

# ***Best Practices in Harm Reduction Peer Projects***

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## 1. INTRODUCTION

Street Health is a community-based health care organization in Toronto that provides services to address a wide range of physical, mental, and emotional needs for people who are homeless, poor, and socially marginalized. Street Health's program areas include nursing care, mental health support, street outreach, HIV/AIDS prevention, Hepatitis C support, and identification replacement and storage.

The Crack Users Project (CUP) is a community capacity-building initiative, developed by Street Health and Regent Park Community Health Centre, with the goal of reducing the harms associated with the use of crack cocaine among users in southeast downtown Toronto. The project began in October 2005 and includes several weekly drop-in groups, a low-threshold health care clinic, counselling and case management services, as well as peer education and outreach. The project's objectives are to: increase communication with and among marginalized crack users; build capacity among crack users to develop and implement peer-led, crack-specific harm reduction strategies; and to improve access to physical and mental health services for this population.

Funding for the Crack Users Project has been provided by Health Canada and requires Street Health to develop a 'best practices' guide to peer education with illicit drug users, based on a two-year pilot of the CUP project and scan of current practice in the field.

This report summarizes the results of the scan of current practice in the field, conducted between January and April 2006. It is based on a review of the literature and interviews with harm reduction practitioners across Canada. It identifies challenges to developing and maintaining peer projects, the key factors influencing the success of these initiatives; and makes a series of best practice recommendations for service providers, policy makers and funders.

Section 2 provides background to the best practices scan, describing the theories underlying the type of projects reviewed by this study and the frameworks used to guide both the data collection and analysis.

Section 3 details the study methods and components of the scan.

Section 4 presents the barriers and challenges to peer work that emerged from the scan.

Section 5 presents the factors that were identified as critical to successful peer initiatives.

Section 6 presents the recommendations and guidelines for best practice in peer work for service providers, policy makers and funders.

Section 7 is a discussion of some of the limitations of this scan, as well as suggestions for future studies.

Section 8 contains a descriptive bibliography of key documents for further reading in specific areas related to this study.

## 2. BACKGROUND

### 2.1 Harm Reduction and Peer Education

Harm reduction is a set of strategies focused on reducing the health, social and economic harms related to drug use. Harm reduction, at its core, can be defined as: "any program or policy designed to reduce drug-related harm without requiring the cessation of drug use" (CAMH 2004). Harm reduction is a pragmatic, non-judgmental approach to drug addiction and one that recognizes the importance of peers in supporting behaviour change. The popularity of harm reduction as a means of addressing drug issues grew in response to the public health crises of AIDS and Hepatitis C transmission through injection drug use (Cheung 2000), and as an alternative to abstinence-focused programs and punitive drug policies (Riley et al 1999).

Peer Education is often used as an umbrella term to describe a range of approaches that engage members of a particular target group in delivering health promotion initiatives to their peers. Peer education is a method of intervention that draws on a number of health behaviour change theories<sup>1</sup>. It is based on the belief that peers can be more successful than professionals in passing on information and sharing knowledge. While peer education is often a passive process in which health professionals use members of the community to deliver professionally designed health education interventions, it can also refer to more participatory forms of engagement whereby community members not only deliver, but also develop responses to health and social issues (Southwell N.D.).

Despite the apparent value of peer education and its widespread involvement within harm reduction initiatives for illicit drug users, there is a lack of research about the factors that contribute to the success of these initiatives and of the processes and approaches that could be considered best practices.

Most existing research examines how and why peer education or harm reduction projects are theoretically successful or looks at the theoretical issues underpinning the use of a peer education or harm reduction approach (Walker 1999). In harm reduction, the focus of published evaluations is often limited to quantitative, specific disease outcomes, such as HIV or Hepatitis C incidence. Evaluations that take into consideration the larger scope of harms associated with drug use are few. Most process evaluations, when they occur, are based on individual projects and are difficult to generalize.

There are several studies that examine why harm reduction projects fail and/or the factors that limit their success. Some examination of what constitutes a successful harm reduction program model also exists, but these do not necessarily focus on programs that involve peers. Peer education is, itself, often recommended as best practice within harm reduction (Bottomley, et al. 1997), but analysis of this particular practice within harm reduction is rare.

## **2.2 Best Practices Framework**

Across Canada, harm reduction peer programs with illicit drug users are immensely varied in terms of: level of peer involvement, settings, administrative profile, project goals, approaches, funding sources, project impetus, and political and social context.

Because of the different assumptions and values which underlie various programs, and because programs are diverse in terms of level of peer involvement, setting, political context and other factors; what constitutes 'best practices' in harm reduction peer projects and how success is defined are open to considerable interpretation. Still, there appear to be some common understandings and central elements which are critical to their successful operation, and that can be found across projects.

For the purposes of this project, best practices are common characteristics (actions, principles and approaches) across multiple programs that appear to be important to the successful implementation of peer projects and in achieving outcomes. In order to arrive at these critical success factors, the challenges and issues of peer projects, and how these have been overcome, must be understood. Best practices in this context will take the form of guidelines gleaned from the literature and from key informant opinion, from which others can learn, adapting them to their own situations (Bridgman 2004).

This best practice framework was used to guide both the data collection and analysis of this study.

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<sup>1</sup> Theories with relevance to peer education include: Social Learning Theory, Social Inoculation Theory, Role Theory, Differential Association Theory, Subculture Theories, Communication of Innovations Theory (Turner, 2005).

## **3. STUDY METHODS AND COMPONENTS**

### **3.1 LITERATURE REVIEW**

The first phase of the scan involved a review of the literature. Articles were filtered and prioritized for studies that contain elements of harm reduction, peer education and illicit drug use. This phase also included a web-based document scan for community program-related reports and evaluations that discuss harm reduction peer education with illicit drug users but which have not been published in academic journals. See Section 8 for a detailed bibliography of key documents in the field of harm reduction and peer work with illicit drug users.

### **3.2 INTERVIEWS**

The second phase of the study consisted of semi-structured qualitative interviews with individuals responsible for harm reduction peer projects, activities, or programs within Canada. Key informants were identified through snowball sampling, which involved consultation with practitioners, academic researchers, and others identified through the literature review, document scan, and Street Health contacts; to develop a comprehensive list of initiatives and individuals involved in harm reduction peer projects.

A total 12 key informants were interviewed. Participants were program managers within agencies or organizations responsible for harm reduction peer education initiatives. Although it was anticipated that key informants would be project managers/leaders and not peers themselves, some project managers identified also as peers. The organizations and individuals interviewed were selected for regional diversity and to represent the current diversity of practice in the field, based also on how well they meet the study's overarching inclusion criteria of interventions that: (a) target illicit drug users; (b) involve peer educators to some degree; and (c) employ a harm reduction approach.

Ultimately, data was collected from representatives of community-based organizations (4), community health centre programs (4), a drug user organization (1), an AIDS service organization (1), a municipal public health program (1), and a coalition project (1). The nature of the peer role within these harm reduction projects varied widely. In some cases, organizations and programs were entirely peer-run; in others, peer involvement was limited to ad hoc volunteer roles and program feedback. The work of peers considered in this study includes: outreach, advocacy, education, program management, volunteer community helpers, presentations at workshops and conferences, theatre productions, board membership, participation in research, drop-in managers, and support group facilitators.

### **3.3 ANALYSIS**

Data collected from the interviews was coded and analyzed using an inductive approach to identify emergent themes. These findings were also compared with information gleaned from the literature review. Analysis focused on uncovering common features that had the potential to become generic criteria for best practices.

## 4. BARRIERS & CHALLENGES TO PEER PROGRAMS

Participants were asked to identify barriers and challenges to developing and maintaining successful peer programs. Significant common issues, as well as places of difference, are highlighted below:

### Who is a peer?

The definition of 'peer' varied between projects and presented some challenges within particular projects. This term was not used by all of the study participants. How to define what makes someone a peer is something many organizations felt they struggle with, since defining what makes someone a peer or whether or not to use the term has financial and social implications.

### Stigma

Many participants felt that the stigma around drug use, and of being a drug user, is still fierce and harmful. Some participants highlighted how drug use gets targeted when things go wrong and it becomes a license for others (staff, board members, police) to mistreat peer workers as a major challenge. As one participant describes:

*"When they know that we're community health nurses, our program gets incredible respect – when they think that we're just ex-users off the street who feel like doing this job because we want to give back to the community, we lose the respect for what we do. The community doesn't see a value in users being part of the program and they don't recognize that someone who is currently using has much to contribute."*

### Boundaries

Many participants expressed as a challenge the unique boundary issues that peers face as they attempt to live and work in the same environment. Participants argued that peers face a difficult transition every time they come to work:

*"Peers are in a difficult position that none of us are ... five minutes before a shift, they could be hanging out with people who will then become their clients. Their relationship with their buddies has to change."*

Remaining part of their drug-using community can also mean that peers are at risk for being re-traumatized or triggered.

### Community (Over) development?

Some participants expressed concern that in professionalizing social contacts, role models, and other already established means of sharing information and advice, peer projects may be destroying more sustainable and naturally occurring forms of community social capital among peers and their networks:

*"People do a lot to help each other for free all the time ... when you start paying them, you might create an expectation that you can't help anyone without being paid – on the other hand, poverty is an issue and we get paid for what we're doing."*

### Drug use

Several participants also cited drug use itself as an occasional challenge to peer work. Participants expressed that drug use can intervene, at times, making it hard for people to follow through, slowing things down and causing frustration:

*"It can be difficult to get peers for some projects. It's a chaotic lifestyle. People might become homeless over the course of the project and they won't necessarily tell you ..."*

Some of the disruption caused by drugs may not be related directly to drug use per se, but to the related issues and harms associated with use, such as having to go to jail, or a having to deal with a serious health issue.

### **Lack of agency commitment and integration**

Where projects take place within larger organizations, participants cited a lack of commitment to peer work and/or harm reduction from the larger agency as a major challenge. This lack of commitment limits the amount of support peer projects and peers themselves are given. Related to this, some participants felt that workers in other programs didn't consider peers to be equal staff and have difficulty seeing someone who used to be a client now as their a co-worker. One participant describes this challenge:

*"The community health centre model is integrated ... multidisciplinary ... comprehensive ... but it's often very tokenized - it's there but not really ... we need harm reduction in all different areas of the centre and not just segregated to the peer program."*

How well integrated a peer program is within a larger agency was commonly identified by several participants as an issue. Some expressed that their program felt like an "add-on" or, in fact used to operate as a 'stand alone' program. In one instance, a program that used agency space but couldn't refer clients to other agency programs or at one point in time, even allow harm reduction clients to come inside the agency.

### **Grassroots / Mainstream trade-offs**

Debate exists around whether harm reduction peer programs work better from the grassroots or within more mainstream health services. Several key informants expressed that being part of a bigger organization makes simple things too complex, makes flexibility and quick decisions difficult, and does not always allow for meaningful user participation. Some participants felt that when harm reduction projects are part of more mainstream organizations, however, you enjoy a certain amount of 'public health' capital. Public perception is more positive, you are likely to receive better funding and staff support, and may have closer connections to additional supportive social services.

*"Our challenge is that as a regional program, every decision has to be approved by the board – we can't just decide that something is a great idea and then do it – so many rules and regulations and levels of bureaucracy – entire region has to be evidence based. Great ideas require A LOT of work – have been trying to get crack pipes for years but there isn't enough evidence to convince [the board]."*

### **Meaningful participation**

Levels of peer involvement in harm reduction projects varied widely. Some projects have a high degree of user participation. Other organizations did not feel that they had, as yet, been able to develop a process by which drug users could be meaningfully involved. Some of the barriers to participation that were identified by participants include: not having enough funding, not having enough time, and not being able to relinquish power and control. Examples of these barriers are described:

*"We are big on input – but it's difficult to ask people for input when can't act on it ... because of funding. For example, users have asked for crack pipes but we can't fund them."*

*"Five years ago we had no clients involved in the program at all. The support group helped to create an interest in helping to improve things. Some things take time. They buy into the program more now. It's a growing thing."*

*"You have to understand your own control issues – there are times when you can't control [the process] and have to sit back and let it happen without interfering."*

### Constant Conflict

Interpersonal conflict within the project, conflict around putting the principles of harm reduction into practice, and conflict between drug users and hostile community responses were cited as a significant barrier by participants. As one participant said:

*"Things can be very mean here – we're up against an attitude that thinks drug users are 'bums' who need to 'get back to work'."*

### Supervision

Being both the 'boss' and support person for peer workers at the same time was identified as a challenge for several participants. Walking the line between flexibility and not being able to tolerate when drug use interferes with work responsibilities was highlighted as an issue.

### Legal framework

Participants identified police as both a barrier and facilitator to peer work. Attitudes range from "cops are so evil" to "quite good in working with us." Two participants also identified punitive drug laws as a challenge. As expressed by one participant:

*"Cops are so evil here – they pretend to be progressive but they are actually getting worse. They spend so much money on police – that's all we get in this town. The Four-pillar approach is just a sneaky way of getting more police. They are empowered to do whatever they want to do while on duty to enforce the criminal code."*

### Funding

For most participants, the main barrier cited to successful peer work is funding. Only one person interviewed felt that their program was well taken care of financially. Many expressed that they have no room for extra costs that come up and that they could do much more for peers and the community with more funding. Many participants felt that peers are too often unpaid, underpaid, not paid for training, or not given benefits. Two different participants describe this dual program/peer funding challenge:

*"There is huge potential within peer projects that are often under funded and really struggling to survive year to year."*

*"There is no way to pay peers to participate other than giving them food or bus tickets – the way that the region is set up, we can't pay them to participate."*

### Political Context

Several participants felt that while there is support for some of the tools of harm reduction (like finding better ways to connect with people) and recognition that there are benefits to user participation, it is not followed up with policies, legislation or funding. Participants argued that decision makers are shortsighted and don't provide structures that would allow for the long-term benefits of peer work to be fully realized. Several participants identified the provincial government as being least supportive, both financially and ideologically, of harm reduction. The support of municipal government also varied across projects.

*"Oh sure, people love it – governments eat it up – but it doesn't translate into much money and we all still hate drug users. It's not provincial money that loves it, it's federal."*

## 5. SUCCESS FACTORS

In addition to naming issues and challenges, participants were also asked to discuss how they had overcome these challenges and what other factors (principles, practices, approaches, strategies) were in place in their programs, that they felt were critical for successful process and/or outcomes. The critical success factors identified in this study fell under 5 broad areas: (1) program design and underpinnings, (2) the role of staff, (3) peer support, (4) agency environment, and (5) social context. These five themes are explained and explored in detail below:

### 5.1 Program design & underpinnings

Many participants cited the adoption of **alternatives to the typical client-provider model** as a key element of successful peer projects. A non-hierarchical or collective-run model was described by several managers. One manager described a 'neighbourly-inclusive' model where there are 'no barriers' between staff and peers. Connected to this was the concept of boundaries, or barriers, which were a theme that emerged from every project. While only a few managers described their projects in 'no boundaries' terms, there was agreement that traditional client-provider boundaries are not workable and being able to maintain **flexible boundaries** is critical to successful peer projects.

**Re-orienting services** and processes to the unique needs of peers were cited by many of the study participants as key to successfully maintaining peer initiatives. Some examples identified include: not planning meetings or activities when social assistance cheques are expected, and allowing for breaks every hour during meetings or workshops.

Many participants highlighted operating under a 'true' harm-reduction model, and having this philosophy also run throughout other programs within larger organizations as critical to project success. This included **being non-judgmental**, which was emphasized by several participants. One participant cited a harm reduction approach that emphasizes human rights, in addition to the more mainstream public health emphasis, as key to successful peer project long-term success.

A focus on **empowerment** within projects, whereby peers have meaningful roles, decision-making power and are involved in program development as well as program delivery, was argued to be critical component of several projects. As one project manager explained:

*"Peer projects are primarily about empowerment, so let it be about that ... let them drive it ... let it be peer-driven."*

Some participants felt it was critical that peers be brought in right at the beginning to help plan programs. The importance of **consulting peers first**, before other stakeholders, and of ensuring that peer voices outnumber non-peer voices in any community consultation was argued to be critical to successful peer programs. As one participant describes:

*"The secret of this program has been that, right from the beginning, we have consulted the community that this program affects. A lot of programs make the mistake of asking the community at large and not the drug using community. Whenever you are at a meeting with the larger community, make sure there are more drug users than staff because otherwise drug user voices are intimidated and they won't speak up."*

Several participants cited an **informal and inclusive** form of program design as a key to success. Having 'drop-in' membership in ongoing groups, and a welcoming atmosphere where everyone has a chance to participate in some way was considered important.

## 5.2 The Role of Staff

Being a **good facilitator** was highlighted as an important staff role, and a key to project success. Training in facilitation techniques, such as 'popular education', was cited as critical to the success of two projects.

**Conflict management skills** were also identified as critical to successful projects. Accepting that there will be conflict: around operational principles, interpersonal issues, between your project and the bigger community; and being able to anticipate, minimize and educate others around these issues was seen as an ongoing issue for many projects and, when well-managed, a critical factor in maintaining a successful project.

Several participants also identified the importance of **managing expectations**, of both programs and peers. Having realistic expectations, thereby not setting programs or peers up for failure, was identified by several projects as an important factor. This included having clearly articulated policies around job performance expectations. Many participants felt that because boundaries are, and need to be flexible, it is also important to be clear about what limits do exist. A clear policy about drug use, about what as a supervisor you are prepared to offer in terms of personal support and what you cannot, were felt to be important best practices by some participants:

*"You need to have a clear policy about use. You have to understand that drug use might become chaotic and not penalize a peer for that ... there needs to be some flexibility there. The boundaries will mingle – the peer will mingle with clients. You hire a person who uses drugs – that's an expectation ... and then you try to impose on them certain restrictions that are not functional. This has to be worked out, documented in writing and agreed on between worker and agency."*

There was agreement that an important staff role within peer projects is to **provide balance**. Participants discussed the need to maintain the balance between process and outcomes, between program needs and the personal needs of peers, between providing a structure and adapting it constantly to the realities and circumstances of drug use, to providing some control but also being able to sit back and let things happen without interfering. As one participant put it: *"Your job is just to try to keep it on an even keel."*

Several participants felt that successful peer projects required **personally dedicated staff**. This staff characteristic was described as being 'persistent', 'guerilla', as requiring the investment of personal energy, and as a "willingness to commit to the work that it takes". Several participants also expressed the need to be politically savvy.

## 5.3 Peer support

Several participants felt that **adequate and effective training** for peers was critical to a successful project. Participants singled out communication and counseling skills as important training areas:

*"Training is also really important so they can do more than just hand stuff out ... so they are doing a little bit of counseling, some referrals ... and so they feel confident in their skills."*

One participant also recommended using other peers to provide training, where possible, *"so that [peers in training] can see the future."*

Several participants identified **open and respectful communication** as a best practice. Two participants felt that good communication eliminates any incorrect assumptions – around expectations and around personal struggles that may be impacting performance. Another participant felt that communication was the key to minimizing conflict.

**Adequate supervision** was cited as a critical success factor for several projects. Participants felt that peers, who may not have had a conventional job in years, or in their lifetime, require more support than other employees. Some participants felt that supervision was critically important because of the unique position that peers are faced with, having to live and work in the

same difficult environment. Participants recommended regular supervision at both the group (in the form of team meetings) and individual level (one-on-one to discuss personal and individual performance issues).

Many projects identified practices that help to **protect peers from the stigma** of both drug use and peer work. Using the terms 'users and former users' to describe project participants or calling peer-workers 'assistants' so they can receive more pay from funders who refuse to pay 'peers' an adequate wage, were strategies that participants described. Protecting peers' basic human rights when conflicts arise within the agency and advocating on their behalf with the police, in court, and with other service providers, were other critical supports of this kind that were identified. One participant explains the reason for one such protective strategy:

*"We say users and former users because it protects the anonymity of the spokesperson. They need to be able to hide behind it. A former user is admired and an active user is despised. It's important that peers are protected."*

Many participants cited **rewarding peers** both financially and with a sense of accomplishment as a best practice. Many felt that rewarding peers financially for their participation was vital, even if only through bus tickets or food. Ensuring that peer workers also experience success, on a personal level, was also cited as a critically important component of the project process. Related to this, one participant cited the importance of communicating less tangible successes and explaining why success has not occurred, or has been delayed by external factors.

Taking care of **basic needs** was identified as a critical factor for many projects. Some examples cited by participants include: providing food at drop-ins, a phone or voicemail service, a shower, transportation to meetings, helping a peer to get housing, or making sure that these things are taken care of elsewhere. As one of the participants describes, some of these activities have dual benefits:

*"Do it over food, it's a necessity, and it's welcoming."*

While every participant agreed on the beneficial impact of peer work for the peers themselves, several also noted how challenging and potentially negative for peers this work can be. Being equipped to provide **support for any unintended consequences** was seen as critically important for peer work. For peers whose 'lived experience' is current or very recent, some of the issues and circumstances they will be dealing with may still be very painful or even traumatic:

*"If I was a user, I wouldn't have fought the fight. You have to have no scars of oppression from your drug use in order to be that fierce and get the battle won."*

*"It's not so easy ... no quick fix ... being aware of someone else's suffering and to be able to understand it intimately can be too much sometimes ... it can be difficult if peers feel helpless to improve someone else's quality of life and it can be detrimental to their own mental health ... it's a daunting responsibility that we are putting on people ... do we have the capacity to support all that can come out of that?"*

Out of this understanding, several participants felt that hiring peers with a good degree of stability in their lives was a necessary best practice for certain initiatives.

Several participants highlighted **creating the time** for peers and for peer work as an important element of a successful project. Allowing the time for peers to establish themselves, to reflect on their input, and the need for patience throughout the process were stressed in various ways by several participants:

*"It takes time ... a year is nothing ... it can take a good six months just to figure out the area ... and then establishing themselves as someone who can be trusted and relied on" (K14).*

## 5.4 Agency Environment

Where peer or harm reduction programs are situated within larger organizations, ensuring that the program is **truly integrated** into the broader work of the organization was identified by many as central for effective and sustainable peer work:

*"The rest of the staff are really supportive of what the peer workers are doing. That makes a big difference. A lot of other peer programs have to spend a lot of time educating the rest of the staff about what the value is of a peer program."*

Related to this is the importance of having complete 'buy-in' from the management structures of the larger organization. **Supportive leadership** and a genuine commitment to peer work were highlighted as extremely important. Having a harm reduction approach that runs throughout the organization's other programs was also highlighted as a major facilitator to peer work.

The agency **space** itself was highlighted as an important factor for success. Participants described a home-like environment or a place where people feel comfortable, safe and respected as an important contributor to a successful program.

Although most participants managed projects that were part of larger agencies, several participants (even those situated in larger organizations) felt that **smaller, independent, or "grassroots" settings** better facilitate best practice in peer work.

## 5.5 Social context

Participants identified a variety of strategies that they felt helped them to work most effectively with the broader community.

**Confronting program adversaries.** Several participants felt that meetings and open dialogue with the adversaries of peer work and/or harm reduction was an important approach in developing and maintaining projects. Having statistics that demonstrate program effectiveness was also cited by several projects as critical to success in this area. One project helped the community to form its own residents group and allows one member to sit on their community advisory committee, thus ensuring that the community is only one voice offering input and that the voices of drug users are not overwhelmed. As one participant described their confrontation style:

*"We need to confront the adversaries of harm reduction fiercely but politely, and with good data."*

Trying to **work with law enforcement** was cited by two projects as a key element of success. One project has invited a police officer onto its community advisory board, which they feel helps to manage the negative attitudes and behaviour of other police officers within the division.

A few participants also felt that one of their biggest strengths were their **partnerships** with other agencies and community groups. Being able to rely on other community groups for meeting space, extra funding for special initiatives, and practical advice was seen by some as a critical success factor.

## 6. BEST PRACTICE RECOMMENDATIONS

All of the participants in this study felt that their projects could, with some adaptation, be replicated anywhere. Below is a series of guidelines gleaned from the literature and from participant input on transferable approaches and elements of peer projects that appear to result in successful outcomes.

### 6.1 FOR SERVICE PROVIDERS

- **Peer? Consider alternative terms**  
Using the term 'assistant' instead of 'peer' has allowed some groups to pay their peers higher wages. It may also give peers greater professional credibility. Allowing all peers to identify as either 'current or former drug users' protects current users from some of the stigma attached to drug use. This form of anonymity may help in smaller cities where recruitment is more difficult.
- **Employ a variety of peer positions (of varying threshold and commitment)**  
This allows users to try on different roles depending on where they are in their lives. It also provides an entry point that may enable peers to participate more fully in program design/delivery later on. This combination of formal and informal, multifaceted program design has also been advocated as a best practice in other research studies (Bottomley 1997, Henman 1998; Riley 2003; GLADA 2004).
- **Involve users in program design, not just delivery**  
Bring peers, and potential clients, into program planning as soon as possible. This will ensure relevance and buy-in from your most important stakeholders. Research studies confirm that groups who identify their own specific needs and tasks are more successful than those whose activities reflect outsider interests and objectives (Henman 1998; Jurgens 2005).
- **Provide flexible boundaries and clear policies**  
Traditional strict supervisor/staff or client/provider boundaries are not feasible in harm reduction or in peer work. Clear policies and discussion around the expectations and limits of these boundaries needs to take place with each peer worker and at an agency level. Recent studies by Carol Strike at the Centre for Addiction and Mental Health provide a more detailed discussion of the challenges of defining the boundaries of outreach work (2004).
- **Educate your board and staff about harm reduction and the value of peer work.**  
Persuading others about the value of harm reduction and peer work is a challenge but, once accomplished, can be a major facilitator to successful programs. Ensuring that you have a genuine commitment from larger agency management will avoid conflicts and tension as projects are developed and maintained.
- **Consider ALL the implications of peer involvement**  
Benefits to peer involvement have been documented at a societal, organization and individual level (Jurgens 2005) and were likewise found in this study. However, it was argued in this study, and has also been recognized in other research, that, on an individual level, this experience can also be negative (EPPI 1999). Service providers need to be sensitive to this and equipped to deal with requests for peer support.
- **Consider the social determinants of health**  
Most harm reduction programs do more than simply 'hand out needles' – they provide individual counseling and advocacy, referrals to other service agencies, and other kinds of support. The provision of other services and social programs has been cited as a key to success for harm reduction programs. This same approach should be taken with peer workers. Peers with more stability in their lives, such as housing and other supports are generally more successful at becoming meaningfully involved in harm reduction work (Orme & Starkey 1999; Conner, et al 1999). Helping peers to secure housing, a health care provider, providing food at meetings, providing transportation, etc., will enhance their capacity to do peer work.

- **Don't forget training**  
Adequate training is an important support for peer workers. Do not assume that lived experience is, in itself, sufficient to take on the task of harm reduction outreach, advocacy or other peer roles. Peer work will be more effective and peers will feel more confident when training suited to their particular job is provided.
- **Target the broader community**  
Many feel that harm reduction projects need to move beyond individual and group level programming to explore how the improvement of their broader community context can help reduce drug related risks and harms (Erickson & Cheung 1999; Rhodes 2002). Take aim at policies and procedures that violate or are unsupportive of the rights of peers and clients. Join forces with other groups in your community who are working to make society more equitable.
- **Quality over quantity**  
It's as much *how* you do it, as what you do. So whatever you do – be welcoming, be patient, be non-judgmental, be flexible, and be supportive. Research has shown that the less tangible aspects of service are, perhaps, the most critical for program success (Neale 2002).
- **Make friends with your funder.**  
Find out who sits on funding boards and make friends with them. Invite them to your project, introduce them to peer workers and clients. Personalizing your work will reduce build empathy, understanding and creates allies.

## 6.2 FOR FUNDERS & POLICY MAKERS

- **Projects must be adequately resourced.**  
No project in this study received core funding for its peer program. This practice is short sighted and a disservice to both peers and the broader community. The value of peers and of harm reduction will never realize its full potential unless adequate financial support is provided. Sufficient and distinct funding should be made available for program evaluations.
- **Funding cycles need to be made sensitive to the realities of peer projects**  
Working with peers, developing individual and community capacity, takes time. Funding cycles should be 3 to 5 years to reflect this reality and should not require time-consuming quarterly reports while projects are still being implemented. Funders must be sensitive to the fact that the lives of drug users are sometimes unpredictable (because of ill health, unexpected jail time, etc) and that timelines may be affected as a result.
- **Peer pay equity**  
Honorariums are not enough. Many peers do the same work as non-peer staff across different agencies. Peers should be recognized for the work they do and paid equally for work of equal value. Agencies should be supported to pay peers adequately and to be able to offer them the same benefits as other staff.
- **Create supportive policy**  
The United Kingdom has statutory requirements to ensure that drug users are actively involved in policy, planning and decision-making in their health and social care provision (GLADA 2005, 1). A similar supportive policy would help to create more spaces for user participation, especially in larger organizations where user voices can often get lost.

## 7. DISCUSSION

The purpose of this study was to identify the actions, principles and processes that could be considered best practices in harm reduction peer education initiatives that address the needs of illicit drug users. While some very concrete and quantifiable examples were cited by participants as critical factors to project success, such as providing basic needs and adequate training, the majority of responses suggest that critical success factors are related to more qualitative aspects of program delivery, such as 'flexible boundaries', 'being non-judgmental', 'providing balance', 'personal dedication', and 'creating time'. This finding is reflected in a study by Joanne Neale (2002), which examined good practice towards homeless drug users from the perspectives of both service providers and services users in the United Kingdom.

The findings of these studies suggest the need to rethink evaluation criteria. Participants were asked about how their projects were evaluated and, it is perhaps not surprising to find that few projects have time or funds for regular, comprehensive evaluations of their work. Two participants expressed a desire for more "open-minded", less quantitative forms of evaluation that are better able to take into account the broad range of harms and issues that most peer projects are impacting, beyond disease transmission. They also expressed a need to re-evaluate our notions and indicators of success. These kinds of evaluations require a capacity that does not seem possible given the current circumstances of harm reduction programs in Canada, which desperately lack the necessary time and funding.

As Neale notes in her study mentioned above, some elements of best practice may not feature in findings simply because they were not raised by the participating individuals on the occasion of their interview (2002). A series of focus groups, community forums, or other less-individualistic methods may have produced more robust results since group conversation might have spurred ideas that participants would not come up with individually. It would have also created a space for real consensus building and debate, that is not part of one-on-one interviews and individual analysis. While common themes and principles did emerge from the interviews, different models for peer work and differences of opinion about 'how' peer work should be undertaken clearly exist. A significant limitation of this study and document is its lack of peer worker and/or service user perspective. It is clear from this study that open consultation and debate with a wider range of stakeholders would produce a better picture of the activities, processes and approaches that should be considered best practice.

## 8. FURTHER READING

Below is a selection of papers, articles and other key documents for further reading in specific areas related to this study.

### 8.1 HARM REDUCTION: OVERVIEW

For an overview of the guiding principles of a harm reduction process and of effective harm reduction programs, focusing on injection drug use: D. Riley. *An Overview of Harm Reduction Programs and Policies around the World: Rationale, Key Features and Examples of Best Practice*. Available through the International Affairs Directorate, Health Policy and Communications Branch.

For a provincial harm reduction guide, including recommendations for developing a municipal harm reduction response: BC Ministry of Health. (2005). *BC Harm Reduction: A British Columbia Community Guide*. Victoria: BC Ministry of Health. Available at: [www.healthservices.gov.bc.ca/preent/substance.html](http://www.healthservices.gov.bc.ca/preent/substance.html).

For an international comparison of the factors influencing harm reduction work: Health Canada. *Harm Reduction and Injection Drug Use: an international comparative study of contextual factors influencing the development and implementation of relevant policies and programs*. Available at: [www.healthcanada.ca/hepc](http://www.healthcanada.ca/hepc).

### 8.2 BEST PRACTICE: PROGRAMMING & SERVICE DELIVERY

For a series of case studies evaluating promising community led programs that address the problems caused by crack cocaine: Greater London Alcohol and Drug Alliance (GLADA). (2004). *Community-led innovation in addressing the problems caused by crack cocaine in London*. Available at: [www.canadianharmreduction.com/facts.php](http://www.canadianharmreduction.com/facts.php).

For an examination of best practice from users' and service providers' perspectives: J. Neale. *Good practice towards homeless drug users: research evidence from Scotland*. Available in: *Health and Social Care in the Community*. 10(3): 196-205.

For best practice recommendations for needle exchange programs: C. Strike et al. *Ontario needle exchange programs: Best practice recommendations*. Available at: [http://www.ohtn.on.ca/pdf/Compass/Best\\_Practices\\_Report.pdf](http://www.ohtn.on.ca/pdf/Compass/Best_Practices_Report.pdf).

For an examination of the strengths and challenges of four needle exchange service delivery models: C. Strike. *Needle Exchange Programs – Delivery and Access Issues*. Available in: *Canadian Journal of Public Health*, Sep/Oct 2002, 93(5).

For a summary of the issues around professional boundaries between outreach workers and clients: C. Strike. *Pushing the boundaries of outreach work: the case of needle exchange outreach programs in Canada*. Available in: *Social Science & Medicine*. 59 (2004) 209-219.

For a commentary on what determines successful implementation of harm reduction strategies, focusing on social, political and economic conditions: G. Stimson, and T. Rhodes. *Conditions for the successful implementation of harm reduction*. Available in: *Drug and Alcohol Review*, 16, 178-179

For an evaluation of a nurse-run program employing an empowerment framework for peer programming with homeless people: A. Conner. *Peer education project with persons who have experienced homelessness*. Available in *Public Health Nursing*. 16(5): 367-373.

### 8.3 USER INVOLVEMENT & PERSPECTIVES

For an examination of why it is important to increase the meaningful participation of people who use illegal drugs in the response to HIV and Hepatitis C and recommendations outlining how this can be done: Canadian HIV/AIDS Legal Network. *Nothing About Us Without Us: Greater, Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical, and Human Rights Imperative*. Available at: [www.aidslaw.ca](http://www.aidslaw.ca).

For practical suggestions and recommendations on how to run a peer program: Toronto Harm Reduction Task Force. (2003). *Peer Manual: a guide for peer workers and agencies*. Available at: [www.canadianharmreduction.com](http://www.canadianharmreduction.com).

For the summary of a study aimed at understanding and improving effective user involvement: The Greater London Alcohol and Drug Alliance (GLADA) (2005). *Lessons Learned: some approaches, tools and good practice for improving drug user involvement*. Available at: [www.london.gov.uk/gla/publications/health.jsp](http://www.london.gov.uk/gla/publications/health.jsp).

For case studies on the experiences of a variety of successful user initiatives, including best practice recommendations: National Treatment Agency. *Public Draft 2: A Guide to Involving and Empowering Drug Users*. Available at: [www.canadianharmreduction.com/readmore/facts\\_southwell.pdf](http://www.canadianharmreduction.com/readmore/facts_southwell.pdf).

For an overview of a user-run organization and lessons learned: Health Canada. *Responding to an Emergency: Education, Advocacy and Community Care by a Peer-Driven Organization of Drug Users. A Case Study of Vancouver Area Network of Drug Users*. Available at: [www.phac-aspc.gc.ca/hepc/hepatitis\\_c/pdf/vanduCaseStudy](http://www.phac-aspc.gc.ca/hepc/hepatitis_c/pdf/vanduCaseStudy).

For a description of the challenges and successes of a drug user empowerment initiative: Vancouver Area Network of Drug Users (VANDU) (2004). *Creating Vectors of Disease Prevention: Empowering Drug Users – Final Report*. Available at: [www.vandu.org](http://www.vandu.org).

For a study that documents the health and social impact of crack use from users' perspectives, with recommendations for service delivery and policy: The Safer Crack Use Coalition. *Toronto Crack Users Perspectives: Inside, Outside, Upside Down*. Available at: [www.canadianharmreduction.com/articles.php](http://www.canadianharmreduction.com/articles.php)

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