EQUIP Pathways
Building capacity to end stigma in health care

Rate Your Organization on Harm Reduction and Reducing Substance Use Stigma

A Discussion Tool

Use this worksheet to assess your own organization, agency, or setting in terms of the 10 strategies below. The goal is to support conversation among all staff to optimize the organization's actions and capacity for harm reduction.

This is designed as a group activity, with all staff. It can be used across organizations, but is intended as a prompt for discussion among people within the same organization or unit. It is intended to contribute to processes of organizational change by:

(a) helping to set the stage for individual reflection and input,
(b) assessing where the organization or unit is 'at' with respect to harm reduction, and
(c) supporting priority-setting and action planning.

Substance use stigma is a major driver of the harms associated with substance use and prevents people from seeking health care. **Reducing substance use stigma** is part of harm reduction.

Harm reduction is a health and wellness-centered approach and is an evidence-based response to promote health equity in relation to substance use and stigma. It is both a philosophy and a set of strategies that focus on preventing the harms associated with substance use. Such harms are often the direct result of barriers to safe using supplies, safe substance supply and criminalization. Harm reduction is not about reducing substance use per se. Abstinence may be part of harm reduction, but is not a harm reduction strategy or an end goal.

Health equity means paying particular attention to people who are experiencing the greatest health challenges, and recognizing that some people are subject to more stigma related to substance use, surveillance and mistreatment by systems such as health care, policing and legal systems.

Instructions:

Each person should take about 10 minutes to score your organization on each strategy. After each group member has completed their ratings individually:

1. Each person should identify whether they would like to start with the first strategy, or another strategy and why (less than 1 minute per person).
2. Aim for group consensus about the first strategy for discussion.
3. Each person briefly give their rating on the selected starting strategy (about 1 minute per person to state their rating and primary rationale).
4. As a group, consider the following questions:
   - What are the similarities among the group's ratings?
   - What are the differences, and what accounts for these differences?*
   - What does the group learn from hearing the range of ratings?
   - What are the implications for action?
5. After about 10 minutes, repeat with a second strategy, ensuring that each person has an opportunity to discuss their rating and rationale. Depending on the group, work through the strategies in order, OR focus on two or three strategies that are most relevant to your unit or organization.
6. A next step can be to gather this discussion into a SWOT (Strengths, Weaknesses, Opportunities and Threats) format or SOAR (Strengths, Opportunities, Aspirations and Results) format.

*Differences are very helpful to surface. They often arise from different experiences and perspectives, which brings a useful range of perspectives to the discussion; each person is thinking about a different level of their organization or unit, again contributing important perspectives.

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Rate your organization, where 0 = "not at all attending to this strategy", and 10 = "fully attending to this strategy".

1 **Harm reduction is identified as an explicit commitment in mission, vision, or other foundational policy statements of your organization.**

Harm reduction (not abstinence-only) is a strategic priority and leadership is committed to reducing substance use stigma at all levels of the organization. The organization protects people from the potential harm of policing while accessing services.

0 10

2 **Supportive structures, policies, processes, and training opportunities are in place or in development to support the commitment to harm reduction.**

Structures, policies, and processes to support safe use, non-stigmatizing practices, prevent withdrawal etc. and to ensure consequences and accountability of all people in the organization are in place. Staff have knowledge about substance use, including both potential positive and negative effects, stigma and harm reduction.

0 10

3 **Places and spaces are used optimally to make all people feel welcome.**

A range of strategies are used to make the space welcoming - e.g., quiet rooms or waiting areas, water. People are supported to access safe spaces and supplies for substance use. Signage that conveys a confrontational tone, or expresses judgement of/intolerance for substance use is replaced by welcoming, non-violent signage.

0 10

4 **Time is used in a flexible way to meaningfully engage with people who come for services.**

Time is used in the best interest of the person accessing services to optimize their experiences. Flexibility is shown with scheduling, timing and length of appointments, based on understanding that people have multiple, competing priorities.

0 10

5 **Power differentials are attended to.**

During interactions with people who come for care, providers understand that they may be perceived as intimidating, regardless of intentions or actions aimed at making people feel comfortable and welcome. Providers work to mitigate any stigma and judgement people might anticipate. All levels of staff, regardless of role, have meaningful input into how services are offered.

0 10

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6 **Programs, services and resources are tailored to local contexts.**

Context refers to the broader cultures, structures, political, economic and legal systems, and the local history of a particular place. With respect to substance use, this means knowing and adapting services to the patterns of substance availability, policing practices, and harm reduction prevention and treatment resources available.

0 10

7 **Racism and discrimination are actively countered.**

Staff members actively counteract stigma based on substance use, or perceived use, racism, age, gender, sexuality, ability, etc. Regardless of intentions of providers, claims of discrimination are taken seriously, and acted upon.

0 10

8 **People with experiences of substance use stigma and community leaders are meaningfully engaged in strategic planning decisions.**

Input from people who have experienced substance use stigma use is systematically sought (through consultation, guidelines, online tools, etc.) and acted upon in planning and delivering care. Such engagement is supported with resources.

0 10

9 **Services and program are tailored to address inter-related forms of violence, including violence in the past that continues to exert effects in the present.**

Substance use is often (but not always) related to histories of violence with traumatic effects (including racial violence, child abuse and sexual or intimate partner violence), and ongoing structural violence (such as imprisonment and incarceration, systemic and organizational racism, absolute poverty, etc). Trauma- and violence-informed approaches are integrated throughout all services.

0 10

10 **Services and programs are tailored to address the social determinants of inequity and harm.**

Circumstances of peoples' everyday lives have major impacts on health and substance use related harm, for example, access to affordable, safe housing, income level above the poverty line (social assistance/disability incomes are not), and interactions in the social world that are respectful, non-stigmatizing, non-discriminatory. Service providers acknowledge these inequities, tailor services and advice to people's circumstances, and support wider social change toward equity.

0 10

Key Dimensions of Equity-Oriented Health Care

Published in: Browne, A. J., Varcoe, C., Ford-Gilboe, M., Wathen, C. N., Smye, V., Jackson, B. E., . . . Blanchet Garneau, A. (2018). Disruption as opportunity: Impacts of an organizational health equity intervention in primary care clinics. International Journal for Equity in Health, 17(1), 154. doi:10.1186/s12939-018-0820-2

10 Strategies to Guide Organizations in Enhancing Capacity For Equity-Oriented Services

- Explicitly commit to equity
- Develop supportive organizational structures, policies, and processes
- Re-vision the use of time
- Attend to power differentials
- Tailor care, programs and services to local contexts
- Actively counter racism and discrimination
- Promote meaningful community + patient engagement
- Tailor care to address inter-related forms of violence
- Enhance access to the social determinants of health
- Optimize use of place and space

References

The evidence-base for this exercise is based on research published in:

Browne, A. J., Varcoe, C., Ford-Gilboe, M., Wathen, C. N., Smye, V., Jackson, B. E., . . . Blanchet Garneau, A. (2018). Disruption as opportunity: Impacts of an organizational health equity intervention in primary care clinics. International Journal for Equity in Health, 17(1), 154. doi:10.1186/s12939-018-0820-2

Browne, A. J., Varcoe, C., Lavoie, J., Smye, V., Wong, S., Krause, M., . . . Fridkin, A. (2016). Enhancing health care equity with Indigenous populations: Evidence-based strategies from an ethnographic study. BMC Health Services Research, 16(544). doi:10.1186/s12913-016-1707-9

Browne, A. J., Varcoe, C., Ford-Gilboe, M., & Wathen, C. N., on behalf of the EQUIP Research Team. (2015). EQUIP Healthcare: An overview of a multi-component intervention to enhance equity-oriented care in primary health care settings. International Journal for Equity in Health, 14(152). doi:10.1186/s12939-015-0271-y

Browne, A. J., Varcoe, C., Wong, S. T., Smye, V. L., Lavoie, J. G., Littlejohn, D., . . . Lennox, S. (2012). Closing the health equity gap: Evidence-based strategies for primary health care organizations. International Journal for Equity in Health, 11(59), 1-15. doi:10.1186/1475-9276-11-59

How to cite this document
EQUIP Health Care. (2021). Rate Your Organization on Harm Reduction and Reducing Substance Use Stigma: A Discussion Tool. Vancouver, BC. Retrieved from www.equiphealthcare.ca

Version | May 2021

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Financial contribution from

Public Health Agency of Canada | Agence de la santé publique du Canada