Shifting Roles: Peer Harm Reduction Work at Regent Park Community Health Centre

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EXECUTIVE SUMMARY

Peer involvement is a central feature of the harm reduction program at Regent Park Community Health Centre. Over the years, and in partnership with other agencies such as Street Health and South Riverdale Community Health Centre, the peer program at RPCHC has evolved in unanticipated directions. This report about the peer program highlights its success in broadening the range of opportunities for its peer workers and offers some thoughts for future program development.

The continuum of peer work

The positive outcomes of peer involvement in the harm reduction program have far exceeded those imagined. This has stimulated an expansion of the program and opened up the model of peer work in directions unanticipated at its inception. One way to look at the evolution of the program is to see it expanding along a continuum of peer work that ranges from a *peer participation model* to an *employment development model*.

The program draws on elements of both peer work models, mixing and adapting features of each according to the particular needs of individual peer workers and in response to the resources available to the program (See Figure 1, page 12). This has enabled the engagement of a very diverse group of peers including those who want the flexibility and informality of a low-threshold, peer participation model, and those who are looking for intensive training and employment opportunities. Accommodating both groups is a significant challenge for the non-peer workers and the Health Centre, particularly in a context of insecure or short-term funding.

The peer harm reduction workers perform a number of tasks that may be grouped into two main roles: community outreach and on-site support (See Table 1, page 22). These roles fall along the continuum of peer work, and reflect varying degrees of responsibility and required levels of skill, commitment, and stability. Regardless of the role, the goal of the program is to provide an enriching experience where peers can gain a sense of accomplishment, small financial reward, and feel less socially isolated and marginalized.

Broadening the roles of peer workers

Peer workers wear many hats: they are clients, peer workers, co-workers, community members and friends. Managing the "fuzzy boundaries" of peer work presents a challenge to peer workers, clients, non-peer workers, and the Health Centre. Supervision and support are crucial ingredients for the assisting peer workers in negotiating these boundary issues and learning how to use discretionary powers.

The close partnership between RPCHC and Street Health has enabled the development of a wider range of peer opportunities and provided a great deal of support to the peer workers. Despite extensive communication between the non-peer workers involved with the peer program, this partnership can lead to confusion about which agency is

responsible for supervision and support. In particular, the peer workers are not always certain for whom they are working, and whether or not they are able to claim affiliation. This is key to establishing their legitimacy as service providers and as advocates.

A shift in the program

As the Regent Park CHC peer harm reduction program has evolved, greater opportunities have become available for peers, and positive outcomes for peer workers and their clients have emerged beyond those anticipated. With this expansion, the program itself has shifted and the objectives of the program have become less clear. The questions arise: what are, or should be, the goals of the peer program? Who is the program for? How these questions are answered has implications for what resources are needed to meet the diverse needs and expectations of the peer workers.

This shift has required an expansion of the role of non-peer workers, stretching their time and their resources. Non-peer workers dedicate considerable time to finding ways of broadening the opportunities available to peer workers. Through their creativity and collaboration, they have succeeded in expanding the range of roles available to peer workers. At the same time, it is becoming increasingly more difficult to equitably allocate available resources and opportunities amongst the pool of peer workers.

Lack of secure, sufficient funding hampers program development and limits the potential of the peer program. From a service delivery perspective, peer workers are under-utilized by the Health Centre. Opportunities to provide peer-delivered services to the wider community are restricted by the lack of available peer shifts. The capacity of the program of offer opportunities to new participants is limited because the existing group of peers is eager to take on more roles and responsibilities. Within this group are peer workers who are looking for opportunities beyond what RPCHC is able to offer. The very success of the program has stretched its resources to capacity.

Future Directions

The peer program has played an important role in the lives of individual peer workers and in the larger community. Engagement in peer work has stimulated significant changes within people, contributing to their better health, increased self-esteem, greater stability, and development of new goals. It has also provided access to services to clients previously unconnected to the health centre. When the program began, it was mostly oriented towards a peer participation model. Over time, it has incorporated more and more features of an employment development model, whilst still providing a low-threshold, flexible program open to a wide group of people.

The current situation suggests that continued expansion at either end of the peer work continuum is unsustainable given the available resources and high demand. This necessitates deciding whether to shift the focus of the peer program towards an *employment development model*, or a *peer participation model.* Clarifying the objectives of the program may contribute to identifying what resources are needed and what strategies may be employed to meet the needs and expectations of peer workers.

SHIFTING ROLES

Peer Harm Reduction Work at Regent Park Community Health Centre

Peer involvement is a central feature of the harm reduction program at Regent Park Community Health Centre (RPCHC). Over the years, and in partnership with other agencies, the program has endeavoured to meet the widening range of expectations and needs of its growing pool of peer workers. This report focuses on how the popularity of peer work and the responsiveness of the RPCHC's harm reduction non-peer workers have opened up the model of peer work in directions unanticipated at the peer program's inception.

The goals of this report are to present a picture of peer work at Regent Park Community Health Centre, and to offer points for consideration for future program development. Before presenting our findings, we offer a brief background on peer work at the Health Centre, and on the *Shifting Roles* research project.

Background

The Regent Park community, like many other inner-city communities, faces many challenges, including high concentrations of problematic substance use. One of the RPCHC services that aim to reduce health and social problems associated with problematic substance use is a peer-based harm reduction program.

Harm reduction refers to programs, policies, and practices that aim to reduce the social, health, and economic consequences associated with substance use for people who use drugs, their families, and communities[1] (IHRA 2009). A harm reduction approach is based on a commitment to public health and to human rights, and it focuses on the prevention of harm rather than the prevention of substance use. It promotes the principles of dignity and compassion, and the rights to "the highest attainable standard of health, to social services, to work, to benefit from scientific progress, to freedom from arbitrary detention and freedom from cruel inhuman and degrading treatment" (Ibid.). Harm reduction is an evidence-based approach, and favours interventions that are easy to implement, cost-effective, safe, and effective.

A central principle of harm reduction is the meaningful involvement of people who use substances, and other affected communities, in policy development and program

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[1] International Harm Reduction Association (IHRA). (2009). *What is Harm Reduction? A position statement by the International Harm Reduction Association.* Retrieved from http://www.ihra.net/files/2010/05/31/IHRA_HRStatement.pdf on February 18th, 2011.

implementation, delivery and evaluation. Stemming from this principle is the development of peer programs where people who use (or have used) drugs are engaged in harm reduction work (THRTF 2003). Although they do not have professional or formal credentials, peer workers are valued as having experiential knowledge and the ability to make use of their personal relationships, natural contexts, and common values with other drug users to deliver interventions in culturally appropriate and congruent ways (Gates and Akabas 2007, Weeks et al. 2009).

Harm reduction programs often incorporate peer-based programming to serve both budget containment and community development goals by leveraging existing social networks, and to broaden their scope and reach to diverse clients (Weeks et al., 2006). Evidence shows benefits for peers and clients in terms of improved health and wellbeing (WHO, 2004). Peer workers are able to access more diverse and often hidden groups and encourage more widespread changes in behaviour (Broadhead et al., 1995). Interventions with drug-using social networks demonstrate that training one member of the network to provide risk reduction education can reduce risk behaviour across the entire network (Lankin, 1998). In this way, peer work provides opportunities for individual and community capacity building.

Peer work is typically characterized as casual, short-term, unskilled, insecure, informal, supervised by professional employees, and either unpaid or compensated with honorariums or low wages. For the purposes of this report, we refer to formal agency staff members as "non-peer staff". These may include community health workers, administrative personnel, housing workers, outreach workers, nurses, and doctors. Typically, non-peer workers have more professional experience and are on a formal contract or are permanent employees of the Health Centre. Although non-peer workers may have lived experience with substance use, this is not specified as a requirement in their job description. The non-peer workers we interviewed for this study were those directly involved in the peer program – either as supervisors or as co-workers and mentors. We refer to them in this report as "non-peer workers" and as "Staff" when referring to them in the included quotations.

Peer work has become a feature of many harm reduction programs, however there is not much information about different models of peer programs that could help guide agencies through the challenges of peer programming. In this report, we identify features of two different models of peer work (the *peer participation model* and the *employment development model*) that co-exist within the peer program at the Health Centre and discuss the tensions that have arisen. Rather than prescribe a direction or a preference for one model over the other, we present a discussion of these tensions and the questions that they suggest, which may help guide the RPCHC peer program development.

The Regent Park CHC Peer Work Program

The peer program at Regent Park CHC has evolved through its partnership with Street Health. In October 2005, the Crack Users Project began as a community capacity-building initiative with the goal of reducing the harms associated with the use of substances among marginalized users in southeast downtown Toronto (Mooi 2008). The Safer Stroll Outreach Project began in May 2008 with the goals of increasing the capacity of female sex workers to better respond to high-risk situations, and to increase the capacity of community service agencies to better respond to violence against women involved in sex work (Safer Stroll Project 2010). Peer harm reduction training is a central feature of both of these projects. The success of the peer training has spurred an evolution in the peer program as Street Health and Regent Park CHC seek to provide peer work opportunities to its graduates. At the time of data collection for this study (summer 2010), there were approximately 25 peer workers performing tasks such as outreach, kit-making, supervising the drop-ins, public speaking, and providing relief to formal staff. Additionally, some graduates of the peer-training programs have pursued formal education and employment opportunities.

Shifting Roles: A Community-Based Research Project

In 2010, Regent Park CHC partnered with the Centre for Addiction and Mental Health (CAMH) to collaborate on a community-based research project. A primary objective of the project was to analyze the factors that contribute to role tensions and challenges for peer workers. The project team members from Regent Park CHC included four peer workers, an outreach worker, the Director of Community Health, and a researcher. A scientist from CAMH and two health promotion practicum students from the University of Toronto were also on the team.

To collect data, we held two focus groups (one with all men, the other with all women) and we conducted semi-structured in-depth interviews with five peer workers, five non-peer workers (from RPCHC, Street Health, and South Riverdale CHC), and four clients. All of the participants were invited to answer a demographic survey. After an initial thematic analysis of the data collected by the primary investigators and the research assistants, the project team was reconvened. The team provided feedback that was then used to refine the analysis. For a more detailed description of our methods, please see Appendix 1.

RESEARCH FINDINGS

PARTICIPANT CHARACTERISTICS

Responses to the demographic survey provide a description of the participants' characteristics. Twenty-three surveys were completed, however the data from the three non-peer workers were excluded from the analysis so that we could focus on the characteristics of the participating clients and peer workers. Seventy-nine per cent of the respondents were involved in peer work (twenty-five per cent were from the Crack Users Project). The survey asked what roles respondents held at the Health Centre, i.e., client, peer worker, or non-peer employees. Forty per cent of the respondents stated that they hold more than one role, for example, they are both a peer worker and a client of the program.

Some of the programs at RPCHC are specifically geared towards a particular population. For example, the Safer Stroll Outreach Program works only with female street sex workers. Other programs, such as the Crack Users Project (CUP) program, are designed for male, female and transgender clients. Male clients far outnumber the female clients who use the harm reduction services at RPCHC (RPCHC 2011), however the majority of respondents to our survey were women (n=12, 60%). This reflects the greater attendance for the women's *Shifting Roles* project focus group compared to that of the men's.

Congruent with the profile of clients currently using harm reduction services at the Health Centre, ninety per cent of the respondents were born in Canada (RPCHC 2011). Forty per cent identified as being of Canadian ethnicity, and thirty per cent identified as Aboriginal. The majority of respondents (seventy-nine per cent) were between the ages of 40 and 59 years. None of the respondents were youth (under the age of thirty years).

Fifty per cent of the respondents rely on Ontario Disability Support Program for income and thirty-five per cent are recipients of Ontario Works. Only ten per cent are employed. Three respondents (fifteen per cent) indicated that they rely on other sources for income. There was considerable variation in education levels and backgrounds: Twenty per cent of the respondents have completed college or a university program while thirty per cent of the respondents have not completed high school.

A significant proportion of the clients who access harm reduction services at the RPCHC are homeless or have a precarious housing situation (RPCHC 2011). In order to get an understanding of our participants' housing situation, our survey asked about the places respondents had stayed in the last six months. At the time of data collection, seventy per cent of the respondents were living in their own accommodation. However, twenty per cent of the respondents have lived in more than one place within the last six months (such as in jail, in parks, at a friend's place, or at a motel). These figures show the precarious nature of housing for many peer workers and their clients.

> *"I'm trying to get housing and I'm having a hard time, 'cause I don't want to live at a shelter… I want my own key to put in my own door." (Client 1)*

Respondents were asked if they had taken any drugs over the past one year. The majority of those who use drugs (seventy per cent) mentioned that they had either smoked or snorted or swallowed drug(s), and fifteen per cent indicated they had injected drugs in the past year. According to a recent survey of drug users in the neighbourhood (RPCHC 2011), smoking crack is the most common form of drug usage and crack appears to be the most common drug used in the east downtown Toronto.

Forty-two per cent of the survey respondents mentioned that they had accessed the services of peer workers within the last six months, either by coming into the Health Centre or seeing outreach workers in the community. Clients reported feeling more comfortable talking to a peer worker because of the peer worker's personal experience with substance use and with homelessness, and as clients of services. For example, one client said: *"They got the street level education. That's what I like about it… They're easy to talk to." (Client 5)*

Those who had not accessed peer workers in the past six months may not have done so for a variety of reasons. Seventy-nine per cent of respondents were peer workers themselves and they may have less need for the type of services offered by peer workers (e.g., they already have access to safer use kits and are connected to ongoing supports). Additionally, peer workers may not consider the support that they get from each other as "accessing a peer worker".

> *"There's a real deep peer support really, amongst each other. And then just a general sense of trying to make sure people are okay." (Staff 2)*

> *"It helped me a lot when I was on the street and I had a lot of problems. I needed someone to talk to, I'd go on the street and I'd talk to harm reduction peer workers, even people that weren't peer workers – Calvin and stuff." (Peer 3)*

Sixty-eight percent of the respondents have accessed non-peer workers (e.g., a formally employed community health worker or outreach worker) in the past six months. Many of the peer workers referred to having established positive supportive relationships with nurses and community outreach workers. These non-peer workers are more readily available to clients compared to peer workers. A non-peer worker suggested that there is a lack of opportunity for clients to see peer workers because there are very few shifts available for peer workers. The current level of funding for the peer program restricts the opportunities for clients to connect with peer workers.

Survey respondents were asked which other community health centres besides Regent Park CHC they have accessed for harm reduction services in the past year. Thirty-one

per cent of the respondents use the harm reduction services at Street Health on a daily basis. Sherbourne Health Centre and South Riverdale Community Health Centre are also frequently accessed.

The survey findings are summarized in Appendix two.

MODELS OF PEER WORK

The Regent Park Community Health Centre's peer harm reduction program has evolved a great deal since its inception. The success of the training programs, the engagement of the peer workers, and the efforts of the RPCHC and Street Health staff to provide employment opportunities to the graduates have spurred an evolution of the peer program in unanticipated directions. One way to look at the evolution of the peer program is to see peer work as a continuum, ranging from a peer work model that focuses on peer participation on one side, and one that focuses on employment development on the other side. Based on our interviews with peer workers, clients, and non-peer workers, our findings suggest that the peer program has evolved from a peer participation model to include characteristics of a employment development model.

> *"With this program, we just set up the drop-in, we set up the training program... and it just went from there. It was just so much pleasure! And people were, the peers were just so eager, and just hungry to belong somewhere; to contribute somehow, to do something positive in their life, to help others. That's why they wanted to become peer workers ... they did it themselves; we were just there and patted their back or gave them the ear of helped them with some practical stuff. It was the easiest thing ever. And the outcomes were just mind-blowing." (Staff 1)*

A Continuum of Peer Work

There are characteristics of two different program models surfacing within the Health Centre's peer program. Here, we refer to these models as the *peer participation model* and the *employment development model*. We can see these models as being at either end of a continuum of peer work, reflecting different objectives and tasks, and requiring different levels of skill, commitment, and stability. The peer harm reduction program contains elements of both models, and in practice, peer workers shift their position along this continuum according to their individual needs and the availability of opportunities in the program. It is important to note that these models are not meant to be fixed or definitive but rather to represent a range of program characteristics that may inform program development.

A focus of this report is on the continuum of peer work. A two dimensional matrix can be used to map out the different roles and characteristics of the peer program (See

page 12). The horizontal axis is the peer work continuum, ranging from a peer participation model to an employment development model. The y-axis suggests the degree of formality associated with the various roles. More formal roles involve greater expectations of the peer workers (e.g., levels of experience, reliability, commitment) and are more likely to be ongoing, have longer shifts, and have greater compensation. It is crucial to note that the formality of a role (as measured by demand for ongoing commitment, for example) may be an effect of the amount of funding available for a project or position.

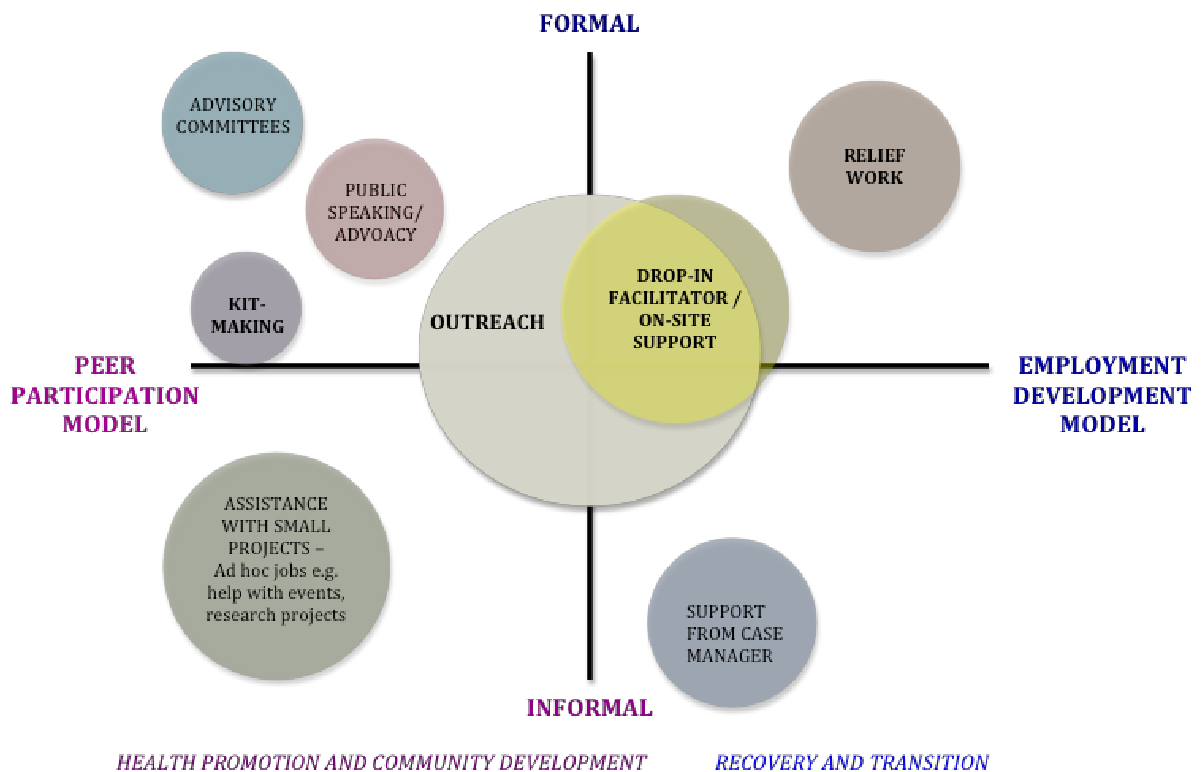

Figure 1: RPCHC Peer Program Roles and the Continuum of Peer Work

The Peer Participation Model

On the far left end of the continuum we have the *peer participation model*. Its goals include skills development, enhancement of self-esteem, and engagement with services and other community members. A central aim of this model is to build community capacity through the provision of skills, knowledge and access to resources and services, and through nurturing a sense of community and mutual support amongst the participants.

> *"I just found that by giving them information and the support and the opportunity to have a community that they felt comfortable in and belonged in, people make those adjustments around substance use on their own. Or ask for help if they felt that they were at the point where they wanted to make a step…"* (Staff 1)

> *"There's just a way we can help our selves and help people and make money and possibly change the way things are being looked at, after, and arranged for people that have habitual use, cause the need is here." (Men's focus group)*

> *"I hand out kits, educate them on Hep C or if they need any referrals, any help on housing, like anything, for food… It just makes me feel good to give back to the community.... I'm learning something new. How to manage my own problems, health problems too."* (Peer 4)

The peer participation model is consistent with the principles of harm reduction in that it recognizes that drug users themselves are the primary agents for reducing the harms of drug use. The peer participation model also has the goal of encouraging participants to share information, knowledge, and resources amongst each other. In this way, information spreads through social networks and contributes to the health of the greater community. Peer participants share strategies with each other that they have found useful and that meet their actual conditions of use. This is a central principle in harm reduction[2]. Indeed, peer involvement has been recommended as a best practice for needle exchange programs[3].

> *"They give out the kits and stuff like that, its better because then you know you are getting clean kits… I think they [peer workers] are doing pretty good because if it wasn't for them, they'd [people who use substances] be going out there and getting a dirty needle and then it would be worse for them." (Client 1)*

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[2] Harm Reduction Coalition. "Principles of Harm Reduction". Retrieved from www.harmreduction.org/section.php?id=62 on February 18th, 2011.

[3] Strike, C; Leonard, L; Millson, M; Anstice, S; Berkeley, N; Medd, E. 2006. *Ontario Needle Exchange Programs: Best Practice Recommendations.* Toronto: Ontario Needle Exchange Coordinating Committee

"I give someone a clean stem or spread, so I know they're not catching the disease and they're doing the right thing by getting new supplies, right?" (Men's focus group)

"I've found that we're very important people in this community, very important to a lot of people". (Women's focus group)

The peer participation model reflects a health promotion approach that extends beyond the goal of decreasing negative consequences of substance use, and seeks to empower people to improve and increase control over their health. Health promotion models seek to create supportive environments, provide health education, and build community capacity[4].

"Helping others and getting the reward of helping others; educating others would be my first thing. Helping myself right? It really helped me as a person to get more employment, to better my lifestyle, to cut back and harm reduction, like I've applied all those technique in harm reduction to my life. So it helped me as a person, it helped me mentally, psychologically, emotionally, physically. Yeah. Um, the benefits are always in the money. I love the money. Food, you get to come in and eat the food in the program too. So if I'm working three drop-ins a week, I'm getting my breakfast three days a week, so you know, that helps. Just other odd things that come up, you're more in touch with what's going on at the Centre, so you're better off, you're going to get better healthcare for sure... You're going get your feet checked out. You're gonna, you know… you're on the spot… you're in the health centre anyway." (Peer 5)

"There's easy access to services that you need… One of the things we consistently hear… is a change in self-concept… coupled with a sense of belonging and a greater connection to the community and that sense of giving, that they have something to give." (Staff 2).

"[I] try to pass along a positive message too. I think that's part of my training too." (Peer 3)

This model aims to provide equal opportunities to all who wish to participate and, thus, it involves sharing resources amongst many people. An indicator of this model's success is how many people participate, and the distance of its reach into the community. A comment made by one of the staff members interviewed reflects this orientation: *"I'd just love to see people be able to participate no matter what's going on for them."*

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[4] Bartholomew, L.K.; Parcel, G.S.; Kok, G.; Gottlieb, N.H. 2006. *Planning Health Promotion Programs: An Intervention Mapping Approach*. San Francisco: Jossey-Bass, John Wiley & Sons, Inc.

At this far end of the continuum, peer work participants may not be required to have more than basic training. Peers engage in supervised instrumental tasks that require low levels of responsibility and commitment. The expectations placed on peer workers are minimal, and participation is open to anyone regardless of their level of stability or level of functioning. The monetary compensation for participation is small, and participants largely retain their status as a client of a program.

The Employment Development Model

Moving to the other extreme end of the continuum is an *employment development model* that provides comprehensive training and employment opportunities to people with lived experience of substance use and homelessness. At this end, peer workers are expected to have a level of stability[5] in their lives that enables them to commit to the responsibilities of providing services to clients.

The focus of this model is the (re-)integration of people with lived experience into the mainstream workforce and recognition of the expertise and skills of peer workers in providing relevant and appropriate services. Peer workers may be hired on contracts, receive more competitive compensation and benefits, including professional development opportunities, and are recognized as professional employees with expertise and authority.

This end of the continuum reflects a recovery-oriented[6] or "transition-approach" to peer work programs. This approach calls for the concentration of resources and opportunities on a small group of individuals who are committed to making substantial changes in their lives, primarily in the area of employment. It involves more intensive training and case management, with clearly defined goals and expectations, including the goal of transition to mainstream employment. A non-peer worker explained: *"People actually got full time jobs and have gone to school, colleges, so they can do it."*

> *"Since I've applied for this job, now that I'm doing it, it's excellent. It's like I turned a full circle and I can't believe I'm here most times. But every time I do, you know, it makes me know that I'm on the right track. And it's motivating me to do more." (Peer 2)*

While the Health Centre's peer program may have begun with an orientation more in line with a peer participation model, the program has expanded along the continuum to include characteristics of an employment development model. The development of peer work opportunities with CUP and the Safer Stroll Project evolved as a 'next step' for the

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[5] This level of stability will vary person to person.

[6] From a harm reduction perspective, recovery does not require abstinence, although it can encompass abstinence.

graduates of peer training. The success of these programs and the expansion of opportunities to include more in-depth training and employment opportunities has given rise to the informal development of characteristics associated with a recovery-oriented or "transition approach" to peer work.

> *"Everyone was doing it just for the money at first. They didn't think they were going to get anything out of it…. I think they got an idea of what they could do. And they got positive back up saying 'Yes, you can do it." And the ones that did succeed and did graduate, they're successful peer workers now." (Client 5)*

> *"When I go out and help somebody, its just, I'm climbing up the ladder through the levels and getting established as a clean, straight human being again." (Men's focus group)*

> *"[Peer work] has provided some incentive to stabilize their use, and it helped them to stop using as much. And then the training, the employment that we've been providing has helped them to think of it as a possible career. So people are going back to school…" (Staff 5)*

Moving along the continuum

The above discussion about peer work models and the attempt to situate the RPCHC peer program along a continuum of peer work might suggest a false fixedness. Instead, the peer program draws on elements of both of these models, mixing and adapting features according to the particular needs of the individual peer workers. This flexibility and responsiveness makes it difficult to capture exactly which model the program most reflects. One non-peer worker described this by saying:

> *"So there is a kind of responsibility that's trying to be instilled in them. And it's very low threshold too, but of course there are some stronger peers… and who are just more reliable than other peers. We say low threshold training program… because its more casual and it's more about relationship-building" (Staff 4)*

The RPCHC peer program offers a variety of shifts to peer workers that start at the peer participation end of the continuum (for example, kit-making) and that move along the continuum to shifts that require additional training, greater stability, commitment and responsibility. For those who want to move along the continuum, a certain degree of stability is necessary. Training and peer work experience supports an increase in stability, although this is not a linear process. The experience of peer work has positive spillover effects related to housing status, nutrition, and substance use that reinforce a peer workers engagement with peer work. In short, peer work helps build stability, which in turn helps peer workers take advantage of existing opportunities to develop their skills. This is demonstrated in the following comments:

"I've seen real, positive, concrete outcomes in a short period of time for people without us the service provider actually kind of pushing it on them. We just created an environment where information and involvement was encouraged and nourished and rewarded just by people feeling better about themselves…. We've accepted in our program people that we were not sure about because they were just way too chaotic on the street and had too many conflicts with people on the street and it just didn't seem like they would be able to keep up with the structure. But they did." (Staff 1)

"My first year out of jail, when I first started doing outreach, my first thought was 'Oh that went well. I've been out of jail for a year. I'm doing outreach.' I was doing harm reduction speaking, did that course, did first aid, did about six different courses. And those six courses I did, everything worked out well. And made me feel good everyday, like I say every day: 'Man that works out good. Must be doing something good… And you know, hopefully next year, I'll be done smoking crack. That's the way I feel now." (Men's focus group)

The *Shifting Roles* survey suggests that a number of the peer workers currently use drugs. Abstinence is not a requirement for peer workers. Peer workers indicate that their patterns of consumption have changed to accommodate their work, and that they refrain from use while working. Below, a client and a non-peer worker remark about this:

"[Drug use] gets moderated more. Like they have their priorities, so they think, 'Okay, I gotta work today so I can't get high tonight'. So I think it changes their way of thinking – not their attitude or anything – it's the way they think. Cause most drug addicts think 'Money. Okay. I'm going to do drugs now.' You know?" (Client 5)

"Abstinence wasn't required in order to work. You know, people had to show up in reasonable shape; they couldn't be all messed up. But other than that, whether they use or not, in their private time, it wasn't a concern for us. But on outreach, often when we met friends of the peer that they used to use with before, the assumption was 'Oh the peer is working, well, they must be abstinent.' Right? So there was an opportunity for the education of other people: 'You don't have to be abstinent in order to be involved in something positive and good'. So that's another good outcome of using peers… it showed other people that even though you are still using, you can still add to your life, you know, in good, positive activities." (Staff 1)

PEER HARM REDUCTION WORKERS' ROLES AT RPCHC

> *"What we expect from our peer workers is to work with staff jointly to do outreach and … to do in-house support, like laundry, shower, to help us with our drop-in planning and program development and also help us staff our drop-in time. Our expectations of a peer worker is that they work alongside staff and in the delivery of a service for people who have addictions to drugs and alcohol. And at the same time, they wear these two hats… as a client as well as a peer." (Staff 2)*

Defining peer worker roles can be a difficult task for a number of reasons. For one, the availability of positions changes over time. Non-peer workers advocate for more tasks to engage the growing number of people interested in peer work, and to find new opportunities for more experienced peers to continue to develop their skills. They are always looking for ways to provide work for peers. For example if a new project is funded, if an event is being planned, or if a study is taking place, peer workers will be encouraged to participate. This means that some roles are restricted to a specific task and are time limited, while other roles are ongoing. Additionally, roles are adjusted to meet the needs of the peer worker "where they are at" for any point in time. This demands a great deal of flexibility and creativity on the part of non-peer workers, and support from the agency and funders.

Another complicating factor arises from the growing competence and expertise in the pool of peer workers. This means that there are areas of overlap between the tasks performed by peer workers and non-peer workers. However, *non-peer* workers (e.g., community health workers) provide a wider range of services (for example, case management, appointment accompaniment, development of training programs and workshops, and facilitating the drop-in programs). Typically, non-peers have greater job security and receive competitive wages. They have more responsibility, but also more power. Frequently, the peer workers expressed interest in taking on more of these tasks and responsibilities, specifically they would like to do administrative work on the computer and provide case management.

> *"We probably do similar or the same thing they do, just not as much as they do… They have more seniority; they have more responsibility… And they do more administrative stuff." (Men's focus group)*

Non-peer staff found it difficult to explain in any definitive way which responsibilities, tasks, schedules, and expectations are associated with different peer roles. The approach the non-peer workers adopt is one based on experience and discretion, founded on their understanding of the individual peer worker, the larger client group, and the Health Centre's principles and policies. As one non-peer worker described it:

> *"It just got a little difficult to describe the different roles that peers have here… most of this work is done intuitively, as long as it aligns with our sense of equity. Intuitive work isn't always easy…" (Staff 5)*

Although it is difficult to pin down a definition of peer roles, our findings suggest that the peer workers perform a number of tasks that may be grouped into two main roles: community outreach and onsite support. These roles fall along the continuum of peer work, and reflect varying degrees of autonomy and responsibility, and necessary levels of skill, commitment, and stability. Regardless of the role, the goal is to provide an enriching experience for peer workers where they can gain a sense of accomplishment, and feel less socially isolated and marginalized. As such, efforts are made to meet the peer worker where they are at, providing flexibility to accommodate their particular needs and challenges at whatever stage that they are at. Some peers take on different roles according to their needs at that time, while others consistently hold on to the same role.

Table 1: Setting and Roles of RPCHC Peer Harm Reduction Workers

Setting	Role
Out in the community	Outreach Worker
	Public Speaking and Advocacy Work
On-site (RPCHC)	Kit-making
	Drop-In facilitator– Safer Stroll, CUP
	Shower/Laundry supervisor
	Relief staff

Peer Outreach:

Outreach involves peer workers accompanying non-peer staff (Street Health nurses, or Street Health / RPCHC outreach workers) into the community to connect with people who are street involved, distribute safer drug use kits and other basic needs (food, hygiene supplies, socks), and provide referral information and general support. Graduates of the peer-training program are eligible to sign up every month for outreach shifts. Shifts are two hours long, and peer workers always work alongside non-peer staff. Outreach work involves both instrumental tasks (such as distributing safer use kits and hygiene supplies) and interpersonal tasks (such as providing support and making referrals). Peer workers engage in these tasks according to their levels of skill and confidence. They are paid an honorarium.

On-site support:
The on-site support roles include putting together safer use kits, facilitating the drop-in centre, and working the laundry/shower shift. Assembling safer use kits is a task that fits in with the peer participation model. No training is required for this role. At RPCHC, a community worker has invited a number of clients who are reliably consistent to do this instrumental task. Some of the peer outreach workers sign up for to put together harm reduction kits at *Street Health* as a way of making some extra money or when they want to take a break from doing outreach work. Compensation is a small honorarium.

The drop-in and laundry/shower workers are more experienced workers who have demonstrated consistency in their work and who seek opportunities with a greater variety of tasks. Graduates of the peer-training program are recommended for these roles. In these roles, peer workers perform instrumental tasks (such as needle exchange and provision of hygiene supplies) and interpersonal tasks such as facilitating a safe social space, managing conflict, and providing support. Though still low, the honoraria for these roles are more than that for the outreach positions.

Relief work:
Some of the peer workers have been hired as relief staff for the laundry/shower room and for the reception desk. Relief workers are on RPCHC payroll, make more money, and work longer shifts than peer workers. They perform most of the day-to-day tasks of the non-peer worker, however they do not have the same level of responsibility. For example, the relief workers do not have full access to the computer system and client files. Relief workers work more independently than when in a peer position, and they receive support and supervision from the non-peer workers.

Other Roles:
The above describes the most common roles that peer workers occupy in the peer program at the Health Centre. In addition to these, some of the peer workers also engage in public speaking, anti-stigma, and advocacy work in the community. Peer workers take on odd jobs around the centre as they arise, and will participate in agency or community events and research projects, when such work is available.

The peer workers who do outreach include those who are new to peer work and those who have been doing peer work for a number of years. Some of the peer workers consider their outreach role as an informal opportunity to make some money, share their knowledge and their skills, and interact with the community. Some of the peer outreach workers find that the two-hour shifts and relatively low levels of responsibility fit their current needs very well. One peer worker commented: *"It's good for us, two hours, every time… we can't do eight hours shifts - I can't."* Similarly to this peer worker, other participants voiced their appreciation for the flexible, informal structure of the

program and find that their needs and expectations are well met through a peer participation model of peer work.

Other peers see this role as a stepping-stone towards more formal employment. This group is eager to have more work, longer shifts, and greater responsibilities. One peer worker commented: *"It could be longer hours… You're just getting in to the groove of talking to people and all of a sudden its time to leave."* There are a growing number of peer outreach workers who seek greater employment and training opportunities beyond what the current program is able to offer.

Efforts to accommodate these emerging needs have stimulated an evolution of the peer program to include aspects of an employment development model. The non-peer workers have endeavoured to expand the types of jobs and duties to match the increasing expertise amongst peer workers. At the same time, they strive to maintain a flexible structure that accommodates the ups and downs peer workers may face in their lives.

> *"Through the years, that we had the project, people organized their substance use in a more functional way so they were able to come to meetings more reliably. They were able to make those kind of changes without us telling them 'You need to work on this and that'. They knew what they needed to work on and we just provided the structure and support and resources that they needed to accommodate." (Staff 1)*

The following table attempts to tease out the different tasks and skills associated with the peer roles at the Health Centre.

	Peer Participation Model Health Promotion / Community Capacity Building		Employment Development Model Recovery and Transition	
	KIT-MAKING	**OUTREACH**	**ON-SITE SUPPORT WORKERS**	**RELIEF / SUPPORT STAFF (SHOWER/LAUNDRY, RECEPTION)**
Training requirements	No training	Basic peer training	Basic peer training	Advanced peer training and / or extensive peer worker experience
Duties	*Instrumental*: Assemble safer use kits	*Instrumental*: Distribute kits, hygiene supplies. Outreach in the community with nurse or community worker. *Interpersonal*: Relationship-building. Support. Referrals. Advocacy. Education. Introduce clients to health and community workers.	*Instrumental*: Distribute kits, hygiene supplies. Organize and restock supplies. Provide information about resources and safer use practices. Drop-in: Set up food, drinks, and coffee; and clean up the space after. *Interpersonal*: Relationship-building Support, Referrals, Advocacy, Create a welcoming and safe environment. De-escalate conflict.	*Instrumental:* Organize and oversee supplies. Distribute kits, hygiene supplies. Assist clients with laundry as needed. Provide information about resources and safer use practices. Administrative tasks. *Interpersonal*: Relationship-building Support clients, Referrals, Advocacy, Manage social environment. Manage and de-escalate conflicts.
Necessary skills	No prerequisites.	Knowledge of harm reduction strategies. Understand harms and risks associated with substance use. Non-judgmental approach Familiarity with community resources. Good 'people' skills. Work well in a team.	Good communication skills. Knowledge of harm reduction strategies. Understand harms and risks associated with substance use. Non-judgmental approach Familiarity with community resources. Good 'people' skills. Consistency. Ability to de-escalate and manage conflict	Good communication skills. Knowledge of harm reduction strategies. Understand harms and risks associated with substance use. Non-judgmental approach. Familiarity with community resources. Ability to de-escalate conflicts. Administrative skills. Good 'people' skills. Confidence in asserting boundaries. Good advocacy skills. Ability to work independently. Consistency.
Useful skills	Consistency – show up and follow instructions.	Confidence in asserting boundaries. Ability to de-escalate and manage conflict. Good self-care practices.	Confidence in asserting boundaries. Good self-care practices. Advocacy skills	Good self-care practices.
Compensation	Informal / honoraria	Informal / honoraria (more than kit-making)	Informal / honoraria (more than outreach)	Formal / RPCHC staff on payroll
Recruitment	Street Health: sign up sheet; RPCHC: asked by community outreach worker.	Graduates of peer training.	Graduates of peer training.	Open job call. Graduates of peer training that are recommended for this position.
Scheduling	RPCHC: Staff assign SH: sign up sheet.	Monthly sign up.	Monthly sign up.	Cover shifts for vacationing or absent staff (Scheduled in advance, or short notice)

Table 1: Positioning RPCHC Peer Harm Reduction Roles along a continuum of peer work

BROADENING THE ROLES OF PEER WORKERS

The program has been very successful at broadening the roles and opportunities for peer workers. This expansion of roles has implications for what kinds of support and resources are needed to help peer workers succeed. Peer workers face tensions navigating between their different roles as clients/peer workers/co-workers, and as peer worker / friend. Peers need support to help them work through issues that arise from these tensions, such as the use of discretion and claiming affiliation. Peer and non-peer workers describe peer work as having "fuzzy boundaries" and the roles are not always clear. Regular supervision is essential for working through these challenges.

Managing Boundaries: Client / Peer Worker / Co-worker

Peer workers perform different roles at the Health Centre: they are "clients" *and* "peer workers", and some are also "relief staff". Frequently, they move between these roles, sometimes creating role confusion as described by one of the non-peer staff:

> *"This is where it becomes so blurry, we use peers in so many different ways. We also have these peers, who are not really peers - they are actually our relief workers. But they are our relief workers because they are peers. But they're not peers when they're working as relief workers. So what we expect of them is very different because they're employees of the Health Centre, compared to a peer who only gets an honorarium." (Staff 4)*

Peer workers may continue to receive services as clients (related to housing, substance use, counseling, healthcare, etc.) while also being employed (even if informally) by the Health Centre. Amongst the twenty respondents to the survey, forty per cent identified as having more than one role at RPCHC (i.e., they are a client, CUP worker, Safer Stroll Outreach worker, relief worker). Not only does this demonstrate the range of options available to the peer workers, it also reflects the important role of the program in the peers' lives. The opportunity to engage in a variety of roles supports their connection to the Health Centre, enhancing their access to support and services, and contributes to their wellbeing.

At the same time, moving between the roles of service consumer/client and service provider/peer worker can create confusion around the expectations and boundaries for peer workers, for clients, and for the non-peer staff of the Health Centre. The following excerpts from the interviews with the non-peer workers illustrate the confusion and tensions that arise for both peer and non-peer workers.

> *"One of the conversations that I consistently have with peer workers is even if you're not working and you're at a place that you work out of, there's a different expectation for your behaviour. And that's because of a lot of things and one of*

them is association… if a service user is coming in and if they see you, maybe you're having a really bad day, or bad moment and you're aggressive or talking with somebody in a negative way, that may likely affect if they're going to access service. …And if (the peer worker is) coming in and not working… the expectation is you're the same as anybody else coming in and using the services." (Staff 2)

"I think this is hard for a lot of workers or agencies, the relationship is different, right? It's not a client/staff type of relationship. And it's not really a coworker/coworker relationship either. We need to be equally mindful again, about the dynamics of that, and the barriers kind of get fuzzy." (Staff 1).

"The peers… are still experiencing barriers, discrimination as drug users, poverty. They're still living in poor housing. So they have all these things that they're experiencing but then – and then they are still coming to work. You expect them to be on time; you expect them to not leave early… And if they don't show up… they may not get as many shifts next week until they can prove, come have a conversation with you about what happens in the work field, you know?" (Staff 4)

As peer workers move along the continuum of peer work, it may be challenging to determine how best to define their roles in a way that does not foreclose the flexibility accompanying the title of 'peer', or limit the opportunity to take on the responsibilities of non-peer work. This challenge is articulated in this non-peer worker's description of the development of a 'professional identity' in peer workers:

"There's a natural progression that will happen. There's the whole question about when do you stop becoming a peer… When are you just a worker?" (Staff 2)

Another non-peer worker described the difficulty that arises from the term "peers":

"(Peers) are eager to be seen as a normal kind of worker. And if we can normalize some of their duties… that would be the goal that we would try and normalize the work as much as possible and reduce the use of the word 'peer' and maybe we could call them something else…. There would be less doubt about "Is this okay for me to do? Or, 'Am I trusted to do this?'" (Staff 5)

These issues suggest the shifting of the program and of the roles of the peers towards an employment development orientation.

Managing Boundaries: Peer Worker / Friend

The broadening of responsibilities and tasks available to peer workers is accompanied by challenge of managing boundaries and using discretionary powers. In addition to their roles of "client" and "peer worker", peer workers are also "friends", "acquaintances"

and "fellow community members" with the people to whom they provide services. A non-peer worker describes the peer workers as wearing "two hats":

> *We expect our peers to work alongside staff and in the delivery of a service for people who have addictions to drugs and alcohol. And at the same time, they wear these two hats because when they're talking to someone that they may have just last night done drugs with… or someone who maybe they're staying at the shelter together… it's one of those things, they wear these two hats kind of as, you know, a client as well as a peer."* (Staff 2)

There is a sense of loyalty and solidarity with clients that create a source of tension that is exacerbated as peer workers move to greater amounts of autonomy and responsibility in their work. This may be particularly challenging where peer workers are expected to use their discretion when working with clients with whom they have personal histories, as suggested by a non-peer worker interviewed: *"There are peers that have had conflicts with other people in the neighbourhood, and a lot of those conflicts are still unresolved." (Staff 5)*

Frequently, clients will pressure peer workers to bend the rules, challenge peer workers' authority, or question peer workers' loyalty. This creates tensions for peer workers responsible for distributing supplies to clients who are also friends and acquaintances.

> *"In the beginning when you would come to me, I was happy I got the job so I was…showing off more or less… The week before, I was just smoking crack with you in a crack house. Now you see me here. And you want things… I can give you extra, but I don't. In the beginning, that always hurt me so I did. But you can't do that… It came a point where somebody would come for something and I didn't have it because I gave it to somebody else, and this person now is more in need of it. So that's when I started saying 'No, I just gotta start regulating this properly'". (Peer 2)*

Peer workers are very careful to navigate the complex boundaries of peer work in order to keep their positions. This can be very difficult when they are able to identify with the lack of resources available to their friends and community. Both peer workers and non-peer workers discussed this challenge:

> *"I'll make you a bag lunch… I'll load you up with a thing of pop, this, that whatever, I don't care… How do you turn somebody away to eat? You can't. I know when I go home, I'm going to have a meal. I'm going to have a full belly…" (Peer 3)*

> *Do they cross small boundaries? Of course they do… And they're the first ones to tell you that they've crossed. I also think that for us to expect that they wouldn't cross the boundaries when we're asking them to work with their own peers who*

are in terrible, dire, dire conditions… They're peer workers. They're not expected to hold the same boundaries that I would, they're here for a short period of time." (Staff 4)

Balancing the expectations of the agency with those of one's friends and associates can become very complicated for peer workers and result in feeling pulled in different directions: *"Perhaps you're in a place where you have to hardline somebody, and in a half an hour you're going to be out on the street with them. I think its incredibly difficult and very enmeshed"* (Staff 2). Peer workers are caught between the expectations of their peers with whom they spend most of their time, and the expectations of the Health Centre for whom they work only a few hours a week. As one peer worker said: *"I was their friend before I got this job, so why would I stop being their friend now? I'm not gonna let a job stop me from being their friend or ruin a friendship…" (Peer 3)* This peer worker continued by describing the efforts taken to protect the job including having to walk away from conflict and refuse offers of drugs. For example, the peer worker says: *"If somebody comes along and offers me drugs or any of that – I'm not going to say 'Yeah, man, here man, take it.' And then come back, the next time I'm suspended, like I've seen happen to somebody in the past... It's not worth it to me".*

One of the clients interviewed acknowledged the tensions that arise for peer workers who provide services to members of their personal community: *"It gets stressful, so [peer worker] don't want to say 'No', but they have to because it's their job. So you know, they can't go against that, they'll lose their job…" (Client 1)*

Using Discretion

A challenge in service provision is knowing how to respond to individual needs within the context of rules and procedures, limited supplies, and, at the same time, great need. Discretion is used to determine when and how to adapt or bend the rules to meet individual needs and circumstances. Three influential factors that promote appropriate use of discretion are the ability to confidently assess individual need, cooperation and respect from clients, and the confidence that colleagues will back up and support your assessment and action. These factors will vary according to where one is along the peer work continuum, and certain positions offer a wider range of discretionary powers to peers. In the peer participation model, the use of discretion by peers will be minimal. Moving along the continuum, one accumulates responsibility and accountability, and is afforded greater use of discretion.

Peers develop assessment skills to determine client needs through observing and modeling program staff (including outreach workers and nurses), by drawing on 'common sense', and reflecting on their personal experiences. Many of the peer workers spoke of the importance of having opportunities for on the job training, and learning by modeling staff workers. One peer worker explained: *"I basically try and follow what the*

staff are doing, like I see the people with more experience like Calvin or Dean or Paula." (Peer 3)

Practice and familiarity with the role and the clients instill confidence in one's ability in their assessment skills. Peer workers find that when they work regular shifts they are better able to provide consistent client-services than if they are only coming in sporadically. The continuity of working many shifts in a row provides an opportunity for peer workers to become more aware of the clients' needs and patterns, and how to respond in manner consistent with agency policies and principles.

> *"Some peers still haven't adapted to the favouritism because they haven't been working on the job, or do these jobs enough times. They get it maybe once, twice a month, where if you do it everyday, it's different. You see who needs and who doesn't need. And you get to appreciate more the person's needs." (Peer 2)*
>
> *"Because it's a rotation, it's like not constant like they're working five days of work, because when you're doing something, and you're doing it five days of the week, you more get the hang of it, but if you're just doing it basically once a month or something like that, you'll have a lot of knowing how to do it but you might slip or don't remember some things." (Staff 3)*

Non-peer staff encourage peer workers to refer to the idea that consistency is important for managing boundaries: *"The discussion that we have is consistency is your best friend and the more you can be consistent and firm, the more people will know that its not worth their time" (Staff 3).* Peer workers affirm this approach, but also struggle with watching non-peer workers and other agency staff exercise their discretion in ways that they are not permitted and in ways that they don't always perceive as fair.

A large part of providing harm reduction services is based on the use of discretion, however the privilege of using discretion is not evenly distributed amongst the peer workers. It is a source of potential conflict amongst the peer workers, between peer workers and clients, and between peer workers and non-peer workers. The use of discretion is based upon different factors that may be more salient than others for different peers or providers. Perception of need, for example, may vary between non-peer workers and peer workers. It is seen as unfair that the non-peer workers could decide to break the rules when they thought it was necessary and deny this same right to the peer workers.

Learning under what conditions rules may be overlooked takes time, experience, and a mentor / supervisor to model. The availability of shifts for peer workers will influence the process of learning how to use discretion equitably and appropriately. One of the peer workers explains:

> *"I watch how they [the non-peer workers] and I try to follow them. 'Cause if I see someone ask [a non-peer worker] for a pair of socks and not having a shower, I figure if he can do it, so can I… The man's not having a shower, he needs a pair of socks, I'm going to use my own judgment on it." (Peer 3)*

While some peer workers want greater discretionary power, others find the ability to pass over the responsibility for decision-making to non-peer workers helps to minimize potential conflicts with friends and associates who are clients of the program. For example, one peer worker said: *"I just say no. You can be mad at me all you want, threaten me all you want, I don't care. It's my job; it's what I was taught to do; that's what I'm doing." (Peer 3)*

Peer workers are more comfortably able to use discretion when they feel trusted and supported by their supervisors. Frequent and timely supervision meetings may provide an opportunity to resolve some of these issues. A more detailed discussion about agency support continues below in the section below.

Claiming Affiliation

A tension that arises for peer workers involves their ability to claim affiliation with an agency when working with clients and interacting with other agencies and community members. There are two connected issues reflected in this tension: legitimacy as a service provider, and the uncertainty regarding to which agency one belongs when there are two agencies leading the program.

The first issue refers to the sense of authority and credibility that workers derive from their role as an employee of a community health centre or community agency. The ability to affiliate one's self with a larger recognized agency provides legitimacy to peer workers advocacy efforts and eases interactions with other agencies, thereby providing enhanced client services and interagency collaboration. Claiming affiliation with either the health centre or the agency (or both) provides a sense of legitimacy, professionalism, and authority.

Some of the peer workers are unsure as to whether or not it is appropriate for them to represent themselves as affiliated with RPCHC or Street Health because they do not have full employment status. Some peer workers have hesitated from claiming affiliation unless they have had explicit permission and approval from non-peer workers to do so. This reflects the "in-between" status that some peer workers experience as they move along the continuum of peer work.

> *"Peers may not know how to utilize the name of the health centre as well. They may not be comfortable using the name of the health centre. Like when you call up another agency and you say you're a representative from that agency, there's*

some confidence you can exert in that, and there's also an implicit trust that's implied with that, because you're seen as a representative of an agency and there's certain qualities and qualifications and expertise that's related to being an employee of an organization… I don't think we've been explicit enough in saying "Yes, you are an employee here. You can call-up agencies if you need to advocate for a client, and say you're a representative of the health centre… a peer worker from Regent Park Community Health Centre." (Staff 5)

"Peers are in a position to hear more of the injustices perpetrated by other agencies, other workers, and they do have this position of being an employee here, they could utilize that position a little better and provide some advocacy… I don't know if we've taught them how to do that or been explicit enough that they understand that they can do that… I haven't seen a lot of that happening… You have to have a certain comfort level with the agency that you're working for and the position that you have." (Staff 5)

The Health Centre's ability to offer this continuum of peer work is founded on the partnerships the agency has with other community organizations such as Street Health. Undoubtedly, the success of the program in broadening the roles of peer workers reflects the close collaboration between the two agencies. These partnerships facilitate the growth of the program, however a tension opens up for peer workers regarding issues of affiliation. Some confusion arises from the fact that both CUP and the Safer Stroll Project are collaborations between *Street Health* and Regent Park Community Health Centre. While this collaboration clearly has many benefits for peer workers (for example, greater access to training, work opportunities, resources, and diverse sources of support), it is sometimes difficult for peer workers to assert which agency they work for, and to whom they are most accountable. The following excerpt from the men's focus group illustrates this confusion and complexity for both peer workers and for non-peer workers.

Peer A: "We're actually working with Street Health and Regent Park joined in eventually… All of our money comes form Street Health."

Peer B: "But our outreach is here too. We do the showers and the laundry".

Peer C: "That's only one day of the week."

Peer A: "One day a week we're working here, mostly I was at Street Health. That's where our main offices are, that's who hired us, Street Health."

Below is another example from the men's focus group. The group was asked "If you have a really bad experience on one of the shifts, is there someone designated for you to go to, to talk to?"

Peer A: "That's the problem, I don't know."

Peer B: " It's usually like Calvin or Dean or –"

Peer A: " But Calvin or Dean is not working with Street Health. We gotta go to Street Health, Dean and Calvin work here. If it happens here, you can talk to them, but up there at Street Health – When we go out on outreach with one of the staff of Street Health and we have a bad day, all we're gonna worry about after a long day, most of the time, I want to go home. Okay? If we've got things on our mind to talk about, who are we gonna talk to?"

This discussion demonstrates how training and hiring in one place and working in another (or both places) may make organizational affiliation and lines of supervision less clear. A further complication may arise from potentially contradictory policies or practices, and by differing levels of acceptance and support for peer workers at each agency. The non-peer workers that were interviewed all highlighted the efforts made to ensure good communication between the agencies (such as regular meetings and day-to-day interactions) in efforts to avoid such situations. It is this close partnership between Street Health and RPCHC that facilitates peer work and has led to the program's very success. Both agencies have an organizational culture that values peer work and community development. Through their collaboration, Street Health and RPCHC are able to provide a greater range of training and peer work opportunities.

"You can tell when the peers are in an environment where they are respected and seen as experts in their niche. And it gives people tremendous feeling of self-worth because… you give people an opportunity where they can prove to themselves and to others that they actually can. It really lifts them up and it motivates them to do more and try more and maybe not to be so discouraged when they come up against a barrier or some kind of unpleasant experience or situation." (Staff 1)

A SHIFT IN THE PROGRAM

As the Regent Park CHC peer harm reduction program has evolved, greater opportunities have become available for peers, and positive outcomes for peer workers and their clients have emerged beyond those anticipated. With this expansion, the program itself has shifted: the expectations of the program have shifted, the roles of the non-peer workers have expanded, and the existing resources for peer workers are stretched.

A shift in the expectations of what the program offers

- *Who is the program for?*
- *What are the objectives of the program?*

The expansion of the program has brought about a shift in the expectations of what the program offers. It leads to questions about the objectives of the program (i.e., peer participation or employment development) and to whom the program should be tailored. One of the non-peer workers described the program as consisting of a group that is *"really diverse… people participate in different ways".* Indeed, there is considerable diversity amongst the peer workers in terms of their levels of *stability*, their *skills and experience*, and their *expectations of the program*. These differences stretch the program across the continuum of peer work and create tensions. Here, these tensions are discussed in relation to the differences amongst the pool of peer workers stability, expectations, and experience.

a) Stability – Within the peer program, there is a wide range of people who are at different stages in their lives, and who have greater or lesser stability related to their housing status, their physical and mental health, or their substance use (amongst other factors). While engagement in peer work is difficult without stable housing, peer work contributes to establishing greater stability. Peer workers have attributed the greater stability in their lives to their involvement with peer work. In turn, this stability stimulates further opportunities for their development as peer workers (assuming that shifts and training sessions are available). Peer work helps build stability, as described here:

> *"I find it helps me deal with my own addiction … It gives me a thought, you know, then I must be trying to help myself a little bit. I mean, I cut back a lot. I mean seven years ago I was smoking hard, and had no place to go. For the last seven years, I've had a place. I've been out of jail for seven years." (Men's focus group)*

> *"[The peer program helps] their ability to manage their health in different ways, make healthier choices, get the health care they need. I think it does translate into their work as simply as, you know, they are feeling better, they are able to*

work better…In the second year of training, something like thirty-seven per cent of the peers were able to get housing out of the group that wasn't housed." (Staff 2)

Peer workers who have greater stability in their lives are more likely to be available to take shifts and engage in peer work in a reliable and consistent way. Their stability allows them to take advantage of opportunities that then leads to the development of a more experienced group of peer workers. Their consistent participation reinforces their learning and sense of accomplishment, and has encouraged some of the peer workers to pursue higher education or transition into the 'mainstream workforce' where they can secure competitive wages, benefits, opportunities for advancement, and consistent shifts. For those with less stability, the informal structure and low threshold approach keeps the door open to participation in the program. However, because of the growing number of more experienced peer workers, opportunities for those with more chaotic lives may be increasingly restricted.

"Once you become reliable, I think then you're used a lot. And there's some peers who are reliable; they have cell phones or they come by all the time; versus the peer who doesn't have a cell phone, who's using more, that maybe you can't find them. Also some peers are … stronger… and that's where I think it becomes difficult…" (Staff 4)

"If I wasn't addicted to a drug, I'd be a very good spokesperson, but I don't know, I'm so frigged up in my drug use that I can't get a hold of it." (Client 1)

b) Skills and Experience – There is a wide range in the level of skills and experience amongst the peer workers. Some have been involved with peer programs since their inception, while others are very new to the program. A few of the peer workers hold positions at other community agencies (for example, Street Health, Queen West CHC, Sherbourne Health Centre) and some have been hired as relief staff at Regent Park CHC. There is also a group of peer workers who are less intensively involved in peer work and have less experience. They have had basic training to do peer work tasks and participate sporadically according to other life demands and interests.

The duration and depth of training varies according to available project funding, and this contributes to differences amongst the peer workers. Typically, peer workers attend twenty weeks of training sessions. When longer courses have been offered, the non-peer workers have witnessed a shift amongst the participants reflecting an increase in their self-esteem and self-capacity. Additionally, the non-peer workers have noted the development of deeper cohesion amongst the group that occurs with longer training courses:

"One thing that really struck me was there was a fundamental shift for these women, all at about the same time…. Maybe we were into week twenty-eight or

> *thirty-two, something like that. And so, for the group, it seemed like there was an awareness that abuse in their lives wasn't okay and further to that, a need to address that. And so we saw, I think, eighty per cent of them connect with more in-depth services." (Staff 2)*

Similarly, with increased experience in peer work, non-peer workers have witnessed the development of a professional identity amongst the peer workers that arises from increased self-esteem and sense of accomplishment achieved through their work. This is clear in the following reflection by a non-peer worker:

> *"I tend to notice a difference with folks that get to a place where they can see their own potential, and there seems to be a click that happens around professional identity." (Staff 2)*

The differences amongst the peer workers present a significant challenge for the non-peer staff, and the agency, to meet their needs and expectations. Without the necessary funding, staffing support, and community linkages, the program ends up not completely satisfying the needs and goals of either the group of peers who wish to participate in a health promotion activity or those who want to transition to more formal employment. The very success that the program has achieved then contributes to some feelings of frustration and disappointment amongst the peer workers at either ends of the continuum, alongside their strong enthusiasm for their work and what the program offers.

c) Expectations - Participation in peer work provides the opportunity to gain some skills, gain a sense of accomplishment, and make some modest income. For some peer workers, the informal and casual engagement in peer work is an end in itself. Many of these peer workers find the informal flexible structure of the program well accommodates their current needs, lifestyles, and preferences. Some spoke of peer work as a social activity. One of the peer workers commented: *"Money is not big, so, I just like to help people in general myself. I mean, I just get a certain satisfaction from it."*

There is tension that arises from the co-existence of peers who want the flexibility and informality of a low-threshold, peer-participation model, and those who are looking for intensive training and employment opportunities. Accommodating both groups is a significant challenge. Although all of the peer workers emphasized their appreciation for the opportunities they have, some expressed that they also feel frustrated and disappointed that there are not more opportunities. One peer worker commented: *Now, yeah, there's no availability and there still isn't. Like I could do this all day long, but there's three hours a day max sometimes." (Peer 3)* Another peer worker stated: *"I just want a job. A stable job." (Peer 4)*

Many of the peer workers acknowledge lack of funding as an obstacle to greater opportunities. One peer worker said: *"The best is to have funding. This opens up jobs for them".* In addition for the need for more funding, another peer worker recommended expanding the schedule for the shifts to include evening hours, thereby providing more shifts for peers and also providing peer services to the community at hours when people most need harm reduction supplies and support.

In addition to more hours and shifts, some of the peer workers argued that they should receive better pay to reflect their work, their training, and their experience:

> *"They should raise the salary range. They should raise the wage for peers. Instead of fifteen dollars an hour at cap, it should be twenty-five, thirty. Then I can at least make a decent pay. Cause I work hard and I don't see why they have to keep the wages so low for a peer, especially if you've had three or four years experience. It's not fair." (Peer 5)*

There is a concern that if resources are concentrated in the smaller group of more stable and experienced peers, this will reduce the opportunities for those who prefer or require a lower-threshold, more casual involvement in peer work. There is also the risk that this will lead to fewer spots for new people to experience that 'taste' of peer work that has spurred others to build significant changes in their lives.

One possible solution to this problem that was put forth by a number of people interviewed (including peer workers, non-peer workers and clients) is to have different streams or tiers of peer workers:

> *"I'd just love to see people be able to participate no matter what's going on for them. So it may mean exploring what peer work is, can you have different tier programs. Can we open it up to cater to a larger and diverse crowd." (Staff 2)*

> *"If they put the money to use, to make another peer group, I think it would change a lot more people. And it would make them feel a lot more respected… like in themselves, and with other people. Like me, for instance: If I were to actually go through one of those groups, and actually be able to adapt to people being around me so much, I could actually be a good worker." (Client 4)*

Additionally, both peer workers and non-peer workers hold the perspective that if training is made available to people, there should be opportunities to use these new skills:

> *"Less peers then, don't hire a whack of peers. Don't hire fifty million Safer Stroll girls, or just do two or three groups so they can work for a long, long time. They know they're not able to work full time the rest of their life, so it can be one focus – I don't know, it reaches a lot of women but you can't make it, you can't*

keep starting up programs, programs, programs and then have no where to put the people after…. Provide more job opportunities, provide more hours, for a program, if you're going to take someone on, train them for three years, three months to a year, at least give them work. Solid work, not every day full time work, but you know…" (Peer 5)

Tensions emerge from conflicting ideas regarding the perceived objectives of the program, and who is (or should be) the target population. The peer program provides different things for different people, thereby requiring a wide range of resources and opportunities. Further, distributing resources (such as shifts) amongst the peer workers becomes very challenging.

Expanding the roles of non-peer workers

Non-peer workers involved in the peer program expressed great enthusiasm about the program and their work, and emphasized the importance of their ability to work collaboratively and creatively to respond to the needs of the peer workers and the wider client group. They spoke with pride about the successful transformations that they have witnessed in people's lives, especially the growth in peer workers' self-esteem and sense of purpose. Additionally, they described the challenges of providing such a wide range of supports to this diverse group.

As the group of peers has evolved, so, too, have the roles of the non-peer workers. They are supervisors, co-workers, and community support workers. They adapt their roles to meet the needs of the peer workers and seek new opportunities for peer workers who are graduating out of the program. They are continuously looking to secure funding opportunities for more training or positions, and designing programs to match available grants. These demands stretch their time, making it difficult to provide the kind of support that they would like give to peers.

"I believe that, you know, you can't just hire peers to do work unless you are willing to support them." (Staff 4)

"We don't necessarily have the time, the money, all that kind of stuff to support the programs in the way they really need to be supported… It's been a real struggle so we're piece-mealing together project funding to get these programs up and running. It doesn't afford the opportunity to do long-term planning, to be as comprehensive as we need to be." (Staff 2)

The range of support that is offered has also expanded. They provide supervision, mentorship, education, employment counseling, and other forms of support. They expressed the difficulty in fulfilling all of these roles for a growing group of people. They emphasized the importance of having sufficient time to provide effective supervision

with each peer worker. Their relationship with the peer worker is what allows them to appropriately adjust the tasks and responsibilities to meet needs of the peer worker.

> *"One of the hardest things about peer work is how it's not funded by the ministries… They want everyone to be working with peers, but that don't get that supervision of peers, training of peers, ongoing supervision, ongoing support, is instrumental; that unless you are doing that too… it just doesn't work… it just leads to burn out." (Staff 4)*

Additionally, timely supervision is key to teaching important skills such as use of discretionary powers, advocacy, and counseling. It is also very important for helping peers negotiate the complex boundaries with which they are faced in providing services to their friends and acquaintances. The non-peer workers' responsiveness, flexibility, and support greatly contribute to the peer workers' ability to find success in this program. The partnership between RPCHC and Street Health is crucial to this:

> *"I think that we're really good about providing ongoing support. And I think we are very good about respecting and making peers feel very comfortable working at the Health Centre… I think that we create a really healthy environment… And I think we are stretched… we don't get funding for peer work… we don't have a fulltime harm reduction worker. I think we rely a lot on Street Health to provide some of the more ongoing supervision, but I think [the non-peer workers at RPCHC] are constantly checking in with [the peers]"* (Staff 4).

Stretching Resources

Tensions arise from the struggle to meet program and client needs without secure funding and sufficient staffing. The expansion of the program in terms of both numbers of peers and the scope of peer work has stretched limited resources. There are a growing number of peer workers who have graduated from the current capacities that the program has to offer. The program is not able to provide more shifts or greater compensation to these peer workers. Additionally, opportunities to include a greater number of peer workers and open up the program to new people are restricted. The program is in a tight place. The non-peer workers continue to find new ways of opening the program, but the question arises: is it better to concentrate resources on the smaller group of peers or spread them out amongst a larger, wider group?

> *"I consider the people who have gotten involved with peer projects really lucky because there's so many more people who wanted to be involved that never had the opportunity just because capacity was limited." (Staff 1)*

Both peer workers and non-peer workers expressed a frustration that more could be done with the peer program if there was more funding. People who used drugs and

other substances are generally isolated and frequently lack access to services and resources in the community. Peer workers play a vital role in bridging the gap to between marginalized individuals and agencies such as RPCHC.

> *"The nurses are always commenting on how the peer was able to connect them with an individual or group of people that otherwise, they wouldn't have been able to make that connection with. And in some extreme occasions, it's life saving; the person really needed that medical treatment. And I think the majority of times, it's what is required, it's the currency required for the nurses to be able to build relationships with some of the folks out there that are harder to reach." (Staff 2)*

One of the peer workers remarked that lack of peer shifts limits what information and resources get out to the community, even though there are enough peers to provide these services:

> *"One thing is get to them at night time, when everything is happening, you know what I mean? …When everyone's partying and getting high and there's no pipes or needles around to be had, you know what I mean, or services… I wish we could provide twenty-four hour services, is what I wish… There's enough people but not enough access to set these people up so that they can get that information out… We have enough peers but there's not enough jobs for peers. So we got enough peers but not enough…like… space or the room to set the person up so they can get the information out to the public or to the community…. But all that goes with funding, so that starts with funding." (Peer 2)*

> *"So I think sometimes we under, under-utilizing peers, and I think within the Health Centre, I think we could be using peers more than what we do."* (Staff 4)

FUTURE DIRECTIONS

At present, the peer program seeks to provide opportunities to a very diverse pool of peer workers while continuing to attract new peer workers. Over the course of the program's evolution, two groups of peer workers have emerged: those oriented towards a peer participation model and those oriented towards an employment development model (although many shift between these models over time). The existence of these two groups creates tensions regarding the distribution of program resources (such as shift times and training opportunities) and the evaluation of participation criteria (i.e., what level of skills are required to be a peer worker?). Efforts to accommodate both groups may lead to frustrations amongst and between them as they compete for limited resources.

Both groups of peer workers express personal satisfaction that they derive from providing peer support. They describe how being a peer worker has helped them personally, and how, as peer workers, they have been able to help other people. They describe peer workers as essential components of the harm reduction program because they are able to expand the reach of services to people who may otherwise not be willing to speak with formal workers. The diversity of the peer workers sends a message to other people who use substances that they are welcome at the Health Centre and that they, too, can be peer workers. For many who have experienced failures and rejection, this message is an important one that may stimulate involvement in services and peer work, and lead to greater personal change.

As the RPCHC peer program has expanded along a continuum of peer work to include more participants with a diverse range of needs and expectations and in the context of limited resources, the question arises as to what should be the objective of the program. The current situation suggests that continued expansion at either end of the continuum is unsustainable given the available resources and demand. This necessitates deciding whether to shift the focus of the peer program towards an *employment development model*, or a *peer participation model*. The questions that this decision provokes include:

- Who participates? Should the emphasis be on providing equal opportunities to as many people as possible or should the program concentrate on a small group of individuals?

- What are the program objectives? Is the goal engagement and participation or employment development?

- Which model is more feasible for Regent Park CHC? Which is more relevant to the client population?

The peer harm reduction programs at the Health Centre have evolved in ways previously unanticipated. The very success of the efforts to meet the needs and expectations of a diverse population and to provide equal opportunities to all have contributed to the emergence of tensions that pose a challenge to the sustainability and effectiveness of the current approach. Clarifying the objectives of the program may contribute to identifying what resources are needed and what strategies may be employed to meet the needs and expectations of peer workers. If the objective is to provide equal opportunity to participate in peer work to as many people as are willing, considerations must be made for those who will graduate out of the program wanting to further their education and employment skills. Close community linkages with employment and educational programs may benefit this group of peer workers. Concentrating peer work opportunities amongst a smaller group of more expert peer workers comes at the expense of reducing opportunities to others. It also makes it increasingly difficult for non-peer workers to select peer workers for roles and to evaluate training. At root, resolving the current tensions requires reflection on the capacities of the agency and staff, and clarifying what expectations can be met, and what resources might be developed to address existing or anticipated gaps.

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APPENDIX 1: Methods

In keeping with our community-based research model, we held information sessions with peer workers to discuss the project and solicit their involvement, contribution and feedback on the project's goals and methods. From the information sessions, we recruited four peer workers to join the research team. The research team consisted of Regent Park Community Health Centre peer workers, a harm reduction worker, a researcher from the Health Centre, the Director of Community Health, a scientist from the Centre for Addiction and Mental Health, and two health promotion practicum students from the University of Toronto. The team met to discuss the project goals, methods of data collection and recruitment strategies.

To collect data, we used two methods – focus group discussions and face-to-face semi-structured interviews. To recruit peer worker and client participants, poster advertisments were displayed at RPCHC. We conducted two focus groups, one with men and another with women working as peers at RPCHC. The focus group guide contained semi-structured questions about the goals, benefits, limitations, challenges, achievements, training needs and experiences with the peer worker program. Focus groups were moderated by the CAMH researcher and were co-moderated by the practicum students. Preliminary analyses of the focus groups discussions were used to identify themes and issues in need of further exploration. These preliminary analyses were used to refine the focus group guide questions and revise it for use during the semi-structured interviews. We conducted in-depth semi-structured interviews with peer workers, clients and non-peer workers at Regent Park Community Health Centre (completed by the practicum students). To be eligible to participate in a client interview, clients had to be over 16 years of age, comfortable speaking English and to have ever used the services of a Regent Park CHC peer worker.

Prior to each focus group and semi-structured interview, participants were asked to read a consent form, and if they agreed, to verbally consent to participate. We read the consent form to any participant with vision and/or literacy issues. As well, at the beginning of each focus group, we reviewed issues related to confidentiality prior to beginning the recording of the session. To characterize our sample, all participants were asked to complete a short questionnaire about their demographic background, drug use and service use.

Following each focus group and interview, the recordings were transcribed verbatim by a confidential and trained transcriptionist. The transcripts were reviewed for completeness and revised as necessary. All transcripts were managed using NVIVO. Data from the questionnaires was entered into SPSS. To protect the confidentiality of the participants, the CAMH and RPCHC researchers and a practicum student (none of whom work directly with the peer program) analysed the transcripts. Using an interative approach, we each hand-coded a transcript, met to discuss our coding and interpretation. We used this discussion as a guide to code the next transcripts. Upon

agreement of preliminary codes, Strike, Mukkath and Penn coded the remaining transcripts, crosschecking for agreement and discrepancy. We met regularly to discuss coding and analyses and to create thematic memoes (i.e., mini-analyses) of the data. We reconvened the whole team to present the preliminary analyse and solicit feedback. We used the information provided at this meeting to refine the analyses. In our report, we provide excerpts from the transcripts to illustrate the analyses.

APPENDIX 2: Survey Findings

The survey respondents consisted of Peer Harm Reduction Workers, harm reduction clients and non-peer workers engaged in harm reduction work from the Health Centre. There were 23 survey participants in total among whom three were non-peer workers. The data provided in this report does not include any data from the non-peer workers. The survey covered all the persons who had participated in the focus group discussions and the individual interviews.

Table 1: Respondents by Roles at RPCHC (N=20)

Roles	Frequency	Percentage
Client	5	25.0
CUP Peer Worker	5	25.0
Safer Stroll Peer Worker	1	5.0
Other (DIP Peer Worker)	1	5.0
More than one Role	8	40.0
Total	**20**	**100.0**

Clients using harm reduction services have the opportunity to access several programs or use the services offered at the Health Centre such as laundry and shower, men and women drop-in programs besides workshops. Workshops are held at the Health Centre on various topics such as overdose prevention, safe drug use, etc. Additionally these clients can also access other health services such as doctors, nurses, social workers, housing workers through the WOW service (Wednesday one stop Walk In). Clients may also apply to become Peer Workers through the Safer Stroll program for street sex workers and CUP program. The survey asked respondents the different roles they had at the Health Centre. The above table shows that 40 per cent of the respondents had more than one role at the Health Centre i.e. client, CUP peer worker, etc. Crack Users Program (CUP) peer workers composed a quarter of the total respondents.

Demographics

Table 2: Respondents by Gender (N=20)

Gender	Frequency	Percentage
Male	8	40.0
Female	12	60.0
Total	**23**	**100.0**

Females constitute the majority of respondents. However the gender composition of the clients using harm reduction services at the Health Centre reveals that males far outnumber females. There are specific programs at the Health Centre such as the Safer Stroll program which are restricted to female street sex workers. Other programs such as the Crack Users Project (CUP) are designed for male, female and trans clients. The gender composition of the survey respondents hence may not reflect all the gender groups adequately.

Table 3: Respondents by Age Group (N=19)

Age Group	Frequency	Percentage
30-39 years	2	10.5
40-49 years	7	37.0
50-59 years	8	42.0
60-65 years	2	10.5
Total	**19**	**100.0**

Age wise distribution of survey respondents shows that majority (79%) of the respondents are in the two age groups 40-49 and 50-59 years. Respondents in the 30-39 year age group constitute only a tenth of the total respondents. There are not many youth using harm reduction services at the Health Centre. The youth population may probably go to other centres that are targeted for youth to get their supplies, kits and services. There are no peer workers in the youth category currently working at the Health Centre. Training and employing Youth Peer Harm Reduction Workers may help to reach out to the youth.

Table 4: Respondents by Country of Birth (N=20)

Country	Frequency	Percentage
Canada	18	90.0
Out of Canada	2	10.0
Total	**20**	**100.0**

In order to get a profile of the clients, respondents were asked for their place of birth and if they were born in or out of Canada and the year they moved to Canada. According to the survey the vast majority of the respondents were Canadian born. Only 10 % of the respondents were foreign born. This generally reflects the profile of the clients currently using harm reduction services at the Health Centre.

Table 5: Level of Education (N=20)

Level of Education	Frequency	Percentage
Some High School	6	30.0
High School	5	25.0
Some College/University	5	25.0
College/University	4	20.0
Total	**20**	**100.0**

There is considerable variation in the education levels amongst the peer workers and clients. Twenty per cent of the respondents have completed College or a University program and 30% of the respondents have not completed high school. The development of resources on safer drug use practices (such as brochures, pamphlets, workshops) has to be tailored to meet the educational levels of the client population. Peer workers maybe able to better relate with the persons if they are aware of their educational level and also to create awareness about harm reduction practices.

Table 6: Ethnic Background (N=20)

Ethnic Group	Frequency	Percentage
Aboriginal	7	35.0
Caribbean	1	5.0
Eastern European	1	5.0
East & S.E Asian	1	5.0
Canadian	8	40.0
Others	2	10.0
Total	**20**	**100.0**

The Regent Park and Moss Park neighborhoods and the East Downtown (which constitute the catchment area of the Regent Park Community Health Centre) have a significant number of ethnic groups residing in the area. In fact it is one of the most ethnically diverse neighborhoods in the city. In order to get a picture of the clients using harm reduction services respondents were asked for their ethnic background. 40 per cent of the respondents mentioned Canadian and more than third mentioned Aboriginal as their ethnic background.

Language

Respondents were also asked what language they would like to receive services. Language barriers may also restrict persons from accessing harm reduction services. Peer workers with abilities in different languages and or with different ethnic backgrounds can help people access harm reduction services. This will enhance the accessibility of the services at the Health Centre. All of the respondents mentioned that they would like to receive services in English.

Housing Situation

Table 7: Place of Stay in Last 6 months (N=20)

Housing Situation	Frequency	Percentage
Own Accommodation	10	50.0
Supportive Housing	1	5.0
Shelter	3	15.0
Temporary Accommodation	1	5.0
Rooming House/Hotel	1	5.0
Multiple locations	4	20.0
Total	**20**	**100.0**

Respondents were asked about the places they had stayed in the last 6 months to get a picture of their housing situation. Many of the drug users have an unstable housing situation. The above table shows that a significant proportion of the clients accessing harm reduction services at the Health Centre are homeless. There are a number of shelters and hostels in the catchment area of the Health Centre hence a number of persons living in shelters; hostels use the Health Centre to access health services. The above table shows that half of them lived in their own accommodation in the last 6 months. The rest have lived in shelters and in their friend's house as couch surfers. Twenty per cent of the respondents have lived in more than one place within the last 6 months. The locations include jail, parks, friends' places, and a motel. This shows the precarious nature of their housing situation and their lives. Peer Harm Reduction Workers are able to reach out to drug users living in shelters, hostels and on the streets besides other places because they are well aware of the neighbourhood and places where the drug users generally reside.

Table 8. Current Place of Residence (N=20)

Housing Situation	Frequency	Percentage
Own Housing	14	70.0
Shelter	2	10.0
Rooming House/Motel	2	10.0
Others	2	10.0
Total	**20**	**100.0**

The above table shows that a majority (70%) of the respondents have their own accommodation. Two persons mentioned "other places" as their current place of residence, one mentioned "park" as the current place of stay and another person has "no specific location" as a current place of stay. Providing harm reduction services and supplies to clients with no fixed address can be a difficult. Clients who are homeless may not consider safe drug use practices as a high priority when their living situation is

precarious. Having Peer Workers providing services and supplies on a regular basis makes them more accessible to the homeless population since they may know many of the hang outs of the homeless and are thus able to provide services effectively. A peer worker's housing status may influence their ability to engage in peer work and training. Appropriate and affordable housing provides a stability upon which a peer worker can develop their skills and take on shifts regularly. Peer work may also nurture one's stability, thereby making it easier to maintain housing.

Table 9: Respondents Residing in East Downtown (N=19)

	Frequency	**Percentage**
Residing in East Downtown	14	74.0
Not residing in East Downtown	5	26.0
Total	**19**	**100.0**

The majority of the persons using the harm reduction services are residing in East Downtown area. Only a fourth of the respondents are from other neighborhoods. The Health Centre is able to provide harm reduction services to clients from other neighborhoods. These clients may be served by the outreach work of the Peer Workers or they may visit the Health Centre to access harm reduction supplies.

<u>Income</u>

Table 10: Source of Income (N=20)

Source of Income*	**Frequency**	**Percentage**
Employment–(Full time)	1	5.0
Employment–(Part Time)	1	5.0
ODSP	10	50.0
Ontario Works	7	35.0
Other income sources	3	15.0

***Multiple Responses**

Only 10 per cent of the clients are employed. Clients are dependent on government transfers such as ODSP, Ontario Works to meet their living expenses. Clients also work under the table, to be able to meet their living expenses besides engaging in other activities such as sex work to supplement to the welfare support. It is a known fact that the social welfare income supports are not enough to meet a person's needs that recipients often have to depend on food banks and hand outs to make ends meet.

Drug Use Patterns

Table 11: Respondents by Drugs Smoked, Swallowed, Snorted, Used (N=20)

Response	Frequency	Percentage
Yes	14	70.0
No	6	30.0
Total	**20**	**100.0**

Respondents were asked if they had taken any drugs over the last one year. Drug users were also asked to distinguish between the different drugs they had snorted, smoked or swallowed and the drugs they had injected to analyze the drug use pattern in the neighborhood. The majority of the drug users (70%) mentioned that they had either smoked or snorted or swallowed drug(s). According to a survey of drug users in the neighbourhood conducted by the Regent Park Community Health Centre in 2011 smoking crack is the most common form of drug usage and crack appears to be the most common drug used in the East Downtown Toronto. This may be because crack is easily available in these neighborhoods and or affordable.

The survey shows that Peer Workers are also currently drug users. Though the Peers maybe currently using drugs they are able to function normally in their daily routines. Discussions with Peers reveal that they do not use drugs while at work and they are also able to function well in their respective role as Peer Workers.

Table 12: Use of Injection Drugs (N=20)

Responses	Frequency	Percentage
Yes	3	15.0
No	17	85.0
Total	**20**	**100.0**

According to the survey only 15 per cent were injection drug users. Other studies on the drug use patterns in the Regent Park and Moss Park neighborhoods show that injection drug users generally do not reveal that they use inject drugs. In the hierarchy of drug users, injection drug users are supposed to occupy the lowest rung. There is a common perception among drug users that injection drug users are infected with HIV/AIDS and other such diseases. Hence they are generally looked down upon. According to the Peers there is a higher percentage of injection drug users in the neighborhood.

Harm Reduction Service Clients

Table 13: Accessing Peer Harm Reduction Worker's Services (N=19)

Response	Frequency	Percentage
Yes	8	42.0
No	11	58.0
Total	**19**	**100.0**

Drug users are generally isolated and usually lack access to services and resources in the community. Peer Harm Reduction Workers play the vital role of bridging the gap to these drug users by providing the essential link to agencies such as the Regent Park Community Health Centre in addition to providing harm reduction supplies. Peer Workers are able to connect with drug users because they are better able to reach out to them besides being aware of their problems and issues. Survey respondents were asked if they have seen a Peer Harm Reduction Worker within the last six months. 42% of the respondents mentioned that they had accessed the services of Peer Harm reduction workers within the last six months. The respondents to this survey were composed of clients and Peer Workers. The Peer Workers may not have the necessity to access the services of other Peer Workers within the last 6 months.

Table 14: Frequency of Seeking Assistance from Peer HR Workers (N=16)

	Frequency	Percentage
Every Day	1	6.0
1- 2 times/week	5	31.0
> 3 times a week	1	6.0
Once in a While	6	37.5
Don't Know	1	6.0
Never	2	12.5
Total	**16**	**100.0**

Harm reduction service users can either use the services of staff at the Health Centre or Peer workers. Respondents were asked how often they sought assistance from Peer Workers. According to the survey, 43% of the respondents seek assistance from Peer Workers on a frequent basis ranging from daily to more than 3 times a week. Only 12% mentioned that they have never sought assistance from Peer Workers.

Table 15: Type of Service Accessed (N=16)

Type of Service	Frequency	Percentage
Crack Kits & Condoms	1	6.2
Food, clothes & socks	1	6.2
Other Support Services	2	12.5
More than one service	12	75.0
Total	**16**	**100.0**

The above table shows the different type of services used by harm reduction service users from Peer Workers i.e.; getting safe drug use kits, condoms, hygiene supplies to getting other support services like information, referrals, etc. The majority of the respondents mentioned that they get more than one service from the Peer Harm Reduction Worker. Drug users may not need to get any supplies from workers on a daily basis but may need to talk to the worker for information or support. Peer Workers offer vital services to drug users in the community through their outreach to otherwise isolated individuals. Peers also act as role models for drug users, this can effectively help their clients reduce risk behavior. Training and educating peers in safe drug use practices can help to disseminate information successfully to the drug user community.

Table 16: Usual Method of Accessing Peer Worker Services (N=15)

Method of Access	Frequency	Percentage
Use Walk–In at RPCHC	11	73.0
Peer Worker Comes to Look for Me	1	7.0
When I come to RPCHC	2	13.0
Others	1	7.0
Total	**15**	**100.0**

Peer Workers provide harm reduction services at the Health Centre on a daily basis and also do outreach work in the East Down Town area. Clients can access the services of Peer Harm Reduction Workers in several ways. Since Peer Workers share the same experiences as drug users and have an understanding of the problems and issues of drug users they are more accessible to harm reduction service users than staff. When respondents were asked of the usual way in which they see a Peer Worker. The majority (73%) mentioned that they usually walk-in to the Health Centre to get assistance from their peers. 7% per cent mentioned other means such as the phone to get assistance from Peer Workers. In addition to using the walk–in facility to access Peer Worker services, clients can also get to see them whenever they drop-in at the Health Centre to see a doctor or a housing worker.

Table 17: Accessing Services from Non-Peer Harm Reduction Worker (N=19)

	Frequency	Percentage
Yes	13	68.0
No	6	32.0
Total	**19**	**100.0**

The success of the Non–Peer Worker in reaching out to the service users may depend on several factors such as the Non-Peer Worker's familiarity with the neighborhoods, with the drug users and also with the problems and issues of the drug users.

The Harm Reduction worker and the Peer worker work together especially when they do outreach in the streets. The above table shows that a high percentage (68%) of harm reduction service users utilize the services provided by the Non-Peer Workers.

Table 18: Frequency of Seeking Assistance from Non-Peer HR Workers (N=17)

	Frequency	Percentage
Once in a While	10	59.0
1-2 times a week	3	17.0
> 3 times a week	2	12.0
Don't Know	2	12.0
Total	**17**	**100.0**

Peer Workers are stationed in the Health Centre on a daily basis providing harm reduction supplies to clients and also doing outreach work. Whereas Non-Peer Harm Reduction Workers provide several other services i.e., case work, accompanying clients to agencies, referrals, organizing workshops, weekly drop-in programs in addition to providing supplies and outreaching to the drug users. The above table shows that nearly 30% of the persons using harm reduction services do it as often as 1-2 times to more than 3 times a week.

Table 19: Type of Service Accessed from Non-Peer HR Workers (N=15)

Type of Service	Frequency	Percentage
Crack Kits & Condoms	1	6.7
Food, clothes & socks	3	20.0
Other Support Services	2	13.0
Referrals	1	6.7
Accompaniment & Filling forms	1	6.7
Access More than two services	7	47.0
Total	**15**	**100.0**

The roles of the Peer Worker and the Non-Peer Worker overlap to some extent however Non-Peer Workers are sought out more often for referrals to programs in the Health Centre or other agencies and for other services like support and accompaniment.

The Non Peer Workers offered harm reduction services much before the Peers Workers were trained to take on these roles. The roles played by the non-peer worker and the peer workers currently compliment each other well providing more time for the non-peer workers to work on other issues affecting their clients.

Table 20: Usual Method of Accessing Non-Peer Workers (N=16)

Method of Access	Frequency	Percentage
Use Walk–In at RPCHC	13	81.0
When I come to RPCHC for other services	2	13.0
Use More than One method	1	6.0
Total	**16**	**100.0**

Majority (81%) of the harm reduction service users access Non-Peer Workers by walk-in method or when they come to the Health Centre to use other services. None of the service users mentioned using outreach as a means of accessing the Non-Peer Worker. Though Non-Peer Workers are available to meet with the harm reduction service users at the Health Centre they also do outreach to the drug users on a regular basis.

Table 21: Respondents by Health Centre Visited & Frequency of Visit in the Past Year (N=18)

CHC Visited	Everyday	1- 2 times a week	> 3 times a week	Once in a while	N
Street Health	31.2 % (5)	25.0 % (4)	37.5 % (6)	6.2 % (1)	**16**
Queen West	50.0 (1)			50.0 (1)	**2**
Sherbourne		25.0 (2)	12.5 (1)	62.5 (5)	**8**
Parkdale				100.0 (2)	**2**
The Works				100.0 (4)	**4**
South Riverdale	12.5 (1)	50.0 (4)		37.5 (3)	**8**
Other CHC's		25.0 (1)		75.0 (3)	**4**

Respondents were asked about the different Health Centres they visited besides the Regent Park Community Health Centre in the past one year to get harm reduction services and the number of times they visited the Health Centre. The table shows that clients use harm reduction services from different Health Centres besides RPCHC. The most popular Health Centre is Street Health. 31% mentioned that they used the harm reduction services at Street Health on a daily basis. Street Health Services has a large number of Peer Workers which may account for the popularity of its services. Sherbourne and South Riverdale Community Health Centres are also visited often by drug users to access harm reduction supplies.

Shifting Roles: Peer Harm Reduction Work at a Multicultural Community Health Centre.