VERSION 2

DECEMBER 2017

PEER ENGAGEMENT PRINCIPLES AND BEST PRACTICES

A GUIDE FOR BC HEALTH AUTHORITIES AND OTHER PROVIDERS

Written in partnership with peers and providers

This guide was developed by the Peer Engagement and Evaluation Project Team
through a research project funded by Peter Wall Institute for Advanced Studies

CONTENTS

CONTACT INFORMATION 3

ACKNOWLEDGEMENTS 3

ABBREVIATIONS 4

EXECUTIVE SUMMARY 5

- The principles and rationale for peer engagement 6
- Peer engagement checklist 8

I: BACKGROUND OF THE PEER ENGAGEMENT AND EVALUATION PROJECT 10

- PEEP: An engagement project 11
- How were these guidelines created? 12
- PEEP focus groups 13
  - Compassionate Engagement Modules 15
- PEEP knowledge Translation Exchanges 16
  - Strategy & Planning 16
  - Implementation 17
  - Lessons 17
- PEEP evaluation 18

II: A BASIS FOR PEER ENGAGEMENT 19

- What is peer engagement? 19
- The importance of peer engagement 20
- Sharing the table – and power 20
- The benefits of peer engagement 23
- Regional differences 23
- Stigma and trust 23
- Organizational leadership needed for peer engagement 24
- Peer networks 26

III: PEER ENGAGEMENT BEST PRACTICES 28

- Start Early 28
- Equitable participation 28
- How many peers should I engage with? 28
- Recruiting peers 29
- Provide engagement expectations ahead of time 29
- Provide information on who will be involved ahead of time 29
- Partnering with Peer Based Organizations 30
- Key practices for working with Peer Based Organizations 30
- Peer Based Organizations in British Columbia and Canada 31
- Setting up compensation 32
- Setting expectations with peers and providers 32
- Expectations of peers 33
- Developing a team memorandum of understanding 34
- Defining objectives for engagement 35
- Capacity building and training 36

ENGAGING PEERS 37

- Do's and don'ts 37
- Overcoming barriers 39
  - Childcare 39
  - Literacy and communication 40
  - Substance use 40
  - Peer substance navigators 41
  - Location 42
  - Travel 42
- Setting ground rules for meetings 43
- Building a work plan 43

SUPPORTS 44

- Setting up supports for peers and other staff 45
- Peer mentors 46

WRAPPING UP OR DISENGAGEMENT 46

- Avoiding sense of loss at completion 46
- Evaluation 47
- Disseminating knowledge 48

REFERENCES 49

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ABBREVIATIONS

BC:	British Columbia
BCCDC:	British Columbia Centre for Disease Control
BCHRSS:	British Columbia Harm Reduction Strategies and Services
CSUN:	Coalition of Substance Users of the North
IAP2:	International Association for Public Participation
MoU:	Memorandum of understanding
OAT:	Opioid Agonist Therapy (formerly known as Opioid Substitution Therapy (OST))
PRA:	Peer research assistant
PEEP:	Peer Engagement and Evaluation Project
VANDU:	Vancouver Area Network of Drug Users

EXECUTIVE SUMMARY

INTRODUCTION

Peer engagement can be defined as the active participation of people with lived experience of substance use in different research, program, and policy decision-making processes. Peers are people with lived experience of substance use who use that experience to inform their professional work. Peers can provide insights into the realities of substance use and their local risk environments, and the applicability of programs and policies. Peer engagement can be mutually beneficial in promoting health equity in programs and policies while building capacity for peers and health authority representatives.

CONTEXT FOR THIS REPORT

The BC Harm Reduction Strategies and Services Committee (BCHRSS) is committed to engaging peers to ensure harm reduction services across the province are equitable and meeting the needs of people who use substances. Over the past decade or so, peer engagement has been an evolving, iterative process. Although peer engagement has improved, there remains an overall lack of understanding of peer engagement principles and practices among health authorities and other providers.

This identified gap led to the development of the Peer Engagement and Evaluation Project (PEEP). PEEP is a research project that builds upon BCHRSS experiences and existing relationships with peers. This participatory project aims to enhance peer engagement and listen to voices that have been missing from decision-making tables across the province.

PEEP METHODS

PEEP engaged seven peer research assistants/advisors and several health authority representatives from across the province as active members of the research team throughout the project, including the creation, dissemination, and revision of this document. In 2015, the PEEP team conducted 13 focus groups with 83 participants with lived experience of substance use all five regional health authorities. The qualitative data was coded by all team members and themes were derived through a participatory process. The final four broad themes determined by the PEEP team were 1) societal and community readiness, 2) peer networks, 3) peer engagement, and 4) stigma and trust.

In 2017, the PEEP team presented to health authority leadership who supported the dissemination of the best practice guidelines to their staff. The PEEP team traveled to all five regional health authorities and held exchanges with the community and with service providers. PEEP returned to 13 communities, and held 22 exchanges with people who use drugs, and health authority and community agencies. In total, 120 people who use drugs and 99 staff participated in these facilitated discussions about the peer engagement best practices and

readiness to engage. These exchanges and the uptake of these practices were evaluated.

Together, the focus groups, literature review, and the team's experiences engaging with peers and other professionals has served as the basis for the initial document. The document was revised following the regional exchanges with service providers and with peers.

These practices were developed and written in partnership with peers, peer based organizations, service providers, and researchers involved with PEEP across BC.

THE PRINCIPLES AND RATIONALE FOR PEER ENGAGEMENT

We provide justification and support for enhancing peer engagement among BC health authorities, along with important considerations that provide the rationale for the best practice guidelines. We discuss that peer engagement is based on the theoretical roots of inclusion and equity, benefits to peer and providers, regional differences, sharing decision making power, addressing stigma and trust, organizational support, and independent networks of peers.

PEER ENGAGEMENT BEST PRACTICES

Peer engagement practices are not limited to one-on-one participation processes; they include certain considerations in the preparation, engagement, support, and conclusion stages of the peer engagement process. This document provides both an overview and details of these processes to support meaningful and equitable engagement between service providers and peers. An overview or checklist of these practices is provided in the beginning of the document.

CONCLUSION

Promoting peer engagement within health authorities and other community agencies can improve the involvement and uptake of peers' voices in health service planning and policy development in BC. Individuals who work with people who use drugs can use these peer engagement principles and best practices to foster meaningful inclusion, which can in turn promote positive relationships and capacity building for everyone involved and improve the relevance and acceptability of services.

PEER ENGAGEMENT PRINCIPLES

PEERS AS EXPERTS	Peers are the experts in the context and content of decisions that affect their lives. Through lived experience with substance use, peers have gained highly specific knowledge and insights about the realities of using substances and accessing health services. This expertise is valued by recognizing peers' interests, placing emphasis on their voices, and providing fair and equitable compensation.
EQUITY	Peers experience barriers, discrimination, and differences in relationships, compensation, and health due to the social positionality of people who use drugs in our society. This positionality can result in social, physical, and economic inequities in peer work, including power imbalances in decision making. Promoting equity requires acknowledging these factors and addressing them, and restructuring power differences in decision making.
DIVERSITY	One size does not fit all. Peers can experience different barriers to doing peer engagement and these barriers vary over time and between people. Similarly, peers are not all the same, and have a range of voices and experiences that need to be heard.
TRANSPARENCY	Transparency includes acknowledging successes and failures, or not meeting expectations. Transparency includes providing evidence and rationales for decision making, revealing hidden power dynamics, and providing honest and forthcoming explanations for processes and outcomes. Transparency is the antithesis of bureaucracy, in which peers have full knowledge of the processes that impact their lives and work.
ACCOUNTABILITY	All peer engagement practitioners must take responsibility for their decisions and actions and provide rationales for these decisions and actions in order for the team to learn from their experiences.
SHARED DECISION MAKING POWER	Decisions that affect the lives of people who use drugs should ideally involve peers in all aspects of that decision. The conditions that peers experience in our society create inequitable power relations with decision makers and other members of the public. Recognizing and addressing the differences in power that are entrenched at decision-making tables is paramount to the success and validity of the voices of peers in peer engagement work.
INCREASING CAPACITY	Capacity building is the development of concrete skills, knowledge, goals, and confidence. In peer engagement, capacity building is experienced among both peers and other professionals alike.

PEER ENGAGEMENT CHECKLIST

BEFORE COMMITTING TO AN ENGAGEMENT PROJECT

- ✓ Ensure the initiative has adequate resources (human, financial, time, and skill); peer engagement requires time, support for peers and an unwavering commitment to the work.
- ✓ Provide fair financial and human resources on the project for the duration of the project and after. Start early and build a solid foundation (i.e. ethical approval, understanding of organizational processes, work plans, etc.) for the project.

BEFORE ENGAGING PEERS

- ✓ Provide adequate and appropriate training in peer engagement best practices, harm reduction principles and philosophy, a history of drug policy, and cultural safety and trauma informed care principles and practices to peers and other professionals on the project.
- ✓ Analyze critically who is at the table to enable a recruitment approach that ensures equitable representativeness and shared power at the table.
- ✓ Provide peers with information on how they are being engaged, what their role is, and how the information they provide will be used (i.e. are peers the decision makers, or are they there to be informed of a project, or are they being asked to share their experience). Do this ahead of time.
- ✓ Research financial department and organizational procedures in advance; identify barriers within these procedures and create solutions.
- ✓ Hire peer mentors or navigators who have experience working with health authorities, other professionals, and the local scene. They can help support and guide new peers.
- ✓ Provide information to peers about who will be attending (names and roles) the meetings ahead of time.

ENGAGEMENT

- ✓ Don't assume you know what is best for peers; peers know what's best for themselves and peers. **One size does not fit all.**
- ✓ Provide fair compensation to peers in cash where possible, and discuss any financial barriers.
- ✓ Develop clear expectations of peers and staff in the beginning. Develop a memorandum of understanding for the overall project that the entire team understands and agrees to.
- ✓ Be transparent and have clear expectations about the level of participation you will engage in.
- ✓ Follow the Nothing About Us Without Us guidelines (9), Guidelines for Ally's (23), and the BCCDC do's and don'ts for How to Involve People Who Use Drugs (10).
- ✓ Have a conversation with each peer to identify and adopt communication that works for them.
- ✓ Identify specific barriers and challenges peers might face in the engagement process, and identify potential solutions with peers.
- ✓ Building capacity is important among both providers and peers – consider investing (funds, resources, including educational opportunities) in capacity building for everyone involved.
- ✓ Value, respect, enable, and understand peer expertise and strengths.
- ✓ Set ground rules and group agreements as a team at meetings.
- ✓ Recognize that professionals in the room hold power (i.e. resources, decisions) by default; it is their responsibility to foster equal voices and share power at decision making tables.
- ✓ Schedule regular self-care check-ins for peers and providers.

DISENGAGEMENT

- ✓ Develop wrap-up and plans for peers and other staff, and share this with peers and staff to establish clear expectations and avoid a sense of loss.
- ✓ Peer engagement is an evolving process; evaluate and share your peer engagement process publicly to both learn from the experience and gives other access to this information.

BACKGROUND OF THE PEER ENGAGEMENT AND EVALUATION PROJECT

"Peers" are people who have past or present lived experience of drug use who use that experience to inform their professional work. People who use drugs are more likely to contract HIV and hepatitis C virus, to experience mental illness and physical morbidities, and to die prematurely (1). Harm reduction programs are supported provincially, nationally, and internationally to reduce the transmission of blood-borne viruses and infections, promote safer drug use and sexual behaviors, increase access to healthcare and other supports, and prevent and reverse overdoses (2,3). However, simply making harm reduction supplies available is not sufficient (4). A recent survey of harm reduction clients in British Columbia (BC) revealed that patterns of drug use and the types of harm reduction services available vary considerably across the province (5). The BC Harm Reduction Strategies and Services Committee (BCHRSS), comprised of representatives from the five regional health authorities, Provincial Health Services Authority, First Nations Health, and BC Ministry of Health, is committed to engaging peers to ensure that harm reduction services across the province of BC meet the needs of the populations they serve.

Peer engagement is the active participation of people with past or present lived experience of drug use who are engaged in research, programming and policy settings. The principle behind peer engagement is that people who use (or have used) drugs should have a voice in shaping polices and interventions that affect their lives. The involvement of people who use illegal drugs has, in part, emerged from the "nothing about us without us" movement among networks of people who use drugs and drug user groups (6). Examples of peer work include (but are not limited to): research partners, assistants and advisors; outreach and harm reduction workers; partners in policy making; educators; mentors; service providers; program directors coordinators, and assistants.

Peer engagement is at the heart of harm reduction. Given that peers are the 'experts' about the realities of illegal drug use, they provide valuable insights about the barriers and enablers to accessing harm reduction services in their communities (7). Recognizing this expertise, and the value of this expertise, have been identified by peers as key components of the inclusion of people who use drugs (8). This expertise is essential to better understand local risk environments, including issues related to physical, social, and political environments. Furthermore, engaging with peers when designing harm reduction solutions can help to mitigate equity issues through capacity building and empowerment (7). This means recognizing that access to

and distribution of resources may be different between individuals, and that many people face structural barriers. Therefore, it is essential that peers are supported in ways that ensure everyone gets a fair chance to participate fully. This Practice Guide will provide insight into some of these supports and ways in which they may be carried out.

Engaging peers in regional and provincial planning of harm reduction service delivery has been an evolving process for the BCHRSS committee. In 2010, the committee began offering each regional health authority financial support for peer engagement efforts locally. These funds have been used to create peer support groups, provide training to peers so they can become peer educators, support the formation of user networks, send peers to workshops or conferences, and facilitate community dialogue (9). To guide this work, the BCCDC adapted the "Nothing About Us Without Us" guidelines (6) to develop the "How to Involve People Who Use Drugs", which highlights the do's and don'ts of peer engagement (10). In 2014 and 2015 the BCCDC conducted a process evaluation of BCHRSS peer engagement efforts by reviewing primary and secondary data, formal documents and meeting minutes (11). We found peer engagement was an evolving process that increased and improved over time as a consequence of reflexive learning. However, lack of support, coordination and formal guidelines were factors that undermined peer engagement efforts and a better understanding of practices was needed.

The Peer Engagement and Evaluation Project (PEEP) aims to enhance peer engagement networks in BC through the development, implementation and evaluation of peer engagement best practices in programs and policies. Building on the BCHRSS experiences and existing relationships with peers, the PEEP project will expand the scope of peer engagement across BC to foster more meaningful and sustainable dialogue between peers, providers, and policy decision makers. This project will establish peer engagement as the norm and expand the opportunities for the voices of peers who have been missing from our tables. Our hope is that the peer engagement best practices will empower and inspire BC Health Authorities and other providers to invite a broader representation of people in their communities to the table.

PEEP: AN ENGAGEMENT PROJECT

PEEP employs a community based participatory research (CBPR) framework, engaging peers and health authorities throughout every aspect of the project (Figure 1). The concept and application for funding for PEEP was a result of discussions between providers and peers at the Harm Reduction Services and Strategies Committee in 2013–2014. Once funded, PEEP re-partnered with many of the peers who had initiated the project, including those from Northern Health Authority, VANDU, and SOLID Outreach. The PEEP research team consists of a dynamic team of peer research assistants (PRAs) that were recruited from each of the regional health authorities and have worked on the project from beginning to end. They come from diverse experiences, ethnicities, and ages. They offer invaluable lived experience of substance use and knowledge of the local context within their health region. The PEEP team also includes several academic researchers from the BCCDC and University

of Victoria, harm reduction coordinators, and students from local universities. Together, the PEEP team developed the scope, protocol, and methodology for the project. In line with a participatory approach, the PRAs contributed and are co-authors along with the academic researchers on these guidelines and all manuscripts, posters, and presentations that the PEEP project has created to date (Figure 1).

HOW WERE THESE GUIDELINES CREATED?

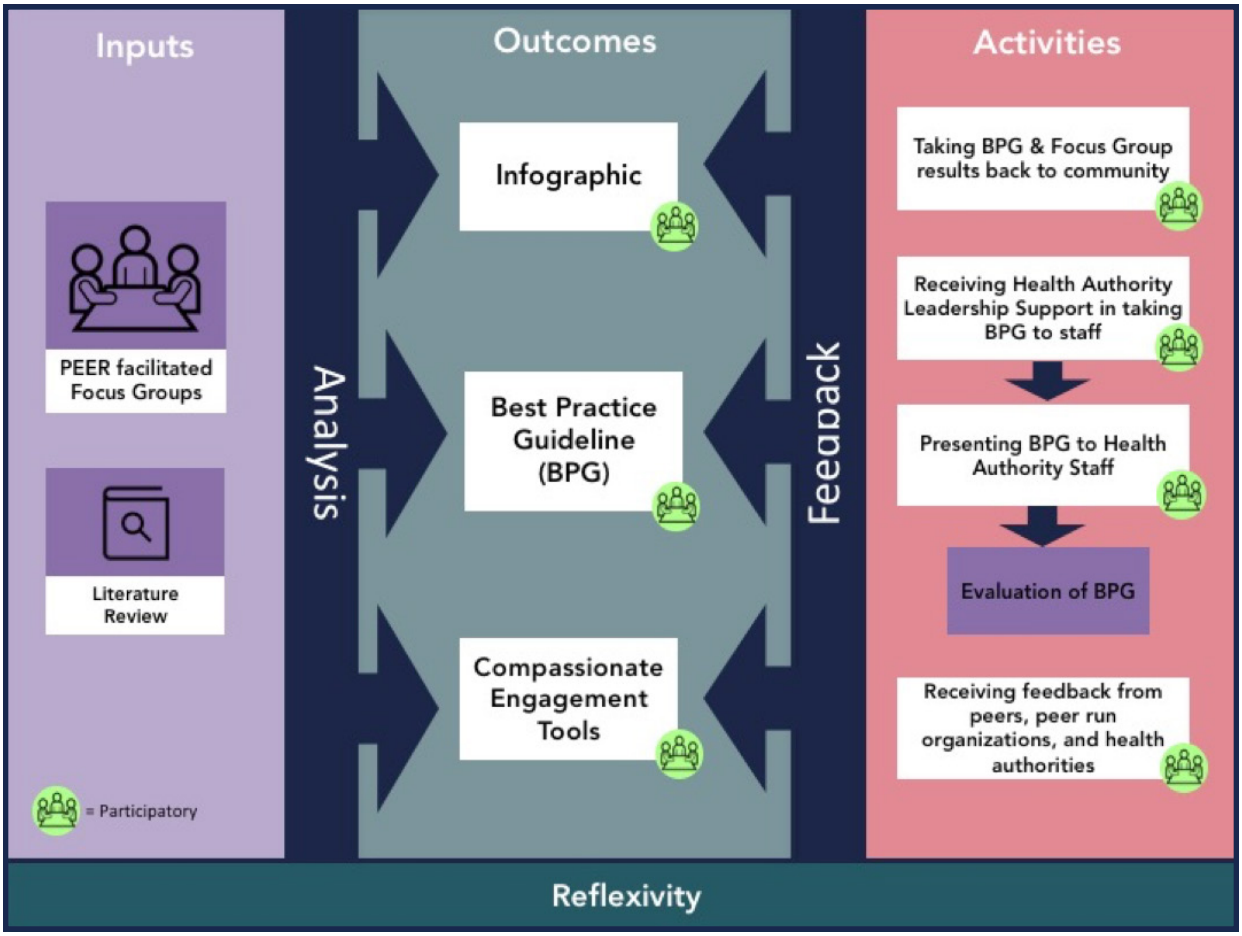

Figure 1: Participatory process in creating the Peer Engagement Best Practice Guidelines

PEEP FOCUS GROUPS

The PEEP team came together in person in 2015 at the BCCDC to train about research methods, ethics, data analysis, and knowledge translation. Thirteen focus groups (n=83) were held in twelve locations across all regional health authorities in the summer of 2015. Data was collected in at least one urban and one rural site in each of the five health regions to investigate rurally sensitive initiatives. PRAs assisted in organizing the focus groups, as well as advertised and recruited participants for focus groups in their regions. Focus groups were co-facilitated with PRAs using the final question guide, which examined sources of health information, peer networks, and barriers and strategies for peer engagement. The question guide was first developed with the entire PEEP team and tested at two locations. Following which, the language in the guide was changed to improve the flow and be more accessible to peers. The transcripts from the focus groups and interviews were organized and coded thematically in NVivo. The thematic structure was first developed by the BCCDC research team and validated by consensus with PRAs.

COMPLETED FOCUS GROUP SITES

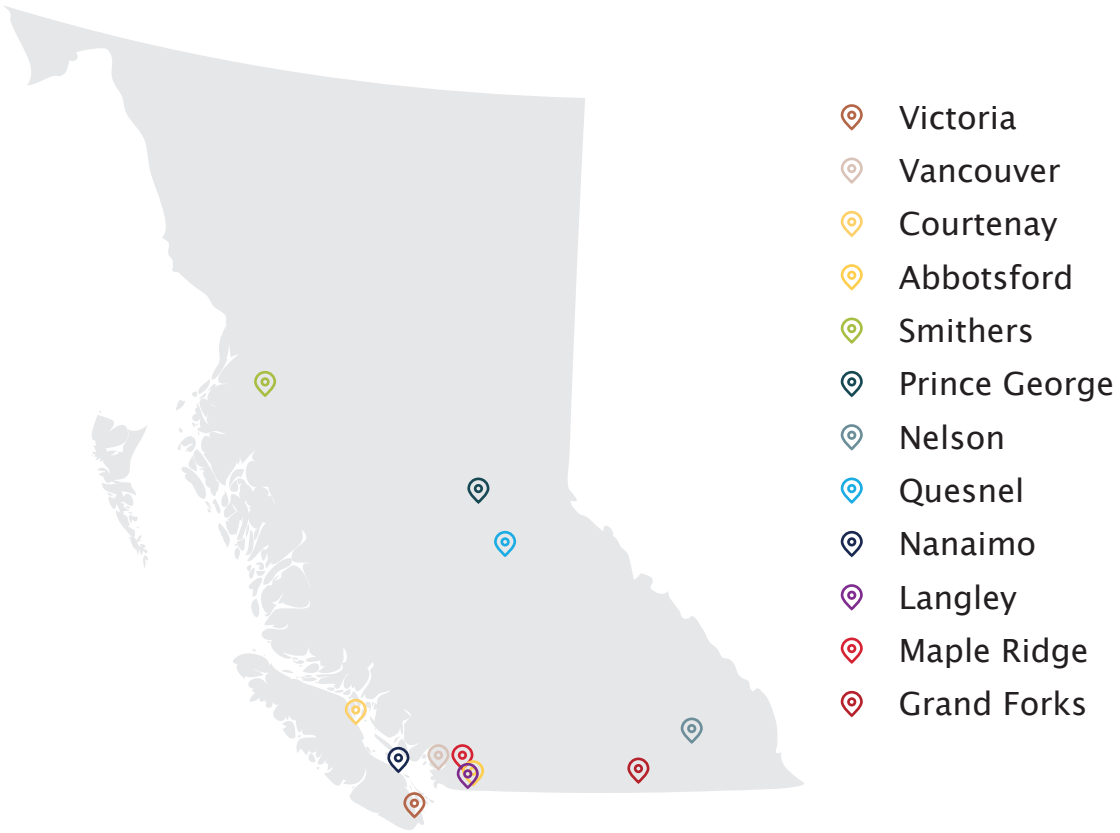

Figure 2: Locations of focus groups and regional exchanges facilitated by PRAs

The final four broad themes determined by the PEEP team were 1) societal and community readiness, 2) peer networks, 3) peer engagement, and 4) stigma and trust.

Together, the focus groups, literature review, and the team's experiences engaging with peers and other professionals has served as the basis for the initial document (Figure 4). The document was revised following the regional exchanges with service providers and with peers (Figure 5).

In the spring of 2017, the PEEP team of peers and academic researchers collaboratively created the PEEP infographic (Figure 3). This infographic was published and shared during the exchanges among people who use drugs, providers, and more broadly across BC.

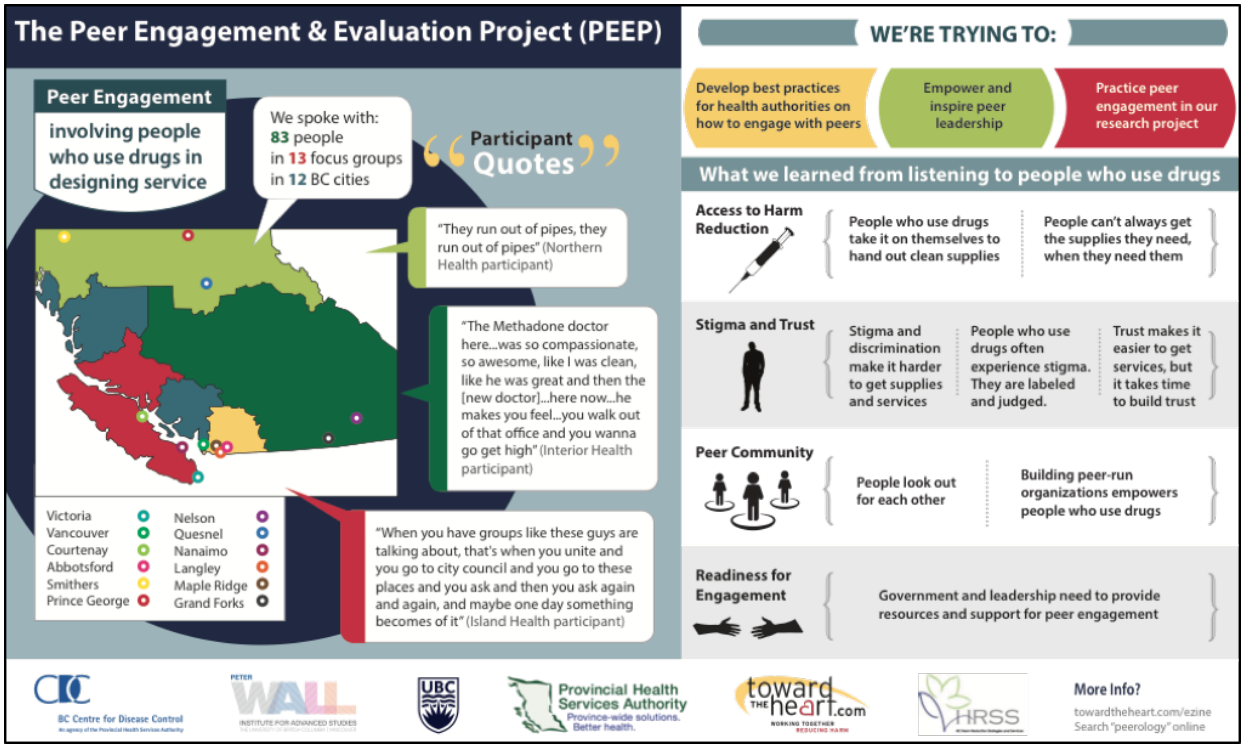

Figure 3: Infographic of the Peer Engagement and Evaluation Project focus group findings.

COMPASSIONATE ENGAGEMENT MODULES

In addition to these guidelines, educational workshop materials were developed to engage health care providers to consider their own inclusion and engagement – a prominent theme that was generated from the PEEP focus group theme of stigma and trust. The PEEP team collaboratively created case studies and a photo series (see pg. 24) (12). The scenarios were based on personal experiences and findings from the focus groups. The PRAs narrated the scenario in a presentation showing situational photos staged by the team and then read direct quotes from the focus groups.

The facilitators' guide was developed to support these interactive compassionate engagement modules. The facilitators should include both a local service provider and a person with lived experience. The facilitators show the photo narrated case study clips and lead the participants through a discussion about what happened in the case study and encourage the participants to consider positive and negative aspects of behaviors, service design, and stigma. The group may re-enact the cast study, changing behaviors they think could be done differently.

The goal of the modules is to promote reflection and consideration of why people act in a particular way in healthcare settings to they can improve understanding and engagement. The materials summarize the take-home messages, or "do's and don'ts" for healthcare providers interacting with peers, to improve compassionate engagement in these interactions. Healthcare providers and substance use professionals also provided feedback on the content of the materials while they were developed.

A more detailed description of the PEEP project methodology and process of running a cross-jurisdictional participatory research project has been written for publication (under review). It should be noted that our participatory process guided and informed these guidelines (Figure 1).

PEEP KNOWLEDGE TRANSLATION EXCHANGES

The PEEP knowledge exchanges were initiated to share the initial version of the Best Practice Guidelines for Peer Engagement and other tools. Figure 5 is an overview of the process PEEP engaged in to strategize, plan, and implement these tools.

Figure 4: Strategizing, planning, and implementing the knowledge translation of the Best Practice Guidelines

STRATEGY & PLANNING

The PEEP team developed a knowledge translation strategy which began with obtaining provincial leadership's support for the incorporation of Best Practices Guidelines into health authority staff's work (Figure 6). As the team was (engaging) with provincial leadership, the PRAs discussed what returning to communities to share findings and tools would look like if it were done ethically. The team determined that for the psychological safety of people who use drugs, PEEP should have separate exchanges for people who use drugs and for harm reduction service providers from health authorities and community organizations. The PRA, regional Harm Reduction Coordinator, and key community informants collaborated with PEEP coordinators to plan and implement knowledge exchanges in each of the five regional health authorities. The PEEP team developed presentations for both exchanges, and an infographic about PEEP for people who use drugs (Figure 3).

IMPLEMENTATION

Along with the Knowledge Translation coordinator and Project Coordinator, health authority representatives and PRAs co-facilitated the exchanges in the region that they represented. Service providers participated in facilitated discussion on applying the Best Practice Guidelines to their work, and examined how they could promote more meaningful participation of peers in peer engagement initiatives. People who use drugs discussed focus group results, what experience they had in common with the findings, and information on harm reduction and peer engagement. PEEP conducted knowledge exchanges in 13 communities, with a total of 99 service providers, and 120 people who use drugs. They also presented to over 30 public health leaders to gain leadership support prior to the exchanges.

LESSONS

The exchanges reinforced the importance of having peer co-facilitators lead conversations on the expertise of peers and illustrate the realities of peer engagement with their lived experience. It became apparent that communities across BC vary greatly in their experience with, and readiness for, peer engagement. There was a notable difference between experienced and less experienced peer engagement practitioners, in that more experienced practitioners tend to be critical of their own practice, because they are aware of the ethical complexities of peer engagement. Sharing and discussing the best practices with communities allowed the team to reflect on the best practices, and revise presentations as well as the guidelines

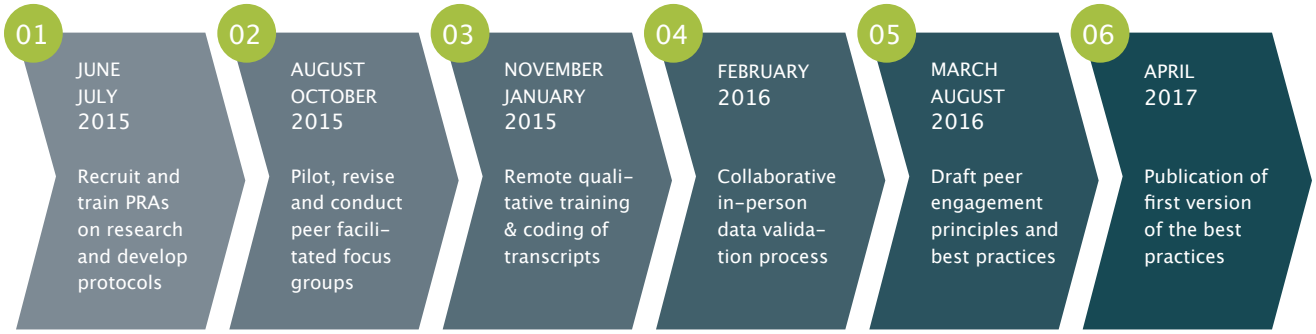

Figure 5: PEEP process of developing the best practice guidelines version 1

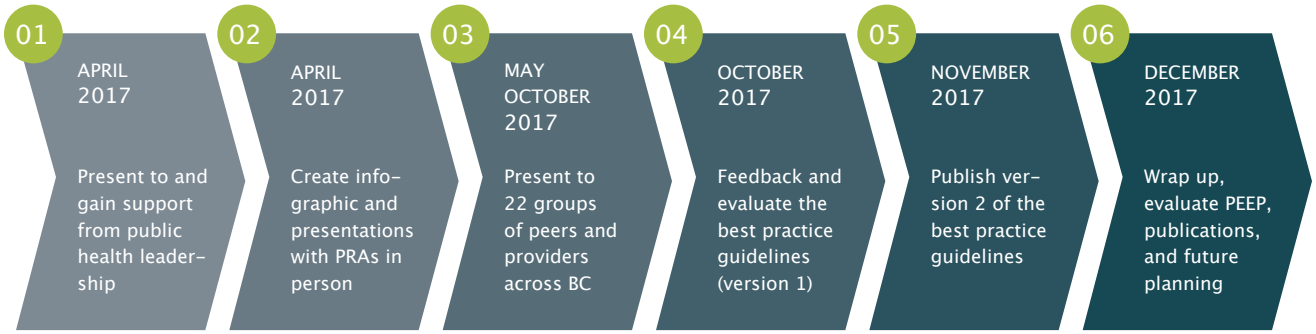

Figure 6: PEEP process of disseminating and revising version 1, and developing the best practice guidelines version 2

PEEP EVALUATION

Evaluating the uptake and appropriateness of the best practice guidelines was a key step in promoting peer engagement in BC. The aim of the evaluation was to assess the current state of peer engagement in BC, and the appropriateness, barriers, facilitators, and impact of the best practices among health authority staff. Before and after the regional exchanges with health authority staff and other service providers, PEEP handed out self-administered evaluation forms that captured both quantitative and qualitative information.

The two administration points in person captured the baseline and immediate impact of the exchanges. In addition, we gathered follow-up evaluations (ongoing) that captured the lasting effect and uptake of the best practices.

The knowledge gained from these evaluations has been discussed among the PEEP team and integrated into version 2 of this guide. The full methods and results of the evaluation will be published at a later date.

A BASIS FOR PEER ENGAGEMENT

WHAT IS PEER ENGAGEMENT?

It is increasingly apparent that to reduce health inequities and achieve social justice, the process through which decision makers reach consensus is as important as the outcomes themselves (4,13). In principle, peer engagement in harm reduction is similar to the engagement of marginalized community members in other participatory public health processes where there is openness, respect, equity, and fairness at the table (14). Public participation practices have been researched and developed to a large extent. Public participation can be defined as involving those who are affected by a decision in the decision-making process (15,16). The International Association for Public Participation's (IAP2) Public Participation Spectrum shows that participation activities range from informing and consulting on decisions to collaboration and empowerment among stakeholders (16). Other frameworks for engagement have also been developed, including Arnstein's ladder of citizen participation (see Figure 2) (17) and adapted versions including Hart's ladder of youth participation (18) or Pretty's participatory learning model for sustainability (19). In all models, a policy, program or project can elicit equitable participation in resources, recognition, results, and knowledge by sharing power in partnerships (20). The IAP2's spectrum has been adapted (see Table 1) to show the range of peer engagement activities that can occur. A good guide on how the Ladder of Engagement can be used can be found in the Peer Positive Toolbox developed by the Northwest Toronto Service Collaborative (http://www.peerpositive.ca/resources/).

In Canada, the majority of peer engagement efforts to date have been limited to exchanging information without sharing any decision-making authority among peers; thus, peer engagement efforts have merely been tokenism (11). Tokenism is the practice of only making a symbolic effort to include peers, to demonstrate equity and inclusiveness, without giving people who use drugs a voice, providing support, building capacity, or sharing any decision-making power. This includes recognizing and making space for different perspectives, and following through on decision making. Therefore, efforts must be made to move along the spectrum of engagement (or up the ladder), from tokenism to greater degrees of power among peers, including partnership, delegation, and peer control over decision-making.

"Peer involvement makes me to understand the situation better. So, I believe that peer influence moulded to understand the situation in more practical way rather than theoretical way."

- BC HEALTH AUTHORITY STAFF

THE IMPORTANCE OF PEER ENGAGEMENT

From a health equity perspective, harm reduction services must be accessible, accommodating, affordable, and acceptable (4). Enhancing peer engagement strategies can address equity issues to improve the utilization of harm reduction services, making them responsive to the needs of people who use drugs across BC. Peer engagement is essential to understand local risk environments, including issues related to physical, social and economic environments, which vary between and within health authorities (i.e. suburban vs rural vs urban). Peers are increasingly involved in varying roles but still underutilized (21). 'Experts' in academia and government who design healthcare 'solutions' without including the expertise and needs of the people affected may perpetuate the marginalization and injustice faced by these groups. Engaging with people who use drugs as the experts when designing harm reduction solutions helps to mitigate these equity issues through capacity building and empowerment. Recognizing peers as experts who bring and use valued lived experience in their work is one of the key aspects of the inclusion of people who use drugs in peer-based work (8).

> *"I think you would need people that have been… have lived that kind of life and who are willing to…like with their stories and their understanding of what it was…like just somebody who knew…"*
>
> - FOCUS GROUP PARTICIPANT

SHARING THE TABLE – AND POWER

In health authorities and other organizations, deciding to engage peers may depend on the initiatives being developed and the type of input required. Decisions that affect the lives of people who use drugs should ideally involve peers in all aspects of that decision. On the other hand, not all decision making requires peer engagement. The goal of engagement should be to obtain meaningful and purposeful input and decision making with peers. Simply involving peers for the sake of engagement is not an adequate justification for engaging. The quality rather than the quantity of engagement should be cultivated when developing peer engagement standards within organizations.

> *"It is often overlooked but this [peer engagement] is very important"*
>
> - BC HEALTH AUTHORITY STAFF

Including peers at decision-making tables should, in theory, create equal and distributed power and voices at the table; thus, creating more equitable and fair policies for communities that are often silenced (22). However, people who use drugs are often affected by health and social inequities that position them with less power and resources due to economic, social, historical, and political conditions in society. These conditions that peers experience in our society create inequitable power relations with decision makers and other members of the public. Recognizing and addressing the differences in power that are entrenched at decision-making tables is paramount to the success and validity

of the voices of people who use drugs in peer engagement work. In reality, systems within health authorities and other organizations are not set up to accommodate peer positions that hold power and authority. As such, providers must acknowledge the limitations they face from lack of adequate resources (financial, human), and therefore the inability to create true collaboration and empowerment in their work. Leadership within health authorities and other organizations can advocate for the need for systems transformation that may allow us to move beyond levels of consultation and involvement, to levels of collaboration and empowerment (Table 1).

	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
PEER ENGAGEMENT GOAL	Translate balanced and objective information to the community using language and a method that makes sense to them; assist them in understanding the problem, alternatives, opportunities, and/or solutions.	Obtain feedback from peers on harm reduction programming, policies, and decisions, including alternatives and analyses of those initiatives.	Work directly with peers throughout decision-making processes to ensure that the communities concerns and aspirations are understood and considered.	Equal partnership with peers in all aspects of decision-making, including the development of alternatives and the identification of the preferred solution.	Place the final decision about harm reduction initiatives in the hands of peers.
PROMISE TO PEERS	We will keep peers informed in a way that makes sense to the community.	We will seek your feedback on harm reduction initiatives. We will keep peers informed, listen to and acknowledge their concerns and aspirations, and provide feedback on how peer input influenced the decision.	We will work with peers to ensure that their concerns and aspirations are directly reflected in the initiatives and provide feedback to peers and the community as to how their input influenced the decision.	We will work with peers to formulate solutions and incorporate your advice.	We will implement what the peers decide.
ROLE OF PEER	Audience of decisions.	Provides feedback after decisions are made.	Provides feedback before decisions are made.	Equal partner in decisions	Leader of decisions.
EXAMPLE OF INVOLVEMENT	Presentation of a regional overdose prevention strategy to peers at a syringe access program.	Receive feedback from peers on the feasibility and uptake of an overdose prevention strategy that has already been developed.	Consult with peers before an overdose strategy is developed; use knowledge from peers to develop the overdose prevention strategy.	Partner with peers in developing the overdose strategy with them – from beginning to end.	Empower peers to develop the overdose prevention strategy themselves and implement that initiative.

Table 1: Spectrum of peer engagement in decision making in harm reduction initiatives (adapted from IAP2's Public Participation Spectrum)

THE BENEFITS OF PEER ENGAGEMENT

Choosing to engage peers in public health policy, planning, programming and evaluation comes with several benefits. Input from the community ensures initiatives are relevant and can minimize and identify unintended consequences. Partnering with peers promotes the credibility and legitimacy of health providers, thereby increasing buy-in from the community and acceptance of decisions. By ensuring decisions will be acceptable and equitable, peer engagement reduces costs and minimizes implementation issues, ultimately producing more sustainable decisions overall.

REGIONAL DIFFERENCES

There were vast differences in the availability, accessibility and delivery of harm reduction services across the province. In many rural and remote regions, the concept of harm reduction and peer engagement were new and radical concepts. Language and values expressed in these regions echoed underpinnings of Alcoholics Anonymous and other abstinence-based ideologies. Many participants could not conceive why service providers would want to engage with them and ask their opinions. Stigma and discrimination in these areas were identified as the main barrier to trusting harm reduction service and health care providers. Many participants from rural regions articulated that the focus groups were the first time they had been in a "safe space" to share their opinion and "discuss these sorts of things".

STIGMA AND TRUST

One of the main findings from the PEEP focus groups was the reported amount of stigma and discrimination that is experienced by people who use drugs from healthcare and service providers in BC. This finding was particularly prominent in more suburban, remote and rural communities. The lack of trust towards healthcare providers serves as a major barrier for people who use drugs in accessing harm reduction services across all health authorities in the province. Harm reduction agencies can promote and build trust with people who use drugs if they are committed to the work. In the focus groups, participants described positive examples of where trust has been developed between providers and peers over time – for some peers it took years to develop such a relationship. People who use drugs that we talked to stressed the importance of taking the time to build credibility and rapport, as well as maintain and reinforce confidentiality.

Peer engagement best practices are one approach to promoting compassionate engagement and increasing trust between providers and people who use drugs. Working with peers can support compassionate engagement and inclusion in the workplace. Furthermore, workplaces can recognize and train providers in trauma-informed practice. It is important that trauma-informed practice training is reinforced with opportunities for staff to examine and reflect on how they are enacting the key principles of trauma-informed practice, starting with safety and engagement (23-25). Where possible, workplaces should encourage cultural safety training and other tools, including the **PEEP compassionate engagement training** (12).

Figure 7: Images from the Compassionate Engagement Modules (page 15)

> *"There is still underlying tones/feelings of stigma & discrimination. Lack of trust. Discrimination towards substance users needs to be addressed, especially within our health authority."*
>
> - HEALTH AUTHORITY STAFF

ORGANIZATIONAL LEADERSHIP NEEDED FOR PEER ENGAGEMENT

Health authorities and other organizations have the power to determine who can be involved, to what extent they can be involved, and in what aspects. We have heard from service providers across the province that there is an overall lack of support for peer engagement coming from management. Resources, including adequate time, training, space, and financial support for peer engagement, can undermine the integrity and validity of the overall peer engagement process. In general, the level and quality of peer engagement coincides with the level of commitment from all parties involved. While this Best Practice guide aims to enhance health authority capacity to support peer engagement, and increases the clarity about the roles and practices of peer engagement, meaningful peer engagement requires multiple levels of leadership and support including the health authority, Provincial Health Services Authority and Ministry of Health as well as programmatic support. Management could support peer

engagement by freeing up staff time, creating and supporting peer programs, and engaging with people who use drugs themselves. Such leadership will in turn provide support for service providers to be engaged in learning about culturally safe and trauma informed practices, and increase compassion, inclusion and engagement overall.

Organizational barriers to engagement also came up in the focus groups. In general, participants felt a lack of support or willingness from their communities to allow them to get involved with policies, programs, or peer groups. One man frankly stated that "space and money" were the biggest barriers to expanding peer run harm reduction services and peer engagement. When discussing the opportunity to organize with other peers in user groups or peer-based organizations, participants frequently discussed municipal or regional structures that "wouldn't allow" them to organize or get involved. Individuals also felt the constraints of funding, as well as the lack of peer engagement guidelines and policies.

During the regional exchanges and in the evaluation, we learned that organizational support is a major barrier to doing meaningful engagement with the community. Often, health authority providers wanted to do peer engagement but often did not have the time, resources (financial, human), capacity, knowledge, or training on how to do it well. Many described the lack of standards or supports in place that are needed to do peer engagement. They also saw stigma embedded within the organization as a main barrier to moving forward and gaining support. In Table 3, we have extracted a sample of quotes from health authority staff and other providers who provide insight into the barriers and potential solutions for promoting and delivering equitable peer engagement in the future.

> *"Yeah support this organization that just needs a better building, more funding, it's already helping the peeps locally. They've got huge big plans, you know, but they're sound, you know good leadership, good communication and…there needs to be like on staff full-time, they need more money and a physician."*
>
> - FOCUS GROUP PARTICIPANT

Table 3: Quotes from Health Authority Staff and Other Providers

WHAT BARRIERS DO YOU SEE TO DOING PEER ENGAGEMENT?

The perspectives of health authority staff and other providers

- I do not feel peers are supervised or supported adequately – related to no funding or time in my role.
- We need more resources (human/financial) to support this work – supervision, support, compensation for peers – [and] standards… Sometimes there are challenges with the capacity of the organization to support, train, supervise peers.
- Breaking stigma around peers is important… [including] educating employers about the benefits of hiring peers.
- Time and money. My position is packed, and we do not have a budget to pay peers.
- Financial barriers, stigma, and long process [for peer engagement positions] to be approved.
- Organizational culture and leadership support.
- Opportunity and funding has not supported this to happen. Community does not recognize the roles of peers insight. Some community does recognize, but not enough for movement.
- Resources needed: Improved linkage between peer serving agencies & health authority. Culture change towards "nothing for us without us."
- Lack of knowledge, capacity, health authority support.

PEER NETWORKS

Through the PEEP focus groups we learned that peer networks in BC operate as both formal and informal health information sharing systems. Some of the advantages to being involved with a network of people who use drugs included getting health and harm reduction information. Peer networks seemed to fill gaps where health authorities may not reach, particularly amongst those in rural/remote communities. In this way, peer networks seemed to behave in an informal, unfunded outreach system. Often times, people who use drugs would not trust information from health care or service providers; people who use drugs were seen as the most reliable and knowledgeable source. Focus group participants of people who use drugs saw the value in increasing the access to information through peer networks, and suggested that health authorities and other organizations engage with peer networks and/

or peer based organizations where they exist in order to increase access to information.

There has been increasing attention to building and bolstering peer networks in BC. The peers in the PEEP project voiced it as a main priority in the project and have since been working to expand networks of people who use drugs (peer networks) and start peer based organizations across the province. For peers, networks create a sense of community and solidarity, build peers' capacity, and give people who use drugs the opportunity to discuss and act on issues that matter most to them.

In some cases, the desire to create peer networks has come from non-peer individuals who work for a health authority. Peer networks that are initiated by health authorities or other organizations often have much different priorities than that of people who use drugs. We found that peer networks have been created so health authorities or other service providers could draw upon a repository or "pool" of experiential people. While this model does promote engagement, it can result in relinquishing power and control over priorities, resources, and decision making for peers.

"I trusted it more when I heard it second hand from someone else, from an actual peer, somebody that I was using around or using with or, you know what I'm saying?"

- FOCUS GROUP PARTICIPANT

PEER ENGAGEMENT BEST PRACTICES

PREPARING TO ENGAGE

START EARLY

It is important to start thinking about engagement early on so providers can properly prepare and organize engagement efforts. Ensuring there is appropriate time, commitment, and human and financial resources available before engaging will prevent superficial engagement efforts. In general, peer engagement takes far more time than anticipated – particularly if it is a new initiative and/or there are members new to a team. Dedicating several weeks or months in the preparation stage of engagement will foster a strong and rich peer engagement experience.

EQUITABLE PARTICIPATION

Peer engagement efforts should ensure all experiences are respected and represented at the table to address the diverse and unique health needs of all peer communities. Lived experience, age, race, gender, sexual orientation, physical ability, drug of choice, active use-abstinence, Indigeneity, and geography are all important factors to consider in developing and delivering harm reduction services that are culturally safe. Some of the factors may hold more weight depending on the type of decision on the table. For instance, if a health authority or other agency is designing a harm reduction strategy for rural communities, peers from remote regions should be invited to participate in the design and approach to this strategy.

HOW MANY PEERS SHOULD I ENGAGE WITH?

It is best practice to invite more than one peer as several peers at the table will give a stronger, more diverse voice. Multiple peers can bring a range of backgrounds, ideas and perspectives from their communities. As well, peers can support each other. Being the only peer at a decision-making table can be an intimidating experience and may silence peer voices altogether. Connecting experienced peers who have been involved with health authorities in the past may help new peers navigate through the engagement process. Employing a peer mentor may be warranted in longer or more demanding engagement opportunities. More information on peer mentors can be found on page 46. Also, see the Nothing About Us Without Us guidelines (6) and the modified BCCDC's "How to Involve People Who Use Drugs" (10) that offer several do's and don'ts on who and how to invite peers to the table.

"It is difficult for peers to identify themselves as they may fear consequences from staff."

- HEALTH AUTHORITY STAFF

RECRUITING PEERS

Health authorities and other providers may be able to access local peer coordinators who can help recruiting peers, although flyers and word of mouth at several locations also work successfully. However, relying on relationships between peers and providers, or inviting peers who have been involved in the past without considering the community and background that they represent, may limit the diversity and reach of peers involved. In some regions where illegal drug use is highly stigmatized, it may be difficult to recruit a diversity of peers, as they will be "coming out" as a person who uses drugs.

We learned in focus groups that identifying as a person who uses drugs has its ongoing impacts within the communities they live in. As such, anonymity and confidentiality cannot be stressed enough during this process. Job descriptions can be useful, but be sure to have a peer review the description before distributing it to ensure the language and description are understood as intended. Recruiting peers may take time, so start at least 6–8 weeks in advance. Peer based organizations serve as an excellent source of recruiting peers. People engaging with peers should be considerate of peers' capacity (phone, travel, literacy, etc.) and their ability to support and build capacity among peers. Through PEEP's experience, it is important to engage a minimum of two peers; however, if you cannot engage two, this is not a good reason or excuse to not engage at all.

PROVIDE ENGAGEMENT EXPECTATIONS AHEAD OF TIME

It is important to provide information about the project or meeting to peers before engaging them. This information includes the purpose of the meeting, how peers are being engaged, how they will be employed, and how the knowledge and expertise they provide will be used. One tool to use is Arnstein's Ladder of Participation which outlines different levels of engagement that peers and providers could expect (Arnstein, 1969). This exercise can help providers determine the level of participation they can realistically engage in. It may also promote providers to take one step up the ladder towards more meaningful engagement.

PROVIDE INFORMATION ON WHO WILL BE INVOLVED AHEAD OF TIME

Other information that is essential to provide to peers in advance is who else will be involved. The number of peers involved, as well as who other staff are will give the opportunity for peers to gain insight into the nature of meeting and dynamics that will be in the room. It is essential to tell peers ahead of time if any law enforcement will be present in the project, on calls, or in person. This includes law enforcement, social workers, probation officers, and other community members such as religious leaders.

PARTNERING WITH PEER BASED ORGANIZATIONS

Peer based organizations (also known as drug user groups) are organizations that have been created by peers, are run by peers, and service peers. Peers who work with peer based organizations includes those with past or present lived experience of drug use. Many peer based organizations receive some funding from health authorities, but remain autonomous and self-governing. There are several peer based organizations available as a potential resource and partner for health authorities across the province. Examples of peer based organizations in BC are SOLID Outreach in Victoria, the Coalition of Substance Users of the North (CSUN), the Vancouver Area Network of Drug Users (VANDU) in Vancouver, BC/Yukon Drug War Survivors, and Rural Empowered Drug Users Network (REDUN) in the Kootenays region. Peer based organizations can assist in the recruitment process or give feedback on how to recruit in communities where peer based organizations may not exist.

Working with a peer based organization can be an effective approach to peer engagement. Health authorities and other agencies should contact the organization leadership and pitch the peer engagement opportunity to the Board. The Board can then nominate peers from the community who are representative and considered best suited for the project. This process may look different depending on the organization and opportunity, but nonetheless offers an equitable and fair way to recruit peers from that community. Furthermore, engaging with a peer based organization can promote positive communication and future partnerships between the health authority and the organization.

After consulting with peers across the province from several peer based organizations, several key practices for engaging peer based organizations emerged:

KEY PRACTICES FOR WORKING WITH PEER BASED ORGANIZATIONS

- Build relationships with the Organization, not just one person.
- Don't assume that one person represents the whole Organization; there is a range of voices within a Peer Based Organization.
- Don't assume all Peer Based Organizations are the same.
- Bring the findings or things you create back to the Organization.

PEER BASED ORGANIZATIONS IN BRITISH COLUMBIA AND CANADA

Vancouver Area Network of Drug Users (VANDU)
380 E Hastings St, Vancouver, BC V6A 1P4

Eastside Illicit Drinkers Group for Education (EIDGE)
380 E Hastings St, Vancouver, BC V6A 1P4

BC Association of People on Methadone (BCAPOM)
380 E Hastings St, Vancouver, BC V6A 1P4

Western Aboriginal Harm Reduction Society (WAHRS)
380 E Hastings St, Vancouver, BC V6A 1P4

Salome/Naomi Association of Patients (SNAP)
84 W Hastings St, Vancouver, BC V6B 1G8

BC-Yukon Association of Drug War Survivors
2420 Montrose Ave, Abbotsford, BC V2S 3S9

Surrey Area Network of Substance Users (SANSU)
10697 135a St, Surrey, BC V3T 4E3

SOLID Outreach
857 Caledonia Avenue, Victoria BC, V8T 1E6

Coalition of Substance Users of the North (CSUN)
146 Carson Avenue, Quesnel, BC, V2J 2A9

Rural Empowered Drug Users Network (REDUN)
101 Baker St, Nelson, BC V1L 4H1

Canadian Association of People Who Use Drugs (CAPUD)
1748 Napier St, Vancouver, BC V5L 2N2

Updated December 10, 2017

SETTING UP COMPENSATION

When it comes to compensating peers for the time and value that they offer, one size does not fit all. Setting up compensation early on is important in order to establish expectations, overcome bureaucratic hurdles, and prevent delays in payment. It is best practice to compensate peers for the entirety of the engagement process rather than expecting them to volunteer their time. The Pacific AIDS Network suggests that paying peers for the work they do "support[s] inclusion and the effective and equitable participation in [engagement] processes by easing financial constraints" (26). Inadequate compensation can create tension and resentment can arise from power dynamics and misunderstandings about pay. A cash honorarium is typically paid for short-term engagement opportunities. Gift cards are sometimes given but not recommended as adequate compensation. In Canada, opportunities that will compensate more than $500 per calendar year require a T4A to be issued. It is essential that providers understand the complete financial departmental process and nuances of compensating peers, and set up expectations about pay with them – amount, frequency, and method – early on. The procedure of paying peers can be complex. Issues to consider include options for payment in cash or cheque, financial institution barriers, income assistance/disability, employment earnings exemptions, and compensating expenses (i.e. telephone, travel).

Please review the BCCDC Paying Peers Guide – a guide that outlines these processes in detail, including key questions to ask when onboarding peers. This guide was created from what we learned as a team, and offers strategies for overcoming barriers to equitable pay such as employing peer mentors and assisting with bank account set up. It is critical to review and understand these financial processes prior to peers initiating work, so start early. As well, do not assume you know what's best for paying peers, that peers do not want to pay tax, or that peers are receiving income assistance.

SETTING EXPECTATIONS WITH PEERS AND PROVIDERS

Setting the expectations of peers, providers, and the team early on can prevent potential conflicts during the project. Expectations can be set by providing information to peers and other staff before and during the project. Questions to ask individuals and team members can be found in Table 1.

"It's not enough to be inclusive - their capacity and rights must be identified and protected respectfully. Their labour must be held in a way that no harm is done."

- HEALTH AUTHORITY STAFF

EXPECTATIONS OF PEERS

One of the most important practices in peer engagement is setting clear expectations early on. Expectations should be set verbally and writing, including how peers will contribute to decisions, the length and scope of the project, resources, training, support, communication, confidentiality and disclosure, compensation, and what happens when the project ends. For instance, not all peers have access to computer, Internet, and sometimes telephones. Therefore, mode of communication should be discussed and mitigated in advance. Providing hard copy materials that include clear visuals such as flow charts can improve effective communication and understanding. Other expectations to clarify include:

EXPECTATIONS OF PROVIDERS

There should also be a discussion about peers' expectations of providers. Peers expectations of providers could include what providers can offer in terms of support, learning and leadership. This step can help establish healthy and clear boundaries between providers and peers. This discussion should also be put into writing, similar to the expectations of peers. Providers can use the Respectful Language guidelines (12) or Language Matters Infographic developed with peers to help them develop guidelines around language in their projects.

QUESTIONS TO ANSWER FOR PEERS:

- How long is the project?
- What is the purpose of engaging with that particular peer? What are they being asked to contribute, and what are they responsible for?
- What resources can providers offer?
- How is confidentiality being protected? What information about the peer can or cannot be disclosed to others on the project?
- Is the peer receiving disability or income assistance? What are their exemption limits?
- When, how much, and in what method will they be paid? Will there be any delays in pay? Will they be paid at the end of each day, week, or project? How will the organization address any unexpected delays?
- How often are they expected to work?
- Are there any materials or office supplies they may need?
- What support does the peer need? What does that look like at different times?
- Are there any literacy or learning barriers?
- What is the best way they learn?
- What training is needed (i.e. computer training, research training)?
- How peers will contribute: over the telephone or in person at meetings?
- What way, days and hours are appropriate to contact them?
- What is the best mode of communication? Does the peer have access to internet/phone?

Table 1: Questions to ask when developing expectations for peers and other professionals

- Will the project provide telephone/ internet or computers?
- What level of response is expected if asked to provide input?
- What benefits or pitfalls do they see in being involved in this project?

QUESTIONS TO ANSWER FOR HEALTH AUTHORITY STAFF AND OTHER PROFESSIONALS:

- Who will be the main contact or coordinator?
- Who is responsible for hiring and what does this process look like?
- Who is responsible for payment and what does this process look like?
- How will they be contacted (phone, email, text), when, and how often can they be contacted?
- What support will they provide to peers?
- How will differences in opinions between people be handled?
- What specific resources (financial, time, human) are needed to support providers to be successful in this project?
- Is any further training for peers or other staff (ie. cultural safety, trauma informed care, harm reduction principles, drug policy) offered?
- What language can providers use that is respectful to the community?
- How many hours per week will providers spend on this project?

DEVELOPING A TEAM MEMORANDUM OF UNDERSTANDING

If a team of several peers and providers are engaged on a project, it is useful to discuss the expectations of the team, such as roles and responsibilities, decision making authority, conflict resolution, and team support. One strategy in developing team expectations is through the development of a memorandum of understanding. Developing a memorandum of understanding (MoU) (also called a "Team Agreement" or "Team Expectation Agreement") is one strategy that can be used to establish agreed-upon expectations for all parties. The agreement commits all team members to working together cooperatively and in equal partnership around a mutual goal. Points agreed upon in the MoU should be written down, printed, and signed by all parties. If the project is long term, it can be useful to refer back and revise the MoU at various points during the project to stay on track and within scope of the project goals. Some questions that can be asked for the MoU (but not limited to):

- What is the purpose of this project or meeting?
- What do we want to get out of this project or meeting as a team?
- What are the risks of this project or during this meeting and what will we do about them?
- What skills do we want to learn?
- How can we do check in's? Who is responsible for contacting who?
- What can we do if someone is not meeting their obligations?

- How should we decide what gets written about the project or meeting? What does authorship look like and how are people represented (i.e. are real names used)?
- If it is a research project, who will attend conferences and presentations? Who will pay for these and when?
- What if there are differences in opinions about the decisions made? How will we resolve these differences in opinions?
- What kind of credit would we like to receive for our work? How should we be described in materials?
- How can we use the information/knowledge created? How do we ensure knowledge is not misrepresented?
- How will the team debrief after events/meetings?
- What is the agreed process to update the MoU as the project progresses?

Some of the questions used to develop the team MoU may overlap with those in the individual peer-provider expectations list. There may be items that peers are more comfortable asking in a group setting, or may be better to ask one-on-one. It is best to review often and offer many opportunities for discussion, as well as reiterate the expectations of the project and individual. It is important to remember that the MoU should be developed by and apply to the entire team as equals.

DEFINING OBJECTIVES FOR ENGAGEMENT

In addition to developing expectations of the people involved on the project, expectations of the scope of the project need to be explicitly outlined and understood before the project begins. The goals and strategy should be discussed and any questions or concerns should be addressed early on. This step ensures all parties involved share a collective vision and understand how the project and engagement process will work. Defining the project scope will prevent confusion, getting side tracked, and wasting time. However, having a flexible schedule is also important. Developing an agenda together can develop rapport and trust, prevent inconsistencies of information shared among peers, and provides an opportunity to include the needs of peers (i.e. adequate number of breaks).

Clearly defining project scope will also determine the time commitment, project duration, and type of peer engagement employed (see Table 1). Some projects will require one-time engagement opportunities (i.e. one-time consultation), while others will be an ongoing process and project (i.e. community research partners). Longer-term engagement opportunities are beneficial in that they develop relationships and trust between providers and peers, as well as capacity among peers. “One-off” engagement opportunities are not recommended and can be seen as “tokenistic” engagement (17). Peer engagement projects will require a clear endpoint or expectations if they are transitional. When a project ends, there can be a loss of the sense of purpose among the peers. Efforts can be made to provide ongoing engagement

or other employment opportunities after the project concludes. A sustainability plan can be discussed in the beginning or developed as the project is carried out. If it is a participatory project where decision-making power is equal across all parties, objectives and goals may change over time. Therefore, changes in timelines and goals must be communicated clearly throughout the project.

> *"It's all based on relationship building, so you say that [agency name], I don't feel judged from them then I feel that they give me back my credibility so I'm not looked down upon…because I'm homeless or even worse and it's like, you know, I'm not being watched constantly."*
>
> - FOCUS GROUP PARTICIPANT

CAPACITY BUILDING AND TRAINING

It is best practice to develop the skills, abilities, and knowledge (capacity) that peers and other team members need to thrive and succeed. Capacity building can also take a strengths-based approach; identifying and bolstering the strengths and assets peers and other staff bring to the team. Building capacity also sets peers and other team members up for success in the future. Capacity building can also foster the development of peer networks that sustain and support each other.

Training opportunities for peers are essential to the development of individuals, networks, and organizations. Training opportunities include those related to cultural safety, trauma informed care, compassionate engagement, and other skills training (i.e. Research 101, computer skills). This planning includes providing background information about the project, team members, subject matter, roles and goals. Such information ensures peers and other staff can collaboratively plan and teach each other important cultural competencies, as well as identify areas for growth. By doing so, peers and other staff can identify where and how they can contribute, and where or how they may want to develop their own capacity.

ENGAGING PEERS

DO'S AND DON'TS

In 2007, the BCCDC Toward the Heart program adapted the 2005 Canadian HIV/AIDS Legal Network Nothing About Us Without Us guidelines with input from peers to create the document "How to Involve People Who Use Drugs" (10). Researchers at the University of Victoria have also created guidelines on how providers may better engage peers at decision making tables (22). Below in Table 2 are the BCCDC "Do's and Don'ts" of involving people who use drugs for people engaging with peers. These have been revisited and revised in light of the findings from PEEP and incorporating the voices of people with lived experiences heard from around the province and PEEP research assistants.

Table 2: How to Involve People Who Use Drugs (10)

HOW TO INVOLVE PEOPLE WHO USE DRUGS	
DO invite several of us	**DON'T** invite just one of us
DO invite a peer-based group to select representatives	**DON'T** hand-pick the same person you know and are comfortable with every time
DO invite people who actively use drugs	**DON'T** only invite people who formerly used drugs – it is OK to invite them and they have lots to offer, but they are not the same as people who are actively using drugs, who also have a perspective that is valuable and needs to be heard as well
DO invite people who formerly used drugs, in addition to people who actively use drugs	**DON'T** just ask the question because it is politically correct to ask us
DO listen to and integrate our answers	
DO financially support peer-based organizations if you expect representatives to consult with members of their community before the meeting	
DO give us information about what the meeting is about, what our role will be, and how we can contribute	
WE DO VALUE OUR PRIVACY SO PLEASE…	
DO guarantee and protect confidentiality	**DON'T** identify what a particular person said in the proceedings of the meeting
DO let us know who else will be at the table including law enforcement, social workers, parole officers, religious groups and city officials	**DON'T** require us to disclose: HIV (or other health) status, exposure to trauma, or proof of income when involving us or as a requirement for participation

WE MAY NOT BE USED TO YOUR STYLE OF MEETINGS SO PLEASE…

DO provide us with training and a support person

DO ask us to help define group expectations

DO show flexibility with meeting styles (times, agenda, level of participation)

DO ask us what we need

DO train us for ongoing or future committee or board events

DO acknowledge that you may have needs too, and that unfamiliarity may make you uncomfortable

DO consider providing oppression informed training specific to the issue of peer involvement, and ask us to participate

DO ask for our participation in planning sessions for consultations or meetings

DON'T run your committee or board meetings without considering that it may be the first time for us to be on a committee or board

DON'T hold a meeting or consultation just the way you are used to; work with peers to make it inclusive

DON'T hold a meeting at 9 a.m. or on cheque issue day

DON'T be afraid to ask for support from a peer committee or group that have experience

DON'T assume that we are the problem and the only ones who need to learn

DON'T think that you can't learn how to integrate us and our experience

DON'T think that we cannot do more, such as work for you in a paid position

WE ARE NOT VERY MOBILE OR WEALTHY SO PLEASE…

DO hold a meeting or consultation in a low-key setting or in a setting where people who use drugs already hang out

DO provide a stipend – contrary to most people who attend your meetings, we are not paid to attend by our jobs, but still need to look after our needs

DO give us money in cash

DON'T hold meetings in a government building

DON'T assume that we don't need a stipend or would just spend it on drugs (or that it wouldn't be justified even if we did)

DON'T write us a cheque or give us a coupon

DON'T ask us to come and meet you in Ottawa unless you provide us with adequate support and compensation

IF YOU WANT US TO TRAVEL PLEASE…

DO help with arranging methadone carries

DO arrange for advice from a local person who uses drugs – drugs may be more dangerous in a different city and travelling puts us at risk

DO provide accommodation close to the meeting space

DO have a healthcare provider available to support us

DON'T invite us at the last minute and assume we can deal with this alone

DON'T just leave us on our own in cities we don't know

DON'T assume we have identification (or credit cards) to check into hotels or board flights

OVERCOMING BARRIERS

It is important to identify what potential barriers exist for peers to participate in engagement opportunities. Common barriers for people who use drugs include location, travel, childcare needs, substance use, and literacy. It is critical for those who are about to engage with peers to consider these barriers and to take steps to remove them. Arranging travel, particularly in rural and remote regions, may be necessary. Where possible, developing a list/map of commonly accessed resources in the host community can be helpful for out-of-town peers. It is also critical to recognize that while peers often face barriers to participation, assumptions should never be made as to which barriers peers face or how they should be navigated. Peer based organizations, such as SOLID Outreach and VANDU, can also provide support and resources but recognize that they are working with limited resources (27).

"[Peers] want to help empower and move people forward, not just use the system."

- FOCUS GROUP PARTICIPANT

CHILDCARE

Peers may have the responsibility of children preventing their participation or full attention at the meeting. Where possible, providers should arrange childcare and/or offer compensation for childcare for the duration of any engagement opportunities. In some cases (depending on topics and situations), a child may be able to be present in the meeting if the peer thinks it is appropriate and does not think it will interfere with their participation.

"Providing low barrier access to positions for peers who want to get involved. Also being flexible in that role to help anyone who is interested succeed."

- HEALTH AUTHORITY STAFF

LITERACY AND COMMUNICATION

Do not assume peers can read and/or understand the materials that are developed for providers – also, do not assume that they can't! Where possible, ask peers what is the best way they learn – this may be visually, verbally, or a combination of the two. If materials are printed off and given to peers the days or weeks before the meeting, they have the opportunity to review and reflect on the material. Peers may not have access to telephone, computers or email; do not assume they do. Establishing and respecting the best mode of communication with peers in the beginning of a project is an essential first step in establishing expectations. If peers do not have access to email, computers, or telephone, providers can mail hard copies of materials to peers, or work with local agencies to provide access to telephone or Internet on a weekly basis.

It may be stigmatizing or difficult to disclose a low reading comprehension or learning disability or to assume that an individual has a disability. Therefore, developing trust and facilitating discussion about literacy early on in the engagement process is important. Peer mentors can also assist in developing materials that are accessible to other peers. Use non-technical words and clearly define all acronyms, which can be placed on flip charts or placed in a glossary in meetings and reports. In addition, set up environments within group agreements to enhance comfort in asking the meaning of words or acronyms that they are not familiar with Peers and peer mentors can review the materials used in documents and presentations to ensure the language is accessible to the community.

SUBSTANCE USE

Engaging peers involves working with people who use or have used illegal substances. Some peers may be prescribed opioid agonist therapy (OAT) (i.e. Methadone, Suboxone) while others will be using illegal substances and will need to access them in order to avoid experiencing withdrawal symptoms. Peers who face opioid or other substance withdrawal symptoms will not be able to be fully present or contribute to the meeting – undermining the goals of engagement altogether. Providers should provide sterile supplies including syringes, cookers, pipes, sharps containers, and naloxone kits etc, and arrange for a local peer or peer based organization to consult with out-of-town peers on where and how to use more safely. For peers who are staying in a hotel room alone, providers, peers, or peer mentors can develop a drug use plan, especially if peers are using drugs from a new city or drug source (dealer). For instance, peers could schedule a check in phone call or room check after they plan to administer drugs or make a plan in using with other peers.

OAT letters for peers/physicians should be provided at least 2 weeks before the meeting. For peers who are receiving OAT, carry dosages (carries) may need to be arranged well before the meeting. Do not assume peers will organize this process by themselves; a discussion early on in the engagement process can prevent peers from being unable to attend a meeting due to lack of OAT arrangements. Providers can draft a letter and send it to the prescribing doctor or peer that outlines the dates, purpose, agenda, and location of the meeting. Be sure to request carries for the travel days as well as dates of

the meeting. Peers may need to pick up their OAT medication the morning of the meeting, which may require a later meeting start time.

Access to naloxone and safety plans should offered before and during engagement. Where possible, information on supervised consumption sites or overdose prevention sites should be made available. Transportation to and from these sites may be offered. At meetings, it may be possible to set up a short-term on-site overdose prevention site.

PEER SUBSTANCE NAVIGATORS

Ethically, it is important to consider how out of town peers may use substances safely. For out of town peers it may be dangerous to navigate the local drug use scene and find a source that they can trust or a place they can use safely. Peer navigators who are familiar with the local scene or who have relationships built with peer based organizations can help out of town and other peers navigate the local drug use scene. They can also assist peers who are new to the project by providing them with information about the engagement project/meeting and answer any questions they may have.

Conversations with peer substance or meeting/project navigators need to occur around protecting the privacy of people accessing substances so that peers can be as comfortable as possible. For instance, if peers and peer navigators discuss substance use in certain settings, it may have implications for those who choose to be abstinent or those accessing substitution treatment. From our experiences, the PEEP team has suggestion several actions that can be taken to reduce the risks associated in these settings, or in providing aftercare:

- Protect the privacy of people – conversations between peers and navigators need to happen in a place where peers are comfortable.
- The setting and people present during conversations about substances should be considered, particularly because some peers who are trying to remain abstinent may have difficulty being present during these conversations.
- Speak with all peers about where they are in their use; with peers' consent, inform other peers of the people who do not want explicit conversations about substance use to happen around them.
- Take steps to ensure all peers will use safely when in a new town/area: plan naloxone kits, information about and access to (via transportation or on-site) overdose prevention sites, and health checks/check-ins if people are not comfortable using around others.

Navigators can also follow up with peers who resume use while they are in a new town/area by having conversations around:

- If someone chooses to use and it is how a person needs to get well, that is ok.
- Conversations around combinations of stressors that meant their stress level exceeded available coping resources, and what we can do next time to provide more support.
- Following up on self-care plans for when they get home.

The peer navigator role is an important but can be a stressful position. Stresses include the risk of witnessing an overdose, their own substance use, supporting peers, unusual work hours, managing peers' expectations, and coordinating logistics. The peer navigator

position will require additional support than other peers, including emotional support and financial compensation for the time to contact peers before their arrival, the duration of the peer engagement event, and debrief/follow-up time and/or access to employee supports such as counseling.

LOCATION

Meetings are most often held at governmental organizations and other agencies such as the BCCDC, Ministry of Health, and health authority offices. It is important to consider that some peers have never been in these spaces and so may not know where they are, how to navigate the reception area, or find the office or room itself. Peers have voiced concerns in the past over urban centres being triggering to their use. However, urban centres offer easy transportation routes and are often a location most people on the project can access. Therefore, it may warrant a discussion around the pros and cons of holding a meeting in an urban location, or decide on where would work best. For instance, in Vancouver the accommodation and meeting can be held away from the Downtown East Side.

Providers must arrange and pay for travel, particularly for out-of-town peers, and meet peers in the lobby or off-site before the meeting. Peer mentors or peer navigators, who have previous experience engaging with health authorities or other professionals, can also be employed to help peers navigate through the engagement process. Useful things to point out to peers include the restroom location, kitchen, drinking fountains, exit doors, elevators, and where/how they can go for a cigarette break. Additional supports for peers who may be triggered in urban centres or other settings should be discussed and arranged before the meeting.

TRAVEL

Engagement opportunities may happen away from peers' local area. For instance, a meeting may be held at the BCCDC that invites peers from all five regional health regions. In this case, booking and paying for air travel and hotel accommodation may be necessary. It is important to discuss with each individual peer to see what mode of travel they are most comfortable with – air, ferry, taxi, shuttles, vehicle, or bus. Health authorities and other providers should make all attempts to accommodate peers if they are uncomfortable with air travel, or have other physical disabilities that may make their attendance challenging. In addition, providers must ensure peers hold legal identification (i.e. driver's license) required for air travel. Meeting peers at the airport and/or hotel and accompanying them to the meeting will prevent late meeting times and ensure peers do not get lost finding the meeting location.

Reimbursement for expenses may be an issue for some peers. It is unreasonable to expect peers to pay for their own expenses and be reimbursed afterwards. If travel such as shuttles or gas for vehicles need to be paid in cash before the meeting, providers should forward cash to peers before the meeting and request a receipt upon their arrival. Misunderstandings and lack of expectations for payment of travel can be stigmatizing and develop unbalanced power relationships between peers and providers. **Expectations for travel expenses and reimbursement procedures need to be discussed and agreed upon well in advance before the meeting.**

> *"Time, yeah, and sometimes getting to where it is, like you know like I have to take a bus, I took a bus here and you know luckily we found a shortcut but otherwise I woulda had to transfer and come up around and I don't know the bus system very well so..."*
>
> - FOCUS GROUP PARTICIPANT

SETTING GROUND RULES FOR MEETINGS

Ground rules during meetings are different from establishing expectations for the project and team through the MoU. Meeting ground rules help create a safe space for peers and providers to engage openly and honestly; they allow participants to say what they need to ensure a safe environment to discuss difficult and controversial issues. Setting these boundaries is necessary in order to have difficult conversations where everyone at the table feels comfortable to share.

There are several effective ways to create ground rules for groups or partnerships. The first way is to simply list the ground rules (usually developed from previous meetings) for the group. If this is the case, be sure to inquire whether the ground rules are agreeable. A second way is to allow the group to generate the entire list – which can be difficult. The most effective way to create ground rules is to ask the group to come up with a list but prompt them toward particular rules that are often important to the success of engagement. Using a flip chart and developing the ground rules together makes for an opportunity to build a sense of cohesion with the group.

BUILDING A WORK PLAN

Peer engagement work can range from one-time consultancies to long-term participatory projects. Regardless, a work plan should be developed which outlines the overarching short term and long-term goals. A work plan gives details about each activity for each objective over time. Work plans often answer these questions (28):

- What resources will you need?
- What activities have you planned?
- What is the timeline for each activity?
- What is the product for each activity?
- Who is responsible for the activity?
- What is the result for each objective?
- How do you know the objective have been accomplished and activity is over?

A work plan can first be developed during the creation of the MoU (see page 34-35) and setting expectations, and reiterated at every meeting thereafter. However, keeping a clear and concise idea of the project scope, goals, and where the team is an in reaching those goals can be paramount to the success of a peer engagement project.

It is equally as important to identify challenges and overcome them, as it is to celebrate reaching goals. In building a work plan, small, easily achievable goals can be used to maintain motivation, and track and celebrate progress. Work plans also help individuals identify their roles and contribution to a project.

SUPPORTS

Peer engagement can be an emotionally, mentally, and intellectually rewarding and challenging experience for all parties involved. The peer engagement process can be dependent on supports, being explicit about expectations, commitment to communication, and ability to maintain boundaries throughout the project. Boundaries include expectations around staff (peers and providers) availability, support with personal issues, sharing trauma, feeling respected and safe at work, honesty, and accountability. Developing a support plan before the project begins can reinforce commitment to peer engagement and work to address problems as they come up. It can also enhance employee satisfaction, productivity, and retention. Project leadership should exemplify, monitor, manage, and maintain their own wellness and promote the creation of these expectations around support.

Peer engagement is a learning experience for everyone. It may be some staff members' first time working with peers under a harm reduction framework. Several supports can be put in place including:

- Schedule regular check in's with staff. Ask: how are you doing emotionally, mentally, spiritually, intellectually, and professionally?
- Be a good role model: build an ethic of solidarity and create a work culture that supports wellness
- Create a safe space with and without peers where providers can ask difficult questions without judgment.
- Acknowledgement that we are working within a system, alongside individuals who may have survived and continue to survive many violations of their human rights, continue to be victimized, marginalized, and criminalized, But, do not always assume that is the case.
- Debrief individually and with the group after meetings (may be daily or post-meeting)
- Create collective and individual care plans. Ask: How are we going to help each other shoulder this work when it becomes heavy? What have you done or planning to do for yourself this week?
- Provide professional resources through counseling referrals.
- Train and discuss healthy boundaries. Ask: What do healthy boundaries look like when working with peers? Encourage ongoing critical reflexivity.
- Develop a plan if the engagement process is too much for a staff member or if boundaries are being crossed.

SETTING UP SUPPORTS FOR PEERS AND OTHER STAFF

MENTAL/EMOTIONAL SUPPORT

Engaging peers and other professionals in policy, practice and research can sometimes bring up emotionally charged topics. The issues discussed often bring up experiences of stigma and discrimination. The stories and language used at the table could also change power dynamics and feelings of exclusion. It is important to set up several supports to mitigate the potential of emotional turmoil and what to do if these feelings come up. Regular "check outs" or debriefing before leaving the table can help bring up and address any issues that were not resolved during the meeting. Providers can also develop a regular debrief plan after meetings to ensure issues are addressed quickly and not worsened. Providers should check in with peers regularly to see how they are doing professionally and personally. Providers should promote and exercise healthy boundaries and coping mechanisms.

> *"I have worked with several peers in the past but I feel we need to help peers build capacity in order for them to speak out freely."*
>
> - HEALTH AUTHORITY STAFF

SUBSTANCE USE SUPPORT

In many peer engagement projects with multiple peers at the table, people will be at different places in terms of drug use; some people may be abstinent while others may use licit and illegal substances multiple times per day. Both those who use and those who are abstinent may find it triggering or difficult to be around each other. Providers can play a role in creating a safe space for peers regardless of where they are at in their use. An excellent guide for cultural safety has been developed by researchers at the University of Victoria that can assist in this training (25). Providers and peers can work together to develop a plan to respond to triggers. For instance, peers can use a buddy system to debrief or person to call if they are triggered. Providers or peer mentors can do check in's through the phone or in person regularly and frequently to see where peers are at and to provide supports where needed.

FINANCIAL PLANNING SUPPORT

Peers may need financial planning support. Some engagement opportunities offer a large amount of compensation at different points in time, which may put some peers in an uncomfortable situation. Financial strategies and other life skills trainings can be offered early on in the engagement process to help peers prepare for their new source of income. Providers can also help peers set up bank accounts and budgeting. Some organizations can also support financial planning with peers. For instance, financial processes may enable peers to save a certain percentage of staff wages, or pay staff at a different frequency (i.e. all at the end of the month or end of project). For projects providing cash stipends, some peers may be more comfortable making alternate payment arrangements (e.g. meeting and being paid at the bank so they do not have to carry around a large sum of cash). When in doubt, ask.

PEER MENTORS

Peer mentors are people who have lived experience of substance use (past or present) who have previously engaged with providers, or who have experience engaging with other professionals, organizations, or systems. They are an invaluable resource that can be utilized as "translators" or "buddies" to new peers who have not engaged before as they have insight into the engagement process. Peer mentors have experiential knowledge they can share about key factors such as the dynamics at a decision-making table, reasonable expectations, and background about certain issues. They can also assist other peers with setting up a bank account, signing employment contracts, and providing support and resources. Mentors can give peers an alternate confidante if they feel uncomfortable bringing up issues with their employer, or need advice. Ideally, peer mentors are the first peer to onboard and the last to disengage at the end of a project, so they can oversee the wellbeing and progress of other peers throughout the duration of the engagement opportunity. Peer mentors should receive the same (if not more) supports as other peers on the project.

Peer mentors may also take on the role of peer navigator (see page 41–42).

WRAPPING UP OR DISENGAGEMENT

AVOIDING SENSE OF LOSS AT COMPLETION

Participation in a peer engagement initiative can give peers a sense of purpose, confidence, and community, especially when engagement occurs over a long period of time. Consequently, there can be an intense feeling of loss and isolation among peers and providers at the end of a peer engagement project.

This sense of loss often emerges from a lack of direction or purpose once the project is finished. There is always a risk that the skills learned, and confidence gained by the peers could dissipate because opportunities for utilizing these qualities, and continuing peer engagement work in their communities were not integrated into the wrapping up process. The barriers and inequities peers face are a part of our society regardless of how successful the project was. It is important to be mindful of not cultivating a false sense of independence and success during the project without acknowledging the real barriers and inequities peers face in continuing to do peer engagement, and the support needed to continue their work and growth.

From the start, it is important to consider how peers' support networks are created. Connecting and collaborating with other healthcare authorities/service providers in the communities where peers originate can assist peers during and after the transition out of a project. Through these networks and continuing advocacy for more peer work initiatives we can minimize the isolation and

sense of loss felt by peers and service providers as a project concludes.

Another step to consider could be the development and review of clear work plans with timelines in the beginning and during the project that can help peers prepare for the end of a project. Staff and peers can review the new skills and knowledge peers gained through the peer engagement process and apply these to future opportunities.

EVALUATION

Peer engagement is an evolving process. The strategies outlined in this guide are not exhaustive, nor are they all applicable to every setting. As such, we highly encourage peer engagement opportunities to be evaluated in order to learn from and expand opportunities in the future. Evaluation can also help peers and providers on the project feel heard and seen. It gives them a chance to debrief on the entire experience. This will enhance peer engagement in the future by being able to both better identify and overcome system barriers, as well as a better ability to adjust and update measurable outcomes in the roles of peer workers.

Evaluation can ensure that resources were used in an efficient and effective manner. Elements to keep in mind when conducting an evaluation of peer engagement include:

- Consider what you wish to accomplish in your engagement activities and determine if you achieved what you set out to do
- Ensure that the results you wish to achieve can be observed and measured
- Ensure that you identify what you wish to achieve at the beginning of the engagement planning process
- Determine whether or not information gathered was used to inform the discussion and/or implementation of decisions/policies

"I am grateful that studies, such as this one, are available and support and education may be increased, and more opportunity of people who have lived it get a voice."

- HEALTH AUTHORITY STAFF

DISSEMINATING KNOWLEDGE

Peer engagement projects can produce a vast amount of knowledge and information about the issues at hand, as well as promote team and community building. Disseminating this knowledge back to the community and more broadly is a fundamental step of the peer engagement process. Taking information from the community without giving it back may perpetuate marginalization and injustice experienced by these communities. Communicating the results of a peer engagement effort back to those who participated and the community ensures that those who contributed understand how their insights were acknowledged (13). As before, it is important to determine the dissemination plan from the start of the project to ensure the plans are followed through and the team are held accountable. It also gives the group the opportunity to keep track of the process, including an opportunity to reflexively look at how the team has changed over the course of the project.

Peers should be highly involved in the dissemination plan; this includes their input on details around the how, when, where, what, who, and why knowledge is disseminated. How peers who were involved in the project are acknowledged as authors or contributors should be discussed at the beginning of the project begins. In most instances, peers should provide input and be acknowledged as co-authors and contributors, and approve the final product. However, some peers may not feel comfortable using their real names as identifying as a peer or peer researcher, as it can be outing within their communities, and can have unintended negative consequences in the future. Therefore, authorship and recognition should be discussed fully and decided on in advance.

People who use drugs may have insight into a barrier or channel of information providers are not aware of. Peer networks in BC, particularly in rural and remote regions, operate as an informal harm reduction information system. Peers can help tap into these networks and disseminate information. Sharing information should not simply be a one-time event at the end of the project (13). Instead, knowledge should be shared with peers and the community on an ongoing basis during the overall engagement process.

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