PEER ENGAGEMENT PRINCIPLES AND BEST PRACTICES

A guide for BC Health Authorities and other 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

April 2017


BC Centre for Disease Control
An agency of the Provincial Health Services Authority


UBC


Provincial Health
Services Authority
Province-wide solutions.
Better health.


PETER
WALL
INSTITUTE FOR ADVANCED STUDIES
THE UNIVERSITY OF BRITISH COLUMBIA | VANCOUVER


toward
THE heart.com
WORKING TOGETHER
REDUCING HARM


HRSS
BC Harm Reduction Strategies and Services

ACKNOWLEDGEMENTS

Peer Engagement and Evaluation Project Team:

Alissa Greer (BCCDC; University of British Columbia)
Ashraf Amlani (BCCDC)
Cheri Newman (BCCDC; Fraser Health)
Charlene Burmeister (BCCDC; Northern Health)
Brian Leblanc (BCCDC; Interior Health)
Katie Lacroix (BCCDC; Island Health)
Hugh Lampkin (BCCDC; Vancouver Coastal Health)
Erin Gibson (Fraser Health)
Jeff Walsh (Interior Health)
Alex Scott (Vancouver Coastal Health)
Dr. Bernadette Pauly (University of Victoria)
Dr. Jane Buxton (PI) (BCCDC; University of British Columbia)

Special thanks to:
Emily Ogborne-Hill, Sonya Ishiguro, Margot Kuo, Heather Burgess, Lauren Mathany, Sara Young, Jessica Bridgeman, Kate Fish, Griffin Russell, Camille Drexl, Florence Ranville, James Tigchelaar, Janine Stevenson, Dr. Kenneth Tupper, Kathleen Perkins, Reanne Sanford, Jonathan Spence, and all the staff and clients at participating community focus group sites.

CONTACT INFORMATION

BC Centre for Disease Control
Harm Reduction Program
655 West 12th Avenue
Vancouver BC V5Z 4R4

Email: **a.greer@utoronto.ca**

Original Date of Publication: October 15, 2016
Revised Edition: April 1, 2017
Report is available at www.bccdc.ca

Suggested citation

Greer, A.M., Amlani, A.A., Buxton, J.A. & the PEEP team. (2017). Peer Engagement Best Practices: A Guide for Health Authorities and other providers. Vancouver, BC: BC Centre for Disease Control.

EXECUTIVE SUMMARY

INTRODUCTION

Peer engagement can be defined as the active participation of people with lived experience of substance use in research, program, and policy decision-making processes. 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 is often a lack of understanding of peer engagement principles and practices among Health Authorities.

From this identified gap, the Peer Engagement and Evaluation Project (PEEP) was initiated. PEEP is a research project that builds on BCHRSS experiences and existing relationships with peers. This project aims to enhance peer engagement and voices that have been missing from decision-making tables across the province through the development, implementation, and evaluation of best practices guidelines for BC Health Authorities.

PEEP METHODS

PEEP is participatory in that it engaged five peer research assistants and several Health Authority representatives from across the province as active members of the research team throughout the project. In 2015, the PEEP team conducted 13 focus groups with 83 participants across all five regional Health Authorities. The qualitative data was coded by PEEP team members

and themes were derived through a participatory process. The final four broad themes were societal and community readiness, peer networks, peer engagement, and stigma and trust. These themes, along with the experience our own team has had in engaging peers, and review of the literature have informed the focus and content of the peer engagement principles and best practice guidelines for BC Health Authorities.

PEER ENGAGEMENT PRINCIPLES

The principles outlined in this report provide justification and support for enhancing peer engagement among BC Health Authorities and include the definition and importance of peer engagement, consideration of power dynamics, benefits to peer and providers, regional differences, 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 peer engagement. This document provides both an overview and details of these processes to support meaningful and equitable engagement between Health Authority representatives and peers.

CONCLUSION

Promoting peer engagement within Health Authorities can improve the involvement and uptake of peers' voices in health service planning and policy making in BC. Individuals who work in Health Authorities can use these peer engagement principles and best practice guidelines to foster meaningful engagement, which can in turn promote positive relationship and capacity building for everyone involved.

TABLE OF CONTENTS

GLOSSARY OF ABBREVIATIONS

BC:	British Columbia
BCCDC:	British Columbia Centre for Disease Control
BCHRSS:	British Columbia Harm Reduction Strategies and Services
IAP2:	International Association for Public Participation
MoU:	Memorandum of understanding
OST:	Opioid Substitution Therapy
PRA:	Peer research assistant
PEEP:	Peer Engagement and Evaluation Project
PWUD:	People who use drugs
SOLID:	Society of Living Illicit Drug Users
VANDU:	Vancouver Area Network of Drug Users

BACKGROUND

PEER ENGAGEMENT AND EVALUATION PROJECT (PEEP) RATIONALE

People who use illegal drugs, or **'peers',** 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.

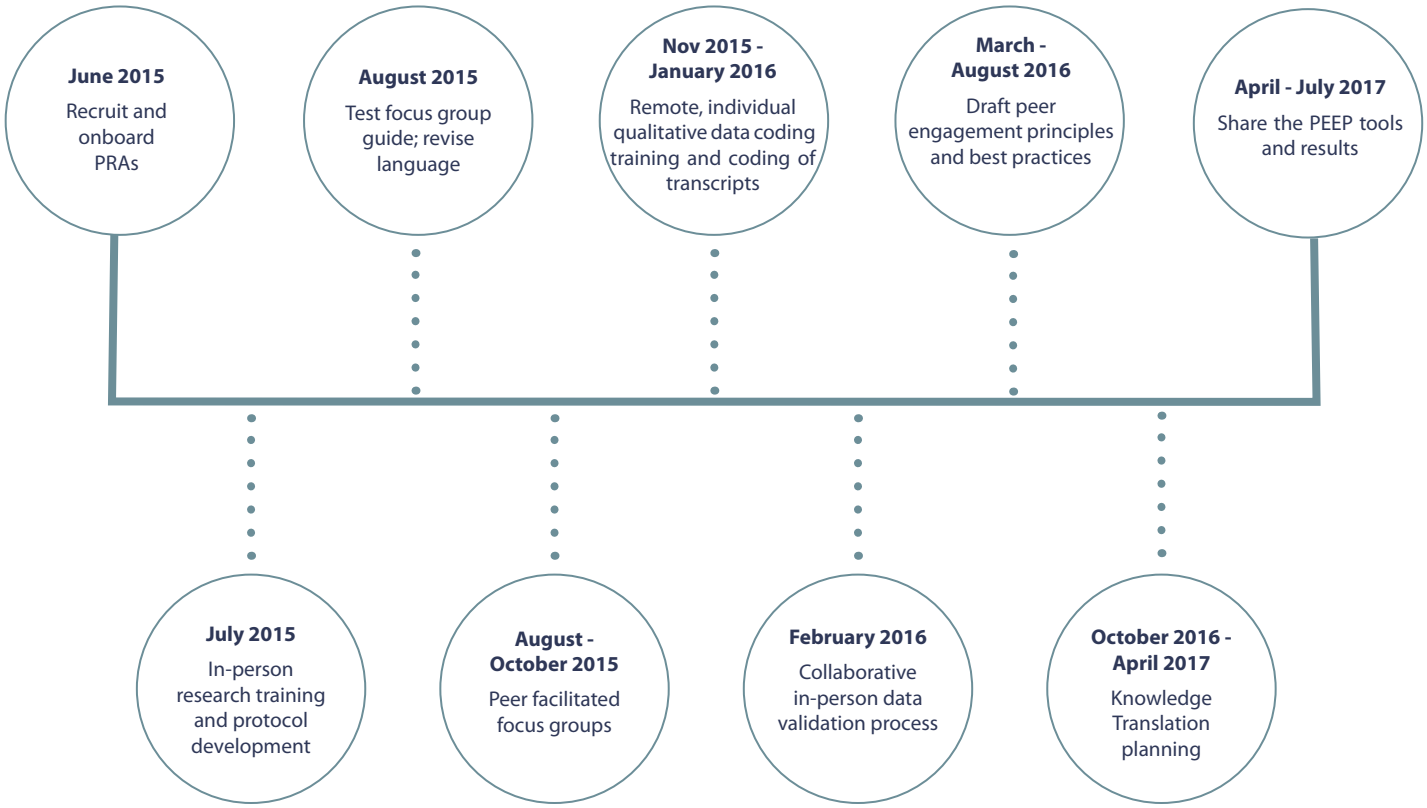
Peer engagement – the active participation of peers in research, programming and policy – is at the heart of harm reduction. Peers are the 'experts' about the realities of illegal drug use, and provide valuable insights about the barriers and enablers to accessing harm reduction services in their communities (6). Peer engagement is essential to better understand local risk environments, including issues related to physical, social, and political environments. Engaging with peers when designing harm reduction solutions can help to mitigate equity issues through capacity building and empowerment (6).

Engaging peers in regional and provincial planning of harm reduction service delivery has been an evolving, iterative 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 (7). To guide this work, we adapted the "Nothing About Us Without Us" guidelines (8) to develop the "How to Involve People Who Use Drugs", which highlights the do's and don'ts of peer engagement (9). 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 (10). We found peer engagement was an iterative 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 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 to invite a broader representation of people in their communities to the table.

PEEP METHODS

PEEP employs a community based participatory research (CBPR) framework, engaging peers and Health Authorities throughout every aspect of the project. The PEEP research team consists of a dynamic team of five peer research assistants (PRAs) that were recruited from each of the regional Health Authorities. They come from diverse experiences, ethnicities, and ages. The PEEP team also includes several academic researchers from the BCCDC and University of Victoria, Health Authority harm reduction coordinators, and students from local universities. Together, the PEEP team developed the scope, protocol, and methodology for the project. Team building started in July 2015, when the team came together in person at the BCCDC to train on 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. The final four broad themes, namely – societal and community readiness, peer networks, peer engagement, and stigma and trust – have informed the focus and content of these best practice guidelines and principles for peer engagement. 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 this process guided and informed these guidelines.

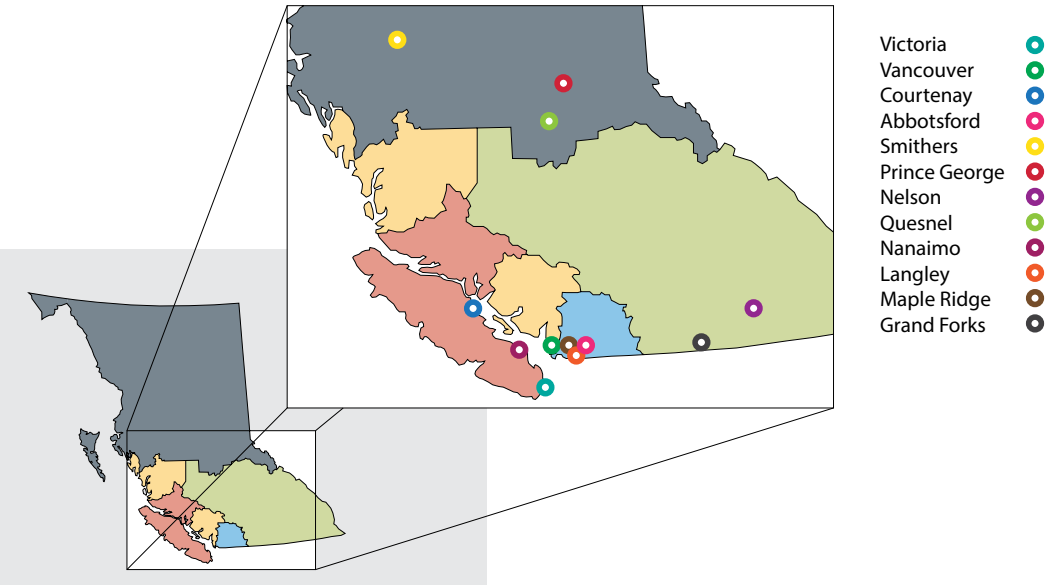


Figure 1: Locations of focus groups facilitated by PRAs

PEER ENGAGEMENT PRINCIPLES

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 (4,11). 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 (12). 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 (13,14). 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 (14).

Other frameworks for engagement have also been developed, including Arnstein's ladder of citizen participation (15) and adapted versions including Hart's ladder of youth participation (16) or Pretty's participatory learning model for sustainability (17). In all models, a policy, program or project can elicit equitable participation in resources, recognition, results, and knowledge by sharing power in partnerships (18). The IAP2's spectrum has been adapted (see Table 1) to show the range of peer engagement activities that can occur.

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** (15). Therefore, efforts must be made to move along the spectrum of engagement, from tokenism to greater degrees of power among peers, including partnership, delegation, and peer control over decision-making.

THE IMPORTANCE OF PEER ENGAGEMENT

From a health equity perspective, harm reduction services must be accessible, accommodating, affordable, and acceptable (4,19,20). Enhancing peer engagement strategies can address equity issues to improve the utilization of harm reduction services, making them responsive to the needs of peers 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 peers as the experts when designing harm reduction solutions helps mitigate these equity issues through capacity building and empowerment.

"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…"

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

	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.
Exammple 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.

SHARING THE TABLE—AND POWER

In Health Authorities, 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.

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 economical, 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 peers in peer engagement work. In reality, systems within Health Authorities 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 thus the inability to create true collaboration and empowerment in their work. Leadership within Health Authorities 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).

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 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 peers 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 peers in accessing harm reduction services across all Health Authorities in the province. Harm reduction agencies can promote and build trust with peers 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. Peers 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 peers. 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 (please contact the authors of this report for access).

ORGANIZATIONAL SUPPORT NEEDED FOR PEER ENGAGEMENT

Health Authorities have the power to determine who can be involved and to what extent. Limited 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 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. 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 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 user-run 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.

"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."

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 peer network included getting health and harm reduction information. Peer networks seemed to fill gaps where health authorities may not reach, particularly amongst hard-to-reach peers and rural/remote communities. In this way, peer networks seemed to behave in an informal, unfunded outreach system. Often times, peers would not trust information from health care or service providers; peers were seen as the most reliable and knowledgeable source. Peers saw the value in increasing the access to information through peer networks, and suggested that health authorities engage with peer networks and/or peer run organizations where they exist in order to increase access to information.

"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?"

PEER ENGAGEMENT BEST PRACTICES

OVERVIEW

- Ensure the initiative has adequate resources (human, financial and skill); peerengagement requires time and an unwavering commitment to the work.
- Provide adequate financial resources and human supports for the duration of the project and after.
- Start early and build a solid foundation for the project.
- 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 staff.
- Critical analysis of who is at the table to enable a recruitment approach that ensures equitable representativeness and shared power at the table.
- Partner or consult with Peer Run Organizations or other peer networks where possible.
- Research financial institution procedures in advance and provide fair compensation to peers in cash where possible. As well, discuss financial assistance status with each peer.
- 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.

- Apply an appropriate level of engagement and expectations that aligns with the project goals and objectives.
- Hire peer mentors or navigators who have experience working with Health Authorities and other professionals to help guide new peers through peer engagement processes and support them getting to the decision making table.
- Follow the Nothing About Us Without Us guidelines (8), Guidelines for Ally's (22), and the BCCDC do's and don'ts for How to Involve People Who Use Drugs (9).
- Have a conversation with peers to identify and adopt appropriate communication that works for peers and to accommodate different learning styles.
- Identify specific barriers and challenges peers might face in the engagement process, and identify potential solutions with peers.
- At meetings, set ground rules and group agreements as a team.
- Promote and foster equal voices and a diffusion of power at the decision making table.
- Schedule regular self-care check in's for peers and providers. Teach and model healthy boundaries to all members of the team.
- Develop a sustainability plan and avoid "one off" peer engagement opportunities.
- Set a wrap up plan for the project early on and share this with peers and staff to establish clear expectations and avoid a sense of loss at completion.
- Peer engagement is an iterative process; evaluate your peer engagement process to learn from the experience and apply this knowledge to future opportunities.

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, 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 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 seen as 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 new 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 23. Also, see the Nothing About Us Without Us guidelines that offer several do's and don'ts on who and how to invite peers to the table (8).

RECRUITING PEERS

To recruit peers, flyers and word of mouth at several locations typically work best. Simply 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 run organizations serve as an excellent source of recruiting peers.

PARTNERING WITH PEER RUN ORGANIZATIONS

Peer run organizations (also known as drug user groups) are organizations that have been created by peers, are run by peers, and service peers. Many peer run organizations receive some funding from health authorities, but remain autonomous and self-governing. There are several peer run organizations available as a potential resource and partner for Health Authorities across the province. Examples of peer run organizations are the Society of Living Illicit Drug Users (SOLID) in Victoria, the Vancouver Area Network of Drug Users (VANDU) in Vancouver, and Rural Empowered Drug Users Network (REDUN) in the Kootenays region (see Appendix 1 for a list of peer run organizations available to agencies in BC). Peer run organizations can assist in the recruitment process or give feedback on how to recruit in communities where peer run organizations may not exist.

Working with a peer run organization can be an effective approach to peer engagement. Health Authorities should contact the organization president 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 run organization can promote positive communication and future partnerships between the Health Authority and the organization.

SETTING UP COMPENSATION

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 that 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. For opportunities that will compensate more than $500 per calendar year, a T4A must 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 offers several 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.**

SETTING EXPECTATIONS WITH PEERS AND PROVIDERS

Setting expectations of peers, providers, and the team early on can prevent potential conflicts during the project.

Expectations of peers

Providers should discuss and put in writing their expectations of peers during the project, 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:

- 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?
- What way, days and hours are appropriate to contact them?
- Are there any materials or office supplies they may need?
- What support does the peer need? What does that look like at different times?
- 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 level of response is expected if asked to provide input?
- Are there any literacy or learning barriers?
- What is the best mode of communication?
- Does the peer have access to internet/ phone?
- Will the project provide telephone/ internet or computers?
- What benefits or pitfalls do they see in being involved in this project?

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.

- 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 disputes with peers or providers be handled?
- What specific resources (financial, time, human) are needed to support providers to be successful in this project?
- Is any further training (ie. cultural safety, trauma informed care harm reduction principles, drug policy) needed?
- What language can providers use that is respectful to the community?
- How many hours per week will providers spend on this project?

Expectations of the team

Lastly, 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

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 to 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?

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 (15). 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.

ENGAGING PEERS

DO'S AND DON'TS

In 2014, the BCCDC Toward the Heart program adapted the 2005 Canadian HIV/AIDS Legal Network "Nothing About Us Without Us" guidelines to create the document "How to Involve People Who Use Drugs" (9). Researchers at the University of Victoria have also created guidelines on how allies (providers) may better engage people who use drugs at decision making tables (22). Below in Table 2 are the "Nothing About Us Without Us" Guidelines adapted into do's and don'ts to involving people who use drugs for Health Authorities.

Table 2: How to Involve People Who Use Drugs (9)	
Do invite several of us	**Don't** invite just one of us
Do invite a user group to select representatives	Don't hand-pick always the same user you know and are comfortable with
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 listen to our answers	Don't just Ask the questions because it's politically correct to ask us
We may not be used to your style of meetings so please…	
Do assign us a support person or provide training (if you ask us to be on a committee or board, not just a one-time event)	Don't run your committee or board meetings without acknowledging that it may be the first time for us to be on a committee or board
Do show flexibility with meeting styles	Don't hold a meeting or consultation just the way you are used to
Do show flexibility with meeting times	Don't hold a meeting at 9 AM, or on welfare cheque issue day
Do ask us what we need	Don't be afraid to ask
Do acknowledge that you may have needs too, and that unfamiliarity may make you uncomfortable	Don't assume that I am the problem and the only one who needs to learn
Do consider training for you and the other committee or board members specific to the issue of user involvement, and ask a user to participate	Don't think that you can't learn how to involve me better
Do consider our participation in planning session for consultations or meetings	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 users already hang out	Don't hold it in a government building
Do provide honorarium – 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	Don't write us a cheque or give us a coupon
Do give us money in cash	Don't ask us to come and meet you in Ottawa
We do value our privacy so please…	
Do guarantee confidentiality	Don't identify what a particular user said in proceedings of the meeting
Do protect confidentiality	Don't requrie disclosure of HIV or other health status
If you want us to travel please…	
Do help with arranging methadone carrier	Don't invite us at the last minute and assume we can deal with this alone
Do arrange for advice from a local person who uses drugs – drugs may be more dangerous in a different city and traveling puts us at risk	Don't just leave us on our own in cities we don't know
Do provide accommodation close to the meeting space	
Do have a healthcare provider available to support us	

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 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 run organizations, such as SOLID and VANDU, can also provide support and resources but recognize that they are working with limited resources (27).

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, a child may be able to be present in the meeting if the peer does not think it will interfere with their participation.

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

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. Providing materials at the table such as drawing and coloring materials (i.e. adult coloring books), play dough, or other things to keep their hands busy may help in relieving stress and enhancing focus during long meetings. 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 substitution therapy (OST) (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 can give access to "hit kits" (i.e. sterile supplies including syringes, cookers, pipes, sharps containers, and naloxone kits etc), and arrange for a local peer or peer run organization to consult with out-of-town peers on where and how to use more safely (sometimes referred to as "Bunk Patrol"). 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.

For peers who are receiving OST 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 OST 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. OST letters for peers/physicians should be provided at least 2 weeks before the meeting. Peers may need to pick up their OST medication the morning of the meeting, which may require a later meeting start time.

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 should make all attempts to

"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..."

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. drivers 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.**

SETTING GROUND RULES FOR MEETINGS

Meeting 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 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.

These prompts include rules around:

- Speaking and listening
- Making sure people feel heard
- Providing time for those who haven't had a chance to speak
- Disagreements
- Respect for others opinions
- Confidentiality
- Language (i.e. "drug users", "addict", technical language
- Asking Questions
- Breaks
- Cell phones
- Flexibility in the agenda (respecting time)
- Participation
- Not expecting absinence
- Debriefing

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):

1. What resources will you need?
2. What activities have you planned?
3. What is the timeline for each activity?
4. What is the product for each activity?
5. Who is responsible for the activity?
6. What is the result for each objective?
7. 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 15-16), 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

HEALTHY BOUNDARIES FOR HEALTH AUTHORITY PROVIDERS

Peer engagement can be an emotional, mental, and intellectually rewarding and challenging experience for all parties involved. Dedication to the peer engagement process can be dependent on supports, being explicit about expectations, commitment to communication, and ability to maintain boundaries throughout the project. 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 healthy boundaries.

SETTING UP SUPPORTS FOR STAFF

Peer engagement can be 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 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 marginalized and criminalized

- **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

Mental/emotional support

Engaging peers in policy, practice and research can sometimes bring up emotionally charged topics. The issues discussed often have to do with 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" 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.

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 in recovery while others may use licit and illegal substances multiple times per day. Both those who use and those in recovery 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 for 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 also 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 institutions can also support financial planning with peers. For instance, institutions can 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).

PEER MENTORS AND NAVIGATORS

Peer mentors are people who use drugs 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.

WRAPPING UP

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 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 (11). 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 before the project begins. In most instances, peer should be acknowledged as co-authors and contributors. However, some peers may not feel comfortable using their real names as identifying as a peer 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.

Peers 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 (11). Instead, knowledge should be shared with peers and the community on an ongoing basis during the overall engagement process (11).

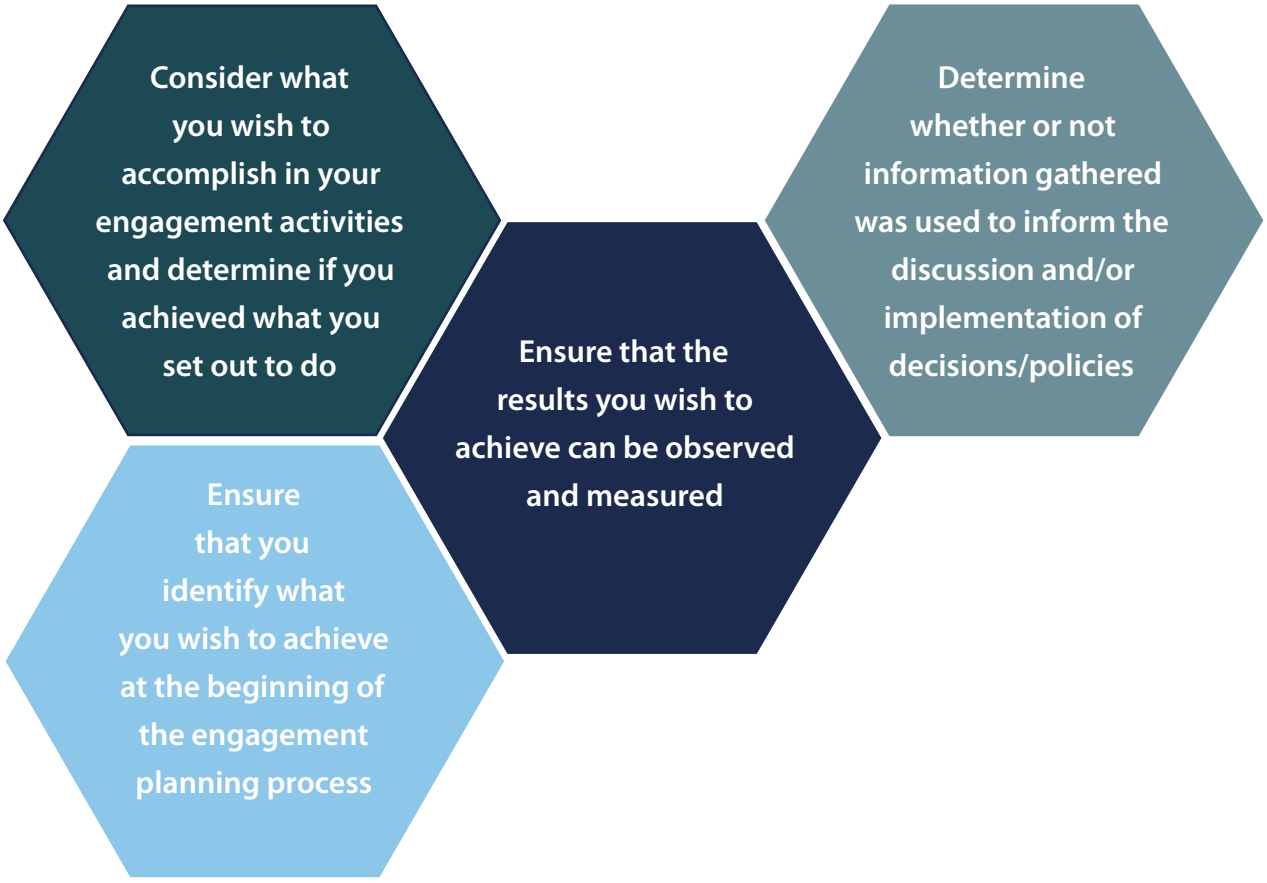
AVOIDING SENSE OF LOSS AT COMPLETION

Participation in a peer engagement initiative can give peers a sense of purpose, confidence and community. Consequently, there can be an intense feeling of loss and isolation among peers and providers at the end of a peer engagement project. Developing and reviewing a clear work plan with timelines in the beginning and during the project can help peers prepare for the end of a project. Providers can also help by finding other engagement or employment opportunities. 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 iterative, 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 (11):



REFERENCES

1. Degenhardt L, Hall W. Extent of illicit drug use and dependence, and their contribution to the global burden of disease. The Lancet. 2012 Jan;379(9810):55–70.

2. Best Practices for British Columbia's Harm Reduction Supply Distribution Program [Internet]. Vancouver, BC: BC Center for Disease Control; 2008 Aug [cited 2017 Apr 3]. Available from: http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/Other/BestPractices.pdf

3. Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injection drug users [Internet]. World Health Organization; 2004 [cited 2017 Apr 3]. Available from: http://whqlibdoc.who.int/publications/2004/9241591641.pdf

4. Pauly B. Harm reduction through a social justice lens. Int J Drug Policy. 2008 Feb;19(1):4–10.

5. Kuo M, Shamsian A, Tzemis D, Buxton JA. A drug use survey among clients of harm reduction sites across British Columbia, Canada, 2012. Harm Reduct J. 2014 Apr 27;11(1):13.

6. Lazarus L, Shaw A, LeBlanc S, Martin A, Marshall Z, Weersink K, et al. Establishing a community-based participatory research partnership among people who use drugs in Ottawa: the PROUD cohort study. Harm Reduct J. 2014;11:26.

7. Peer & Community Funds [Internet]. Toward the Heart. [cited 2017 Apr 3]. Available from: http://towardtheheart.com/ezine/

8. "Nothing About Us Without Us" Greater, Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical, and Human Rights Imperative [Internet]. Canadian HIV/AIDS Legal Network; 2006 Mar [cited 2017 Apr 3]. Available from: http://www.aidslaw.ca/site/wp-content/uploads/2013/04/Greater+Involvement+-+Bklt+-+Drug+Policy+-+ENG.pdf

9. How to involve people who use drugs [Internet]. BC Center for Disease Control; 2014 [cited 2017 Apr 3]. Available from: http://towardtheheart.com/assets/hrss/how-to-involve-people-who-use-drugs-20140227_39.pdf

10. Greer AM, Luchenski SA, Amlani AA, Lacroix K, Burmeister C, Buxton JA. Peer engagement in harm reduction strategies and services: a critical case study and evaluation framework from British Columbia, Canada. BMC Public Health [Internet]. 2016 Dec;16(1). Available from: http://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-016-3136-4

11. Public Engagement Guide [Internet]. Newfoundland Labrador: Office of Public Engagement; nd [cited 2017 Apr 3]. Available from: http://ope.gov.nl.ca/publications/pdf/OPE_PEGuide.pdf

12. Lesen A. Scientists, experts, and civic engagement: walking a fine line. Ashgate Publishing; 2016.

13. Making a difference: a guide to evaluating public participation in central government [Internet]. London, UK: Involve; 2007 [cited 2017 Apr 3]. Available from: http://www.involve.org.uk/evaluation-guide/introduction.shtml

14. IAP2: A model for engagement [Internet]. Victoria, Australia: The International Association for Public Participation; 2013 Oct [cited 2017 Apr 3]. Available from: http://www.dse.vic.gov.au/effective-engagement/developing-an-engagement-plan/a-model-for-engagement

15. Arnstein SR. A Ladder Of Citizen Participation. J Am Inst Plann. 1969 Jul 1;35(4):216–24.

16. Hart RA. Children's Participation in Planning and Design. In: Weinstein CS, David TG, editors. Spaces for Children [Internet]. Springer US; 1987 [cited 2017 Apr 3]. p. 217–39.

17. Pretty JN. Participatory learning for sustainable agriculture. World Dev. 1995;23(8):1247–63.

18. Cornwall A. Unpacking "Participation": models, meanings and practices. Community Dev J. 2008 Jul 1;43(3):269–83.

19. BC harm reduction strategies and services policy and guidelines [Internet]. BC Center for Disease Control; 2014 Dec [cited 2017 Apr 3]. Available from: http://www.bccdc.ca/NR/rdonlyres/4D0992FA-0972-465B-81DD-970AEF178FDD/0/BCHRSSPolicyandGuidelinesDecember2014.pdf

20. Penchansky R, Thomas JW. The concept of access: definition and relationship to consumer satisfaction. Med Care. 1981 Feb;19(2):127–40.

21. Marshall Z, Dechman MK, Minichiello A, Alcock L, Harris GE. Peering into the literature: A systematic review of the roles of people who inject drugs in harm reduction initiatives. Drug Alcohol Depend. 2015;151(0):1–14.

22. Belle-Isle L, Pauly B, Hall B, Lacroix K, LeBanc S, Sproule R, et al. From one ally to another: practice guidelines to better include people who use drugs at your decision-making tables. Victoria, BC: Center for Addictions Research of BC (CARBC); 2016.

23. Christine Urquhart FJ, editor. Trauma-Informed Practice Guide. 2013. 13–14 p.

24. Trauma-informed care toolkit [Internet]. Canadian Centre on Substance Abuse; 2014 [cited 2017 Apr 3]. Available from: http://www.ccsa.ca/Resource%20Library/CCSA-Trauma-informed-Care-Toolkit-2014-en.pdf

25. Pauly B, McCall J, Parker J, McLaren C, Brown A, Mollison A. Creating cultrually safe care in hospital setting for people who use(d) illicit drugs [Internet]. Victoria, BC: Centre for Addictions Research of BC; 2013 [cited 2017 Apr 3]. Available from: https://www.uvic.ca/research/centres/carbc/assets/docs/bulletin11-creating-culturally-safe-care.pdf

26. Compensating peer researchers [Internet]. Pacific Aids Network; 2014 [cited 2017 Apr 3]. Available from: http://pacificaidsnetwork.org/wp-content/uploads/2014/06/CBR-Tips-Compensating-Peer-Researchers-Pacific-AIDS-Network-Final.pdf

27. Collective voices effective change: A final report of National meeting of peer-run organizations of people who use drugs [Internet]. Victoria, BC: Centre for Addictions Research of BC: Canadian Association of People Who Use Drugs; 2014 [cited 2017 Apr 3]. Available from: static1.squarespace.com/static/53015f40e4b0c6ad9e406a13/t/53972833e4b0240065925810/1402415155682/CollectiveVoices+Report+FINAL+30May14.pdf

28. Tools for Community Building: A Guide for Helping People Plan Projects in their Community [Internet]. Nunavut Literacy Council [cited 2017 Apr 3]. Available from: http://www.ilitaqsiniq.ca/sites/default/files/files/tools_for_community_building.pdf

APPENDIX 1: LIST OF PEER RUN ORGANIZATIONS IN BRITISH COLUMBIA

BC/Yukon Drug War Survivors:	www.drugwarsurvivors.org
Canadian Association of People who Use Drugs (CAPUD):	www.capud.ca
Rural Empowered Drug Users Network (REDUN)	
Society of Living Illicit Drug Users (SOLID):	www.solidvictoria.org
Vancouver Area Network of Drug Users (VANDU):	www.vandu.org
Western Aboriginal Harm Reduction Society (WAHRS):	www.wahrs.ca