directed work -Trauma-informed relationship management -Deepened training required for role -Ability to advocate for and support clients -Paperwork and administration -Participation on interdisciplinary teams -Confidentiality	-Physically demanding/ stressful -Naloxone training -Sophisticated, technical, complex work -Participation on multi-disciplinary staff teams -Clinical training- ability to assess and manage an overdose		-Transition to permanent, full-time, professional positions in HR work -Mainstream employment expectations/pay/ benefits -Often credentialled
Increasing formality, technicality and responsibility of HR role →							
Growing HRSW knowledge, expertise, confidence and competence →							

Movement is also optional, and circumstantial: the process must respect what each individual HRSW wants of it, and what they may want specifically at a given point in time. Harm Reduction is about drugs. This makes the work complex, risky and challenging, and can undermine participants' personal progress with managing their own use.

Nevertheless, all of the CHRRT HRSWs were able to create a balance of basic needs/stability, less chaotic use, stress management. They also enhanced support networks that gave them the personal resilience to weather the challenges of their new occupation. They have shown strength and courage as they advance, working to accept themselves and keep a sense of perspective about what is realistic for them to achieve.

CHRRT has demonstrated that HRSWs respond to a robust offering of participatory, 'just-in-time', adult education strategies including: group learnings led by community leaders; regular webinars; organizational

orientations; group gatherings; on-the-job mentorship and informal learning; and community HR courses that promote 'micro-credentials' for advancement in the HRSW role.

Champions drive change but cannot single-handedly embed and sustain HR practice

In many respects, the CHRRT partner/supervisors became champions of HR in their organizations. Many have played a 'maverick' role, pursuing a kind of daily activism designed to bring change at many levels. They championed innovative low-threshold approaches in institutional contexts, they stewarded the cultivation of HR values in their programs and broader organization, and they provided a role model for fairness and compassion in a sector that in recent years has become focused on efficiency and outcomes.[2] The work has transformed all of the CHRRT organizations regardless of where they are in the long process of embedding HR into organizational operations.

The role of partner/supervisors has contributed greatly to the success of CHRRT's HR strategy, revealing the power of a committed, capable manager in advancing low-threshold HR. Yet it is clear that a HR champion, while influential, cannot single-handedly advance the embedding of the HR philosophy and approach into partner organizations.

'Response Teams' offer potential for the establishment of a social enterprise

Through its model with a strong central anchor, CHRRT has built low-threshold HR capacity, managed implementation, and facilitated the training and employment of dedicated HRSWs. CHRRT has also remained true to its social inclusion mission and has sustained the engagement of its community. Furthermore, the decentralized rollout of the HRSWs' role through multiple community agencies has been powerful and effective, extending reach.

CHRRT's sustained cadre of HRSW-led 'Response Teams' may offer a new way of managing low-threshold HR work and improving HR services for the most marginalized community members, by deploying HRSWs into places often hard to access for those without their knowledge, experience, and expertise in building trustful relationships.

Here might be an intriguing future opportunity for Street Health: to develop a social enterprise. Core capacity building and social development functions of the CHRRT team would remain the same, while the enterprise would take on the function of hiring HRSWs and contracting out their services as HR relief workers, systems navigation experts and community

"Working conditions for HRSWs and their managers are difficult. The result of under-funding/over ambition. The work is driven by activist staff doing lots of pro bono work to make this happen – 'off the side of the desk' takes its toll. It is unrecognized and underappreciated effort."
(CHRRT Partner)

[2] CHRRT managers shared their critique of neo-liberal social work and its expectations that value efficiency, case documentation and results-based outcomes defined by funders. They tend to value a more activist, social justice perspective that offers service users understanding, non-judgment, kindness, flexibility.

trainers. Early evidence suggests a market for the services of HRSWs as relief HR workers to organizations that do not themselves implement HR services (for example, an emerging idea has been to approach public libraries to offer strategic interventions to serve marginalized people who rely on public spaces for safety, community and IT connectivity).

A social enterprise approach would continue to support the social objectives of employing HRSWs and reaching marginalized community members, while also advancing business objectives of identifying fee for service opportunities that would at least partially contribute to the sustainability of the model. This strategy could promote a number of positive outcomes by legitimizing the role of HRSWs in low-threshold HR, changing the public perception of what HRSWs can do, and raising awareness of the expertise and mentoring required to implement HRSW roles.

This mixed-objective social enterprise approach might also resolve some of the grey areas of this form of employment. It could ensure adequate provision of the mentorship, flexibility and accommodation required for successful HRSW employment; establish fair and equitable terms of pay, employment and benefits for HRSWs; and promote community-led standards for the base of training important for quality HR services.

RECOMMENDATIONS

With its strong central anchor services, and decentralized rollout of the HRSWs' role through multiple community agencies, the CHRRT model has been powerful and effective in extending the reach of Harm Reduction in Toronto. Below are a few thoughts based on learning from the pilot as to how a future such initiative might improve on the model.

- Reduce the scale of future initiatives with fewer partners and a neighbourhood focus.
- Establish a continuous process of HR capacity building that engages HRSWs as they advance in their roles and responsibilities.
- Appropriately recognize and compensate HRSWs for their work.
- Invest more intentionally to embed low-threshold HR approaches in implementing organizations, in order to strengthen a foundation of capacity and sustainability.
- In order to assure the success of future initiatives drawing on the CHRRT model, it will be important to advocate for and secure flexible long-term, core funding.

Sustainability is a key policy issue

CHRRT partner organizations' HR efforts will most likely experience a setback once the funding stops. Although learning and change will continue to be promoted by the champions, the progress they made over the past few years may not be sustained.

While the CHRRT model did not specifically aim to promote the embedding of HR approaches into partner organizations, it has become clear that to sustain this work demands a broader approach to capacity building. HR must be embedded into organizational fabric.

(Recommendations section of *Scaling-up HR*)