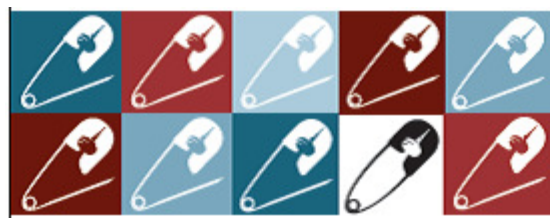


Toronto Harm Reduction Task Force



INFORMATION GUIDE

for peer workers and agencies



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CONTENTS

A POINT OF VIEW.....	6
INTRODUCTION	7
Who is the peer guide meant to serve?	
Who developed this guide?	
What is the intention of this guide?	
WHAT IS HARM REDUCTION	8
PEERS, PEER PROGRAMS & AGENCIES	10
What is a peer?	
What attracts current or past drug users to peer work?	
What are peer programs?	
A successful peer program	
What is an agency?	
What is a mission statement?	
Why do agencies involve peer workers?	
THE BASICS.....	14
Building trust and respect	
The Importance of training	
Intensive agency support and supervision	
SOME CONSIDERATIONS FOR PEERS & AGENCIES.....	16
PEER WORKERS, DRUG USE & STIGMA.....	17
GETTING STARTED.....	19
What does it take to be a peer worker?	
What kind of work is best suited to peer workers and why?	
Learning about an agency	
Goals of a peer program	
How agencies can support peers	
APPLYING FOR PEER WORK/RECRUITMENT.....	22
How can I get a job as a peer worker? How do I apply?	
Where do I look for peer workers? How do I recruit them?	
The job description	
The job interview	
The agency's questions	
Questions peers might ask the agency	
ORIENTATION.....	25
The contract	
Keeping track of hours and work accomplished	
Compensation	
Reporting money received to income maintenance programs	
A peer's plan	
Peers as agency representatives	

TRAINING	29
AODA/WHMIS	
Drugs 101	
Needles/injection drug use	
Kit & kit making	
Communicable infections: HIV, HCV, STIs	
BOUNDARIES & CONFIDENTIALITY	32
What is confidentiality?	
SKILLS DEVELOPMENT	34
Conflict resolution	
Communication	
Active listening	
SELF-CARE	38
Harm reduction through self-care and nutrition	
Trauma Informed Peer Support	
Overdose awareness & prevention	
ADVOCACY/ACTIVISM	46
SUPERVISION	48
What is supervision?	
How can agencies support peers	
How peer supervision is different	
Debriefing	
Evaluation	
When things go wrong	
Consequences	
LEAVING THE AGENCY	54
What's an exit interview?	
Post-contract support	
CONCLUSION	56
APPENDICES	57
GLOSSARY	81

A POINT OF VIEW



A Voice of Experience

I was excited when I learned that the existing peer manual created by the *Toronto Harm Reduction Task Force* was being updated! I've always felt attached to this resource because of the strong impact it had on me when it came into my life . . . at just the right time.

In 2009, I returned to Toronto after having spent several years in my Northern Ontario home community. I returned with renewed commitment and dedication to working in the sex worker and drug using communities. As a street involved kid, I had felt like I was giving the middle finger to the government by not participating in society. Later I'd realized that it was the government that was giving us the middle finger. After losing several friends and family members to HIV/AIDS and Hepatitis C, I began to understand that these diseases were preventable! I came back to Toronto with a richer understanding that many of my experiences were directly connected to poor public policy and the failed war on drugs.

I was a new mama when I moved back here. I had hopes of creating a different world for my daughter than the one I'd experienced. I was living off some money I'd saved and receiving Ontario Works while looking for work. I had next to no (paid) work experience in the social service field or any legitimate field for that matter. I had recently completed a degree in political science, which was proving to be almost useless. I was getting nowhere - not even being invited for job interviews. Then I was told about the *Investing in Neighbourhoods* positions through Ontario Works – paid positions with community organizations that were intended solely for people on social assistance. I found a peer position at a community organization as a peer harm reduction worker. I viewed this as a foot in the door.

Over the next year I learned a lot about peer programs and what they are not intended to be. I desperately wanted to learn new skills and to challenge myself. I dreamed of working in an environment that encouraged me while honouring and celebrating my life experience and passion for change; but I was surrounded by overworked, underpaid, underappreciated frontline workers who saw me as an opportunity to take a break, or to do work they otherwise just didn't have the time or resources for. I was there to fill in gaps – the gaps of underfunded programs that were using peer workers as cheap labour. I was disheartened.

I began to do research and work to re-create my peer position and make it into something empowering and more effective. That's when I came across the THRTF peer manual. It validated my every feeling. It gave me a tool and a point of reference, and encouraged me to challenge my position in the work place. It also helped me feel less isolated at a time when I felt very alone.

Today I have a paid position with a community-based agency that truly values my experience and commitment. I want to say thank you to every person who contributed to and supported the development of this guide, because I know that this 2nd edition will be an even more empowering resource for our community.

INTRODUCTION



WHO IS THIS GUIDE MEANT TO SERVE?

This guide is for drug users, peer workers and the agencies that serve and/or employ them. It was developed to serve in a range of roles but particularly those services which have a harm reduction philosophy and have traditionally served people who use substances. Peer workers are employed of course in a range of settings including housing services, youth, and senior programs, and mental health settings. This guide will be beneficial to not only peer workers in all of these settings and roles, but also to others who are developing their own peer worker programs that may include drug users, former drug users, sex workers, former sex workers, front line workers, grassroots community activists, and harm reduction activists and advocates. Because new concepts and experiences are emerging constantly this guide cannot be considered exhaustive. However it will challenge current conceptions, clarify ideas about peer work, and encourage the further development of harm reduction peer programs.



WHO DEVELOPED THE GUIDE?

This guide is intended to serve peer workers who are generally supporting marginalized populations that are often stigmatized and discriminated against. It was deemed imperative for peer workers themselves to be directly involved in every stage of development of this resource. Peer workers, other drug users and former users, allies, and harm reduction advocates all contributed to the research, development, and writing of this guide.

Due to the ever increasing and changing knowledge base surrounding peer worker programs, and thanks to the ongoing commitment of peer workers and our allies, this guide is a “work in progress” and will be subject to regular updates. For this reason you are now reading the 2nd edition of this guide (the 1st edition was published in 2003). We look forward to feedback and suggestions for inclusion in future updates.



WHAT IS THE INTENTION OF THIS GUIDE?

This guide is intended to provide an easy to use resource for those entering the sphere of peer work. It will assist by helping to clarify harm reduction definitions and terminology, and will speak to the systemic oppression of marginalized populations including people who use drugs. It will challenge some of the misconceptions people have about drugs, drug users, and peer work. It is also meant to encourage the development of additional peer programs. Please feel free to photocopy and hand out all and any part of this guide.

WHAT IS HARM REDUCTION?

Harm reduction is “a policy or program directed towards decreasing the adverse health, social, and economic consequences of drug use, without requiring abstinence from drug use.” *

If you are reading this, then chances are you're either considering working as a peer or hiring a peer. You may also work in an agency that is considering starting a peer program. That being the case, you will have to know what harm reduction (HR) is. Harm reduction is a philosophy and a practice that seeks to reduce the physical, mental, emotional, financial, or social harm to individuals and communities that can be associated with substance use, without requiring abstinence. Abstinence is part of the harm reduction continuum and some people who incorporate harm reduction practices into their lives are working towards abstinence. What makes HR different from other approaches is that harm reduction programs never demand abstinence or see it as the goal everyone should strive towards. Each person's goal is their own.

Harm reduction works not only on a personal level but also with a broader scope. For example, an individual may make personal choices that will reduce the harm that could be caused by their drug use, such as not sharing crack pipes or smoking heroin instead of injecting it, not drinking and driving, or not smoking marijuana before showing up for work. Sharps containers in public places mean fewer used syringes turning up in trash cans or parks, and fewer accidental stick injuries.

Educated choices have an impact on the individual, their friends, families or their neighbourhoods in tangible, real ways. As individuals, peers may also strive within an agency to broaden harm reduction practices and philosophy.

***Harm reduction is a way of life,
and peer work puts you back in
touch with the real world...***

-Heather



Harm reduction philosophy rests on several basic assumptions:

- There has never been and never will be a drug free society.
- Substance use is a health issue, not a moral or criminal one.
- Harm reduction seeks pragmatic solutions to the harms that can be connected with substance use, but also attempts to address the more significant harms that are caused by prohibitionist drug policies.
- Harm reduction philosophy acknowledges that there is no single way to address drug related harms, and many different strategies may work.
- Any strategies to address harm should be based on evidence-based research, public health and human rights.

* Erikson, P., Riley, D., Cheung, Y., & O'Hare, P. (1997) Harm Reduction: A New Direction for Drug Policies and Programs, Toronto: University of Toronto Press

- New measurements of success need to be established. While many current drug policies and programs measure success by a reduction in use, harm reduction encourages people to develop their own markers of success.
- Incarceration does not reduce harms from substance use or trade. It increases them.
- The prohibition of drugs and drug use has caused far more harm than the drugs themselves.

On a broader level, an agency, organization or government may implement harm reduction policies or legislation. This may take the form of outreach programs or organizational policies which encourage peer programs. It could also include the design and implementation of city-wide approaches such as the Four Pillars policy first developed in Vancouver, here in Toronto and elsewhere (for details please see www.toronto.ca/health/drugstrategy). It can also include advocacy regarding legislation such as marijuana laws and policies that can have a very broad impact, affecting the lives of a lot of people.

Many European countries are far ahead of Canada in terms of adopting harm reduction philosophy into their public health and governmental policies. In 2001 Portugal decriminalized the possession of all substances and has seen a dramatic decrease in the harm to individuals and communities. Switzerland, The Netherlands, Portugal and other countries can serve as inspirations, as well as provide examples of how innovative public health policies can reduce harm.

Harm reduction begins by accepting that people have always done risky things, and always will. Some people have always used drugs and some always will. There's not much point in denying this. Harm reduction means anything that manages, minimizes or diminishes risks or harms associated with those behaviours.

Harm reduction is about mitigating the risks associated with drug use to both users and the communities where they live -- without requiring abstinence. Just as drug use is a continuum, all the way from chaotic, problematic use, to use and abstinence, harm reduction too provides for a continuum of tailored strategies that meet peoples' needs to mitigate risks. It's important to stress that there is a difference between use and dependence, and to remember that not all users are addicted. It is also important to qualify that abstinence might mean abstinence from all drugs, or just abstinence from a particular drug.

Essentially what harm reduction means to me is to make sure that substance use is redefined in peoples' thoughts as a public health issue, not a criminal justice one. – Russell

Harm reduction exists on a continuum from relatively simple strategies that individuals can implement to larger scale programs that require community and governmental support.



Some examples of harm reduction strategies include:

- ID clinics so people can qualify for social assistance and get access to healthcare;
- ID vaults or trustees hang on to people's ID to ensure it isn't lost or stolen;
- Meal programs help ensure that users have access to food;
- Good Samaritan policies implemented by drop-ins, health centres and other programs ensure that users feel safe taking action if a friend overdoses;
- Access to condoms, syringes and pipes help to reduce the risk of HCV and HIV infection;

- Distribution of Naloxone kits, and training in their use to reduce overdose deaths;
- Safer use sites reduce overdose-related deaths as well as risk for HIV and HCV;
- Street nurses who meet clients “where they’re at” provide basic health care to marginalized clients;
- Wet shelters and wet housing reduce emergency 911 calls and also reduce the street mortality rate of people who can become critically ill after consuming non-beverage alcohol;
- Opiate replacement therapies (i.e. methadone) which can give people a greater amount of control over their use, and is especially useful for individuals seeking to cut down or abstain from using.

All of these are forms of harm reduction practice. They all save lives, humanize users and improve access to health and social services. Peer work itself is harm reduction, because it helps reach those people that agencies cannot, and improves the role of users in directing and requesting services.

....one of the reasons for low HIV rates among drug users is the practice of some Toronto outreach programs to use peer workers in all aspects of service delivery... - Walter

PEERS, PEER PROGRAMS & AGENCIES



WHAT IS A PEER?

The dictionary says one definition of peer is “belonging to one element of society.” Within the harm reduction context, a peer is a person who has experienced situations similar to those faced by the clients an agency serves. This means peer workers may be hired because of their present or past street involvement, age, sexual identity, life-situation, even specific type of substance use (just to name a few). Generally, peers have some kind of inside knowledge through their experience that can have a positive result in providing services to a particular group. In addition to experiential knowledge, peers can bring credibility and trust to an agency in ways that regular service providers may find difficult because users may distrust and avoid contact with official helpers.

Peer workers mentor, educate and offer emotional, social and community support. They listen, advise, refer and provide practical information and/or supplies. Peer workers conduct community outreach, provide educational workshops and staff drop-ins, harm reduction rooms and support groups.

Peers are people who share significant life experiences – good or bad – and want to use their expertise to help others like them. – Joy



WHAT ATTRACTS CURRENT OR PAST DRUG USERS TO PEER WORK?

There are many reasons people might want to become peer workers. The desire to use their knowledge and experience in positive ways is a common reason. Peers may be seeking experiences that contribute to personal empowerment.

Peer work helps you contribute to society, be a part of the world and reconnect – Heather

The opportunity to hone or develop skills is also important to peer workers. Empowerment can be obtained through opportunities to express their needs, to affect social change in their communities and to reclaim personal history that may have been viewed negatively.

Drug users may want to be in a supportive environment while adjusting to social and/or economic changes or challenges. They may have a desire to help those in their personal networks, i.e. friends, family and community connections. Part-time work provides peer workers with opportunities to get current job experience, a good reference contact and the opportunity to learn about health care and community work. Peers may also be motivated by altruism and/or financial compensation for their work or may want to avoid the isolation that comes to so many drug users.

Peer work involves supporting others in a community of equals who share similar histories and life circumstances in order to promote strength and healing. In the case of peer-based harm reduction work, this means peer workers offer support to others who have substance use issues and similar life experiences.

The best thing about working with peers is the enthusiasm and passion...they help you see different perspectives and remind you to think outside the box - Deborah

Benefits for peer workers should include training and skills development opportunities (see Appendix A), including a chance to try on the role of service provider. It should also include some kind of payment for the work done. Whatever the nature of the duties performed by peers, or the recognized rewards of the position, peers, agencies and ultimately, clients all benefit from peer programs.



WHAT ARE PEER PROGRAMS?

Peer programs may be relatively new, but the thinking behind them has been around for quite a while. In essence, peer programs are modeled on the more established self-help concept. Peer programs and self-help groups share the premise that *“the wisdom of the community will always exceed the knowledge of the expert”* (John McKnight). The development of peer programs began with this realization. In short, peer workers are the bridge or conduit between service users (or potential users) and the agency. Like any structure, the bridge must be built according to a plan, and will require regularly scheduled maintenance to ensure its ability to support the load safely and reliably. Many components are needed to make peer programs work. These will be explored in more detail throughout this guide.

Peer programs bridge the gap between privileged folks who have gone to school to train...and those who have lived experience... – Leah



A SUCCESSFUL PEER PROGRAM WILL BE:

Voluntary

No one should ever be forced or coerced into taking on a peer worker role. The voluntary nature of the role makes it easier and more natural to build truly trusting and supportive relationships with others.

Respectful

Everyone has something important to contribute. Peer workers are welcoming and accepting of others no matter their community, religion, gender, race or class. Peer workers regard each other with the utmost dignity, empathy and compassion.

Peer work has opened up new horizons in my personal life. It gets me out of bed and up and moving. – Dina

Ensure Confidentiality

Trusting relationships are built over time. People generally test the waters gradually, divulging more about themselves and their needs as the relationship progresses. A breach of confidentiality could not only halt the supportive nature of the peer to peer connection, but may also prevent an individual from accessing this type or indeed any type of support in the future.

Have Regular Training, Supervision and Upgrading Opportunities

It is essential for agencies, organizations and grassroots groups who wish to develop their own peer worker programs to recognize that, like staff, peer workers need not only initial hiring orientation but also ongoing training, education and supervision/support if they are to realize their potential in the peer worker role. Regular training should be built into the programs from day one.

Include Long –Term Planning

To ensure the long-term provision of quality peer worker programs, ongoing planning, review, evaluation and analysis is essential. This must include voices from within the agency including peer workers themselves, front line workers, program developers and supervisors, as well as agency management. Solid evaluation and planning will also include persons from outside the programs' agency, and should include professionals, and experts in the field including peer workers, community members and staff from other local agencies.

Provide Relevant Services

Services provided must make sense and provide supports needed by a particular community of people. For instance, harm reduction based peer outreach makes perfect sense if provided to a community of people who use substances, but may not be relevant to people who are under-employed.

Share Power

To ensure truly equitable services, every person participating in a peer worker program must have the same opportunity to voice ideas, expertise and opinions, with each person having equal importance to the next. This means that all contributions are considered equal and all who contribute share responsibility for outcomes. Sharing power in an equitable manner demonstrates that it is possible to have non-coercive, non-violent means for influencing the world and encourages the continued development of personal empowerment.

Reciprocal

We all have things to offer and learn from each other; each of us gives and receives. Peer relationships differ from other helping or treatment based relationships in this way. We are all seen as equal to one another. As opposed to those receiving the help and those giving the help, peer worker relationships are give and take.



WHAT IS AN AGENCY?

There are a variety of agencies that may be considering developing or may have peer programs and are looking for peer workers. Some of these may be involved in health care such as community health centres (CHCs), or housing agencies such as Fife House. Some may be daytime drop-in agencies, like The Meeting Place, or St. Stephen's Corner Drop-In. Some agencies may be involved in advocacy and changing the system such as PASAN (Prisoners with AIDS Support and Action Network). The Toronto Harm Reduction Task Force, the agency that coordinated the project that produced this guide, is another example of an advocacy agency. Many types of agencies can provide meaningful work for peers.

Since harm reduction is a continuum, all the way from providing access to factual, non-judgmental information to sterile syringes, many models and policies exist within the harm reduction framework. Potential peers should get to know what kind of agency they may be working for.



WHAT IS A MISSION STATEMENT?

Most agencies or organizations have a mission statement or mandate. This is, in a nutshell, what the agency stands for, its philosophy, the kind of work it does and the population it serves. It is usually a short paragraph that describes what an agency does and how they aim to do it. A mission statement is a public document and is available to anyone who asks. When interested in an agency it's a good idea to read its mission statement and any other information available about it (see appendix B). Because the mission statement only outlines the broad goals and vision of the agency, potential peers may also want to talk to other people in the community to find out their opinions and experiences with that particular agency. When it comes to harm reduction, it is important that the agency views substance use as a health issue, not a criminal one.



WHY DO AGENCIES INVOLVE PEER WORKERS?

There are many reasons why community organizations and service agencies put peer programs to work in their communities. By involving peers in working with the client group, organizations can gain a greater understanding of the communities they serve. Whether peers are helping with day-to-day tasks at the agency like answering the phone, organizing and tracking harm reduction supplies or doing street outreach, peer workers provide valuable services to an organization. Making and maintaining contact with socially isolated people can be difficult. Peer programs can be an effective way to reach these people and provide them with information about the agency, its goals in the community and the programs and services it provides. An agency with peers in the house has people with an intimate understanding of the community that the agency wants to reach. Peers have insider knowledge that no amount of observation or formal education can master. Peers can walk the walk and talk the talk; this can and will help develop the trusting relationship necessary for the most comprehensive service delivery. Contact with peers may enable a good agency to help someone who, in the past, may have had bad and painful experiences with agencies less suited to deal with their specific needs. Unfortunately peers may also be hired because it is part of a

There are so many reasons why agencies should incorporate peer programs and services...for community engagement, effective service provision, staff development...a peer program will respond to these issues and so many more.... – Lorie

program's funding requirements, a program is understaffed or because peer workers can be paid far less than professional workers. Peer workers looking for an agency or program to work for should research the program and staff to ensure they value peer work and the expertise that peers bring.

Peers can also be a connection to socially isolated communities. Through the peers' knowledge of and intimacy with those communities, agency staff can increase their knowledge and better serve their clients. Peers are likely to have better information about the current issues in different drug using communities and have practical ideas on how to address those issues.

Peer workers greatly speed up identifying drug users and advocating for the credibility of an outreach program....and enhance the safety and accountability of a program - Walter

Peers can promote services and provide written and oral information on health and safer drug using practices to clients. When properly trained, they can also provide basic counselling, conflict resolution and service referrals. The peers' position should be an education tool for all involved: the peer workers, the clients, the organization and the community.

THE BASICS



BUILDING TRUST AND RESPECT

Having peers in the organization can be a challenge for both the agency and the peer. If an agency has no experience supervising peers there can be significant barriers to establishing a trusting relationship. Having preconceived notions of how peers are going to conduct themselves in any given situation or how an agency is going to deal with any problems that arise can make building trust a real challenge. It is important that both the agency and peers have a good understanding of their rights and responsibilities in this relationship.

It is often the peers' job to reach out to those who don't visit the host agency. Sharing similar experiences with someone from the street community can make it easier for clients to relate to peer workers than regular service providers. However, the agency must help understand and develop firm boundaries regarding work and play.

A contract for peer services should describe the details of peers' duties and responsibilities (see Appendix C). However, it is important that the agency take the initiative and make sure that peers are aware of the organization's role in the community and the rules that govern how people conduct themselves when representing the organization to members of the community.

The people we're trying to reach know they can trust me because they know I've been where they are. – Jim.



THE IMPORTANCE OF TRAINING

Agencies should take a systematic approach to supervising and training peers. A weekly work review and problem solving meeting during an initial probationary period might be used to help determine where the challenges are for peers and what skills they might need to upgrade. Job duties must be clearly defined and set up in a manner that fulfills the agency's need and provides work related supports. These jobs must also have enough challenges built into them for peers to develop new skills. Goal setting and training within the agency can range from learning how to use the special features of the photocopier to learning more complex tasks such as maintaining a database of outreach statistics or crisis intervention.

Typically, peers will need training or skills enhancement in communication skills, work related limits and personal boundaries, conflict resolution, specific job requirements, basic counselling, as well as HIV/AIDS, hepatitis, T.B. and STI education to effectively deliver services. In many cases, agencies receive funding to pay peer workers to do specific tasks, but not all are funded to pay peers to attend training sessions outside the agency. This is unfortunate because there are many free, appropriate training opportunities (see Appendix A) for peers and staff available. Agencies should identify paid training time in proposals to help funders understand how important training is for peers. Skills development and capacity building are big parts of any peer program -- restricting peers' participation in free training is counterproductive to these goals. Many peer programs develop training partnerships with other programs. This can be an effective way of sharing knowledge and experience, and creating opportunities for peers from a wide variety of programs and areas of the city contributes to a united community of peer workers.

***Peer work is the answer to a lot of problems facing society associated with drug use... being a peer has helped me realize that I'm a real person and I matter.--
Janice***

Peers should also become familiar with other agencies working in the harm reduction field, whether right in the neighborhood, nationally or even worldwide (see Appendix D). Listen and learn! Peers have a wealth of experience, and by actively seeking out more and more info about safer sex, safer use or disease prevention, peers can become more effective workers and tremendous assets to an agency.



INTENSIVE AGENCY SUPPORT AND SUPERVISION

Supervising harm reduction peers can be a particular challenge for an agency, and they should be prepared to support peers through whatever difficulties arise. A worker supervising peers should be someone who is capable of recognizing, guiding and recording peers' progress in their position at the agency. A supervisor should be able to understand how people come to be peers in the first place and the special concerns that can arise because of this. Sometimes using substances can be like riding an emotional roller coaster. Agencies should be prepared to support peers whenever they say, "I'm feeling triggered or vulnerable." A temporary reassignment of duties or a few days off, or just letting peers know that this is normal, may help. While an agency might be concerned with supporting the emotional needs of its clients, it may not see staff, volunteers and contract workers as needing such services, and there may be little support for these people in an agency mandate. Peers occupy a special position at the agency and as such should be afforded opportunities for discussing personal problems as they arise. Those who supervise peers need to be wary of burn-out too. They may need additional support as supervising peer workers can be demanding at times.

Peers play interpretive roles both in the agency and on the street. In a harm reduction model, their job is to attempt (with support and resources) to bridge or connect the social/health agency with the underground drug using world.

Peer workers are often under a lot of pressure adjusting to agencies' policies and procedures, while continuing to relate to their using networks. Peers need opportunities to discuss their activities and feelings as soon as possible after each shift to emphasize the necessity of being able to express the difficulties in dealing with their dual position. This is known as debriefing. Peer support workers should feel comfortable speaking their minds and be encouraged to speak honestly without fearing judgment or repercussions.

I've always felt gratitude for the peers I've worked alongside – there have been many lifesaving contributions made by peers in our communities. – Leah

SOME CONSIDERATIONS FOR PEERS & AGENCIES

The past decade has seen considerable expansion of harm reduction services across our health care system. These services are primarily delivered by community-based agencies that vary in both their scope and the diversity of their clientele. From ASOs to youth-centred organizations, to gender-specific and sex-worker groups, to more mainstream CHCs and public health clinics; opportunities for peer work appear more promising than ever. But with this growth, inconsistencies exist, not only with basic training but from the differing workplace cultures within agencies and the various duties that peer work can encompass. This can lead to some confusion and potential frustration for peer workers, coordinators and other staff and management. Differing styles of management can also be a challenge. There needs to be more than just a description of peers' duties: be they kit-making once a week, a regular outreach shift or on-site responsibilities in a needle-exchange. Along with clearly defined duties, it is recommended that all staff members be made aware of the specific roles that peer workers fulfill and the value and expertise they bring to an agency/organization.

Many peer workers come from environments where they've been marginalized if not ostracized or even criminalized for their drug use. Integrating them into a formal workplace -- office or clinical setting -- can be challenging and overwhelming. Peers may have feelings of inferiority and perceive that they are being watched or over-scrutinized despite their valued experience. In addition to training and orientation, sound and supportive consideration about inclusion would ease the transition for everyone. Where appropriate and when possible, include peer workers into staff activities (i.e. meetings, in-house training, hiring committees, special events, celebrations, etc.) This is not simply office etiquette; it helps normalize the workplace for peers and empowers and improves their self-esteem.

Most organizations have governing bodies such as boards of directors and advisory committees. It is well known and established that the inclusion of people with lived-experience such as peers greatly enhances the agency's knowledge of not only harm reduction but advocacy for marginalized people in general. The primary concern with these governance roles

for peers is two-fold. First, is the peer-candidate ready and prepared for the added responsibility? And second, are they more than just token members of the board or committee? Real inclusion and integration requires not simply an opportunity; it requires an equal voice within the group. Being the sole representative of a community can be a challenging and daunting task.*

Harm Reduction at Work: A Guide for Organizations Employing People Who Use Drugs (<http://www.opensocietyfoundations.org/reports/harm-reduction-work>) is an excellent resource targeting primarily agencies that employ peer workers in the harm reduction community. It offers various examples and scenarios of differing work conditions that agencies may find themselves facing when operating peer-based programs.

The employment development model has identified the graduated transition of peers to employees. These duties may include relief and reception work for regular staff, drop-in and on-site facilitation in a more formal capacity, mentoring and training new peers. These roles require more responsibility and reliability and as such, anticipated expectations are much higher.**

It's important to recognize where peer work stands in the larger context and of work. Peer programs have been created not only to provide valuable services to the community, they also serve to nurture and promote peers through a continuum of skills development and ever-widening roles. Agencies should include peers in the decision-making process and make peers feel welcome, appreciated and respected.

I evolved from being a peer to being a peer supervisor and can see how many doors being a peer opened for me.... –Heidi

Peer work is about improving your understanding of drug use, extending that knowledge back out into the community and using your past experiences in a positive, proactive way. - Valerie

PEER WORKERS, DRUG USE & STIGMA

When people identify themselves as drug users or former users, they can experience shame due to the stigma attached to drugs, and to people who use them. This can be particularly challenging for not only peer workers but the agencies that employ them.

Problematic drug use has been noted as a highly stigmatized human condition, due in part to the belief that use is a choice made deliberately and consciously. As such, the user is often considered not only responsible, but deserving of any consequences of that choice.

*Consumer Survivor Initiatives in Ontario: Building for an Equitable Future, 2009, pp. 32-40

**Shifting Roles: Peer Harm Reduction Work at Regent Park Community Health Centre, 2011, pp. 11-17

Many drugs are illegal and use is criminalized; the perception that drug users are unpredictable and dangerous results in them being socially excluded or marginalized. This social climate of stigmatization, discrimination and social exclusion is powerful and often keeps people trapped in a drug centred lifestyle. Blaming people who use drugs and the resulting shame does little to encourage positive changes in behaviour and lifestyle and in fact motivates hiding, avoidance and escape.

Understandably, within marginalized communities there's a distrust of service providers. They're often seen as maintaining the status quo. This is partly because of past experiences when users haven't been taken seriously, or have been denied access to services.

Social service and health care providers often seek to change or rehabilitate problematic drug users. The principles of self-determination and autonomy aren't valued. Not surprisingly, this can lead to reluctance on the part of marginalized people to connect with service providers.

Evidence has shown that including peer workers is an important, effective way of building rapport with people who are marginalized. Peer workers who have lived experience understand the stigma and discrimination experienced by people who use drugs.

By working from a place that meets people where they're at, service providers, including peers, build mutual respect and understanding with clients. Then conversations can take place. Then services can be tailored to really meet the needs of those for whom they're meant. And then, services become more accessible and the people who use them less socially isolated. Including peer workers in program development and implementation is an extremely effective anti-stigma tool.

Peer workers challenge and dispel myths and beliefs attached to drugs and the people who use them, not only at the community level but within drug using communities.

The inclusion of peer workers demonstrates that abstinence is not a requirement for employment. Peers have the willingness and ability to work. They are dependable, responsible and able to meaningfully participate in service delivery.

Peer workers are amongst the lowest paid workers with minimal job opportunities and even fewer opportunities for advancement. Paying peer workers a wage that is equitable, including benefits and raises, in addition to building in opportunities for advancement within the agency or partner agencies, would help staff view peer workers as equals.

Non-judgmental service provision is paramount for a harm reduction service, yet the stigma associated with substance use is so entrenched it is a great challenge for anyone who hasn't struggled with substance use to truly provide non-judgmental service. Peers greatly increase our ability to do so. – Lori

I've never had a problem with drugs. I've had problems with the police. – Keith Richards

In conclusion, identifying employees as peer workers can be stigmatizing. It tends to out people as drug users and inextricably ties them to the target population they are serving. Consequently, it can become a means whereby peers are distinguished from the other employees of their respective agencies. Alternatives to the term peer worker, such as community support worker, need to be considered.

We have to be careful not to confuse “peer program” with the practice of hiring people with lived experience. Each has its own value, purpose and outcome, and each provides a chance for opportunities to truly work with people where they are at. If we hire someone simple because they use substances and expect they will be able to succeed in a professional environment, we have failed before we begin. If we continue to only hire those with lived experience as peers, we have failed then too. Ideally, we will hire those with lived experience to assist in developing and implementing and running peer programs. – Lorie



LANGUAGE & STIGMA

Language matters. Words like junkie, crack-head, druggie and addict carry negative associations. And if someone is clean when they're not using, what does that mean they were before? Dirty?

Imagine if this kind of language was used to describe any other group of people – e.g. women, people of colour, the LGBTQ community, or people with developmental disabilities!!

Using harsh, judgmental words about people is hurtful and does nothing to help them. In fact, people can internalize others' critical words and begin to think of themselves as worthless, which sometimes leads to risky behaviour. People who work from a harm reduction perspective don't use this kind of language, and discourage its use by others.

Drug use does not define people. No single attribute or behaviour defines anybody. Just as we've learned not to talk about the homeless and instead about people who are homeless, people who use drugs are people first and foremost.

No human being has ever been made better by being stigmatized or discriminated against... - Dr. Peter Ferentzy

GETTING STARTED

Both agencies and potential peers must do a lot of work before the program can even start. Peers must decide whether they are ready for the commitment of a job, what kind of work they would like to do, and what type of agency they would like to work for. Agency staff must decide whether a peer program is the best way to address needs in the community, how much time and energy they are willing to put into a peer program, how peers are going to be compensated, what work needs to be done by peers and much more. This section will try to raise some of these issues and point the way to some responses.



WHAT DOES IT TAKE TO BE A PEER WORKER?

One of the most important parts of being a peer worker is to be open-minded, non-judgmental and open to learning. The lived experience peer workers can share can be very helpful, but peers also need to

keep in mind that everyone does things a little bit differently. There is no one right way, and all experiences should be honoured. It is also important to be open to training. While lived experience gives peer workers access to vast amounts of knowledge, everyone has skills they can improve and areas where they can learn more.

For peers, acceptance of drug-using history and/or knowledge is necessary for becoming involved in peer work. Many peers believe that understanding substance use requires peer workers to have lost and gained control of their drug use a number of times. Most peers have experienced the isolation that comes with fighting cravings, the relief of giving in and the frustration of feeling they've let themselves down. This understanding of what can motivate using patterns is experience-based, and many drug users believe this cannot be understood by theory or observation alone.

Being a drug user or even being suspected of having involvement with the drug trade is culturally considered a low class position, particularly if one is poor, injecting or using crack. The social stigma of being a user often creates even more economic and philosophical barriers. Having or having had this position in society is considered vital to understanding the personal limitations brought about by social marginalization. This is the foundation of peers' expertise. They can be drug users that consider themselves specialists in the community.



WHAT KIND OF WORK IS BEST SUITED TO PEER WORKERS?

Peer positions must be created out of community need. Agencies can discover this need through their own efforts (surveys, client interviews, etc.), or through spontaneous feedback or criticism from clients and/or the community. Agencies have employed peers in a wide variety of capacities. Needle exchange programs can offer peer positions both in the needle exchange office and by extending services through community outreach and support programs. Other examples of outreach and support programs are drop-in programs, homeless outreach services, housing access and support services, I.D. clinics, and dedicated case management services. There are work opportunities for peers in all of these.

It's especially important for peer workers to experience at least small successes when starting a new job, and people prefer to do things they're good at. A skills assessment tool can be helpful in determining what kinds of work peers are best suited to, and what skills or experience they are interested in developing (see Appendix E).

Peers have the capacity to listen and provide feedback, counsel, mediate, educate, make referrals, advocate, plan, develop and evaluate tools and programs, facilitate focus groups, do research and administrative tasks, coordinate events ... the list is endless and is definitely not limited to street outreach or condom distribution.

By offering a range of peer-supported services, agencies can help develop a network of community members capable of much more than just distributing health information and basic medical supplies to active drug users, in effect, a broad resource base for healthful change.

When I think of peer based programs the word that comes to mind is "transformation". – Joe



LEARNING ABOUT AN AGENCY

Talk, talk, talk, read, read, read, learn, learn, learn! The clearer peers are with the agency, hopefully, the clearer the agency will be with peers. A lot of mistrust or just bad feelings occur because peers may not know where the agency is coming from, and the agency doesn't know where peers are coming from. The more communication between an agency and its peer workers the better the relationship will be.

Peers need to benefit from the job, and the agency has the responsibility not only to ensure that services are delivered responsibly but to make sure that peers are gaining from the experience. Remember that the experience peers bring is a valuable asset to the agency, and in turn, the agency has the responsibility to ensure that peers get regular support and encouragement. Supervision and debriefing are as important for the agency as they are for peers. Language and specific terms may come up: mandate, procedures, confidentiality protocols, reporting hierarchy and will need to be explained.

Agencies should educate their staff and peers! Peers have often faced stigma and discrimination from other staff that have not worked with peers before or have had no education about the important role peers fill. The more the other staff understand why peers are important and can recognize the incredible connections to communities they make on behalf of the agency the better the relationship will be.

Finally, there is the issue of trust. Agencies have to trust the peers they hire, and show that trust. Remember if your agency works with street-involved drug users, these people have probably been constantly abused by cops, security guards and the general public. By including peer workers at staff meetings or at an agency social event, an agency can go a long way to building that trust.

People are more important than projects. – Russell



GOALS OF A PEER PROGRAM

An agency must be clear about what it expects from its peer program. Some examples might be to have a peer who is reliable and can relate to clients, to have a program that employs people to have a positive influence on the community, clients, and the agency, or to provide enhanced services to their clients. It should be as much a benefit to the agency to have peers, as for peers to have the position. Good training should enable peers to combine old skills with newly acquired ones. This facilitates the process of self-acceptance and the confidence to find employment elsewhere if this is a goal for peers

Adopting a harm reduction based philosophy to service delivery can require the agency to set a new agenda of goals. Harm reduction programming requires staff education and training, new funding directions and language, some restructuring of administrative procedures and appropriate space and access to basic office supports. Many harm reduction agencies engage in the role of advocate in addition to providing direct service. This serves to promote harm reduction in the realms of public education and peer program advancement. This is a practical and natural extension of the agency's role or responsibility to the peer and to the success of the peer program.



HOW AGENCIES CAN SUPPORT PEERS

In order to provide a beneficial peer program the peers' expertise must be valued. A program must prove that they value the peer position by providing skills training in a practical working environment. Agency staff must also be aware of the unique pressures that peers must learn to cope with in a work environment. Creating systems such as regular check-ins prior to and debriefings following each shift, in addition to regular supervision sessions to deal with potential challenges will help reinforce what is expected of peers and how agencies can support them.

One of the best things about working with peers is getting access to current, relevant experience with drugs, alcohol and homelessness. – John

APPLYING FOR PEER WORK/RECRUITMENT



HOW CAN I GET A JOB AS A PEER WORKER? HOW DO I APPLY?

Well the best way is to do some homework. Word of mouth is one way to find out. What do people say about the agency? If an agency is of particular interest, find out more about them through their mission statement or website. Find out if they have a peer program, or if they know of other similar agencies that provide peer programs. Try volunteering for a while to get the feel for what they do and how they operate. Those who are interested in peer work might even send a letter of inquiry to agencies they are interested in working for before a job posting goes out. This lets the agency know that they're serious about a peer position - even if there's nothing available at the time. An inquiry may get a referral to another agency that *is* hiring.

Peer opportunities are often advertised on an agency's website or on bulletin boards in drop-in centres and other user-friendly places. Peer applicants may have a resume, or may not. There are a number of places in and around the city where people can get help putting a resume together (see Appendix F). Often agencies are only looking for a simple letter of introduction because a lot of people may have difficulty putting together a resume. A letter of introduction should have the applicant's name, where and how they can be reached, and just a little bit about the person such as why they think they would make a good peer. Getting someone to help write the letter might be an option. Or arranging a meeting with the person who will be coordinating the peer program might also suffice.

Agencies should understand that an inconsistent work history or literacy issues may make resume writing difficult for some people. The process of applying for a peer position should be made as easy as possible while still seeing to it that the agency gets the information it requires.

We are all faced with a series of great opportunities brilliantly disguised as unsolvable problems. – John Gardner



WHERE DO I LOOK FOR PEER WORKERS? HOW DO I RECRUIT THEM?

Agencies that are already working with clients have a pool of potential peers waiting for them. Talk to clients who show some of the qualities you are looking for in a peer worker and ask if they would be interested in peer work. Talk to other professionals who may know potential peer workers. Putting job postings up in places where potential peers spend time, such as drop-in centres, community centres, street corners, etc., ensures that a lot of different people will see it. Drug users tend to have excellent networks. If your agency does street outreach, have workers hand out mini versions of a job posting. Ask your clients and colleagues to recommend potential peers. Telling a couple of people that your agency is starting this program and asking them to spread the word may be the most effective way of advertising.



THE JOB DESCRIPTION

For peers, it is a great idea to have a copy of the job description or job posting before going in to the interview so they can prepare to show why they are the best person for the job (see Appendix G). The job posting should include any of the requirements the agency is looking for in its peer workers. It may be just a guideline, as most good peer programs have some flexibility to them, but it will give an idea what's offered to and expected of peers.

An agency creating a peer job description will need to consider what's needed in the community that a peer can deliver, how and how much peers will be compensated, how many hours they will work, who will supervise them, etc. The job posting should be easy to read, clear and descriptive of the role the peers will be expected to fulfill. Be sure potential peers know what is required to apply (e.g. letter, resume, in-person inquiry, etc.) and when the deadline is.

The job description itself is also important; it describes the peers' job in detail. Peers need to know what's in the job description because the position might actually be something very different than expected - well below their qualifications or involving something they don't think they're interested in doing. On the other hand, it never hurts to consider new opportunities. Sometimes people find they really do like doing something they'd never thought of before. Peer work isn't for everyone, and agencies that run these programs must be aware of that. If peers change their mind after accepting a job, or if it just doesn't work out, no harm done. But peers and agencies might be in for a pleasant surprise!



THE JOB INTERVIEW

Most people get nervous about interviews. This can be especially true for those who haven't had very many, or have never had an interview before. Try to relax. Even if it's your first interview ever, remember that you'll never have to go on your very first interview again! Peers aren't going to need to dress up or anything like that but should be clean and presentable. Knowing the job description and knowing a little something about the agency will be a great help. Hopefully, the interviewer will be the supervisor or program coordinator. Applicants may be interviewing for a program already in place. The coordinator of the program would then be already experienced in working with peers, and should be very supportive and helpful during the interview.

Remember, too, that peers' life experience is one of the big things the agency is going to value. But peers workers' language may be much different from that of a professional agency. Because of this, some of the interviewer's questions may be difficult to understand. Applicants shouldn't be afraid to ask questions or for clarification. To make it easier, try to imagine the interviewer alone on the street, never having heard terms like 'jonesing,' 'getting vic-ed,' 'keeping six,' or any of the other terms that professionals sure didn't learn in a classroom! The 'p,' or the 'bitch' or the 'bling' is something peer workers understand, but the agency worker might not have a clue what this means! Peer applicants may not know everything that the agency is going to require them to know. Maybe terms like viral load or mucosal resistance, often used in the professional circles when talking about HIV infectivity, seem strange. Once hired, the agency should try to educate peers on many of the things they may not know a lot about, including jargon. Peer workers are there partially to bridge the gap between the street and the agency. Their street experience is important, but they aren't doing the job unless they can learn to bridge the gap.



THE AGENCY'S QUESTIONS

This is not going to be a cheat sheet! Having said that, and even though every agency is different, many agencies are probably going to ask very similar questions.

- Why do you want to be a peer?
- What does harm reduction mean to you?
- What would you need to do this job?
- What qualities do you bring to the agency?
- Scenarios! The interviewer will probably have a couple of situations written down that could happen on an outreach shift, and ask you how you would respond in those circumstances.

Try to be honest, and remember that if hired as a peer, you will be representing the agency on the street. It is also important to remember that the interviewer is probably not a professional interviewer, or human resource specialist. The interviewer may be as nervous as the peer applicant. Unfortunately, interviewers sometimes ask inappropriate questions. Questions related to things like age or sexual orientation* are illegal. Although the questions shouldn't be asked in the first place, they sometimes may be. Applicants can tell the interviewer that the question makes them uncomfortable and they would prefer not to answer. Next to personal information, the most important additional factor will probably be dependability, and whether or not the peer can be reached easily. Peers without a regular place or phone can offer a cell phone number and email address as a means of contact.



QUESTIONS PEERS MIGHT ASK THE AGENCY

Peer applicants should feel free to ask anything that may not be completely clear on the job posting or job description (see Appendix G). They may ask how they are going to be paid, whether on the payroll, or through honoraria, or whether they are going to be eligible for benefits, like life insurance, eye-glasses or a dental plan. Ask about other benefits as well, like whether or not training will be provided and whether training time is paid time. Ask what the possibilities might be in the future with that particular agency, and what can be done to make those possibilities a reality. Make sure the agency's definition of peer workers and what they expect from peers is clear. The whole process must be very transparent, both to peer applicants and to the

agency. No surprises! The more detailed the interview, the clearer both parties will be on what to expect. Be honest - don't just smile and nod and agree to things you don't get. If there are literacy issues, peers shouldn't agree to read something over while the interviewer goes off to do something else. Part of the interviewer/supervisor's job is to be non-judgmental and make sure peers understand the *whole* process.

ORIENTATION

All employees require adequate preparation including a formal orientation to the agency and job-specific training that they may not have prior to their hiring. It cannot be stated more clearly that training is likely the most important part of actual peer work.

All organizations from large community health centres to smaller community-specific AIDS service organizations (ASOs) have a stated mission and within each agency every peer program should have identified a specific community that they serve. In addition to an agency's policies and procedures this information is of utmost importance in helping adapt new peers to the peer program team and gain acceptance within the agency.



THE CONTRACT

At the most basic level, a contract is an understanding between people. A written contract takes this understanding and turns it into a formal, binding agreement. In peer work, the contract is an important tool to keep things running smoothly.

A contract between an agency and peer workers should include:

- what the hours of work will be and how and when schedules will be made up and posted;
- how much compensation the peer will receive;
- how payment will be made, and when wages/honoraria will be available;
- when the contract begins, and when it will end;
- a code of conduct for peer workers that lets peers know what kind of behaviour the agency expects from them;
- an agenda for orientation, probation, training, supervision, evaluation and how discipline is handled;
- the agency's mandate and mission statement and reporting hierarchy;
- a job description outlining what tasks and duties peer workers will be responsible for;
- the name and position of the person responsible for supervising peer workers.

Every agency should use a contract or similar tool (see Appendix C). The new peers and the coordinator should sit down together to go over the contract to make sure both parties understand it fully. It should be signed by the peers and the coordinator and both should get a signed copy to keep. Agencies should consider providing peers with a private, secure place to keep work related documents on site as things like this can be hard to keep track of. The contract is used to make sure both the peers and the agency understand each other and can work together. Writing down the duties of peers and the obligations of the agency on paper is an important tool for settling any problems or misunderstandings that may happen between peers and agencies. It also shows that the agency takes their position seriously and expects a certain level of responsibility from peers.

A contract protects peers and agencies from abuses and can help resolve misunderstandings. It gives peer workers a clear definition of what they must do to satisfy the agency. If a task is not in the contract, then chances are peers are not supposed to do that task. The contract also protects the agency from anything improper peers might do.



KEEPING TRACK OF HOURS AND WORK ACCOMPLISHED

To get paid for work, whether by honoraria or hourly wage, it is necessary for people to prove that they worked. This is true for everybody: peers, professionals, labourers and CEOs. The most common way this is accomplished is by keeping a record of time spent at work (see Appendix H).

By keeping a record of hours, people have proof that they have worked. Every agency will have its own way of keeping track of hours. It is important to understand how the agency wants this done, but also to keep a personal record - in a daytimer, calendar, diary or just a notebook. Agencies are busy, even hectic places, and sometimes dealing with what can feel like a constant state of emergency means little things like getting time cards signed can get lost in the fray. If there is a dispute about who worked when, a written record can save an awful lot of argument.

Peer workers must be given clear, written descriptions of what is expected of them and provided with a code of conduct which respects them as a member of the community... - Walter

Another benefit to keeping records of the time spent on work is to provide awareness that peers are achieving something. Sometimes time slips by one day to the next. When peers and their supervisors go back and start counting the hours spent on a project, they can develop a sense that what is being accomplished is extremely important. Both agencies and peers need to recognize that peer work is real work. Peer experience can help people start building a resume (see Appendix F). By keeping a record of hours worked and tasks completed, peers can show the value of their work to themselves and the agency. Agencies should keep track of all the hours peers work including training courses/workshops even if the latter are voluntary. In this way, it will be easy to show funders how much training time is really needed for peer workers.

The agency benefits in many different ways when peers keep track of their hours. First and foremost this lets them provide accurate reports to funders. Social service agencies have to show funders exactly what they do with the money. This may help the agency get more money for more peer projects. By creating a list of all the hours worked and tasks accomplished by peer workers, the agency can show potential funders and donors that it is responsible. It also allows the agency to compile statistics proving that peer work is a valuable tool in helping at-risk populations by bringing services and information to users and by giving peers the opportunity to have meaningful work experiences.



COMPENSATION

Peer work is different from a regular job. Because of this, agencies sometimes compensate peers by honorarium, which is very similar to being paid as a contractor. Honoraria (plural of honorarium) can be used by non-profit organizations to pay for one-time, part-time or short-term work. The amount of honorarium is set out in the contract with the peer. There is usually no overtime available. Honoraria are usually cash payments with no deductions, no GST or PST charges, and no benefit payments or deductions. There are some legal restrictions about how much people can be paid by honoraria, and peers who receive compensation this way have to report it to income maintenance programs (like OW or ODSP) and on income tax returns.

Unlike being paid a wage, with honoraria there are no taxes deducted at source. So when peers are told they will be paid \$15 an hour, they receive \$15/hour - no deductions. However, this income will not be counted towards the Canadian Pension Plan, and people will not be eligible for Employment Insurance against what they receive for peer work.

Agencies using cash honoraria to compensate peers should check with Canada Customs, Revenue Canada as well as the Ontario Labour Standards Branch to ensure that they are not in contravention of any regulations or laws.

The work of peers is usually done over a period of time because clients need to become familiar with new peers in order to build trust with them. Agencies should schedule regular dates to pay peers and these should be set out in the contract; otherwise hours worked can become confused. Furthermore, an agency's failure to stick to the agreed upon schedule is disrespectful and trivializes peers' work. Whether an agency pays peers by cheque or cash honoraria, they must also supply the peer with a statement or receipt for the money they receive. Most agencies recognize that often peers don't have bank accounts or that banks hold cheques on their accounts. Cash wages or honoraria are therefore very appropriate in some peer programs

When creating a peer program, an agency must also decide what tasks peer workers will be compensated for. This should be stated clearly in the contract. Will they receive money only for outreach or drop-in duty or also for training, staff meetings, supervision time or extra work in the community? Many peers do peer work because they are committed and dedicated to it. But whether or not they are being compensated can affect participation. Agencies should look at how regular staff are paid. Are they paid for overtime, professional development, evening meetings? Peers' time is valuable too, and they should be compensated in a similar way (see Appendix I).



REPORTING MONEY RECEIVED TO INCOME MAINTENANCE PROGRAMS

When creating a peer program, the agency will want to create a system of compensating peer workers that does not ultimately penalize them. Honoraria or wages affect the three most common types of government income maintenance assistance: Ontario Works (OW), Ontario

Becoming a peer worker may enhance their vulnerability, destabilize their lives, distance them from some of their community supports, frustrate them... - Walter

Empowerment is gained through being valued for your expertise and given access to realistic or acceptable opportunities, including opportunities to learn new skills and better ways to use old ones. Peers should be encouraged to have goals they want to realize through peer work.

- Valerie

I've been shocked to learn that some people assume or believe I'm speaking on behalf of my employer, even when clearly I am not. I have to say so to be sure people know I have my own thoughts and opinions.

-Maureen

Get the rules. Get them in writing.

-Rod

Disability Support Program (ODSP) and Employment Insurance (EI). All of these forms of benefits let clients keep some income on top of their regular assistance. Peer workers should be advised to speak to their case worker before receiving their first honorarium or wage. It is the only way to make sure they can continue to receive assistance while participating in a peer program.



A PEER'S PLAN

Peers may also have an idea of what they would like to get out of the job. The supervisor and peers should sit down together to make a plan reflecting what the peers are going to get out of this and what peer work might lead to (see appendix J). This is also a good time to confirm what the project or agency can and cannot offer peers. Peers may not have had a chance to think about any next steps in their lives. This is a good opportunity for them to do so. It also reinforces the supportive relationship the supervisor can have with peers during and after the work contract.



PEERS AS AGENCY REPRESENTATIVES

Peer support workers and the agencies they work with and represent should have similar points of view regarding harm reduction, client needs, and service delivery. It shouldn't be assumed that this is so, however. It's imperative that staff and peers communicate about this. It must be very clear to peer workers how the agency expects them to act in this role, from behaviour in the agency or during street outreach to attending meetings or workshops as part of the job. (see Appendices C, K).

Peers have the capacity to be role models or even mentors to other drug users isolated from mainstream services. They can represent someone who has obtained or is in the process of obtaining better control over personal stability.

Being a peer made me feel like I was setting an example for my friends to get more involved with harm reduction and the programs at our CHC. It gave me an identity as someone who helps....

-Anna

TRAINING

It is up to an agency to ensure that their staff, including peers, have and/or have opportunities to develop the skills and knowledge required to do their job safely and effectively. It is never enough to simply explain the bare requirements of the job. Peers who have had little formal job experience will need training that will both benefit themselves and the clients they serve. At the very least, peer training should include:

- Boundaries & confidentiality
- Communication
- Conflict resolution
- Harm reduction
- Stigma & discrimination
- Safety protocols
- Specific job-related tasks

Peers have helped me to be a better worker by sharing their stories and life experiences so freely, sometimes with little recognition or reward for the valuable work they're doing.
-Leah

Coordinators should be prepared to explain and peer workers prepared to ask specifically about things like:

- All the programs and services the agency offers, even if these don't seem to apply directly to the job.
- How those within the agency communicate with each other: is there a central log or report book? Or is information updated verbally at staff or team meetings?
- Are there places or things within the agency that are off limits to peer workers?
- Is there an internal referral system (e.g. a form to fill out to refer a client to the housing or employment worker, etc.)?
- Reporting hierarchy: What if I have to call in sick and the peer coordinator is unavailable?
- Confidentiality: What if a client I know comes into the agency?
- Right to refuse: What if I just don't feel I can or should do something that's asked of me, or if a situation makes me feel unsafe?
- Discipline: What will happen if I miss a shift and don't call in?
- What about personal phone calls during working hours?

With the wide diversity of peer workers there will also be a range of life experiences and formal education as well as differing levels of literacy and often different learning styles. This can affect peers' self-esteem and can be stigmatizing in itself especially in a group setting. It is important for coordinators to be aware of this before the formal training starts in order to accommodate everyone's needs and also to value and perhaps incorporate their experiences into the training itself. Also to consider are the different attention spans of peers, whether they smoke, if they have had adequate sleep and their transportation needs. Often having snacks or a light meal before the session can alleviate fatigue especially if the training is lengthy. Day-long sessions may be too taxing for all, including coordinators! Half days work best with adequate breaks.

A routine is critical to the success of any training or work schedule. Some peers may be experiencing order in their lives for the first time in many years. Changes can be at times over-whelming, but also can be life-affirming and positive. Some peers may still have chaotic housing conditions. It is important for everyone to be clear about what is expected, and agreements need to be clearly stated in the peer contract (see Appendix C).



AODA/WHMIS

A good starting point would be training in **AODA** (Accessibility Standards for Ontarians with Disabilities Act) which requires the equal-acceptance and accommodation of all people regardless of their disability be it a physical, sensory or mobility concern or a mental health and/or addiction condition (www.mcass.gov.on.ca).

WHMIS (Workplace Hazard Material Information Systems) WHMIS is federally legislated training required for any workers who manufacture, work with or are in proximity to controlled products in their workplace (www.whmistraining.ca). This can include many cleaning products.



DRUGS 101

Most harm reduction peer workers have a vast knowledge about drug use. Some may have only used certain kinds of drugs; others may have more varied experience. All peer workers should be familiar with the various categories of drugs and their interactions with each other, as well as alcohol which is in fact also a drug (see Appendix L).

*I knew about opiates...I learned about overdose prevention, and I saved my friend's life! WOW.
Steve*

Drugs are very much a part of professional sports today, but when you think about it golf is the only sport where the players aren't penalized for being on the grass. – Bob Hope



NEEDLES/INJECTION DRUG USE

The booklet SHARP Shooters-Harm Reduction Info for Safer Injection Drug Use produced by CATIE, Canadian AIDS Treatment Information Exchange (www.catie.ca), is the foremost resource for educating peers, users and coordinators about safer injecting practices. For specific up-to-date training some resources that can be accessed are Public Health Ontario (www.oahpp.ca) or the Canadian Centre for Occupational Health and Safety (www.ccohs.ca) or The Works, a Toronto Public Health needle exchange and harm reduction clinic which can provide more practical information concerning syringe handling, collection and storage. They will also pick-up used sharps via their van (416-392-0520) and distribute needles, other injecting equipment, and smoking kits after hours.



KITS & KIT MAKING

Depending upon the needs of the community a variety of safer drug-use kits can be made available. These typically are custom-made for each program with the appropriate literature insert that can include such points as safer-sex and drug-use as well as overdose awareness, warnings and responses.

Some examples of safer drug-use kits are:

- Injection kits
- Piercing kits
- Condom kits
- Crack smoking kits

Kit making can be part of the peer program and can also be an entry into the field of peer work for people looking for an opportunity or exposure to harm reduction work in general. Kit making provides an agency/program with a captive audience for informing/educating peers and others with harm reduction and disease prevention measures.



COMMUNICABLE INFECTIONS: HIV, HCV, STIs

Despite many medical advances including anti-retroviral treatment for HIV and specific HCV (hepatitis C virus) treatments, along with the progressive responses from public health authorities, people who use drugs are still at high risk of infection. All peer workers need a basic foundation of knowledge around each of these. Since much of this information can be technical, one suggestion is to approach the initial training with a focus on co-infection. An excellent source for this critical training can be found at www.catie.ca. In particular, the pamphlets HIV and Hepatitis C Co-infection and Hepatitis C-You Can Have It and Not Know It, are very helpful. The fact sheets HIV Transmission: An Overview and Sexually Transmitted Infections and HIV Transmission are excellent resources for training and group discussion.

Peers also need to know about PEP (post-exposure prophylaxis) which allows for immediate treatment for suspected HIV exposure, another fact sheet available from CATIE. These are some of the biggest health concerns for active drug users, especially IDUs and sex workers.

Another suggested reference: www.sexualityandu.ca

It is worth noting that exposure to drugs may trigger increased or chaotic use.... It is the obligation of the agency to be helpful and supportive of peer workers in dealing with their drug use... - Walter

BOUNDARIES & CONFIDENTIALITY

A peer worker does not automatically understand the supervisor/worker relationship and may look to their supervisor as their counsellor or case manager. It is important to set up good boundaries with staff from the outset of the relationship.

- Lorie

Boundaries strengthen relationships – all sorts of relationships.

-Beth

Sometimes you only get a moment to reach somebody and you don't want to eff that up, so you need to be very careful... to take a lot of care...

-Sam

We hear a lot about boundaries and boundary issues in any kind of work that involves helping others. Boundaries are hard to define or explain. They are like limits or margins, and they are definitely one of the biggest challenges faced by peer workers because in this role they walk the fine line between helper and client.

The most basic element of peer work is that peer workers are members of the community they serve. What they are asked to do in this role is to be both insider and outsider -- at the same time! They are supposed to relate to clients because they've been there or are there, and also act as a representative of an agency. Peers are meant to connect with clients in a way that professionals cannot, yet maintain a certain distance. In this respect, it can be much more difficult for peer workers to set and maintain boundaries than it is for other workers to do so. It is very important to realize that setting boundaries is not a one-time thing. There isn't a checklist. This is an ongoing process, a way of thinking, a means of understanding the dynamics among people - coworkers, neighbours, anybody - and all of the potential outcomes.

When we want to work to help others, we have to develop professional boundaries too. Boundaries help protect us and the people we serve. Without them, it is impossible to be objective or respectful. In the extreme, a lack of strong boundaries is a sure recipe for stress and burnout.

People who need services have to disclose a lot of personal information to strangers, sometimes over and over again. Many have had so many intake interviews they cannot remember them all. Constant disclosure and forming intense relationships with new people all the time can quickly become normal for them. Sometimes, this can make it seem as if they don't have any personal space - physically or emotionally. Sometimes they have stopped bothering with boundaries. The bottom line is that peers and workers have to be the ones responsible for keeping tabs and keeping interactions appropriate.

Why? Well, since the goal is to reduce harm, nobody wants to do anything that might potentially harm those they're trying to help. Clients are vulnerable and workers/peers have power because they have something clients need or want - clean needles, someone to talk to, condoms, food, tokens, whatever. The first imperative of harm reduction is to be non-judgmental, to provide whatever help or service we can, regardless of race, religion, drug use, gender, sexual orientation and so on. Requiring abstinence, or anything else that is or could be a way of controlling others, at the moment of contact or in the long term, is exploitation. Power, control, it's all the same thing, and it's unfair. It is not fair to clients, and it is not fair to workers/peers, either.

Good boundaries are one way of trying to make sure that the power imbalance is recognized and understood and doesn't turn into exploitation.

Boundaries are really just about exercising good judgment and setting limits. Good judgment grows out of experience - good experiences and painful ones. We've all heard that rules are there for a reason and that rules are made to be broken. It all depends on the circumstances which is why good judgment is critical.

Boundaries have to be flexible and realistic. We are talking about working with *people*, and the cookie cutter approach won't work. There will always be clients that workers are more drawn to than others, and peers are working with clients who they probably identify strongly with.

Crossing boundaries from time to time is inevitable. Sometimes it's okay to do so — if you do so consciously, having thought it through and determined that it is the best thing to do in a specific situation. Sometimes, though, we cross boundaries without realizing it at the time. In any case, the best thing to do if you're not sure about where the line is, or you think you've crossed it, on purpose or by mistake, is to talk to your supervisor or coworkers.

Remember: boundaries protect workers, clients and their relationships with each other. Without them, people don't know what to expect, and there would be no limits as to what workers have to do. Just this once can easily become common practice and believe it or not, it is possible to kill with kindness. Helping others is hard work. If you lose your objectivity you won't be helping others, and you might well hurt yourself in the bargain.

As harm reduction advocates, peers are expected to accept clients' drug use, to assist them in their choices, and to suggest safer alternatives of which the user may not be aware. Sharing a meal is very different than using drugs with clients. This boundaries thing can be really hard to grasp, so we've included some situational examples below (also see appendix M).

CLIENT WANTS	BOUNDARY CROSSING	APPROPRIATE RESPONSE
A Place To Stay	Take a client home with you	Refer/accompany client to shelter
Money	Lend/give client money	Refer/accompany client to social services
Drugs	Score drugs for/share with client	Listen; explain limits of your job; educate about safer use



WHAT IS CONFIDENTIALITY?

Agencies that hire peer workers often have to provide peers with services for personal needs as well as employment and related education. This means both peers and the agency will be wearing different hats at one time or another. Each hat requires a different set of guidelines or boundaries for the agency. Therefore, confidentiality should be a major concern for both the agency employee and the peer workers. A confidentiality protocol can help clarify this often misunderstood issue (see Appendix K). Different groups and agencies can have different expectations around confidentiality. There are times when professionals can confuse boundaries and breach confidentiality. How much more confusing is it for peers who are sometimes working with friends or even relatives as clients. Outlining clear expectations and using concrete examples will help reduce incidences of breaches in confidentiality.

TO ILLUSTRATE:

- 1) Lisa is a peer worker at an agency that serves young women who have recently been released from jail; Penny is a client of this agency. She has confided in Lisa that she has already used drugs several times since her release and did a couple of petty thefts over the weekend. Lisa feels frustrated because Penny doesn't seem to be listening to her advice. Over lunch, Lisa tells her friend Marlene all about Penny and her behaviour. The next day, Penny comes into the office demanding to speak to the supervisor because as she puts it, her life story is now common knowledge. Lisa had breached Penny's confidentiality.

- 2) Doug is a peer worker with an HIV/AIDS prevention agency. One night during outreach he runs into Paul who is dealing crack near Boys Town. Paul is the son of Doug's mother's best friend. Doug knows that Paul recognizes him and he quietly assures Paul that he won't out him because he has promised to respect clients' confidentiality. Eventually, Paul realizes that Doug is not going to tell anyone that he's seen him on outreach and this persuades him to come into the agency for service. Paul's trust is gained by Doug's respect for his confidentiality.

The primary concern in establishing and managing boundaries with each individual client must be the best interest of the client. Except for behaviours of a sexual nature or obvious conflict of interest activity, boundaries often are not clear-cut matters of right and wrong. Rather, they are dependent upon many factors and require careful thinking through of all the issues, always keeping in mind the best interests of the client.*

SKILLS DEVELOPMENT

Conflict resolution is an important skill when working with peers, clients and agencies. Agencies would do well to schedule training for peers on an ongoing basis. Peers can take matters into their own hands and seek out information as well. The following is just a brief overview of conflict resolution.

**CONFLICT RESOLUTION**

Conflict arises from differences, both large and small. It occurs whenever people disagree over their values, motivations, perceptions, ideas or desires. Sometimes these differences appear trivial, but when a conflict triggers strong feelings, a deep personal need is often at the core of the problem. These needs can be a need to feel safe and secure, a need to feel respected and valued, or a need for greater closeness and intimacy. By learning these skills for conflict resolution, peers can keep their personal and professional relationships strong and growing.

*The Bulletin: College of Psychologists of Ontario vol. 25 #1, July 1998

- **A conflict is more than just a disagreement.** It is a situation in which one or both parties perceive a threat (whether or not the threat is real).
- **Conflicts continue to fester when ignored.** Because conflicts involve perceived threats to our well-being and survival, they stay with us until we face and resolve them.
- **We respond to conflicts based on our perceptions** of the situation, not necessarily to an objective review of the facts. Our perceptions are influenced by our life experiences, culture, values, and beliefs.
- **Conflicts trigger strong emotions.** People who aren't comfortable with their emotions or able to manage them in times of stress, won't be able to resolve conflict successfully.

Conflicts are an opportunity for growth:

When you're able to resolve conflict in a relationship it builds trust. You can feel secure knowing your relationship can survive challenges and disagreements.

The ability to resolve conflict depends upon your ability to:

- Manage stress quickly while remaining alert and calm
- Control emotions and behavior
- Pay attention to the feelings being expressed
- Be aware of and respectful of differences

Tips for managing and resolving conflict:

Managing and resolving conflict requires the ability to quickly reduce stress and bring emotions into balance. You can ensure that the process is as positive as possible by sticking to the following guidelines:

- **Listen for what is felt as well as said.** When we listen we connect more deeply to our own needs and emotions, and to those of other people. Listening also strengthens us, informs us, and makes it easier for others to hear us when it's our turn to speak.
- **Make conflict resolution the priority rather than winning or being right.** Maintaining and strengthening the relationship, rather than winning the argument, should always be your first priority. Be respectful of the other person and their viewpoint.
- **Focus on the present.** If you're holding on to grudges based on past resentments, your ability to see the reality of the current situation will be impaired. Rather than looking to the past and assigning blame, focus on what you can do in the here-and-now to solve the problem.
- **Pick your battles.** Conflicts can be draining, so it's important to consider whether the issue is really worthy of your time and energy. Maybe you don't want to surrender a parking space if you've been circling for 15 minutes, but if there are dozens of empty spots, arguing over a single space isn't worth it.
- **Be willing to forgive.** Resolving conflict is impossible if you're unwilling or unable to forgive. Resolution lies in releasing the urge to punish, which can never compensate for our losses and only adds to our injury by further depleting and draining our lives.

- **Know when to let something go.** If you can't come to an agreement, agree to disagree. It takes two people to keep an argument going. If a conflict is going nowhere, you can choose to disengage and move on.

For more information/references: www.helpguide.org



COMMUNICATION

Sometimes what we think we're saying isn't what the listener is hearing at all. And sometimes we don't hear what others are saying, even when we are listening hard. Language is complex (if you don't believe this, just think about trying to learn a different language). In fact all communication is complex. Communicating well is central to providing any kind of service. And in fact, good communication is key to teaching, learning and especially getting along with others in a workplace. Having good communication skills means more than not interrupting others when they're speaking. This is important, but effective communicating also includes the following:

Body language:

- Try to remain calm and keep your facial features neutral. Maintain eye contact. Don't back away, avert your eyes or cross your arms in front of you. Try to be on the same level as the speaker - stand up or sit down.
- Don't make sudden broad gestures (e.g. sweeping arms, getting up or turning away suddenly).
- Nod: this says "I'm listening" - but mean it!

Reality is a crutch for people who can't cope with drugs. -Lily Tomlin

Ask clarifying questions:

- Open ended questions work best: "How do you feel?" rather than "Are you mad?"
- Ask the speaker to tell you more about their concerns or expectations
- Ask "What do you mean when you say...?"
- Repeat what you heard in your own words: "So it upsets you when ..." or "So I understand that you think ..."

Use "I" messages:

- Instead of "you demand too much," try "when you ask me to do that I feel overwhelmed"
- Instead of "you are too picky," try "I don't remember details as well as you do"
- Instead of raising your voice, try "I feel threatened when you shout"
- Be direct without blaming the other person
- Don't accuse ("you always..." or "you never...") or threaten the other person ("you better..." or "you better not..." or "if you...")
- Don't call others names or generalize ("everybody knows you're a stupid cow") or be sarcastic ("well you're just doing your job") or be judgmental ("you should be...") or patronizing ("you poor thing").

If something somebody does or says bothers or concerns you, and you want to talk to them about it, try to do so right away. Make sure you talk to the person privately. Like any wound, it's better to clean it up because it'll only get much worse if you ignore it and let it fester. If you're not going to talk to the person about it, let it go, or tell it to your counsellor, but don't add it to a mental simmering pot or complain to everyone but the other person involved.

And if someone does or says something that you think is terrific, make sure you tell them that, too, and why you think it was a good thing to do or say. We all need feedback, good and not so good.

In either case:

- be specific and give examples of what was said or done
- say why you think it's important to talk about this
- say how their words or behaviour affects you and the agency
- give the other person a chance to respond, and listen to what they say
- thank the other person for hearing you out

If someone approaches you with feedback or criticism: Remember that this works both ways - you're probably nervous confronting others and they are probably a little tense about approaching you, too. But it is really important to give and receive feedback (hint: sometimes it's easier to solicit feedback than to wait for someone to approach you).

Try to remain calm, don't get defensive, practise good listening skills and ask questions. This is an opportunity to find out what you're doing right, how others perceive what you say and do, and what you need to work on to become even better at your job!

The above are general guidelines - agencies would do well to offer communication training to peers as there would be a huge pay off for doing so.



ACTIVE LISTENING

***The word 'listen' contains the same letters as the word 'silent'.
– Alfred Brendel***

Active listening is an important aspect of peer support work. Active listening is a communication technique that requires the listener to feed back what they hear to the speaker, by way of re-stating or paraphrasing what they have heard in their own words, to confirm what they have heard and moreover, to confirm the understanding of both parties.*

Listening isn't the same as waiting for your turn to talk. This means making eye contact, using body language that tells your speaker you are engaged in what they are saying and responding appropriately.

Listening involves observing body language and noticing inconsistencies between verbal and non-verbal messages

Principles of Active Listening:

- Stop talking
- Prepare yourself to listen
- Put the speaker at ease
- Remove distractions
- Empathize
- Be patient
- Avoid personal prejudice
- Listen to the tone
- Listen for ideas, not just words
- Wait and watch for non-verbal communication
- Do not jump to conclusions about what you see and hear. Always seek clarification to ensure that your understanding is correct.

***Real listening is a willingness to let the other person change you.
– Alan Alda***

Practising and training in these skills will be a huge benefit to peer workers, agencies and the community they serve. Active listening would be a great technique to use when dealing with people who have experienced trauma.

Wisdom is the reward you get for a lifetime of listening when you'd have preferred to talk. – Doug Larson

Find out more at: <http://www.skillsyouneed.com/ips/listening-skills.html#ixzz2TOaXP71C>

SELF-CARE

Think of self-care as anything that adds to our emotional, spiritual, physical and social rejuvenation, and that helps us to create and maintain balance in our lives.

Within a health promotion context that views health as a resource for daily living, self-care is seen as empowering. Through developing self-care skills, people are able to participate more actively in fostering their own health and in shaping the conditions that influence their own health.

Examples of self-care behaviours include seeking information (e.g., reading books or pamphlets, searching the Internet, attending classes, joining a self-help group); exercising; socializing with friends; making a healthy meal; seeing a doctor on a regular basis; getting more rest; making time to relax or do something enjoyable; practising positive thinking; being mindful and practising meditation.



HARM REDUCTION THROUGH SELF-CARE AND NUTRITION

Take time to take better care of yourself. How often do we hear such statements and yet never really follow up with any action. Peer workers sometimes lose sight of what they need to improve their lives on a daily basis. Sometimes their using takes priority over their personal health and well-being. They may even end up in the doctor's office or detox if they let things go on for too long.

Sometimes people let themselves get weighed down by their economic situation. Poverty can lead to poor nutrition, sub-standard housing and increased stress overall. How people feel about themselves usually dictates how they care for themselves. Losing focus on life goals, lacking motivation and socially isolating from people that care for them can be all too overwhelming. Substance use causes effects on peoples' nutritional status – the amount of vitamins, minerals and calories in the body. Substance-induced eating and general appetite changes causes nutrient deficiencies and malnutrition. Nutrients are lost from vomiting, diarrhea and the inability to absorb nutrients. It can be hard on the body when it tries to detoxify alcohol and drugs. Even if people are eating a balanced diet the whole time they are using, they aren't getting all the nutrients they require.

Nutrients are the calories, vitamins, minerals and water needed to sustain life. Basically, everything we eat. Nutrient deficiencies show up in many forms: fatigue, weaker immune systems (getting more colds), dental problems, digestive problems, liver disease. People who use substances often have low levels of: folate, calcium, vitamins A, D, B6 and C, magnesium, potassium and selenium. Water is a vital substance to life It regulates temperature, carries nutrients and waste away from cells. People need 8 cups of water a day. It is important to detoxifying from alcohol and drugs.

Some food strategies:

- Using food banks
- Stocking cupboards with staples
- Buying in bulk
- Looking for store specials
- Using coupons
- Shopping in Chinatown and Kensington Market
- Joining a community kitchen
- Taking a life skills class
- Using recipes.com or about.com
- Using no-name brands

HINT: It's FREE to CALL 211 and you can find out about and contact lots of different resources from free meals to where to find warming/cooling centres during weather alerts.

The *Toronto Harm Reduction Task Force* booklet *The 511* is another resource for self-care. This is a great guide that outlines services (harm reduction programs, housing help, shelters, meals & snacks, drop ins and a directory of services) in Toronto that are user friendly. This can be a great resource for not only peers but for the clients they serve. It's available online at www.TOharmreduction.org



ACTIVITY: making a self-care plan

One technique some people use to stay on track or to handle difficult situations is to make a self-care plan (see appendix N). A self-care plan involves knowing what works well for you, and in what circumstances. Some people find a self-care plan helps them resolve how to manage situations when they may not be in the best frame of mind to make decisions. For example, some people have an overdose prevention plan that they follow when necessary, and somebody with a bad back might follow an exercise plan to help reduce pain and flare-ups. These may be part of larger self-care plans.

Working with a support person, (doctor, mentor, counsellor) could help people with their self-care plan. Together, they can decide:

- How to know when things are going well and when things are going off track
- How to manage the situation
- How to reduce harm – what works

Having a self-care plan can help with day-to-day living, especially when life is busy.

People can make self-care plans for themselves. They could choose to share it with other people close to them (or who play support roles in their life) if they want them to be involved in their self-care plan. Some people like to have someone remind them of what they had said works for them or how they want situations to be handled, but this isn't for everyone. Some people prefer to keep their self-care plan private.

Self-care plans are not permanent. People change, circumstances change, and so how they handle ups and downs also changes. If they share their self-care plan with someone else, they should revisit it periodically to make sure that it still makes sense for them and is what they want.*

Housing is one of the most basic forms of harm reduction, and a big part of any self-care plan. In 2010, the Toronto Harm Reduction Task Force peer-driven project produced a video called *How to Keep Your Housing While Actively Using Drugs*. Check it out for some great tips, and share it with your peers! <http://www.youtube.com/watch?v=zlbkU5IK5Do>



TRAUMA INFORMED PEER SUPPORT

What is trauma? What defines a traumatic experience? Trauma can be defined as a threat to life or bodily integrity, or events which threaten emotional or psychological security. Simply put, trauma occurs when an external threat overwhelms a person's ability to cope. Many marginalized people have been affected by one or both forms of trauma. These threats can cause trauma responses. Being trauma informed means recognizing how traumatic experiences can influence people's lives and behaviours.

*Change the Cycle Peer Training Program: Facilitator's Manual and Reflections. University of Toronto, from: Penn, R., Kolla, G., Strike, C., and the CTC Team. (2012)

Some examples of trauma:

- Childhood abuse (emotional, physical, sexual)
- Childhood neglect
- Abandonment or forced separation (apprehension by Children's Aid)
- Interpersonal violence (sexual assault, domestic abuse)
- Institutional or systems abuse (prison, hospital, police, courts)
- Historical violence (e.g. the impacts of colonization on First Nations people)
- Cultural dislocation (immigration, war)
- Chronic stressors (poverty, racism, homophobia)
- Natural disasters
- Medical procedures
- Grief and loss

There are no injuries that run so deep that one cannot add insult to them and make them feel even worse. – Matthew S. Williams

We don't heal in isolation but in community. - S. Kelley Harrell

Practical methods for practicing a trauma informed approach

Communicate an atmosphere of respect and safety by:

- Accepting people for who and what they are
- Respecting the individual's beliefs by not imposing your own or contradicting theirs
- Valuing them and their views
- Being non-judgmental
- Actively listening (resource: <http://seedsforchange.org.uk/activelisting>)
- Being attentive
- Maintaining confidentiality

Communicate interest in a person and build trust by being:

- Straightforward
- Truthful
- Sincere
- Open and clear

Communicate empathy and show that a person's situation is unique by:

- Trying to understand what is really going on for a person
- Asking relevant questions about a person's circumstances
- Thinking, acting and feeling in the other person's interests
- Refraining from making assumptions or judgments

Exploring our inner selves:

- We need to be aware of what kinds of stories or situations are likely to bring up our own traumatic experiences.
- We need to question ourselves about where our own beliefs, understandings, etc. came from to begin with - are they fact based or is there bias?
- We need to examine and challenge ourselves on hidden assumptions about others through ongoing education, supervision, and personal connection to self.

Taking care not to re-traumatize: knowing our inner selves:

- We need to sort out and understand our own limits about hearing and supporting another person when they talk about the trauma they've experienced.
- We need to know how and practice how to tell someone respectfully that we may not be the most appropriate, supportive, ready person to help them cope with trauma they've experienced.
- We need to understand that both of these skills are necessary to avoid re-traumatizing people. We don't want someone to feel that their story isn't worth hearing or that we don't care what happened to them. .
- Disclosing the existence of our own trauma history and the boundaries or limitations we've had to set as a means of self-care can be an important learning experience for us and the other person.
- Setting and explaining such boundaries is a way of modeling self-care and of helping build rapport. The other person may begin to feel safer and more able to take chances trusting other people.

Some terms to learn about:

- Privilege (social, financial, educational, opportunity, networks)
- Dominance
- Anti-oppression (confronting racism, sexism, classism, homophobia, ageism)
- Control
- Coercion (using a person's vulnerabilities in convincing them to do what you want)
- Abuse

Most people have some mix of both privilege and disadvantage, but some have more of one than the other. People who have been marginalized socially and who have suffered abuse are vulnerable. They often face many layers of oppression.

Peers should be aware of the possibility of re-traumatizing people or themselves. This can happen when something in the environment recreates the conditions of the traumatic event. This can include using your privilege to silence, discredit or shame, calling out someone in front of others or coercing them to cooperate with something they're not comfortable with. These are things we can do without being fully aware that we are doing them.

Peers should seek out opportunities for learning further about trauma and how to support people in the most effective, empathetic and empowering ways possible. Peer coordinators should consider including a trauma workshop in their training schedules.

Look to groups and agencies in your community that work to oppose any conditions that contribute to marginalizing people, such as poverty and mental health. Community colleges and universities often offer free public access lectures on a range of topics which could be helpful.

Here are a few resources to get you started:

[In the Realm of Hungry Ghosts](#), by Dr. Gabor Mate, M.D. (available via Toronto Public Library www.torontopubliclibrary.ca)

[Engaging Women in Trauma Informed Peer Work](#)

[Trauma Informed Peer Support](#)

[Munk School - University of Toronto Lectures](#)

CAMH (www.camh.net) and Evidence Exchange Network (www.eenet.ca) link to several webinars on trauma.



OVERDOSE AWARENESS & PREVENTION

Simply stated, an overdose occurs when a person consumes a substance that exceeds the level their body can handle. Overdose can cause changes in breathing, heart rate, blood pressure, body temperature and affect alertness, awareness, thinking and mood.

Anyone who uses drugs is at some risk. Some people are at higher risk than others, such as intravenous users (IDUs), opiate/opioid users and those who mix drugs or use them with alcohol. People living in poverty, those with mental health issues, and people with HIV/HCV or other serious medical conditions are at very high risk of overdose. Many peer workers are still active users and are not immune to overdose. Overdose does not always result in death. Some people survive especially when others respond immediately. Overdose doesn't just result from using illicit or street drugs. Many overdoses occur from prescription medication. Every year we lose friends and colleagues to overdose, despite the growing knowledge and training around overdose prevention.

Prevention/response:

The information below gives an overview about overdose prevention and response. This doesn't stand in for the training that all front line workers, including peers, are encouraged to participate in, but does underline the basics, and the need for sharing of expertise.

Some risks of overdose:

- Drug interactions: mixing drugs, including alcohol, prescription drugs, over the counter medications and/or herbal products;
- Using alone: if the user overdoses, who will be there to help?

- Using after a period of abstinence (jail, drug holiday, pregnancy, hospitalization etc.) when tolerance is decreased; this is also true if the person using has lost weight, or is immune-compromised (i.e. has HIV, AIDS, Hepatitis, even the flu);
- Using unknown substances;
- Being in a hurry to use: judgment is impaired;
- Injecting (whatever it is, it hits your system fastest this way);
- History of depression, anxiety, previous o/d (drugs affect you differently, depending upon your mood when you use them);
- Lack of sleep or food: this can impair judgment about how you use (administration) or how much;
- Not recognizing the risks of overdose, or the need to share information about how to prevent it.

TWO MAJOR TYPES OF DRUGS

Depressants (downers)	Stimulants (uppers)
Opioids (including synthetic ones):	Cocaine, including crack
Heroin, morphine, dilaudid, demerol, fentanyl, oxy-neo, percocet, codeine, methadone, buprenorphine (suboxone)	Crystal meth Ecstasy, Speed, Ritalin
Benzos: "the pams" – diazepam, valium, ativan etc.	Caffeine, Nicotine
Ketamine (Special K), GHB	Many OTC non drowsy meds
ALCOHOL	

SOME SYMPTOMS OF OVERDOSE

Depressants (downers)	Stimulants (uppers)
Pinpoint pupils	Body temp rises/skin feels hot to the touch
Disorientation	Person removes clothing
Dry mouth, cold to the touch, turning blue	Racing pulse, pressure/tightness in chest
Shallow breathing/deep snoring, won't wake up	Seizures, twitching, passing out

OVERDOSE is a MEDICAL EMERGENCY: CALL 911

RESPONSES

Depressants (downers)	Stimulants (uppers)
Shake person, call their name, pinch fingertip	Stay calm; keep the person calm
CALL 911: report MEDICAL EMERGENCY – person unresponsive, not breathing	Isolate the person from loud noises, other people, in a secure comfortable place if possible
Commence first aid including injecting naloxone (see appendix XXXXXX) and administer CPR	Speak to him/her slowly, quietly and reassuringly; apply a cool damp cloth to forehead, upper arms, etc.
STAY WITH THE PERSON UNTIL HELP ARRIVES	If necessary (i.e. repeated seizures, heart attack) CALL 911 and report a MEDICAL EMERGENCY
Tell the paramedics what you KNOW (e.g. he's diabetic and he injected morphine today, etc.)	Tell the paramedics what you KNOW (e.g. she's epileptic and she used cocaine and drank beer tonight, etc.)

Good Samaritan immunity laws

A number of fatal overdoses occur when people use alone. Another problem is when other people are around, but are afraid to call 911. They may fear being arrested, or the stigma around drug use makes them hesitate to call for help. In the U.S. some places have passed 911 Good Samaritan Immunity Laws. These aim to protect people from fear of arrest when 911 is called for an overdose -- provided no other significant criminal laws are broken.* *Preventing Overdose, Saving Lives: Strategies for Combating a National Crisis, US Drug Policy Alliance, pp10-11). The Canadian Drug Policy Coalition (www.drugpolicy.ca) is working with others to advocate and promote similar life-saving strategies here. Some Toronto community health centres have policies similar to Good Samaritan laws that protect people from punitive action if they alert staff to an overdose on site.

Overdose training programs

Programs to help educate and train people to respond to an overdose include the innovative POINT (Prevent Overdose in Toronto) training program that began in September 2011 by The Works (Toronto Public Health) (http://www.toronto.ca/health/sexualhealth/sh_the_works.htm) The training only takes about 20 minutes. It teaches drug users how to identify and respond to opiate overdose using Naloxone (*Naloxone Saves Lives - Learn How to Save a Life* (<http://www.youtube.com/watch?v=zlbkU5IK5Do>)). Also known as narcan, Naloxone is a drug that reverses opioid overdose (see Appendix O).

Since 2003-2004, the Toronto Harm Reduction Task Force, in cooperation with The Works, has recognized a need to develop and deliver training on overdose prevention/response to people who use drugs and people who provide services to them. Beginning in 2006, and with direct input from people with lived experience, we've been offering workshops across the City of Toronto in an effort to address this need. One big reason this initiative has been so

*Preventing Overdose, Saving Lives: Strategies for Combating a National Crisis, US Drug Policy Alliance, pp10-11).

successful is that the “train the trainer” or “each one teach one” imperative has been a cornerstone of how the necessary information has evolved and been shared. Peers disseminate accurate information about overdose awareness, prevention and appropriate response. This free training is offered several times a year and as an in-service upon request.

Agencies working with peers to provide services to any population where problematic substance use is an issue should ensure peer workers have training in overdose prevention and certification in first aid/CPR. Agencies should also consider implementing an overdose protocol. A short helpful video, *The First 7 Minutes: Designing an Overdose Protocol* is available online and a checklist can be found in Appendix P <http://www.youtube.com/watch?v=xPntWemg5Pc>

There are some other great overdose prevention resources on the Internet. Here are a few interesting websites to check out:

<http://www2.catie.ca/en/pc/program/overdose-prevention-project>

<http://www.harmreduction.org/article.php?list=type&type=51>

http://www.harmreductionworks.org.uk/2_films/going_over.html

ADVOCACY/ ACTIVISM

The dictionary tells us that advocacy means supporting a person, cause or proposal, while activism is more about taking action in support of these.

People can be advocates for themselves, or on behalf of others. Advocacy is the “...ability to effectively communicate, convey, negotiate or assert...[the]...interests, desires, needs and rights...” you want to stand up for. *

Self-knowledge is the first step towards advocating for one’s rights. People need to know their strengths, needs and interests before they can begin to advocate.

***I spend half my time comforting
the afflicted and the other half
afflicting the comfortable. – Wess
Stafford***

*Van Reusen “The Self Advocacy Strategy for Education and Transition Planning 9/96 in Intervention in School and Clinic Vol. 32 #1

**Brandon, D. (1995) *Advocacy, Power to People to Disabilities*, Venture Press, Birmingham

Some tips for self-advocacy:

- Learn all you can about your needs, strengths and weaknesses
- Know what accommodations you need as well as why you need them
- Know how to communicate effectively and assertively
- Find out who the key people are and how to contact them if necessary
- Be willing to ask questions when something is unclear*

Advocacy is about working with and on behalf of people toward getting their needs met, or their rights recognized. Advocacy can take many different forms.

Researching, preparing and presenting the information contained in this guidebook is a form of advocacy! Meeting with a city councillor or member of parliament to inform them about a policy or law that affects a group of people negatively, and posing solutions to change is a form of advocacy. Writing a letter to the editor of a newspaper to educate the public about harm reduction as a valuable community resource would be an act of advocacy too.

Peer workers are in a great position to become advocates for advancing harm reduction practice, policy and strategies. Advocacy is a very empowering activity, especially when you're successful in making change! Those who coordinate peer programs should consider adding advocacy training for peer workers. Many of the amazing harm reduction programs in Toronto today started and have been successful because of the advocacy efforts and activism of people with lived experience and peer workers.

Limitations

We all have to be aware, however, that where agencies get their funding can sometimes limit their advocacy and activism. For example, the *Toronto Harm Reduction Task Force* gets a majority of its funding from a federal government program; we are therefore somewhat limited around actions that involve federal legislation or policies.

Sometimes, activists have to get creative and find ways to conduct activism without this being seen to be coming from a particular agency or organization. It's important for peer coordinators/supervisors to make clear what the boundaries are around political activism, and when it is or isn't appropriate for people to identify themselves as peer workers so that they don't get confused about their roles. It's also important to convey what the limitations of the agency are, and why, so that everyone understands what the agency can or will support, and what they can't.

It's also important not to waste energy reinventing the wheel. Many times, when new peer workers are very keen to get in there and make changes their energy is terrific, but it's important to remember that we make the most headway by working collectively, and by building on the gains and momentum established by those who've gone before. While an idea may be new to you, it isn't always new to the harm reduction movement.

LINKS to organizations that advocate for people who use drugs and harm reduction:

Canadian Association for People who Use Drugs: www.capud.org

Canadian Drug Policy Coalition: www.drugpolicy.ca

Canadian Harm Reduction Network: www.canadianharmreduction.com

Canadian Students for a Sensible Drug Policy: www.cssdp.org

Drug Users Advocacy League: www.dualottawa.ca

Toronto Drug Users Union: TDUU.blogspot.ca

Toronto Harm Reduction Alliance: *Toronto Harm Reduction Alliance* on Facebook

Toronto Harm Reduction Task Force: www.TOharmreduction.org

United Networkers of Drug Users Nationally: www.undun.org

Vancouver Area Network of Drug Users: www.vandu.org

Law Enforcement Against Prohibition: www.leap.cc

A great toolkit for all sorts of social justice advocacy can be found at www.results-resultats.ca

SUPERVISION



WHAT IS SUPERVISION?

The agency values peers' life experiences. It also needs to make sure that the agency's goals are met. They need to have a strong relationship with peer workers. To do this, most agencies designate a staff member to coordinate/supervise peers. This coordinator is responsible for peer workers at their agency. They set boundaries for the peers and supervise their work. The coordinator keeps track of all the peer workers and reports back to his/her own supervisor. The coordinator can help guide peers to use their skills and develop new ones, if this is one of the peers' goals. The coordinator provides direction and makes sure the agency's goals are being met by the peer worker; that is, that the peer is meeting the requirements of the job description. The coordinator gives peers a task or tasks to accomplish and then checks to see how and when tasks have been performed.

Without a coordinator, the agency would have no way of keeping peer work on track. Without supervision, the agency would have difficulty ensuring the quality of peer work and supporting peers within the agency and providing proper reports to funders. The peer supervisor or peer coordinator is an extremely important position in peer work. most important thing for peers is to communicate with the coordinator regularly.

Sometimes peers can have low expectations from agencies and supervisors because they've faced numerous forms of discrimination and are happy just to have a job. A good supervisor needs to advocate for peer workers. I learned that in order to do this I had to examine my own beliefs and values around professionalism.

– Lorie

People who supervise peers or peer programs have to be able readjust and realign their expectations and requirements, repeatedly, often quickly, in order to meet the needs of the peers they're responsible for.

-David

...Peer work saved my life....

-Lydia

This communication goes both ways. In an outreach program, for example, the coordinator provides information that is needed for peer work, and peers provide the coordinator with knowledge of the scene: there is a sharing of expertise. The coordinator provides feedback on peer work. Peer workers should listen and learn from the coordinator — they have a wealth of information and experience and it is in peers' best interest to heed their advice, just like it is in the coordinator's best interest to hear what peers have to say.

Peer work isn't like other work where you punch a clock. To keep tabs on things, the agency needs to create a structured time where peers and the coordinator can hook up and check in with each other. This time should work for both the coordinator and the peers. The purpose of this time together should be explained in detail and evaluated regularly to make sure it is working. If it's not, peers and their coordinator should work together to make changes.

The coordinator should be much more than just a boss. The coordinator should be a caring, experienced person who has a genuine understanding of marginalized communities. Because of this, the coordinator can also act as a valuable resource. If any personal problems start to interfere with the peer work, peers should let the coordinator know. Maybe being around familiar places is driving peers to resume or do more drugs. Peer workers should not be afraid of mentioning this to the coordinator—he or she can help. But remember, the coordinator is responsible to the agency and if he or she senses that something is wrong, they have to ask the peer what is happening, and attempt to work with the peer to find mutually acceptable solutions. The coordinator is accountable for peer work. The coordinator is not judging the peer's personal life. Don't hide problems—that only leads to more problems.

HOW CAN AGENCIES SUPPORT PEERS?

Success can be measured in ways that are considered reasonable to the individual. This requires staff and management to project a judgment-neutral attitude. A staff person's view of success may be quite different than peers. In supervision and through discussion, the coordinator can learn what the peer wants to get out of the job or program and help set up ways to work towards those goals.

For many drug users the need for change is often motivated by an equally demanding need to avoid harm and/or isolation. The most troubling dilemma for maintaining control over substance use is balancing internal needs with external pressures. Peers must be given the opportunities, training and support to effectively advocate first for themselves and then for others.

Marginalized people have the need to be taken seriously and be accepted into society. Peers should be an integral part of a working program. The difference between written policy and application of services is often disconnected. Peers, coordinators and agencies as a whole need to give this special attention as peers may tend to take neglect or apparent lack of consideration personally. This also speaks to the necessity to provide positive feedback whenever it is deserved.



HOW PEER SUPERVISION IS DIFFERENT

In the social service field supervision really means making and taking time to support workers, including peer workers, one on one. Supervision meetings are peers' regularly scheduled chance to have the peer coordinator's undivided attention, to find out how they're doing, to raise any concerns they might have and to get and give feedback. Because one of the greatest assets that peers have is their personal history and experience as a user, and because every user's experience is different, supporting or supervising peers is going to vary from peer to peer. A coordinator must have clear expectations for peer workers but remain flexible. Some peer workers may need a lot of personal support that includes reminders of when their shift is, may seek a lot of feedback on how they are doing, or need letters or other advocacy. Other peer workers may simply need to check-in, find out their schedule for the week, in short, know that the coordinator is there and cares how things are going.

Some examples of different levels of support may help:

Jane:

Jane is a 32-year-old woman with a long history of homelessness and drug use. However, she has decided to make changes in her life and finding employment was one of her goals. She was a client of an agency's outreach services for years, is well known by the outreach staff, and is keen to give back to her community. However, when she begins work, her housing is unstable and her landlord threatens to evict her because he suspects she is a drug user. She has not paid her phone bill and her phone is disconnected. She cuts down on her drug use when she gets hired but still finds herself going on runs or binges and has forgotten about a couple of shifts she was supposed to work. She and the peer supervisor sit down and carefully outline a plan to support Jane.

They decide together that keeping her apartment is Jane's main concern. Jane agrees that having many drug using friends over to her place is no longer a good idea, as their parties is what makes the landlord angry. She agrees that as part of her personal harm reduction practice, she will only use with one or two good friends in her apartment and try not to use outside those times. The supervisor agrees to write a letter for Jane to show to her landlord to prove she has started work. In order for Jane to be able to attend her shifts, Jane and her supervisor agree that Jane will buy a basic cell phone on a pay-as-you-go plan with her first payment for peer work.

Malika

Malika is an 18-year-old woman who was homeless for a year. She has been sharing an apartment with her boyfriend for a year and a half. Malika was a heroin user for five years but has not used for three months, although she still smokes pot regularly. Malika has started applying to college to obtain a human services diploma and wants some work experience before she goes back to school. In their initial meeting, Malika lets her supervisor know that she will need letters of support from her for her college applications. She is also a bit concerned that, in doing outreach, she will run into old friends from when she was on the street and it will be hard for her to interact with them professionally.

The supervisor agrees to write letters of support for Malika. They also agree to debrief after each outreach shift to see how Malika is doing about seeing old friends. The supervisor makes a careful effort to answer all Malika's questions during their training on boundaries and keeps a close eye on her during her training shifts, giving her constructive feedback whenever possible.

These two examples demonstrate the differing needs of peer workers. A supervisor must have good boundaries in order to be clear with peer workers what they can and cannot do. There will be times when peers need more support than a supervisor can offer. Solid referrals to other professionals who can offer a deeper level of support to peers should then be made.



DEBRIEFING

One way the coordinator can track the progress of peer workers and create better strategies for the peer program is through debriefing. This is not meant to measure the peer worker so much as to find out what they have seen and done. Sometimes we only see what we want to see. A debriefing helps people go beyond their own prejudices and report more than they thought they knew. A debriefing can catch little issues before they become big problems.

Debriefings ideally occur right at the end of a shift. This way the information is fresh in everyone's mind and easier to get. Sometimes time does not allow this and debriefing will have to happen later, preferably before the next shift. A good idea is for peers to write notes about their shift right after it ends, regardless of when the next debriefing is scheduled. The person coordinating the peer program can create a system to make sure this happens. A team logbook for example, can be a good way to capture what happens on a shift so others can be aware of what happens on other shifts. Debriefing should never occur less often than once a week.

Another good reason for debriefing is to make sure peer workers are okay. Like other staff, peer workers often witness disturbing things, or have distressing interactions with the people they're trying to help. Like other staff, peers, too, sometimes need some reassurance after a shift and this is one way agencies can provide some support. It's well known that one way to help get over something is to talk it out. That's debriefing, too. If peers remember something they should have mentioned before, they can just let the coordinator know they'd like to add some additional information. It's that easy. It is imperative to inform supervisors of crises or disturbing situations so that debriefing can be set up right away. Often, agencies also have particular requirements that peers and other workers fill in an incident report or other documentation in certain circumstances, so reporting these without delay is important.



EVALUATION

While debriefings and supervision meetings are verbal interviews between peers and the coordinator, written communication may also be important and in some cases, necessary. This can mean keeping notes in a progress journal or similar format which may ultimately help in writing peers' formal evaluations. Part of the coordinator's role is to provide feedback to peers on their work. This feedback can come in two forms: verbal and written.

We all use verbal feedback - whether it's to tell someone they smell funny or someone telling you they like your shirt. It's all feedback. Because verbal feedback is everywhere, regular, written communication may help to keep things organized between peers, the coordinator and the agency. Because staff come and go, written records are important. If peers need a reference for another job two years from now, they'll be able to get one if the coordinator has left written documentation about their performance.

A formal evaluation compares what peers are doing and how they're doing it with the expectations in the job description. It is a way for the coordinator to report to the agency about how well peer workers are meeting the program goals and to let peers know how well they think the peer is performing their duties. It is not just a recording of strengths and weaknesses. It isn't like a school report card, because peers must get to have some direct input into the evaluation. A good evaluation process involves discussion between the supervisor and peer workers. It should allow for examination and reflection on both the strengths and areas where peers have opportunities to develop more skills or develop better work practices. This is a great way for the coordinator to offer suggestions that will improve peers' job skills. The formal evaluation can help make good peers great peers.

Formal evaluations do not happen often, perhaps only once or twice during peers' contracts. To help write formal evaluations, the coordinator needs to gather as much information on peers' work as possible. One way a coordinator can do this is by looking at a progress journal, progress reports and/or supervision notes. Documenting progress might take the form of a check-list of what peers have accomplished, along with comments.

If a form to help guide supervision meetings is used to help the supervisor keep track of peers' work and remind peers what is expected of them, peers should know its content. Peers should be allowed access to notes made about them during supervision. It's a good idea for peers to sign any progress or evaluation form that's used to show they have seen and understand it. A supervisor can also look back through these notes to find any patterns in peers' work. Are they always missing work on Monday? Does this mean their drug use is escalating over the weekend? Have communication skills improved since you agreed to work on this?

Progress or supervision notes, like the formal evaluation, are not just about the bad, but the good as well. If you don't not know what is wrong you can't fix it. There should be no fear of repercussion if both peers and coordinators are open and honest with each other.

Peers are often an agency's eyes and ears - coordinators and peer workers need to let each other know what is happening. Fully disclosing information is more important to a coordinator than a happy, fun progress report. Life can't always be good. Progress reports need to reflect reality, not fantasy. The more complete the supervision or progress notes, the easier it will be to write formal evaluations

Peers are more flexible problem solvers than I, more apt to take risks. I have been surprised by what we were providing in the way of service. – Raffi



WHEN THINGS GO WRONG

In a perfect world, everything goes as we like it. But life isn't always perfect. As mentioned earlier, social service agencies can seem pretty chaotic a lot of the time. Being short staffed due to one worker's illness can throw an entire agency's schedule off at a moment's notice. Peer workers, too, will have to cope with illness or personal situations. It is in everyone's best interests to be understanding and flexible, to make the program as a whole work as well as it possibly can.

When something happens to affect peers' ability to work, they should let the supervisor know as soon as possible. All they have to do is call as soon as possible, before the shift starts. As long as peers contact the coordinator as soon as possible, a missed shift is not the end of the world. However if peers regularly book off shifts or don't check in on time, or repeatedly fail to meet the terms of the contract the coordinator will have to look at the peers' commitments.

The same way the agency can be flexible, peers have to be flexible. Sometimes a shift has to be cancelled or rescheduled. There are a lot of unknowns in this sort of work—things happen that the agency has no control over. If peers get a call from the coordinator or shows up and is told that the shift has been cancelled they should take a breath and ask why and find out if and when the shift has been rescheduled.

If a shift is cancelled because of concerns over peer work, this has to be discussed. Peer workers should make time to talk to the coordinator or someone else at the agency. The calmer the peers and coordinator are, the more likely that they'll be able to resolve the situation. Sometimes it helps if peers speak with a friend first and vent any negative feelings when they have a problem with someone or something. This is a great way of reducing friction in work situations. Sometimes a sympathetic ear is all it takes to understand a problem. If peers can talk to someone unconnected to the agency and vent their feelings, they and their supervisors will be able to deal with the issues in a cool and calm manner. However, be aware of confidentiality issues. Peers should choose a sympathetic ear with care and make sure this person won't talk about this with others. And show some respect for the agency they work for. Telling everyone in a moment of anger, that the program/agency they work for stinks could cause a lot of problems down the road. When everyone has cooled off, peers can approach their supervisor to set up a time to talk.



CONSEQUENCES

Unfortunately, sometimes people screw up. Sometimes they know it and admit it, sometimes they don't. But it is up to the peer supervisor to ensure their program runs smoothly. This means they will sometimes have to impose consequences or disciplinary actions, on those they supervise. As with everything else, disciplinary actions should be clearly spelled out for peer workers. Orientation to the job or program should include discussion of expectations and the consequences for failing to meet those expectations. There should be a range of disciplinary action a supervisor can make use of, and they should always include clear explanations of why an action is being taken. But a meeting with peers to discuss unacceptable behaviour should also be a problem-solving meeting. Remember, many peers are going to need more support than a regular staff person. A meeting to discuss unacceptable behaviour can also be a form of support.

For example, a supervisor could ask to meet with a peer to discuss a recent string of missed shifts. Is there something going on in the peer's life that is making it difficult for them to meet their commitments? Is there something the supervisor can do to help the peer meet their commitments? In the end the supervisor and peer might agree that the peer should book off for a week and be referred to a counsellor to talk about some issues in greater depth. However, other solutions should be available, since the loss of income during such a period could be devastating for the peer.

Another example of disciplinary action/problem solving could be using peers' services in a different way, (i.e. in the office under direct supervision instead of street outreach). The supervisor must keep in mind the many goals of the project, one of which is most likely creating opportunities for empowerment among a marginalized population. Using discipline and consequences as a tool to improve peers' performance, rather than as punishment for bad behaviour, is the ultimate goal. In any case, discipline should never come as a surprise if peers and their coordinator have been meeting regularly and talking openly, respectfully and honestly.

LEAVING THE AGENCY



WHAT'S AN EXIT INTERVIEW?

At the end of the contract or if the peers and /or coordinators decide to terminate the contract early, there should be an exit interview. An exit interview is like a debriefing except it gives both parties the chance to speak freely and criticize (constructively, of course) all aspects of their experience. It's also the time for the coordinator to give peers a letter of reference, certificates for any training taken, and any other material that may help peers in the future. The coordinator can remind peers to add any training or work outside their normal duties to their resume. A skills inventory (see Appendix E) may be used to help peers set goals (see Appendix J) needed to move into more advanced harm reduction work if they choose. Thinking of goals as targets to be achieved may lead to feelings of failure if the goal is not achieved. Try thinking of the goals set as magnets drawing you in the direction chosen.

The exit interview is great for peers because they can let the agency know what they found to be positive or negative about their experience as a peer. Peers can ask questions about why something was done and also explain why they thought something was wrong. Exit interviews are also an excellent way for the coordinator and agency to figure out how they may improve their services. If they don't know what is wrong in their approach, they cannot fix it. The peer's free and full criticism is a good thing for everyone, just as the coordinator's final remarks can help peers succeed in future endeavors.

For many peers the end of the contract can become mentally and emotionally overwhelming. Former peers have expressed feelings of loss and abandonment by the agency. The exit interview is a good place to discuss these feelings if they exist. The coordinator can offer to help set up supports around these issues. In a way, the exit interview gives peers and agencies a way to end the working relationship with a little bit of closure, and, hopefully, let the relationship continue on other terms.



POST-CONTRACT SUPPORT

What should agencies be prepared to provide? What should peers expect?

Regardless whether peers' experience was positive or negative (probably a bit of both as most jobs are), the agency is dedicated to serving the user community. Retired peers should always be welcome at the agency. If there are problems, these need to be addressed and worked out. It is as important to former peers as it is to the agency to maintain a good relationship. Former peers can still be ambassadors for the agency. If the agency has a speaker's bureau retired peers may make excellent presenters. They may be able to help train or mentor new peers.

Just as the transition from client to peer requires special consideration, if peers are to become clients of the agency post-contract, both the individual and the agency will have to communicate and agree on what that will mean.

Engaging drug users is about securing and enhancing an open and reflective culture at all levels within drug services. It is vital that user involvement is adequately resourced, but equally that it is underpinned by best practice. There is also a need to expand the research base in this complex and potentially rewarding specialist area of the drug field.

– Mat Southwell

CONCLUSION

This second edition of the guide for peer workers and agencies is a continuation of efforts to build capacity around harm reduction practice through ongoing expansion and enhancement of the roles of peers. This guidebook is the result of many hours of discussion and consultation among people with lived experience of drug use and peer work, as well as those who have created and managed programs that employ them.

Over the last decade the Toronto Harm Reduction Task Force has fostered annual peer driven projects – both community based research and resource development. Findings and information from some of those projects have been used as building blocks for some of the new sections in this guide.

In the long term, we continue to hope that the development of a self-sustaining peer alliance will be possible. This will eventually go a long way toward empowering community members, ultimately becoming a valuable resource for peers and agencies, and ultimately, the people they serve.

APPENDICES

- A) Free & Sliding Scale Training and Workshops
- B) Sample Mission Statement or Mandate
- C) Sample Contract Agreement
- D) Some Harm Reduction Related Websites
- E) Sample Skills Inventory/Assessment Tools
- F) Resume Development: Where to Get Help & Sample Resume
- G) Sample Job Posting & Job Description
- H) Sample Time Card
- I) City of Toronto Wage Increase Recommendations
- J) Sample Goal Planning Worksheet
- K) Confidentiality Agreement
- L) Drugs 101
- M) Boundaries/Confidentiality Situational Examples
- N) My Personal Self-Care Plan
- O) Overdose Awareness & Prevention Chart
- P) Overdose Protocol Checklist

APPENDIX A: FREE AND SLIDING SCALE TRAINING & WORKSHOPS

Toronto Harm Reduction Task Force

www.TOarmreduction.org and Toronto Harm Reduction Task Force on Facebook

City of Toronto Employment & Training programs

http://www.toronto.ca/telmi/cj_ps_employment_and_training_programs.html

Toronto Hostels Training Centre

<http://www.thtcentre.com/>

Dixon Hall

www.dixonhall.org

Fred Victor Centre

www.fredvictor.org

Agincourt Community Services

www.agincourtcommunityservices.com

Toronto Public Library:

Health (Nutrition, Stress Management etc.)

<http://www.torontopubliclibrary.ca/programs-and-classes/categories/health-wellness.jsp>

Computers

<http://www.torontopubliclibrary.ca/programs-and-classes/categories/computers-library-training.jsp>

Toronto Public Health – The Works: Narcan training (for opioid overdose) 416.392.0520

Toronto District School Board – Courses for Adults

<http://www.tdsb.on.ca/site/ViewItem.asp?siteid=200&menuid=983&pageid=721>

CPR Training

<http://www.vitalcpr.com/community.html>

Conflict Resolution

<http://www.sscto.ca/conflict-resolution/public-workshops>

Evidence Exchange Network - webinars and in person workshops on a variety of drug related issues

www.EENet.ca

CAMH

<http://www.camh.ca/en/education/Patients-Families-Public/public/Pages/default.aspx>

APPENDIX B: SAMPLE MISSION STATEMENT OR MANDATE

Fred Victor Centre is a multi-service organization committed to working in partnership with women and men living in poverty to address their needs and hopes and to build a more just society.

Since 1894, Fred Victor Centre has been dedicated to working in partnership with women and men living in poverty in downtown Toronto. Throughout its 100 year history, situated at the corner of Queen and Jarvis Streets, the direction of Fred Victor Centre has evolved from its original focus as an outreach mission dedicated to charitable works, to its present goal, that of helping to create a more just and caring society which values and includes all people, no matter what their background or situation.

Fred Victor Centre is an integrated multi-service organization with many different programs and a wide range of facilities. These have been developed to increase the options and resources available to people in our community with a focus on housing, employment and individual assistance, in addition to providing options for people with substance use issues. Fred Victor Centre supports community members through coordinated continuum of services to respond to the multi-faceted needs of each individual.

Through the programs and facilities of Fred Victor Centre, people are able to address their essential needs for food, shelter, and social contact – the basic requirements for survival. When these needs are met, they can begin to focus on their hopes and dreams for a better future. Men and women are able to rebuild their lives by having meaningful involvement and purpose, as well as the opportunity to develop their skills and capacity. Community members are actively involved in the design and delivery of programs and are included in decision-making.

Courtesy Fred Victor Centre www.fredvictor.org

APPENDIX C: SAMPLE CONTRACT AGREEMENT

Date: _____ This contract is from _____ to _____
for _____ date _____ date _____ peer's name

- 1) Peer workers are hired by the peer coordinator for a _____ month period to work a maximum of _____ hours during the first month at the rate of \$_____ per hour and _____ hours per month thereafter at the same rate of pay.
- 2) Peer workers will arrive on time for their scheduled shifts and will be paid in cash at the end of their last shift of each week. The week runs from Monday morning to Sunday night.
- 3) Peers will not be paid for missed shifts.
- 4) The agency will provide one to two months of training in order to prepare the peer workers for their work. Training time will be paid at the rate of \$_____.
- 5) Peers are responsible for providing education to young people about issues connected to street life including: HIV/AIDS prevention, peaceful conflict resolution, street youth resources and agencies, harm reduction and anti-oppression information.
- 6) Peer workers must be flexible in their availability. Work shifts will vary in length. All shifts will be scheduled in advance and posted at the agency.
- 7) Peer workers will treat all clients, staff, placement students, volunteers, other peers and clients with respect. Peers will refrain from using racist, sexist or homophobic language. Two warnings about such behaviours will be given and recorded before dismissal.
- 8) Use of threats or physical violence will result in immediate dismissal.
- 9) The peer coordinator is the peers' supervisor and a support person. If peers have any questions about their work, they should ask the coordinator. If peers are having personal problems which are interfering with their ability to work, they should let the coordinator know.
- 10) TTC tokens will be supplied to peer workers only for transportation to presentations.
- 11) Peers will always represent themselves on behalf of the agency in accordance with agency policy.

Peer education coordinator

Peer worker

APPENDIX D : SOME HARM REDUCTION RELATED WEBSITES

Toronto Harm Reduction Task Force	www.TOarmreduction.org
Canadian Harm Reduction Network	www.canadianharmreduction.com
Vancouver Area Network of Drug Users	www.vandu.org
Canadian Drug Policy Alliance	www.drugpolicy.org
National Alliance for Medicated Assisted recovery	www.methadone.org
Drug Sense	www.drugsense.org
Harm Reduction International	www.ihra.net
Canadian Students for Sensible Drug Policy	www.cssdp.org
Law Enforcement Against Prohibition	www.leap.cc

APPENDIX E: SAMPLE SKILLS INVENTORY/ASSESSMENT TOOL

Following is a list of some of the skills required for different kinds of work. You may have gained some of these skills at school, through a job or volunteer work, or through life experience. Please check off the boxes beside any of the skills or tasks listed below that you have experience with.

LEADERSHIP:

- planning or organizing activities or meetings, etc.
- encouraging people to get involved in activities
- child care or babysitting
- caring for the elderly or sick
- teaching or coaching
- playing a team sport
- training or supervising others in a workplace

ADVOCACY:

- taking responsibility for finding resources for yourself or others (e.g. food, healthcare, welfare)
- finding out about peoples' rights
- resolving conflicts between others
- speaking on behalf of others
- taking the initiative to change something
- negotiating (e.g. for a better price, more time, a promotion, etc.)

COMMUNICATION:

- writing
- ability to speak other languages (please specify) _____
- speaking to a group
- answering a business telephone line
- providing information or directing calls to other staff

SERVICE:

- greeting customers
- taking or filling orders (including serving food/beverages)
- assisting customers
- receiving shipments, storing/pricing merchandise or supplies
- inventory control, merchandise display
- preparing bills/accepting payments/reconciling receipts

FOOD:

- shopped, prepared food for self or family
- commercial food preparation
- participation in a community kitchen program
- food preparation or cooking course or class
- Smart Serve or other certification (please specify) _____

OFFICE:

- keyboarding
 photocopying
 filing
 computer programs (please specify) _____
 faxing
 internet applications including e-mail

HOUSEKEEPING:

- budgeting money / paying bills
 prioritizing, organizing and accomplishing chores or duties
 accessing community resources (e.g. food bank)
 cleaning (commercial or household)
 laundry (commercial or household)
 grounds maintenance (commercial or household)
 maintenance (commercial or household; e.g. small repairs to appliances, painting, etc.)

OTHER:

- (e.g. First Aid/CPR certification, (please specify) _____)

TRANSFERABLE SKILLS (check as many as apply):

- | | | | |
|---|------------------------------|--|---------------------|
| Accepts feedback [] | Cooperative [] | Creative [] | Detail Oriented [] |
| Eager [] | Enthusiastic [] | Flexible [] | Friendly [] |
| Hard worker [] | Helpful [] | Innovative [] | Patient [] |
| Pleasant [] | Polite [] | Positive attitude [] | Punctual [] |
| Reasonable [] | Reliable [] | Responsible [] | Resourceful [] |
| Sense of humor [] | Take direction [] | Team player [] | Tolerant [] |
| Willing to learn [] | Non-judgmental [] | Motivated [] | Organized [] |
| Outgoing [] | Knowledge of street life [] | | |
| Experience with homeless population [] | | Familiar with illicit drugs/drug use [] | |

APPENDIX F : RESUME DEVELOPMENT
WHERE TO GET HELP & SAMPLE RESUME

Fred Victor Employment and Training Services
416-364-8986, www.fredvictor.org

Next Steps Employment Centres (7 locations)
416-395-9559, www.next-steps.ca

Job Start (3 locations)
416-231-2295, www.jobstart.org

YMCA Employment Centre (various locations)
419-635-9622, www.ymcagta.org

Woodgreen Employment Centre (various locations)
416-462-3110, www.woodgreen.org

Miziwe Biik Aboriginal Employment & Training
416-591-2310, www.miziwebiik.com

St. Stephen's Community House & Employment Training Centre
416-537-5477, www.jobhouse.ca

Social Services Employment & Resource Centres (numerous locations)
www.toronto.ca/socialservices/ercs.htm

Human Resources Development Canada
Employment Resource Centres
www.hrsdc.gc.ca

SAMPLE RESUME

Jane Smith
647-555-1212 (voice mail)

Objective: I am looking for a position as a peer educator with a social service agency that works with drug users.

Skills & Experience

- resourceful and reliable
- experience with homelessness and drug use
- commitment to harm reduction
- conflict resolution training
- knowledgeable about HIV/AIDS prevention

Work Experience

Telephone customer service representative:
ABC Construction, 123 Erie Street, Toronto, M1A 1A1
2009-10

Responsibilities: answering and logging calls from customers and contractors; typing and filing contracts and correspondence

Lifeguard:
1234567 Ontario Ltd. Condominiums, 456 Maple Ave., Toronto, M2B 2B2
summer 2008 (part-time)

Responsibilities: supervision of swimming pool; cleaning pool, change rooms, sauna; responding to residents and guests

Volunteer Work
First Street Community Centre, 1 First St., Timmins, Ont.
2007

Responsibilities: teaching 6 and 7 year olds water safety; keeping track of volunteer teachers' schedules; promoting water safety to grades 1 and 2 at Timmins Public School

Special Training:

Red Cross Lifesaving Certificate
St. John's First Aid and CPR Certificate
Public Health Train the Trainer HIV/AIDS Certificate

References are available upon request

APPENDIX G: SAMPLE JOB POSTING/JOB DESCRIPTION**SAMPLE JOB POSTING****PEER OPPORTUNITIES**

Central Community Services is seeking peer outreach workers to provide services to homeless people in downtown Toronto.

Peer outreach workers are required to work 20 hours per week, including weekends from 7 p.m. to midnight.

Peer outreach workers work on the street along with regular staff in teams of two.

Peer outreach workers are eligible for honoraria of \$15 per hour.

Duties:

Providing needle exchange and condoms and promoting safer drug use and sex education.

Qualifications:

Some experience with people who are homeless, people who use drugs and/or people involved in the sex trade; dependable and willing to work 4 times a week for 6 months; non-judgmental attitude; interested in getting training on harm reduction, HIV/AIDS, Hep-C and sexually transmitted infections.

Central Community Services encourages drug users/ex-users and people who are homeless to apply.

DEADLINE: July 5/2013

Please apply to John Smith, outreach coordinator.

You may send or drop off a letter or your resume any weekday between noon and 5 p.m., fax or email any time or call John on Mondays or Thursdays to arrange an appointment.

Central Community Services
123 Elm Street
Toronto, M1A 1M1
416-555-2121 (phone)
416-555-1221 (fax)
johnsmith@centralcommunityservices.org

SAMPLE JOB DESCRIPTION

Peer outreach workers:

- **Come to work on time as scheduled;**
- **Participate in a 3 day paid agency orientation;**
- **Participate in ongoing training sessions at the agency and outside the agency;**
- **Accompany staff person on street outreach as scheduled (2-3 times per week);**
- **Provide condoms and drug use related harm reduction resources to clients during street outreach;**
- **Provide harm reduction strategies and education and referrals for other services in a non-judgmental way to clients during street outreach;**
- **Encourage clients to use the agency's services;**
- **Keep records (statistics) about services you provide during street outreach;**
- **Be a role model for clients by modelling appropriate behaviour;**
- **Share up to date information about drug use in the city with the agency as you become aware of issues or trends;**
- **Attend weekly peer team meetings with the supervisor;**
- **Participate in weekly individual supervision meetings with the supervisor;**
- **Attend weekly agency staff meetings (every Tuesday at 4 pm.);**
- **Accompany staff/senior peers to presentations about the agency/peer program;**
- **Help to keep the peer office and work stations clean and tidy;**
- **Specific projects as assigned by the supervisor (e.g. development of an educational brochure about injection drug use for clients/peers; organizing a focus group for drug users to discuss housing issues, etc.).**

APPENDIX H: SAMPLE TIME CARD

Peer Educator: **Jane**Month of: **January**

PEER COMMENTS	DAY/DATE	TIME IN	TIME OUT	TOTAL HOURS	SHIFT DUTY	SHIFT INITIAL
Arrived 10 minutes early	Tues. Jan 13	3:50pm	11pm	7	outreach	JM
TOTALS: SHIFTS/HOURS						

APPENDIX I: CITY OF TORONTO WAGE INCREASE RECOMMENDATIONS

Toronto Public Health funds a number of peer programs at agencies across the city. Recently (November, 2012) they issued the following memorandum:

“Toronto Public Health acknowledges the unique and diverse roles that peer workers play in the delivery of services in community-based organizations across Toronto. Peer workers bring an important level of expertise based on their lived experience, and are often able to reach and connect with people who are not accessing supports and services they require.

There are a diverse range of peer models. Some models focus on the participation of individuals as leaders from specific populations to influence their peers through modelling to reduce harmful behaviours and promote positive behaviour change. Other models use a social determinant of health approach that integrates processes that support and enable participants to stabilize their lives and build social networks and connections.

Peer workers are hired for their experiential knowledge and skills, as opposed to professional or formal credentials to provide a specific service to their peers. For the purposes of this program, peer workers are defined as having a temporary, short-term employment agreement with their employer.

Toronto Public Health recognizes and values the important role peer programs play in the projects funded through the AIDS and Drug Prevention Community Investment Programs. Projects with peer worker components must demonstrate they meet the following criteria in order to be eligible for funding at the maximum hourly rate of \$15.

Peer workers must reflect the target population.

Peer workers must be integrated within the organizational culture. This includes, for example, participation in staff meetings, and involvement in relevant policy and program development and evaluation.

Organizations must have fair, transparent and formal policies and procedures in place for the recruitment, hiring, training, supervision, retention, performance management and professional development of peer workers.

Organizations must have a range of informal to formal peer worker roles and responsibilities with a commensurate wage scale in place.

Organizations must demonstrate through organizational policies their commitment to supporting peer workers to advance into the mainstream workforce and/or pursue formal education.

Funding for peer worker rates is for compensation of hourly work; other benefit costs are to be incurred by the employer.

Peer worker positions should in no way be considered as a replacement for full-time and part-time non-peer staff.

References: Penn, R; Mukkath, S.; Henschell, C.; Andrews, J.; Danis, C.; Thorpe, M.; Thompson, M.; Gao, Y.; Miller, C.; Strike, C.; (2011) Shifting Roles: Peer Harm Reduction Work at a Multicultural Community Health Centre. Toronto: Centre for Addiction & Mental Health; Toronto Harm Reduction Task Force, (2003) Peer Manual: A guide for peer workers and agencies, Toron

APPENDIX J: SAMPLE GOAL PLANNING WORKSHEET

SAMPLE GUIDELINE FOR DISCUSSION BETWEEN PEER WORKER AND COORDINATOR

Let's talk about some things you'd like to accomplish in the next few months (health, employment, education, housing, relationships, etc.)

List five goals:

- Which of these goals is the most important to you right now?
- Which do you think you can accomplish most easily?
- What will you need to accomplish this?
- How could participating in the peer program help you accomplish this?
- What's your second most important goal?
- Where would you like to be in 6 months? A year?

These notes should be kept in the peer's file and revisited during supervision meetings. This will help identify and define goals and chart accomplishments.

APPENDIX K: SAMPLE CONFIDENTIALITY AGREEMENT

Peer workers agree to act as representatives of the agency; be open minded; have empathy and compassion for the experiences of others no matter how different; provide service, information and practical aid to clients and take time to listen on the streets and in the agency.

Peers agree to be an example and role model to clients; be respectful and calm when dealing with others; show by their actions that there are ways to leave the streets and other options to living on the street; resolve conflict peacefully and ask for help when needed.

Peer workers understand that they are encouraged to talk to the coordinator when things are tough.

Peers understand and agree that they are not to share any personal information about any other person, other than staff, that they learn while working as a peer educator and that breaching this agreement will result in disciplinary action, including possible dismissal.

Peer worker: _____

Peer coordinator: _____

Date: _____

APPENDIX L: DRUGS 101

* MedLinks Students Promoting Health at MIT

DRUG CLASS	SPECIFIC DRUGS		EFFECTS	SIDE EFFECTS	MEDICAL USE
	SUBGROUP	EXAMPLES			
SEDATIVES	Benzo-diazepines	Diazepam (Valium), clonazepam (Klonopin), lorazepam (Ativan), temazepam (Restoril), flunitrazepam (Rohypnol), triazolam (Halcion), alprazolam (Xanax)	Calm, relaxed muscles, sleepy	Drowsiness, falls, impaired coordination, impaired memory, dizziness	Anxiety, insomnia, epilepsy, many other diseases
	Benzo-diazepine agonists	Zolpidem (Ambien), eszopiclone (Lunesta), zopiclone, zaleplon (Sonata)	Mainly just sleepy, sometimes hallucinations and sleep-like states	Same as benzodiazepines	Insomnia
	Barbiturates	Phenobarbital, pentobarbital, thiopental (sodium pentothal, sodium amytal), secobarbital	Calm, euphoric, sleepy	Same as benzodiazepines, plus breathing suppressed, terrible withdrawal, death	Epilepsy, other diseases in the past and more rarely today
	Alcohol		Calm, euphoric, loss of inhibitions (facilitates socializing, talking, singing, sex), relaxed	Same as benzodiazepines, plus nausea, vomiting, breathing suppressed, terrible withdrawal (including psychosis and seizures), brain damage, various diseases, death	Alcohol withdrawal
	Gammahydroxybutyrate (GHB), GBL, 1,4-butanediol		Euphoric, energetic, sleepy, calm	Same as benzodiazepines, nausea, vomiting, breathing suppressed, psychosis, seizures, death	Narcolepsy (improves cataplexy, not simply a sleep aid)

STIMULANTS	Amphet-amine	Amphetamine (Adderall), methamphetamine (Desoxyn), methylphenidate (Ritalin), phentermine, 4-methylaminorex, phenmetrazine (Preludin), methcathinone, fenfluramine (Pondimin, Fen-Phen), dexfenfluramine (Redux), pseudoephedrine (Sudafed), ephedrine, phenylpropanolamine (old Triaminic), phenylephrine (Sudafed PE), phenethylamine, tyramine	Euphoric, energetic, able to work, concentrate, stay awake. Reduces appetite.	Anxiety, paranoia, psychosis, high blood pressure, heart attack, stroke, brain damage when used excessively	ADHD, narcolepsy, obesity, rarely depression
		MDMA (ecstasy), MDA, MDEA	Euphoric, energetic, deep and unusual thoughts, perceived inspiration and novelty, enhances sex, dancing, music, art, touch and senses. Contentment. Connection to other people, strong emotions.	Same as amphetamine, plus brain damage, confusion, agitation, frequently death due to hyperthermia, heart attack, water intoxication and other problems.	No approved uses, but a few small psychiatric studies have been conducted
	Cocaine	Same as amphetamine (above)	Same as amphetamine, plus a worse risk of heart attack	Local anesthesia and bleeding control, diagnostic tests	

NARCOTICS	Full opioid agonists	Morphine, heroin (diacetylmorphine), hydrocodone (Vicodin), oxycodone (Percocet, Oxycontin), fentanyl, Demerol, codeine, opium, hydromorphone (Dilaudid), oxymorphone (Opana), methadone	Euphoric, pain relief, calm, relaxed, sleepy, appetite suppression	Nausea, constipation, vomiting, drowsiness, breathing suppressed	Pain relief, rarely depression and diarrhea
	Partial, selective, or mixed opioid agonists	Buprenorphine (Suboxone), pentazocine, nalbuphine, tramadol (Ultram), tifludom	Pain relief, not quite as euphoric or relaxing as full agonists (above)	Nausea, constipation, vomiting, drowsiness	Pain relief, rarely depression, opioid addiction
CANNABIS	Active ingredient is mostly tetrahydrocannabinol, some other active ingredients like cannabidiol in smaller quantities		Unusual thoughts and feelings, sometimes calm, happy, hungry, enhanced appreciation of art	Memory, thinking, reflexes, and coordination are impaired. May contribute to psychosis in the long term.	Might relieve nausea, vomiting, and neuropathic pain. Pills already legal, other forms under investigation.
PSYCHEDELICS	Phenethylamines	Mescaline (peyote cactus), 2C-series drugs (2C-B, 2C-I, 2C-C, 2C-T-7), 3C-E, 4-MTA, PMA, DO-series drugs (DOC, DOB, DOI, DOM)	Feeling of novelty, inspiration, reverence. Fast, disordered thoughts, trances. Perceptual anomalies: patterns move, colours brighter, seeing sounds, smelling colours. Crazy ideas and beliefs.	Anxiety, insomnia, paranoia, temporary psychosis. May contribute to psychosis in the long term, or cause flashbacks (HPPD). Some cause nausea, increased body temperature, tremors.	None
	Tryptamines	Psilocybin and psilocin (both in mushrooms), bufotenin (in toads), DMT (in plants), 5-MeO-DMT (in plants), 5-MeO-DiPT, DET, AMT, 4-HO-DiPT			Psilocybin and LSD have been tested for the treatment of cluster headaches

	Ergolines	Lysergic acid diethylamine (LSD), LSA (ergine, in plants)	Same as above, plus other effects, depends of frequency of use and dose.		Other ergolines are used for many diseases but are not psychedelic.
DISSOCIATIVE ANESTHETICS	Phencyclidine (PCP), dextromethorphan, ketamine		Feeling of distance from reality and body, numbing of sensations and pain. Convincing and absorbing hallucinations.	Nausea, vomiting, coma, violence, extreme confusion, temporary psychosis. PCP causes brain damage.	Anesthesia. A related drug, memantine, is used in Alzheimer's disease, and these could be used in stroke sufferers.
DELIRIANTS	Scopolamine and atropine (in plants), diphenhydramine (Benadryl), dimenhydrinate (Dramamine)		Loss of memory, convincing and absorbing hallucinations.	Extreme confusion, temporary psychosis, hot, dry skin, dry mouth, huge pupils, fast heartbeat, death	Many legitimate uses
INHALANTS	Diethyl ether (starter fluid), chloroform, toluene, gasoline, glue, paint, xenon, cyclopropane, freon, halothane, sevoflurane		Calm, relaxed, euphoric, pain relief, hallucinations, strange sensations (different inhalants cause different effects from this list)	Many diseases, death, nausea, vomiting, accidental asphyxiation, falls, varies depending on particular drug	General anesthesia
	Nitrous oxide		Calm, euphoric, pain relief, memory loss	Similar to above, plus vitamin B12 depletion that can lead to partial paralysis and other	General or partial anesthesia
	Nitrites	Isoamyl nitrite, isobutyl nitrite	Head rush, muscle relaxation, dizziness	Dangerously low blood pressure, fainting	Heart conditions

APPENDIX M: BOUNDARIES & CONFIDENTIALITY SITUATIONAL EXAMPLES

SITUATION 1	
Money	Jamie has been a peer worker with a street outreach agency for about 4 months. There is an agency rule that says you are not to lend money to clients under any circumstances. One evening during her shift, Jamie runs into Chris who is a client. Jamie and Chris have really connected because they are both from the east coast. Chris asks Jamie for a personal loan of \$20. Jamie knows that this is against agency policy, but can't see the harm in it, and so agrees to lend Chris the money for a couple of days until welfare cheques come out. Three weeks later, Chris is avoiding not only Jamie but everybody from the agency because she feels badly that she cannot repay the loan. Jamie is really concerned that Chris may not be getting clean works because she cannot reach her.
What went right	Jamie knew the agency rule about lending money to clients.
What went wrong	The reason for this policy wasn't explained to Jamie. Chris ends up feeling indebted to Jamie and cuts off contact with the agency/service, Jamie ends up feeling guilty for breaking the rule and losing contact with the client. Chris may be at higher risk because she is reluctant to accept services from the agency.

SITUATION 2	
Confidentiality & trust	Dave has been working as a peer with an agency that serves the LGBT community for a number of weeks. One night, Dave is out walking down Yonge Street with some friends. He sees Guy, a client, coming toward them. Guy also appears to be with a friend. Dave cannot tell whether Guy has noticed him, so as they pass, he averts his gaze. Guy passes without speaking to Dave. Guy does not want to have to introduce his brother or explain how he knows Dave. Dave doesn't feel slighted because he knows it is up to Guy to decide whether he wants to recognize him or not, and that his client probably has a good reason not to say hello under the circumstances. Guy comes into the agency the next day to apologize to Dave for ignoring him the night before. Dave explains that he gave Guy the option to say hi or not, and why, and that he is not bothered by what happened.
What went right	Dave gave his client the choice of whether to acknowledge him or not. Dave did not take Guy's lack of greeting personally. Guy addressed the situation, and he and Dave discussed what had happened. Guy's trust in Dave has increased.

SITUATION 3	
Identifying with a client	Pat is a single mom. She has worked for an agency that serves young mothers who are dealing with substance use for over a year. One of her clients is a young woman, Jackie, who reminds Pat of herself. Pat has gone out of her way to see Jackie whenever she shows up, even if they don't have an appointment. Sometimes Jackie arrives just as Pat is leaving for lunch and Pat takes her out for a bite. Jackie regularly shows up just as Pat's shift is finishing and Pat always stays late to talk with her. Occasionally, Pat has given Jackie special consideration, slipping her an extra food voucher or box of diapers. Recently, Jackie asked Pat to babysit her 2-year-old daughter for the weekend so she could go away with her new boyfriend. Pat had to say no to this request. A week later, Jackie left a voice mail message for Pat asking her to close her file. Now Pat is very concerned about Jackie, and feels guilty for refusing her request to babysit. Jackie misses Pat's attention and support. Jackie is feeling very isolated and is having trouble taking care of herself and her child.
What went right	Pat recognized that agreeing to babysit Jackie's child would be crossing a boundary. If she had agreed to do this she could have jeopardized the agency in any number of ways, and put herself and her own children at risk.
What went wrong	Pat didn't address the fact that Jackie reminded her of herself. Pat failed to set sufficient boundaries with Jackie. Jackie was encouraged to develop unrealistic expectations about how much Pat could help her. Pat felt so badly about refusing Jackie's request that she neglected to refer her to a respite care program for young moms. Pat and Jackie lost the trust they'd developed. Pat feels guilty and Jackie feels abandoned. Jackie and her child may be at greater risk because Jackie has cut off contact with Pat and the agency.

SITUATION 4	
Cultural differences	Carlos is a peer settlement worker. The agency he works with helps new immigrants get housing, training, childcare and jobs. Carlos helped a refugee family find an apartment, introduced them to a neighbourhood parenting centre and assisted them to enroll in ESL. On a recent home visit, Carlos arrived to find that the family had prepared a special meal to honour him. Although the agency does not permit workers, peers or volunteers to accept gifts from clients, Carlos realized that if he refused to share this meal with his clients they would be confused and offended. He recognized that although this family was on welfare and had limited resources, it was an important part of their culture to share a meal with him as a way of thanking him for his help. He discussed all this with his clients, and as soon as he returned to the agency made a point of speaking to his supervisor who agreed that he had done the right thing under the circumstances.
What went right	Carlos knew and understood the reason for the agency's policy. Carlos assessed and discussed the situation with his clients. Carlos reported the situation and his reaction to his supervisor without delay.

APPENDIX N: MY PERSONAL SELF-CARE PLAN

1. What self-care means to me:

2. Reflecting on how I'm doing:

Signs that I'm doing well

Things I notice about myself:

Things other people might notice about me:

Signs that I'm having a hard time

Things I notice about myself:

Things other people might notice about me:

3. When I'm having a hard time:

It helps when I . . .

It helps when **other people** . . . (*Which people?*)

4. My strategies for dealing with stress

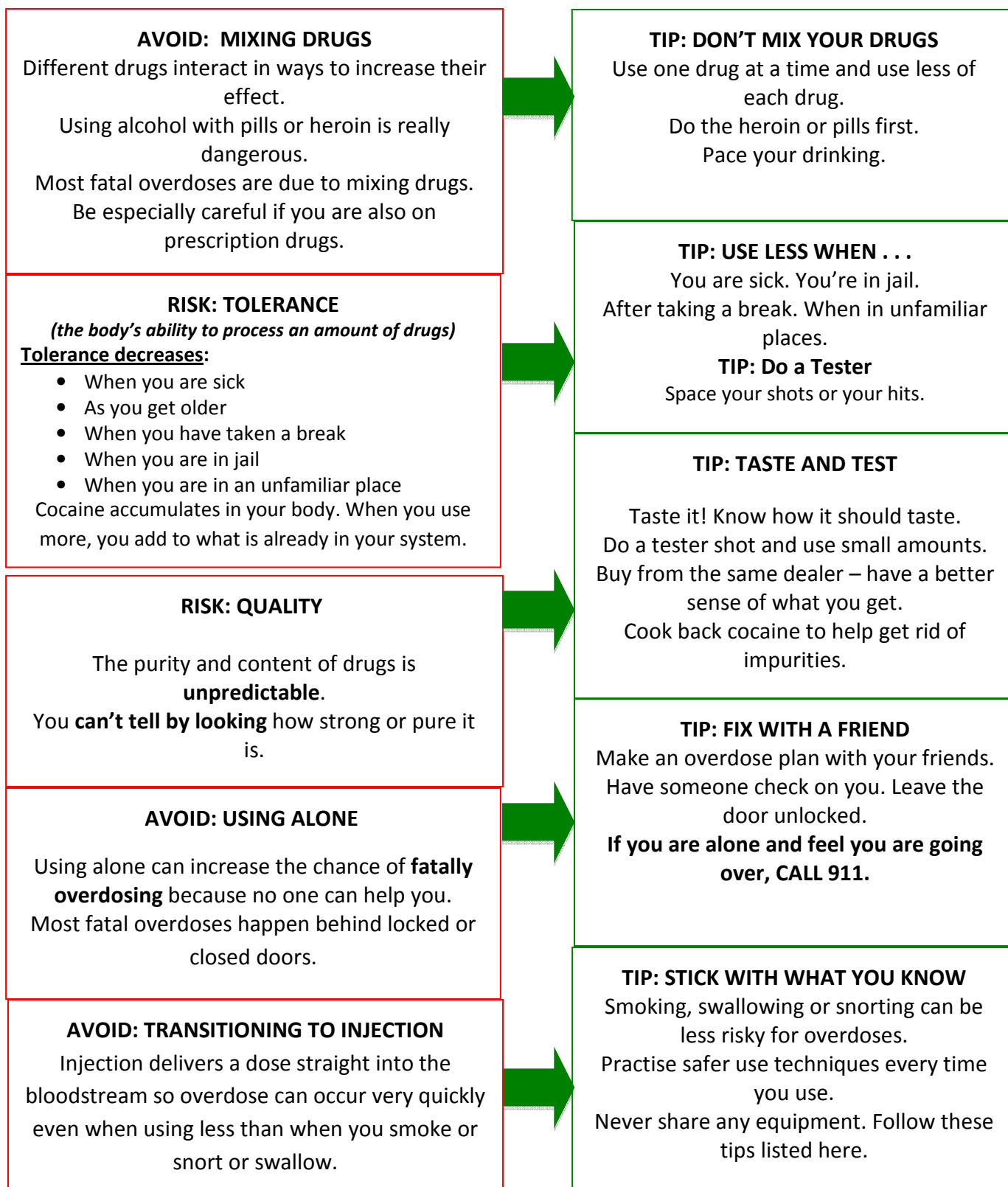
Source of Stress

Strategies for dealing with stress

5. Some people or things that fuel me when I'm feeling empty are:

APPENDIX O: OVERDOSE AWARENESS & PREVENTION

*Change the Cycle Peer Training Program: Facilitator's Manual and Reflections. University of Toronto From: Penn, R., Kolla, G., Strike, C., and the CTC Team. (2012)



APPENDIX P: OVERDOSE PROTOCOL CHECKLIST

“The First 7 Minutes” is a short film designed to promote discussion and the design and implementation of tailored overdose prevention protocols in all agencies that serve marginalized populations – from needle exchange programs to “Money Mart.” It is part of a growing arsenal of resources and services being developed and delivered by the *Toronto Harm Reduction Task Force* and *Toronto Public Health – The Works* to help address the issue of overdose in the city.

Discussion/Checklist Questions:

What are some barriers to designing and implementing an overdose prevention protocol at your agency?

What is your agency’s official policy around substance use on site?

About people accessing services while they’re high or intoxicated?

About sleeping in the drop in or waiting area?

About using washroom facilities?

Does your agency distribute safer use tools (syringes, pipes)?

What are the biggest risks of overdose faced by the clients you serve?

What kind of drugs do clients of your agency use? How do they use these?

At your agency, are there health care professionals on site?

Who is trained in first aid and CPR?

Is there a first aid kit? If so, what’s in it? Who is responsible for keeping it stocked? Does it include rescue breathing masks? Are gloves readily available for universal precautions? Is there a defibrillator in the building? Who has been trained to use it?

Who is responsible for clearing the building in case of emergency (fire or other)?

Are there panic buttons anywhere in the agency?

Is the street address of the agency and notation of cross streets posted by all telephones?

Are there any posters/algorithms on what to do in the event of overdose displayed in your agency?

Does your agency offer ongoing training for front line and peer workers e.g. crisis management? HIV/Hep C prevention? overdose prevention?

What’s the physical layout of the building (e.g. long hallway, offices with doors, fire doors etc.)? Are there places someone might be without being noticed right away?

What about the outside surrounding area? Are there obstacles around (e.g. dumpsters etc.)

GLOSSARY OF TERMS

Abstinence	To refrain from using one or more substances or drugs, temporarily or permanently
Abstinence-based	A program, philosophy or strategy based on non-use of a substance or substances, usually used to distinguish from a program, philosophy or strategy based on harm reduction principles.
Abuse	<p>Distinct from use, abuse is commonly used to refer to problematic behaviours and/or outcomes surrounding substance use. Rather than accepting the terms alcohol or drug abuse, many public health professionals have adopted phrases such as harmful/problematic use or misuse of drugs in place of abuse.</p> <p>Abuse is also used to define violence including unwanted sexual acts etc.</p>
Active listening	A communication technique where the listener feeds back what they heard to the speaker, by re-stating what they have heard in their own words, to confirm that both people understand something.
Advocacy	A political process by an individual or group which aims to influence policy and decisions by governments or institutions.
Activism	Getting involved to make change, achieve political or any other goals, sometimes by demonstrations, protests, etc.
Addiction	“Any behavior that has negative consequences but a person continues to crave it and relapse into it despite those negative consequences” (Gabor Mate, MD)
Anti-oppression	Confronting behaviours, policies, beliefs, etc., that can lead to the marginalization, discrimination and persecution of people.
ASO	Aids Service Organization (e.g. AIDS Committee of Toronto etc.)
Blood-borne	A infection transmitted by exposure to blood as opposed to an air-borne infection like a cold; can be either bacterial or viral, ie: HIV, HCV.
Coercion	Using someone’s weakness to compel or convince them to do something they might not otherwise do.
Capacity-building	Development work - involving training and providing resources - that strengthens the ability of community organizations and groups to build structures, systems and skills that enable them to participate and take community actions (Skinner, 1997).
Co-infection	The simultaneous presence of 2 or more infections which may increase the severity and duration of one or both. In a harm reduction context, this is almost always used to refer to HCV and HIV co-infection.

Decriminalization	To remove criminal penalties in relation to certain acts, perhaps retroactively; regulated permits or fines might still apply. For example, since 2001, Portugal has decriminalized personal possession and use of the most commonly used illicit street drugs - marijuana, cocaine, heroin, crystal meth, MDMA, etc.
Empowerment	Indicators of empowerment include control over personal decisions; autonomy; decision-making, independence and the ability to control things in one's life.
Empathy	An identification with and understanding of another person's situation, feelings and motives.
Equity	Equity is about fairness and equality.
Evidence-based	Means making decisions about how to promote health or provide care by looking at the best available evidence along with the stated needs, values and preferences of those who will be affected.
Four Pillars Policy	Policy developed by Donald MacPherson (Director, Canadian Drug Policy Coalition) which addresses problematic drug use and is defined by four major elements: prevention, enforcement, treatment and harm reduction.
Governance	Refers to the regulation, management and over-sight of groups, agencies and other institutions. This can include the establishing of boards of directors and advisory committees to address decision-making, policy and organizational goals such as staffing and funding.
HIV	Human Immunodeficiency Virus – the virus that causes AIDS
HCV	Hepatitis C
Hepatitis	Disease that affects the liver
Illicit	In terms of drug use refers to illegal use, as opposed to licit drug use, which refers to use sanctioned by law. It can also refer to the substances themselves.
Marginalization	This is the social process by which a person or a group of people are disempowered or become relegated to the fringe or edge or margins of society. Marginalized individuals or groups experience stigma and discrimination as well as social exclusion. Many types of individuals or communities can become marginalized for various reasons, ie: people who use drugs, the poor, First Nations people, LGBTQ persons, people living with HIV or HCV, those with a criminal record, etc.
Non-palatable alcohol	These are substances that contain alcohol but aren't intended for people to drink. Many of these substances like hand sanitizer, rubbing alcohol, cooking wine etc. contain additives which often result in serious health effects when people drink them.

Norm	Norms are social expectations that guide behaviour. Norms explain why people do what they do in given situations. They help us know what to expect from other people's behavior. Some norms are enforced legally. People typically feel strong pressure to conform to norms. Some norms can be cultural, social, religious, gender-based, etc.
Opiate replacement therapy	Refers to medications such as methadone and suboxone/buprenorphine that are used as substitution therapies for opiate/opioid dependency.
POINT Program	Prevention Overdose in Toronto Program at Toronto Public Health – The Works. People are trained to give Naloxone in the case of an opioid overdose.
Political	power
Post Exposure Prophylaxis (PEP)	Treatment started immediately after exposure to a disease-causing virus, in order to prevent infection and the development of the disease. In a harm reduction setting, this almost always refers to PEP for exposure or potential exposure to HIV.
Privilege	This is about the advantages that some groups enjoy while others are disadvantaged. Privilege can be based on ethnicity, social class, sex and gender identity, culture, religion, etc.
Prohibition	The prohibition of drugs through legislation is a common means of attempting to prevent drug use. While most drugs are legal to possess, many governments regulate the manufacture, distribution, marketing and sale of some drugs, for instance through a prescription system. Only certain drugs are banned with a blanket prohibition against all use. However, a continuing problem remains in effect, as the prohibited drugs continue to be available through illegal trade, also known as the black market. The most widely banned substances include psychoactive drugs, although blanket prohibition also extends to some steroids, hallucinogens and other drugs.
Social Determinants of Health	The social determinants of health are: access to stable, affordable, safe, appropriate housing; to education and meaningful work; to health care including mental and dental health care; to enough healthy food and proper clothing and an adequate income. Access or lack of access to these things plays a major role in determining how healthy people are.
Stigma	A negative attribute associated with a person or group of people. People are stigmatized when they possess an attribute or status that makes them less acceptable in other people's eyes.
Stigmatization	Means seeing people in just one way – a negative way. People rely on negative stereotypes to stigmatize people who use drugs. Often, these stereotypes are related to the fact that drugs are seen as morally bad.
Tolerance	Drug tolerance is basically the body's ability to adapt to the presence of a drug. Over time/use, people become less sensitivity to the drug. This is called

tolerance. When we develop tolerance to a drug our bodies need more of it to get the same effect.

Universal Precautions Precautions designed to prevent the transmission of blood-borne diseases such as HIV. Under Universal Precautions, blood and certain body fluids of all people are considered potentially infectious. The precautions include specific recommendations for use of gloves, gowns, masks and protective eyewear when contact with blood or body secretions.

Wet Shelter Is a shelter site that does not require those who access services to abstain from using alcohol on-site and may also provide supportive services. This type of shelter model is a widely recognized form of harm reduction programming.