SafeLink Alberta

Best Practices for **Supporting People Who Use Substances** Toolkit

About SafeLink Alberta
Since 1983, SafeLink Alberta has been committed to supporting those effected by HIV, hepatitis C, and other sexually transmitted and blood-borne infections. We are an organization that works to reduce the risks associated with sexual activity and substance use. With office in Calgary and Medicine Hat, SafeLink Alberta serves and advocates for priority populations throughout southern Alberta by providing education, non-judgemental services, and harm reduction programming.

Land Acknowledgment:
SafeLink Alberta is located on the traditional territories of the Niitsitapi, which includes the Siksika, the Piikani, and the Kainai; the Tsuut'ina, and the Îyâxe Nakoda and on land which boarders the traditional territories of the Cree, Sioux, and Saulteaux bands of the Ojibwa, and everyone who makes their home in the Treaty 7 and Treaty 4 regions of Southern Alberta.

We also acknowledge that we are located on the unceded Battle River Territory of the Métis Nation of Alberta.

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Executive Summary

As a component of the Substance Use Capacity Building Project with SafeLink Alberta, the Best Practices for Supporting People Who Use Substances Toolkit was developed through a detailed review of available literature, extensive consultation with people with lived and living experience (PWLLE), service providers who support people who use substances, other industry experts, and learnings from our own implementation experience. As of January 2023, 55 individual consultations were completed with 31 people who use substances and 24 individuals who support people who use substances as a service provider.

Although the practices identified throughout this document are best aligned with the principles of harm reduction, the evidence-based nature of these recommendations benefit any service provider supporting people who use substances. To find value in this content, it is not necessary to identify as an organization or program rooted in harm reduction.

In pursuit of this project, it was noted that while practices for supporting people who use substances are clear, how to implement these practices within an organization are significantly less clear. This was particularly evident in consideration of employing people with living experience (that is, people who are presently using substances) in positions such as peer worker roles.

In general, key considerations for supporting people who use drugs (PWUD) should include:

- Engaging in best practices for supporting PWUD, including getting to know the stories and lived realities of people who use substances, and providing services in a non-judgemental and low-barrier manner,
- Looking to PWUD for advice on program design so programs better meet their needs,
- The meaningful engagement of PWLLE in program delivery, such as facilitating opportunities for people to share their lived experience and obtain employment with the organization.

For organizations, the meaningful engagement of people who use substances is a fundamental component of creating sustainable programs for supporting people who use substances.[1] Employing PWLLE is integral in developing and implementing both client-centered programs and organizations.[1] Staff members with lived and living experience can assist in providing services to other members of the community and can increase the trust

and credibility of organizations to service users. By providing unique knowledge and insights, PWLLE also build capacity within organizations to connect with potential clients who otherwise may not access their services.[1] Organizations looking to utilize a peer-based service delivery model should consider these aspects and evaluate their organizational approach prior to hiring PWLLE to mitigate and reduce harms that could unintentionally be caused by biased policies and practices, culture, or a lack of knowledge on how to work with PWLLE.

Although the employment of people who are presently using substances is clearly identified as a critical component of success in the engagement of people who use substances, the service providers we spoke to during the consultation process expressed hesitancy to pursue this, primarily due to concerns relating to being able to provide sufficient support for the employee and other team members, and risk management concerns for the organization. As such, a significant portion of this toolkit is dedicated to the employment of persons with living experience.

Further detailed throughout the toolkit, key considerations for employing people with lived and living experience include:

- Organizational readiness – assess your organizational value alignment with employing PWLLE; assess your organization's preparedness to undergo change; assess potential barriers, including financial resources; and assess what change management needs your organization and teams may have.

- Preparing the organization for recruitment and employment of PWLLE – employment policies and processes should be reviewed with a lens that considers the needs of PWLLE and in consultation with PWLLE. These include recruitment strategies, hiring process, onboarding and orientation process, staff training and development, salary grids, supervision needs, and general policies and procedures.

Additional points for consideration include:

- Flexible attendance policies when employing PWLLE, especially those who may be new to the workforce, should be considered.

- Fit for Work Policies should consider all forms of impairment in the workplace. A clear definition of what is meant by impairment should be provided. Organizations should make their expectations related to workplace impairment clear, while working with staff who use substances to understand their needs and what impairment looks on an individual basis.

- Regardless of where they are in their journey of wellness, experiences of trauma can cause PWLLE to be triggered. As triggering events are individual and often unpredictable, supervisors and the organization must work from a trauma informed approach and actively work with employees to help reduce any potential for re-traumatization or triggers within the workplace.

- Boundary setting is not an inherent skill and staff with lived or living experience may need additional guidance in knowing when and how to set and maintain boundaries with their clients. In addition, employees with lived or living experience may feel an obligation to disclose details about their lived experience with clients. Supervisors should work with staff to help them understand how and when self-disclosure may be appropriate.

- Stigma from service providers has a negative impact not only on clients who use substances, but also on staff members who use substances. Organizations must build capacity to reduce stigma and unconscious bias in the workplace.

The benefits of employing PWLLE are vast and mutually beneficial for all parties involved. For PWLLE, these benefits include the opportunity to enhance their capacity and confidence, build practical job skills, share their knowledge, empower others through the normalization of experiences, and save lives.[2]

Introduction

This toolkit has been created alongside several complimentary and free SafeLink Alberta training sessions:

- Harm Reduction 101: Sex, Drugs, and Human Rights
- Substance Use 101: Substances, Safety, and Support
- Safer Substance Use Practices 101: Safely Equip Before Taking a Hit

We encourage you to sign up for these trainings here: https://safelinkalberta.ca/training-resources/

To assist you in navigating this toolkit, we have incorporated insights, examples, tools, and stories from our own implementation experiences throughout. As you read, note the inclusion of:

- Community Voices – valuable insights from people with lived and living experience,
- Best Practices – short summaries of key principles,
- Lessons Learned – learnings from our own implementation process, and
- The SafeLink Alberta Approach – areas in which we've found success, and offerings of our tools and templates.

We also welcome you to connect with our team directly. We would love to hear from you regarding your own experiences with implementing these practices and are happy to offer any additional insights or support that may be of value.

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Preparing Your Organization

Organizational Readiness

At an organization level, the best way to support people who use substances is through the meaningful involvement of people with lived or living experience (PWLLE) of substance use at all levels of program development, delivery, and evaluation. Recognizing and honoring the expertise of PWLLE and incorporating that expertise within the organization is the most effective way to enhance the pathways to care within social service organizations and to create systemic change. While some of these best practices require only relatively simple modifications at a program level, others are considerably more complex and may require consideration of organizational readiness for change.

The SafeLink Alberta Approach

Implementation of these best practices continues to be an ongoing process for SafeLink Alberta; change can be incremental.

Organizational readiness is an assessment of preparedness to undergo change, including consideration of the resources needed, potential barriers to success, and any change management needs. A readiness assessment usually assesses the following: project goals and objectives; expectations and concerns; leadership support of the project; ability to adapt to change; ways to minimize potential project failure, project governance and decision making; and other critical project needs.[3] Particularly for non-profit organizations, this will likely need to include advanced planning for any financial and budgetary impacts.

In implementing the practices identified within this toolkit, some areas for consideration include:

- Value alignment as an organization
    - Do your values align with the principles of harm reduction? Are these values applied in practice as well as theory?

Lessons Learned

The practical implementation of theoretical concepts can challenge your commitment to the principles of harm reduction. For example, are services equitable for people in recovery as well as those actively using substances (people with lived and living experience respectively)? Are engagement opportunities, including employment?

- Value alignment of employees
    - Are existing team members supportive of this work or are there change management considerations to undergo? Do teams have the capacity for additional training in areas such as unconscious bias?

- Financial resources
    - Do you have the resources to add peer employment roles within existing teams? Do you have the resources to provide sufficient cash honoraria when appropriate? Are your accounting and approval systems able to support cash transactions?

- Human resources
    - Who are the stakeholders involved in making decisions and in implementing any changes? Who is missing from those conversations? Do your leaders have the capacity to take on the mentorship of new employees with lived or living experience? Do your client facing teams have the capacity to be flexible with their service delivery approach and with each other?

Further information about each of these considerations are detailed throughout the toolkit.

As detailed below, organizations looking to utilize a peer-based service delivery model should consider their organizational approach prior to hiring PWLLE to mitigate and reduce harms that could unintentionally be caused by biased policies and practices, culture, or a lack of knowledge on how to work with PWLLE. Employers should focus on increasing equity and capacity building for PWLLE, as well as the possible redevelopment of organizational policy to promote equitable, anti-racist, and transparent practices throughout the organization.[2] It may be beneficial for organizations embarking upon this work to utilize the myriad of free online resources relating to organizational readiness and change management; refer to the *Additional Resources* section of this document for suggestions.

Frameworks and Position Statements

The core values and positioning of an organization have tremendous impact on how the organization supports and advocates for people who use substances. Creating and implementing frameworks and position statements can align organizational work and provide ongoing guidance in decision making.

Although there is no universal definition of harm reduction, Harm Reduction International defines it as:

> …"policies, programmes, and practices that aim to minimise health, social, and legal

impacts associated with drug use, drug policies, and drug laws. Harm Reduction is grounded in justice and human rights. It focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that people stop using drugs as a precondition of support".[4](para. 1-2)

In building frameworks and position statements, organizations should consider what harm reduction means to your team as service providers, how you define harm reduction, and in what ways you will utilize the concepts of harm reduction in your work.

Although harm reduction is rooted in ideas and notions related to people who use substances, the concepts of justice, human rights, non-judgemental supports, and reducing harms can be used with all stakeholders, including populations served and agency employees. Clearly outlining how the organization uses harm reduction can help build a strong framework of understanding of the practice and functionality of harm reduction within your team.

The SafeLink Alberta Approach

To view SafeLink Alberta's Position Statements, see **Appendix 1 and Appendix 2.**

Creating position statements within your organization can further your organizational core values and support your vision of systemic change and transformational justice. Position statements can be utilized as a means of translating the organization's values into your advocacy work and can further align the overall strategic vision of the organization with a broader community of advocates.

Language Matters

"Language is fluid and malleable; it drives social attitudes, rather than simply expressing them".[5](para. 11). The words we use and how we speak about people and concepts can either invite people into a relationship or further stigmatize and separate them. Although a simple idea, it is important to be mindful that language really does matter.

As we work towards building just societies, community driven language and our understanding of the most appropriate words to use in each situation continues to evolve. Using person first language is best practice in reducing stigma and creating inclusive communities. People are, first and foremost, people, and should be defined as humans rather than by their current situations or experiences of oppression. For example, identifying someone as a person who uses substances rather than a substance user communicates that

The SafeLink Alberta Approach

SafeLink Alberta continues to work with community to identify appropriate terminology that helps ensure our team is communicating in ways that build up community rather than stigmatize.

See **Appendix 3** for our current Language Matters document.

drugs are something they do, not something they are.

Language should also be intentional in its use. For example, slang terms related to substances or substance use equipment might be appropriate for rapport development within the community of people who use substances. Using street terms (or the language of a community) can communicate common ground and reduce power dynamics between a service provider and a service user. However, using slang terms with non community members, such as government officials or people in positions of power, while doing advocacy work can sometimes discredit the message.

Matching the language of the community can be both a positive and negative, depending on the situation. It can help with rapport development, and it can also unintentionally re-enforce negative self-image or dangerous stereotypes a person may have about themselves. For example, service users may often use stigmatizing language like “dirty” “addict,” or “junkie,” when self-identifying. These types of words can be self-empowering or can further diminish their value and self worth. Although correction of self-deprecating language may not be appropriate, service providers can utilize strength-based words to help the people they are serving to consider alternative identities and ways to think differently about themselves or others.

Education

Although post-secondary institutions are starting to incorporate more courses and professional development opportunities related to harm reduction and substance use, there is still a gap in service provider knowledge on how to impactfully and effectively support people who use substances. Organizations should consider including professional development opportunities related to these areas as part of their required training for staff. Ongoing capacity building in this way can empower staff with strategies and knowledge for support and can enhance the

Community Voices

Consultations with PWLLE and service providers both identified a lack of knowledge from service providers of the realities of substance use on people's lives.

Fact based education can help reduce barriers to care and increase connections to support.

The SafeLink Alberta Approach

SafeLink Alberta works with community to build training for front line service providers.

Our trainings are free, and we are happy to customize our modules to meet the needs of your team. For more information, please visit our website at safelinkalberta.ca.

physical and psychological safety of employees when working with people under the influence of substances. Developing a cultural competence around substance use can also create more welcoming environments for people who use substances, as service providers will have a stronger understanding of how to develop rapport and relate to the people they are serving.

Trauma Informed Care

Research suggests that there is an interconnectedness between experiences of childhood trauma, or Adverse Childhood Experiences (ACE), and the underlying mechanisms that contribute to the development of a substance use disorder. With each additional ACE an individual experiences prior to the age of 18, the likelihood of substance use disorder increases up to four times.[6] In Alberta specifically, people who are seeking treatment for substance use disorder have generally experienced 5 or more ACE's.[7] Understanding this reality highlights the need for a trauma-informed approach when working with people who use substances.

Trauma informed care is an organizational approach which assumes that everyone working within the organization and accessing services has some history of trauma. Trauma informed care shifts the approach from asking, "what is wrong with you? to asking, "what happened to you?". A trauma informed approach is not meant to clinically treat an individual's symptoms related to their trauma, but rather to recognize that trauma exists and to "provide support services in a way that is accessible and appropriate to those who may have experienced trauma".[8(para. 3)] The four basic principles of trauma informed care, as outlined by the Canadian AIDS Treatment Information Exchange (n.d.) include:

1. "Being aware of and understanding the prevalence and impacts of trauma,"
2. "Developing physical, emotional, spiritual, and culturally safer environments,"
3. "Creating opportunities for choice, collaboration, and connection within the service,"
4. "Promoting strengths and skill building and providing opportunities to foster resilience and individual coping skills."

The Canadian Public Health Association and Centre for Sexuality[9] have designed a resource titled Trauma and Violence Informed Care Toolkit for Reducing Stigma Related to Sexually

Transmitted and Blood-Borne Infections to support organizations seeking to build or enhance their capacity for trauma informed work with people who use substances.

Reducing Vicarious Trauma Amidst the Drug Toxicity Crisis

Community Voices

79% of PWLLE consulted in this project have either themselves experience a drug toxicity event or have been the first responder to someone else. Consideration must be given to mental health supports and the impacts of vicarious trauma.

The risks associated with vicarious trauma are not new to those working within the social services sector. Research suggests that Post Traumatic Stress Disorder (PTSD) rates for front line service providers who work with those experiencing houselessness, which are often those to access harm reduction services most heavily, to be 33% higher than the general population.[10] Furthermore, Canada's current drug toxicity crisis is amplifying experiences of vicarious trauma for front line service providers in ways that are not yet fully understood.

Organizations who employee people who are supporting people who are using substances must critically consider the impact of vicarious trauma, PTSD, and the drug toxicity crisis on the mental health of their employees and take measures to ensure wellness and wellbeing for staff in the workplace. Considerations should include proactive measures to help build resiliency, maintenance measures to support staff in self-care practices, and retroactive measures to encourage the emotional process associated with grief and loss.

How an organization works to counter vicarious trauma is driven by the values of the organization and the framework from which it operates. Utilizing a harm reduction and trauma informed approach can extend beyond how an organization works with people who use substances to how an organization works with its employees. The following are some ideas to help proactively help reduce vicarious trauma for staff:

- Paid time off, including sick days and personal days,
- Wellness days and challenges,
- Modeling of meaningful self-care from the leadership team,
- Employee benefit packages which include EAP programs and allowances for counselling and psychological support,
- Frequent (weekly) check-ins (individually and as a team),
- An open-door policy,
- Employer organized grief and loss sessions with trained professionals.

Additional resources to help address vicarious trauma in the workplace include:

- The Zone of Fabulousness: Resisting Burnout and Shouldering Each Other Up – Vikki Reynolds[11]
- Resources on Vicarious Trauma: Self Care and Strategies by Organizations to Support Wellness - Various[12]
- Vicarious Trauma & Self Care Toolkit – City of Toronto[13]

Enhancing Care for Service Users

Best Practices for Supporting People Who Use Substances

Best practices for supporting people who use substances start with looking at the human aspect of the community you serve. At SafeLink Alberta, we call this *treating people with humanity*. In their 2018 report, *Don't Be an A**hole; Best Practices for Health and Social Service Providers working with People Who use Drugs*, the Blood Ties Four Directions Centre Society synthesized their community-based research project and highlighted four key themes organizations should incorporate as best practices for support work; "warmth, trust, power, and accessibility."[14]

- Warmth includes compassion and authenticity from service providers, Open and welcoming body language, a friendly face, calling people by their name, and taking time to get to know people as individuals, are some of the ways service providers can show warmth.[14]

- "Trust reflects the [client's] estimation of trust as an essential precursor to developing a positive relationship".[14(p3)] Trust can include actions such as utilizing a trauma informed approach and maintaining confidentiality, but it can also include employing more people with lived or living experience whose own experiences may naturally strengthen the trust in the relationship through commonality.[14]

- "The theme of power encompasses the inherent power imbalance between social service providers – who act as gatekeepers for needed services – and clients".[14(p3)] Power includes service providers consideration of their own bias's and values within the work and the people they are supporting.[14] By recognizing and addressing the power dynamic within the relationship, service providers should shift to offer non-judgmental, respectful, and client-centered support[14]

- Accessibility takes into account the numerous barriers client's may face on a daily basis, and intentionally works to minimize these barriers.[14] Accessibility may include considerations around agency hours and service availability, as well as connections and supports to bridge the gaps with other services the client may be accessing.[14]

By focusing on the quality of our spaces and relationships, building trusting rapport through interactions and processes, identifying power dynamics, and delivering person centered services, and by literally and figuratively meeting people where they are, organizations can create spaces and services that better support people who use drugs.[14]

Long-term, regular substance use can impact an individual's brain function in a multitude of ways. Some of the more common effects of prolonged substance use may include a limited attention span, reduced memory acuity or the ability to process or recall information, limited impulse control, and reduction in abstract thinking processes, specifically those related to risk perceptions and consequences, decision making, or prioritizing actions. Client supports and organizational policies should be designed with this information in mind to help reduce barriers to service and to increase an individual's engagement and retention in programming.[15] Suggestions for program designs that best support people who use substances include:

- **Service times:** Research suggests that mornings, Mondays, and Fridays are times when individuals are less likely to access services, as these are periods where people are more likely to be high or coming down from using a substance(s) aka crashing.[15] Evenings and mid-weekdays are recommended as the most effective periods for connection to care or appointments.[15] Organizations should also consider offering supports on weekends.

- **Adaptable appointment policies**: Memory and recall can be impacted by prolonged substance use. As such, flexible "no-show" policies should be considered.[15] In addition, timely text or phone reminders (if an individual has a phone) could be helpful to remind people of an appointment. Reminders the day before or the same day are recommended.

- **Flexible, drop-in options**: Allowing an individual to drop-in to access supports rather than offering services through appointment only can help reduce barriers to care.[15]

- **Offer multiple services and supports in one location**: Integration of support services (food, emotional support, case management, harm reduction supplies, testing, etc) in one location may allow an individual to address multiple needs at one time.

- **Brief, short, or no intake forms**: Long-term substance use, specifically methamphetamine use, may cause an individual to react spontaneously to meet their own needs. Therefore, their ability to withstand external stressors or frustrations that can come with having to follow the strict or rigid processes often associated with

accessing services are low.[15] Consider what the steps are currently required to access services within your organization and ways you can minimize those steps to better meet the needs of the individual.

- **Limited wait time**: As an individual's attention span may be limited, their ability to wait may also be limited.[15] Efforts made to reduce any wait times within an organization may help successfully connect people to services.

- **Creative and dynamic approach to support, including physical movement and mindfulness of physical space**: Stimulant use, specifically methamphetamine use, can restrict an individual's ability to sit and talk with someone for a prolonged period.[16] Consider ways to allow physical movement where individuals can move freely while talking when providing support. This can include engaging in an activity such as playing a game, organizing items, or cleaning an area. Providing a physical outlet to accommodate high levels of energy can help further rapport development and ongoing support for people who use substances.

- **Not requiring sobriety to access supports:** A key principle of harm reduction is meeting people where they are. This principle can be included in agency and program practices by removing restrictions related to sobriety as a condition to accessing services. Requiring sobriety can perpetuate the false notion that substance use and social disruption or violent behavior are synonymous. This is a stigmatizing idea that is not necessarily reflective of the way substances impact behavior. Agency policies and practices can be utilized as tools to set behavioral expectations for clients and enhance safe working conditions without being connected to substance use.

Meaningful Engagement of People with Lived/Living Experience

Meaningful engagement of people with lived or living experience (PWLLE) is a foundational concept in harm reduction and an impactful way for organizations to engage service users who use substances. People with lived or living experience have a strong understanding of community needs and how to connect to folks who are often disconnected, and thus are instrumental in enhancing pathways to care. Meaningful engagement of PWLLE has proven beneficial to all parties including service users, the organization, as well as those with lived or living experience.[17-21] For organizations, PWLLE are effective and impactful

The SafeLink Alberta Approach

SafeLink Alberta believes in honouring the expertise of people with lived or living experience through cash honoraria.

See **Appendix 4** for our Honoraria Policy.

intermediaries whose knowledge can strengthen and enhance the relationship between service users and service providers.[22-23] For PWLLE, "benefits identified in the research include reduction in social isolation and the transmission of blood-borne pathogens, enhanced medication adherence, and improvement in mental health".[24(p.2)]

Best Practice

When asking people with lived or living experience to share their knowledge, organizations should honor their expertise appropriately by including costs in funding proposals and program budgets. PWLLE should be paid in cash for their expertise.

Many harm reduction organizations started as grassroots initiatives by the community and for the community and thus naturally included those with lived or living experience at all stages of program development, delivery, and evaluation. As organizations grow, allies and advocates often take the spaces of PWLLE, thus changing the organizational dynamic and inherent community driven knowledge that was once at the core of harm reduction work. Organizations should critically consider how to shift their models back to more meaningful inclusion of people with lived or living experience to best serve the needs of the community.

Volunteering is a common way for organizations to include people with lived/living experience in their work. Volunteers are a foundational component of many non-profit organizations, and their ongoing dedication and support is instrumental for these social service agencies to thrive. Furthermore, for people who use substances, volunteering in harm reduction organizations can help them to develop skills and the capacity needed to help them achieve employment.[25] It is important to remember, however, that "volunteerism is not sustainable and cannot remain the cornerstone long-term".[25(p.1)] Whenever possible, organizations should look to employ people with lived/living experience within their organization.

Lessons Learned

SafeLink Alberta is currently in the process of engaging community to ensure our longstanding Advisory Committee structure continues to include the meaningful (vs performative or transactional) involvement of PWLLE.

Meaningful opportunities to volunteer should be built into every level of the organization, from governance, to operations, to program directives. Prospects could include, but are not limited to, providing formal and informal education to service users, service providers, or other community members, outreach and distribution of harm reduction supplies, organization and facilitation of peer support groups, referral and resource navigation, involvement in community-based research development, or ongoing

involvement on advisory committee or organizational boards.[22] Being flexible, innovative, and creative with engagement opportunities can be part of meeting people with lived or living experience where they are and can facilitate options for them to utilize their knowledge and experience in meaningful ways. Offering one-time, on the spot engagement opportunities alongside longer term options can further help reduce barriers for people who may be interested in sharing their expertise but who are unable to commit to more time or resource intensive projects.

Sharing of Lived Experience

The SafeLink Alberta Approach

When facilitating opportunities for PWLLE to share personal experiences, consideration should be given to the psychological, emotional, physical, and virtual safety of the speaker. See Appendix 5, the Sharing of Lived Experience Handbook for an example of how we support our community members in storytelling.

Facilitating opportunities for people to share their lived experience is another great way to engage people with lived or living experience. This type of advocacy work can help those who hear the story to move beyond the research and best practices and truly connect to the cause. Sharing lived experiences is a powerful form of education and advocacy, one that combats stigma and empowers the speaker.[26] Organizations should continually work with interested community members to find ways to include them in storytelling advocacy work. This can be done through education, meetings and community events, blog posts, videos, and other public engagement opportunities.

Employing People with Lived/Living Experience

Integrated Knowledge through Employment

Community Voices

The utilization and effectiveness of peer-based service delivery models throughout Southern Alberta is still limited.

Since the 1990s, a large body of evidence has been compiled supporting the involvement of PWLLE in all aspects of harm reduction programing, including direct client support, prevention and outreach programs, and treatment programs.[2] Following these best practices, organizations are increasingly employing people with lived or living experience with substance use, knowing that the meaningful employment of people with lived and living experience will not only enrich their workforce and offer insight into real time realities faced by people who use substances, but also impactfully address Canada's drug toxicity crisis.[2]

The benefits of employing PWLLE are vast and mutually beneficial for all parties involved. For PWLLE, these benefits include the opportunity to enhance their capacity and confidence, build practical job skills, share their knowledge, empower others through the normalization of experiences, and save lives.[2] "Engaging in harm reduction service delivery as a PWLLE can help people who use substances feel that they are giving back to their communities by helping others, offers a source of income, and provides opportunities for work experience and employment references".[1(p.362)]

Best Practice

Organizations should consider formalized and standard work arrangements for their employees with lived/living experience. The lack of employment benefits often associated with casual roles can further perpetuate power imbalances for staff with lived or living experience, thus "perpetuating the socioeconomic insecurities and inequities of {people who use drugs}"[27]

For organizations, the meaningful engagement of people who use substances is a fundamental piece of creating sustainable programs for supporting people who use substances.[2] Employing PWLLE is integral in developing and implementing both client-centered programs and organizations.[1] Staff members with lived and living experience can

assist in providing services to other members of the community and can increase the trust and credibility of organizations who employ them to service users. By providing unique knowledge and insights, PWLLE also assist organizations to connect with potential clients who otherwise may not access their services.[1]

Although the reciprocal benefits of employing PWLLE are well documented, challenges associated with peer-based service delivers models have also created negative and harmful experiences for PWLLE who are hired as employees. Individuals employed under these models have shared experiences of tokenism, inequalities, stigma and discrimination, discounting of skills and capabilities, wage inequities, and re-traumatization in the workplace.[2]

Organizations looking to utilize a peer-based service delivery model should consider these aspects and evaluate their organizational approach prior to hiring PWLLE to mitigate and reduce harms that could unintentionally be caused by biased policies and practices, culture, or a lack of knowledge on how to work with PWLLE. Employers should focus on increasing equity and capacity building for PWLLE, as well as the possible redevelopment of organizational policy to promote equitable, anti-racist, and transparent practices throughout the organization.[2]

Preparing the Organization to Hire People with Lived/Living Experience

Prior to taking the initial steps in hiring people with lived or living experience, organizations must be well-prepared for the challenges and opportunities employing a person with experience of substance use may bring. Due to the diverse back grounds of people who use substances, a trauma informed, harm reduction lens should be utilized in all aspects of the organizational structure to best support their needs. Consideration should be given to recruitment strategies, hiring process, onboarding and orientation process, staff training and development, supervision needs, as well as to general policies and procedures.

Best Practice

Intentional organizational readiness prior to hiring people with lived/living experience of substance use is critical for success.

Employment Policies

Organizations should critically review their existing policies and procedures and consider how internal processes may enhance the safety of PWLLE as well as existing staff. Policies should not only comply with provincial and federal law but should also reflect the needs and real-life experiences of all team members. Consider any areas that may be oppressive or stigmatizing for people who use drugs.

Hiring versus Contracting Employment

Best Practice

PWLLE should be compensated for their knowledge and expertise fairly and equitably. Hourly rates or salaries should be in-line with the wages paid to employees without lived experience in similar roles.

As previously discussed, meaningful engagement of people with lived and living experience should happen at all levels of the organization and in a variety of ways. While some engagement opportunities are best captured under a contracted/consulting role and paid via an honoraria or a consulting fee (e.g. one time project consultation, ad hoc sharing of lived experience as a form of public advocacy, advisory committee/working group engagement, etc.), other engagement levels may be more suited to the role of an employee. Best practice, when deciding on employment verses consultant, is to consider the level of client engagement and support the individual would be offering and if a similar position already exists within the organization for people without experience of substance use. If there is direct client contact, or if the role already exists within the organization, the best practice would be to hire the individual as an employee rather than to engage them through contract or honoraria-based positions.

Compensation & Benefits

Lessons Learned

The compensation grid within many organizations is built around a combination of education and relevant work experience. Consider on how or if lived experience can be equitably included within this structure is needed.

Regardless of whether PWLLE are engaging with the organization on an ad hoc bases as consultants or employed by the organization, "equal pay for equal work"[2 (p.12)] is one of the most recurrent recommendations when considering appropriate compensation. The potential for compensation inequities among PWLLE is concerning, especially considering the drug toxicity crisis across Canada and how PWLLE are being propelled into addressing this emergency as a front-line peer worker.[28] Peer workers are often offered little emotional, operational, or financial support within their roles, leading to needlessly high levels of pressure, burden, and trauma.[28] Peer-based programs fall under the banner of "harm reduction", however, peer workers still may not evade the socioeconomic marginalization and structural inequities that people who use drugs face in other job environments.[28]

PWLLE often encounter precarious working conditions. That is, they are often forced to accept nonstandard work arrangements, employment insecurity, low wages, and few to no benefits.[28] These nonstandard work arrangements often lack formal contracts and produce low worker control over wages, hours, and unstable working conditions.[28] They often negate

workers' rights, their social benefits such as sick leave and vacation pay, leaving PWLLE vulnerable to exploitive working conditions and other forms of labour inequity.[28]

Organizations must consider wage equity, employee benefits, vocational training, and ongoing employee support for PWLLE as part of the compensation and benefits structure and their overall budget planning. These considerations should be included into standard operational practices and program budgets prior to hiring PWLLE.

Scheduling and Absenteeism

Policies and practices related to scheduling and absenteeism should also be considered when employing PWLLE. People who use drugs are often negatively impacted by social determinants of health, which are linked to health inequalities.[29] For people who use criminalized drugs, and who are also experiencing socioeconomic marginalization, poor health outcomes are exacerbated by the complexities of inequitable social determinants of health.[29] Proper consideration must be given to staff living with chronic health conditions, such as HIV, tuberculosis, viral hepatitis, and other conditions that may or may not be associated directly with substance use, such as diabetes.[30] Some staff with lived or living experience using substances may need to be offered flexible hours and time off with little notice to allow them to attend medical appointments associated with specific healthcare treatments.[30]

Best Practice

Organizations should consider flexible attendance policies when employing PWLLE, especially those who may be new to the workforce.

Lessons Learned

Flexibility when scheduling new peer outreach workers, or scheduling an additional staff to each shift, can be an effective way to support new hires as they develop their capacity to work within set schedules.

Substance use disorders are often associated with other mental health issues that may affect someone's ability to work. For example, "36%-40% of young adults in treatment for substance use or mental health conditions meet dual diagnosis criteria".[31(p.769)] Common mental health concerns associated with substance use may include depression, PTSD, and Generalized Anxiety Disorder.[31] People who experience comorbid disorders may have increased self-management requirements and are at a greater risk of experiencing negative outcomes that may cause absenteeism.[31] Co-occurring substance use and related disorders can cause symptoms such as fatigue, cognitive issues, profound feelings of sadness, numbness, impulsivity, paranoia, irritability, problems relating to others, and being physically ill.[32] The increased potential of staff with lived/living experience needing unplanned and/or unannounced time off, due to these comorbid issues, needs to be

approached through ongoing support and flexibility rather than rigid policies and procedures which may threaten employment for those who cannot fully comply.

Impairment in the Workplace

Organizations working with people with lived and living experience should consider their approach to substance use in the workplace and what assumptions they may have about substance use and impairment. Organizations should make their expectations related to workplace impairment clear, while working with staff who use substances to understand their needs and what impairment looks on an individual basis.

Best Practice

Fit for Work Policies should consider all forms of impairment in the workplace. A clear definition of what is meant by impairment should be provided.

As per Canadian Occupational Health and Safety, for the safety of themselves and others, staff should not be impaired while at work.[33] Staff who regularly use substances should not attend work if their substance use impairs their ability to work safely.[34] Symptoms of impairment, such as fatigue, paranoid episodes, inappropriate behaviours, or physical symptoms such as lack of coordination, can make the workplace unsafe. These symptoms cannot be ignored and should always be addressed by a supervisor immediately.[34]

Lessons Learned

Use of substances does not necessarily equate to impairment in the workplace. Understanding a staff member's baseline of substance use and what they need to maintain wellness can change the conversation of workplace impairment and create safer work environments for everyone.

Although these symptoms may be associated with substance use, they can also by caused by prescribed medications, or other health concerns like anxiety, depression, or grief.[30] As such, a supervisor should never assume that a workplace impairment is due to substance use. Supervisors should focus on the employee's ability to work and any signs of impairment they are noticing, rather than assuming or accusing them of being "high" at work.[34] "A focus on perceived or assumed drug use only serves to single out employees who use drugs" and can cause staff to not be open and upfront about substance use with their supervisor.[34(p.18)]

The SafeLink Alberta Approach

SafeLink Alberta has clearly defined a wide variety of situations which may cause impairment in the workplace and will work with staff to address the root causes of impairment while keeping everyone safe at work. See **Appendix 6** for our Fit for Work policy.

Some staff with lived or living experience may not be able to function and/or may become physically ill unless they are using certain substances and taking them at specific times.[33] For example, some people who have an opioid use disorder may need to use every four to six hours to maintain wellness.[34] In all situations, substances should not be consumed, nor stored, on work property unless they are prescribed by a physician (prescriptions may include, for example, methadone, suboxone, and antidepressants.[34] Best practices recommend employers provide employees with a lockbox or locker to store prescription medications if there is a concern over potential theft of prescribed substances.[34]

Harm reduction organizations who employ PWLLE must recognize that some staff may have times in their lives where they find it challenging to manage their substance use, to the extent that it may become an issue in the workplace, causing missed shifts or an increase in absenteeism.[30] In these situations, supervisors should work to support staff to manage their substance use in a way that does not have a negative impact on their work performance.[30] International HIV/AIDS International[30] suggests that supervisor's invite staff to meet and review their substance use, discuss how both parties perceive the impact on staff performance, restate the organizations standards and codes of conduct (without shaming the employee), and mutually discuss an effective way to move forward.

Best Practice

Conscious consideration of how the job title "peer" may impact the staff member who carries it is important.

Job Titles and Role Clarification

Consideration should be given to what job title will be given to an employee with lived or living experience. Although the term "peer" is commonly used throughout the industry, this term can have both positive and negative impacts on workers with this job title.[25] The positives associated with this term have been connected to feelings of value, particularly when working with people who use substances.[25] To their peers, the 'peer' title identifies that PWLLE "hold specific value in their connectedness to

Lessons Learned

Removing "peer" from a job title can have both a positive and negative outcome for employees with lived and living experience.

community"[25(p.26)], giving an overall sense of purpose. Furthermore, the title 'peer' can make staff with lived or living experience more approachable to client's, relay their expertise of substance use thus making them more relatable to people who use drugs, and can help negate power dynamics often seen in a service provider/ service user relationship.[25]

Community Voices

There are many alternatives to the job title of Peer. See best practices document *Hear Us, See Us, Respect Us*[25] for alternate job title

At the same time, the term 'peer' can also have a negative impact for staff with lived or living experience. Amongst others within healthcare and social service sectors, the term 'peer' is often considered less than due to a lack of formalized education.[25] The title can also "out" the staff member who holds it, identifying them as an individual with a history of substance use by title alone and removing their discretion to self disclose or not.[25] Individual's who have been given the job title of 'peer' have also disclosed that the title made it harder for them to gain employment outside of the field of harm reduction.[25] Research has also suggested that the job title of 'peer' can contribute to a form of internalized stigma, causing the staff member holding that title to limit themselves and their work capacity within the peer role alone and to not envision growth beyond that title within the organization.[25]

The SafeLink Alberta Approach

Collaborate with staff with lived or living experience to determine what job title they would prefer and be open to using different titles based on the situation. For example, one role may have more than one title (e.g. Peer Support Worker/Outreach Worker).

The role, scope of work., and expectations for peer-based roles should be made clear both to the PWLLE as well as the broader team. Having a clear job description can help the individual to understand what the organization's expectations are and help them to establish boundaries within the role. When establishing the scope of work, it is important to provide opportunities for PWLLE to utilize their existing knowledge while also providing opportunities for them to build and develop new skills. Everyone within the team should work collectively to not tokenize these employees. PWLLE have expertise and knowledge related to their own experiences of substance use, but they cannot and should not be expected to speak as an expert is all things substance use.

Technical Requirements

As the work world moves towards a stronger virtual presence, particularly as a result of the COVID-19 pandemic, many organizations now observe increased relance upon technology.

With this, expectations for staff to not only possess, but also be competent in using, laptops, cell phones, and online meeting platforms have also increased. Organizations which require the use of any personal technology as part of a staff member's role within the organization should consider stipends or other financial supports related to the cost of owning and maintain such technology. In addition, trainings on how to use virtual meeting platforms, as well as on-line meeting etiquette, should also be included as part of the employee onboarding and orientation process.

Criminal Record Checks

Depending on the province in which an organization is located, requesting a criminal record check is often part of the screening process for new employees. Given the disproportionate rate in which people who use substances encounter the justice system, they are often faced with an extensive range of charges which may or may not be directly related to the role for which they are applying. As such, organizations need consider how they view potential candidates who may have previous criminal charges. Rather than a blanket statement prohibiting the hiring of an individual with a criminal record, organizations should be willing to engage the candidate in a discussion about their criminal record and, through that discussion, decide if past convictions pose a threat to the safety of the organization and the work the individual is applying for.[35] Informing candidates of how the organization may handle past convictions in the job posting itself may encourage potential candidates with a criminal record to apply for a role, knowing they will not be omitted from consideration based solely on these convictions.

The SafeLink Alberta Approach

To see how we inform potential candidates of our criminal record check approach, see **Appendix 7** – Harm Reduction Outreach Worker/Peer Support Worker Job Description.

"Stable employment and all the benefits that stem from employment are protective factors against future offending".[36(p.20)] Employment is an effective support for re-establishing people into society and decreasing the risk of recidivism.[37] Individuals who find employment, despite a criminal record, are twice as likely to avoid involvement with the criminal justice system than those who are unable to find employment.[37] PWLLE who find employment are not only shown their own value, but also empowered to have a voice among those who are considered "experts" in the harm reduction field.[2]

Best Practice

Do not omit potentially great candidates for employment based solely on a criminal charge or conviction.

Unfortunately, people with criminal histories generally face substantial challenges obtaining

employment. Criminal record checks not only exacerbate challenges faced by individuals who have been involved in the justice system, they also disproportionately impact groups already marginalized in employment due to systemic racism, such as Indigenous and African, Caribbean, & Black (ACB) individuals.[38]

For organizations looking to employee PWLLE, it is recommended that they create a policy which clearly established which crimes may automatically disqualify a potential candidate from being hired.[38] In addition, policies and procedures should be developed to ensure that any information obtained through the criminal record check is kept confidential.[38] When applicable, the hiring organization should provide candidates time to review and challenge their criminalized past and submit evidence and documentation of mitigation and rehabilitation if applicable.[38] It's important to note that working in human services and under a philosophy of harm reduction does not negate the influence of bias.. As such, those involved in recruitment and employment offers should be provided with anti-discrimination, implicit and unconscious bias, and other training that address myths and misperceptions related to individuals who have criminal records.[38]

Community Voices

Searching for employment opportunities on recruitment websites like *Indeed* may not be where people with lived or living experience are looking for jobs. Word of mouth and job posting on community boards may be a more accessible for those in the community.

Preparing to Recruit

When planning to hire staff with lived and living experience, organizations need to consider how to effectively recruit, interview, and assess candidates, and need to have well thought out hiring policies and procedures in place.[38] Additionally, all staff who will be involved in the hiring process and/or supervision of the applicants should receive training how to conduct effective interviews with PWLLE.[38]

When preparing to hire an individual into a peer-based role, the organization will need to consider whether they are looking to hire individuals with lived experience, or if they are also open to hiring people with living experience. An individual with lived experience has a history of substance use, but is not, at present, actively using substances. In contrast, a person with living experience is presently using substances. It is important to recognize that abstinence from substances may not be a part of an individual's wellness journey.[39]

Regardless of where a potential candidate is in their wellness journey, organizational policies and practices should be written through a trauma-informed, harm reduction lens, acknowledging that any member of their team, either a PWLLE or a staff member who has

never disclosed substance use in their personal life, has the potential to use substances. Creating a cultural of safety and support can help ensure the organization is prepared to respond to staff needs related to substance use when and if they arise.

Lesson Learned

Drug trends in Canada are evolving rapidly and continuously. Employment of people with ***living*** experience provides invaluable opportunity for real time experiences and responses that are applicable within the context of today's challenges (i.e. Canada's current drug toxicity crisis).

Employment of people with ***lived*** experience provides someone who is in a different stage of their wellness journey and who may be able to offer retrospective counsel and insight to clients as they contemplate change and continue to move through their own journey of wellness.

Both experiences provide value to an organization's workforce and the client's they serve.

For some individuals, there may not be a clear delineation between what lived or living experience means. The term 'lived experience' may capture a past relationship with substances that no longer exists but does not necessarily mean substance are no longer used. Allowing for individual self-identification is vital.

Personal Attributes of PWLLE

For peer-based roles, recruiters should be seeking a candidate who identifies with experiences related to substance use.[40] In addition, candidates with lived or living experience should be in a position where they can provide support to others. They should also possess a high level of self-awareness.[40] This awareness should include what they are like when they are feeling well and how they are when they are not feeling well or have been triggered.[40] Self-awareness is vital in ensuring employees can recognize when their wellness is being affected poorly and when they need to take a step back. "Furthermore, expertise in using self-care practices will help them maintain personal wellness while stepping into the role of

The SafeLink Alberta Approach

See **Appendix 7** for SafeLink Alberta's sample job description for a Harm Reduction Outreach Worker/ Peer Support Worker.

support provider".[40(para.5)] Candidates should also possess the ability to maintain professional boundaries, uphold confidentiality, and engage in critical thinking practices when necessary.[40]

Pre-Screening & Scheduling an Interview

As with other roles within the organization, best practices recommend starting the interview process with pre-screening through a phone call, email, or informal discussion.[34] Pre-screening is used to establish that the candidate meets the basic criteria of the role and aligns with the organizational culture.[34]

Best Practice

Provide options in the interview process to reduce any technical barriers that may exist.

Candidates who advance beyond the initial screening should be invited to proceed to the formal interview. When scheduling an interview, candidates should be offered a choice about how the interview will be conducted, via Zoom or another virtual option, telephone, or in person.[38] Providing options to the candidate will assist in eliminating potential barriers such as access to stable internet, a computer, or cell phone minutes.[38] Candidates should also be told about the format of the interview in advance including how many people will be conducting the interview and how long the interview is estimated to take.[38]

Interviewing

For organizations that utilize an interview panel as part of their hiring process, it is preferable not to over-staff the panel when interviewing candidates for a peer-based role.[40] Avoiding this over-staffing can help ensure the interview process is not unnecessarily emphasizing any power dynamics.[40] Organizations may also want include a PWLLE on the interview panel as it could help the potential candidate to feel more comfortable during the interview and can help to ensure the successful candidate is going to resonate with service users.[40]

Lessons Learned

Consider that potential candidates, particularly those with living experience, may have little to no interview experience.

In addition to the typical interview questions an organization may ask, it is recommended that the candidate discuss their reactions to fictional scenarios or role-play, which will provide a glimpse into the candidate's ability to work as a team and to build on the strengths of their potential co-workers.[34] This is often known as Behavioural Interviewing. Important details taken from the fictional scenarios or role-play should be considered. For example, do they dominate a conversation or listen? How effectively can they express an opposing opinion without criticizing?[34] How aware are they of their own beliefs, experiences, and biases and the ways in which they may influence how they provide support?[34] Interviewers may also ask the candidate how their lived experience might apply to the position; however, they cannot ask about specific diagnoses or treatments related to this experience.[38]

Lessons Learned

Asking questions related to personal substance use, when screening and interviewing potential candidates, are not appropriate as they could be viewed as discrimination. Organizations can, however, ask for a candidate understanding of peer work and peer programming models.

For ideas on how to ask about knowledge related to peer-based models, please see **Appendix 8** - SafeLink Alberta's Sample Interview Guide for Harm Reduction Outreach Worker/Peer. Worker.

Interviewers should also be prepared to clarify the expectations and responsibilities related to the position, as well as discuss the organization. The organizational culture, applicable policies, and procedures, including potential benefits, flexibilities, and available wellness resources, and absenteeism and leave policies should be discussed during the interview process, or, if time does not allow, should be included when an offer of employment is made.[38]

Onboarding and Orientation

Onboarding new staff with lived or living experience should be consistent with the onboarding and orientation process for all new staff. Training on agency policies, procedures, data entry procedures, and other standard agency trainings like Mandt/Non-Violent Crisis Intervention or suicide intervention should be included as well. Onboarding, and ongoing supervision should also focus on enhancing front line or client facing skills through professional development opportunities such as crisis intervention, basic client support, trauma informed care, de-escalation, boundary setting, and counselling and support.[25]

Best Practice

Initial and ongoing professional development options should be provided.

In addition to standard onboarding trainings, staff with lived or living experience should also be provided trainings on safer substance use practices and safer sex practices and how to teach this information to client's who use substances. Trainings on sexually transmitted and blood-borne infections such as HIV and hepatis C should also be required as part of the onboarding process. New staff should also receive Naloxone training and be comfortable with administering Naloxone if needed.

Community Voices

In the 2021 report, *Hear Us, See Us, Respect Us* [25] people with lived/living experience of substance use who work in the social service sector created an extensive list of trainings which would further support their capacity in their roles. See page 23 of the document for further details.

Supervision and Staff Development

Not only does being employed in the harm reduction field empower PWLLE to find their own voice, it also allows for the potential to build on their existing knowledge and skill sets.[2] Skills such as communication, negotiation, and other life skills can be developed or enhanced through this work, along with the opportunity to learn more about diverse populations.[2] Additionally, staff are often provided the opportunity to enhance their knowledge of harm reduction strategies as well as increase their access to resources.[2]

Best Practice

Develop staff in areas outside of their lived experience.

Unfortunately, if not implemented intentionally, organizations employing PWLLE for their expertise may cause unintended harms to the employee, including burn-out, exploitation, tokensim, conflicting ideas around value and identify, and triggering events.[1] Organizations and staff supervisors must be mindful of these potential consequences and proactive in building safer spaces for their employees to grow and develop their professional identity.

Organizations who employ PWLLE without intention often lack the capacity to support professional development, failing to supply employees with lived or living experience with proper education and training.[41] When PWLLE are underprepared or when their capacity is not supported, they experience what is called "tokenism".[41] When feeling unsupported in their role, PWLLE often report feeling inadequacy, disappointment, and uncertainty in their roles, alongside a sense of feeling undervalued by the organization.[41]

When PWLLE do not receive adequate training and support, they often report feeling a decrease in their sense of pride, increase in feelings of adequacy, and a decrease in confidence because they are not receiving the same respect as those not hired based on their lived experience.[41] The skills which can be acquired through intentional professional development can support employees with the necessary tools to effectively perform their roles and can create a sense of empowerment for staff with lived or living experience.[41]

Many individuals who work as peers express that more training needs to be done to educate employers and supervisors about what meaningful engagement of PWLLE is, as well as how to use and apply expertise and lived experience within the organization.[41]

Lessons Learned

Many staff come to an organization with previous experience in the social services sector or post-secondary education related to the field. These experiences often bring acquired knowledge related to boundary setting, confidentiality, and general support skills. Organizations should not assume these are inherent skills or common knowledge and should work intentionally with PWLLE to enhance and develop skills within the field. The expectation that PWLLE will learn these skills naturally as they go may create a damaging work experience for staff.

Supervision Types

Due to heavy workloads and limited funding, it is not uncommon for effective and meaningful supervision and development of staff to be overlooked in social service organizations.[34] To ensure staff with lived or living experience are provided effective supervision, it can be helpful for agencies to establish specific expectations and guidelines for supervisors.[34]

Staff with lived or living experience benefit from being supported through several different types of supervision:

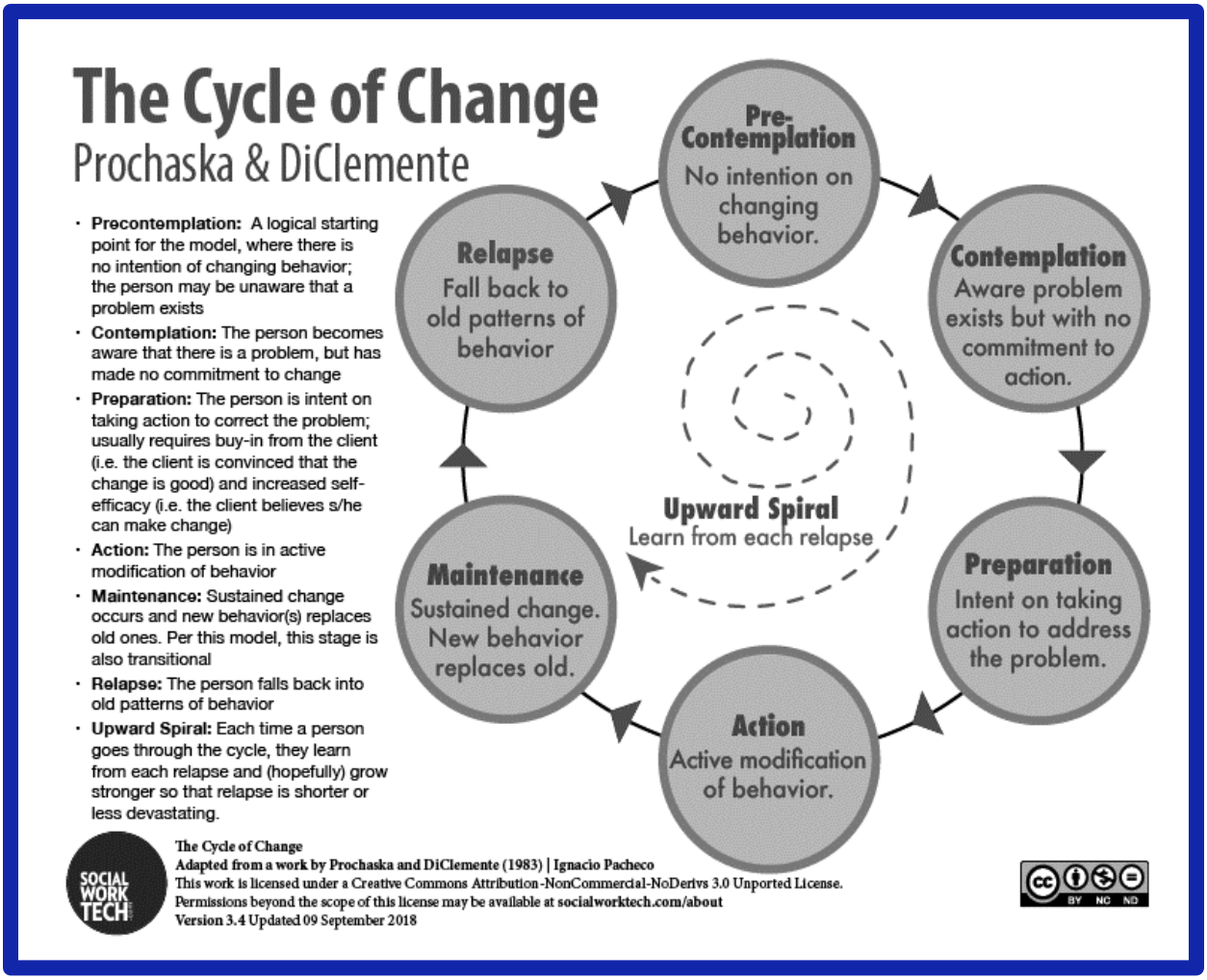
- ***Administrative Supervision –*** supervision focused on basic support associated with communication, administration, and coordination.[34] This form of supervision can include support with time management, planning and delegating work, coordinating tasks, reviewing deliverables, working with community, and effectively sharing information.

- ***Formative Supervision –*** supervision which assists in developing job skills and knowledge related to the organization, job requirements, and the profession.[34] This type of supervision can include identifying the knowledge and skills necessary to do the work, providing educational resources including professional and leadership

development, assessing strengths and growth opportunities, effectively using learning opportunities that arise in real situations, and training other staff on the roles of peer workers.

- ***Supportive Supervision*** **–** supervision which assists staff in developing their interpersonal skills and self-awareness, which in turn will enable them to effectively provide services while maintaining a healthy well-being.[34] This type of supervision can include ensuring meaningful self-care is practiced, recognizing achievements, advocating for and with staff, reassuring and encouraging staff, providing opportunities to debrief or express frustrations, offering different perspective, and building confidence when working with other staff.

Understanding the Stages of Change



When supervising PWLLE, knowledge of the Transtheoretical Model of Change[42] (the Cycle or Stages of Change) may benefit supervisors by creating a structured understanding of what employees may experience as part of their wellness journey. Understanding the Transtheoretical Model of Change[42] may assist supervisors in working with staff with lived or living experience to develop a strong work plan and, if needed, a safety plan.

Within the context of the Transtheoretical Model of Change[42], supervisors should keep the following considerations in mind:

- When in the ***Preparation*** stage, an individual will commit to taking responsibility to change.[42] Supervisors may need to assist their staff in developing a belief that they

can modify their behaviours.[42] It should be noted that the modification of behaviour does not necessarily need to involve substance use. For example, it may include showing up to shifts more regularly or taking on more responsibility at work. It is up to the employee and the supervisor to recognize readiness for change.

- During the ***Action*** stage, change is most visible, as the individual will modify their behaviour in this stage.[42] This modification often requires the most time and effort by the employee and their supervisor.[42] When the employee enters this stage, the employee and their supervisor need to allocate time to reassess the safety plan to ensure it is suitable and to minimize the potential risks associated with the work plan not turning out as intended. For example, if in the *Preparation* stage, the employee committed to limiting their substance use to only weekends, once in the *Action* stage, the employee would begin to implement this plan.[42] It should be noted that the *Action* stage is a process, not instant perfection, so adjustments in how the plan is implemented will likely need to be considered.[42]

- When in the ***Maintenance*** stage, individuals are often attempting to avoid certain situations or people that may interrupt their plan for change.[42] It will be important for the supervisor and employee to discuss potential interruptions in the *Preparation* stage as part of the safety plan.[42] Typically, people are said to be in the *Maintenance* stage after they've maintained their desired change in behaviour for six months.[42] For example, an individual continues to limit their substance use to weekends and to work through triggering events, while understanding that the plan they've developed must continuously evolve as they do.

- During the ***Reoccurrence/Relapse*** stage, an individual returns to the behaviours that they have worked to modify.[42] It is important to understand that this can be a very defeating stage to endure. As such, the supervisor should work with the employee during the *Preparation* stage to help them understand that returning to past behaviour(s) may occur.[42] No shame or blame should be placed on the employee, as there are always things which can be learned through the *Reoccurrence/Relapse* stage.[42] A discussion on how to keep the individual safe from feeling shame may need to occur.

An example of an individual entering the ***Reoccurrence/Relapse*** stage would be if, after a period of only using substances during the weekend, the individual begins using every evening after work.[42] It should be noted that often (although not always) there will be signs that an individual has entered the ***Reoccurrence/Relapse*** stage.[42] These may include increased absenteeism, mood disturbances, avoidance, and/or withdrawing from supervision. It will be important to address this stage honestly but with compassion, and in a way that does not increase the level of shame the employee may already be experiencing.

Community Voices

Although true to the language used in the original Transtheoretical Model of Change42, the term "relapse" can be a trigger word for some people, suggesting failure of their goals and plans. Consider the term reoccurrence rather than relapse when discussing the stages of change with PWLLE.

Understanding Dichotomous Identities

When employing people with lived or living experience of substance use in peer-based roles, it is important to consider how their identity may impact their role and what they believe about themselves. In roles such as these, individuals may become increasingly committed to their professional identity as a peer, with their self-esteem and understanding of their overall worth becoming increasingly dependent on success within their role.[43]

Research suggests that PWLLE who are employed by a harm reduction organization often carry with them two distinct identities.[1] The first identity is one of an individual who uses drugs and accesses harm reduction services.[1] Within this identify, they are part of the organization as a service user, accessing harm reduction supplies and supports as needed.[1] The second identity is one of a peer worker who provides services to others, thus making them a service provider.[1] If this is their first professional role, these employees (as well as other service users of the organization) often idealize what being a service provider means, incorrectly associating the role with no longer having bad days, no longer using drugs, and have their "lives together".[1]

The dichotomous nature of these roles, alongside misconceptions about what being a service provider means, can create identity challenges if individual behaviour runs counter to these misguided ideals.[1] These conflicting identities can lead to a reluctance of PWLLE to report triggering events and/or obtain harm reduction services from their employer, an increase in stress due to a pressure to perform, and resentment related to feeling stuck in positions that are dependent on their identity of substance use.[1]

Supervisors of employees with lived or living experience can help reduce risks associated

with these conflicting identities through the modeling of healthy behaviours for their staff. This can include, but is not limited to, transparency when having bad days, normalizing seeking help from others (personally and professionally), and debriefing critical incidents with all team members. Identifying and developing additional strengths and skills for staff with lived/living experience can also help to remove false notions that an employee's professional identity and value is based solely on their experiences as someone use who uses or used drugs.

Creating Opportunities for Growth and Professional Development

Another challenge often associated with the professional identify of employees with lived or living experience is difficulty in moving beyond their peer position and into positions that do not necessarily rely on their identity as a someone with a history of substance use.[1] For some PWLLE, peer-based work has been the only work they've been able to obtain, a reality that has the potential to make them solely focus on their history of substance use rather than seeing themselves as complex individuals.[1] As a result, it can be difficult for PWLLE to move on into other roles; they, as well as their supervisor, may overlook their value and/or potential.[1] In addition, some PWLLE report not feeling valued or taken seriously by academic "experts" or professionals in the field.[2] Despite their expertise and valuable lived experience, many PWLLE report receiving patronizing responses from those whose employment is not defined by their substance use.[2]

Supervisors must recognize these potential issues and support PWLLE in developing new skills and enhancing existing ones, allowing these employees to become more independent and to develop their professional identity outside of their identity as a person who used or uses substances.[1] In addition to specific educational training opportunities to enhance skill development, supervisors should also consider connection to practical trainings such as resume-writing or budgeting.[1] These types of skill development are beneficial, not only to assist in improving general life skills, but as practical supports they can share with other service users.[1]

Safety Planning with Staff

Similar to working with client's, supervisors should work with employees to develop safety plans that help minimize the risks associated with front-line work. By addressing hazards such as mental health concerns, triggers, and other psychological component with the physical work environment, supervisors can support an employee's overall well-being and professional success in the workplace.[44] Although required for all employees, an Occupational Health and Safety Hazard Assessment may not be sufficient for all (i.e. some might benefit from another format or a secondary document that is more relational). An effective safety plan should be created between supervisor and staff when stressors are not

present and the staff member is at their baseline.[45] Safety plans should be considered a living document which can be changed and modified as the employee and supervisor learn more about what does or does not work for the individual within the work environment.[45]

Utilizing a trauma-informed approach, supervisors should intentionally seek out opportunities to build staff capacity in understanding how the body reacts and responds to trauma. This can not only build a level of self-understanding for staff but can also enhance their capacity to work with other individuals with experiences of trauma. Dr. Dan Siegel's teachings on the *Window of Tolerance* can support the development of self-awareness and self-regulation for those who experience trauma triggers (https://www.mindmypeelings.com/blog/window-of-tolerance)[46] and may aid in creating a safety plan for staff.

The SafeLink Alberta Approach

Safety planning looks different for everyone. See **Appendix 9** for our Staff Safety Plan Template.

Supporting Triggering Events

An important consideration when it comes to supporting employees with lived or living experience are triggering events. Substance Use Disorder (SUD) is often a symptomatic response to a history or experience of past trauma. Experiences of trauma can make it a challenge for people who use substances to tolerate intense distress and/or emotional arousal, thus causing them to seek comfort and to self soothe by engaging in higher-risk activities such as the use of substances, self-injury, or exhibiting aggressive behavior.[47] Regardless of where they are in their journey of wellness, experiences of trauma can also cause PWLLE to be triggered by seemingly unrelated events which may be insignificant to others within the organization. As triggering events are individual and often unpredictable, supervisors and the organization must work from a trauma informed approach and actively work with employees to help reduce any potential for re-traumatization or triggers within the workplace.

To help manage the response, supervisors should ensure alternative activities and options are in place to support staff with lived or living experience as needed, particularly when they start to feel overwhelmed or when a situation becomes too triggering.[1] For example, the option to step away from a client care situation to work on supply packaging, cleaning, an administrative task, etc. for a time. Safety planning and in-the-moment debriefing opportunities can also help support staff with lived experience, especially when a client's trauma or reaction may cause a trigger or vicarious trauma response for the employee.

As triggers are individual, safety and support plans must also be individual and unique to each

employee. Supervisors and organizations should consider the following pieces to help mitigate triggering events and build strong safety plans:

- Clarify expectations about peer role duties and maintain flexibility around absenteeism and substance use so employees do not feel shame if they miss a shift or if they use a substance after a period of not using.[1]

- Remind staff with lived or living experience of the supports that are available to them.[1] These supports may be formal supports like an Employee Assistance Program (EAP), counselling services, other harm reduction organizations, the local distress centre, or the informal supports identified by the staff member in their safety plan.

Community Voices

When a PWLLE first starts with the organization, an increase in supervision is recommended. Check-ins should be done on the first day, after the third day, after the first week, and after the first month, and then continue regularly after that. Both formal and informal supervision can provide ongoing support to new hires to debrief triggering events.

- Remind staff with lived or living experience that triggers happen and they shouldn't feel ashamed if they miss a shift, need a break, or use a substance (within organizations policies & ethics).[11]

- Encourage staff to tell their co-worker or supervisor if they know approaching a specific situation, person, or group of people may be triggering for them. These identified triggers may also be included in their safety plan.

- Schedule regular check-ins to further build a relationship of trust within the supervisory relationship.

- Be prepared to reassign an employee to another task immediately if they find a triggering event has increased their risk or frequency of using substances.

Mitigating Conflict of Interest

A common task for a PWLLE is outreach outside of the office (i.e. street or community outreach), and it is not uncommon that service users in these spaces will be individuals who they currently use or once used substances with.[34] In such instances, staff with lived or living experience have greater likelihood of having a dual relationship with clients. Regardless of whether the staff member is actively using substances or not, supervisors should help staff understand the need to remain coherent, competent, and respectful while representing the

organization.[34] Ongoing reminders of the organization's standards and code of conduct, without shame or judgement, may be needed.

As there is a level of trust created between a staff with lived or living experience and the service user, it may be tempting for the staff member to purchase drugs from a service user.[34] This practice, however, should be considered a conflict of interest, as it creates a level of unbalance between the employee and the client.[34] For example, someone who uses the harm reduction services may feel indebted to the employee and offer drugs at a reduced price, which may cause issues with other members of their community.[34] Supervisors should support their employees in separating their personal substance use from their professional life as much as possible, while understanding the reality that their personal and professional lives may intertwine at times.[34] A work environment needs to be created where the employee feels safe to come to a supervisor when potential conflicts of interests are noticed and collectively work together to mitigate such conflicts.[34]

Boundary Setting

The professional roles of PWLLE are unique and multi-faceted, and at times people in these roles can feel pressure to perform duties outside their scope of practice, changing the way they relate with clients or deliver the service.[38] Signs of this occurring may include employee's focusing on a client's diagnoses or symptoms rather than their strengths and skills, offering advice rather than encouraging clients to make their own decisions, or beginning to feel insecure about being a person hired based on their experiences of substance use.[38] To help mitigate this, supervisors should work with staff to create ways to recognize and immediately address these issues, establishing clear boundaries and expectations.[38]

Community Voices

Collaborating with all staff to draft a code of conduct for the organization will further support team members in understanding the agency standards and best practices surrounding client supports.

To mitigate any potential conflict, supervisors should assist PWLLE to establish and maintain professional boundaries with clients.[38] The National Council for Wellbeing[38(p6)] recommends "boundaries being categorized into three types: 1) physical, such as personal space considerations; 2) mental, including thoughts and opinions; and 3) emotional, including feelings". Supervisors could consider building capacity within all three areas by offering regular check-ins, empowering staff to say no if they believe they are being asked to do something outside their scope of practice, validating staff's emotional responses and feelings, and identifying early signs of burn-out[38].

Because lived experience is critical in effectively working with people who use drugs due to

the mutual trust developed between the staff with lived or living experience and clients, it is not uncommon for boundary lines to become blurred.[38] As PWLLE often relate with clients on a more personal level then other employees and can offer relatable support during times when clients are experiencing a crisis, it can be difficult to differentiate where their personal and professional boundaries lay.[38] When boundaries are stretched beyond an individual's scope of practice, they are at higher risk of triggers, traumatization or re-traumatization, burnout, and creating adverse effects to their clients, co-workers, and the organization.[38] Supervisors must support PWLLE by teaching and empowering them to establish and maintain boundaries with the people they are now supporting.

Boundary setting is not an inherent skill and staff with lived or living experience may need additional guidance in knowing when and how to set and maintain those boundaries with their clients. Common boundaries that are often identified in peer-based models include:

- ***Previously existing or new friendships***
  - Friendship implies a mutual relationship. As staff with lived or living experience are now working in a support role on behalf of their organization, developing personal relationships with clients is not appropriate.[48] Supervisions should help PWLLE to understand the difference between being a friend and being a friendly support person and in establishing their boundaries with clients to reflect these differences. PWLLE should also be encouraged to notify their supervisor of a pre-existing relationship they may have with a client of the organization.[48]

- ***Conflict of Interest***
  - A conflict of interest occurs when a staff members personal interest(s) has the potential to compromise their judgement or actions. Supervisors should work to develop skills within PWWLE to identify possible conflicts of interest and help to ensure that staff member does not use their status to promote personal gain.[48]

- ***Providing Support vs Giving Advice***
  - PWLLE who are hired to support and assist with emotional support, system navigation, and wellness planning should be aware of their scope of work and the difference between providing support and giving advice.[48]

- ***Sharing Personal Information.***
  - To help enhance boundaries in the workplace, supervisors should remind staff that personal information, including home address, personal phone number, email, and social media should be kept confidential.[48] These types of boundaries are established to help keep staff safe and to reduce any expectations and vulnerabilities beyond that of a professional relationship.[48]

- ***Cultural Competency***
  - PWLLE will work with people from all walks of life. All lifestyles, identities, cultures, religions, cultures, and beliefs should be respected.[48] Supervisors should work with staff to build their cultural competency when working with diverse populations.

- ***Financial Boundaries***
  - Supervisors should support staff to establish boundaries and ensure they know it is not appropriate to borrow, lend, or hold any personal belongings for clients, including but not limited to drugs, money, cigarettes, and/or clothing.[48]

- ***Gifts***
  - Supervisors should re-enforce any organizational policy related to the giving or receiving of gifts to/from clients. Accepting a gift from a client may give the impression that the employee receiving the gift is being influenced to show favour or disfavour to someone and may create a power imbalance.[48] Supervisors should work with their staff to feel confident in respectfully declining the offer of gifts from clients without damaging rapport.

- ***Establishing Professional Relationships***
  - Supervisors should encourage and model how to develop professional relationships with clients as it relates to their scope of work. Interior Health Authority[48] recommends staff should be encouraged to:
    - Listen,
    - Empathize,
    - Give information, when appropriate and applicable to their scope of work,
    - Establish and maintain professional boundaries with clients and co-workers,
    - Empower and support clients to make their own decisions,
    - Use self-disclosure only when appropriate, keeping the focus on the needs of the client, and
    - Assist in navigating clients to appropriate resources if they require support.

As a PWLLE, employees may feel an obligation to disclose details about their lived experience with clients. Supervisors should work with staff to help them understand how and when self-disclosure may be appropriate. It should be made clear that just because an individual has lived experience, it is not the supervisors or the organizations expectation that

sharing personal details about their experiences with clients or other staff is a necessary part of their role.

Confidentiality

PWLLE may need coaching and development to understand what confidentiality is within a professional relationship and what steps an employee should take to ensure client confidentiality is maintained. Staff should also be informed of the organization's policies and processes and of the potential consequences for when there is a breach in confidentiality.

Addressing Unconscious Bias in the Team

In addition to professional development for staff hired to work within peer-based models, supervisors should also work with existing and new staff who do not have lived or living experience to address conscious and unconscious bias's they may have towards people who use drugs. Furthermore, people without lived or living experience should be made aware of what the peer worker's role is within their organization, the value of the role, be provided opportunities to learn from staff with lived experience and understand how to meaningful utilize their expertise without tokenizing or traumatizing. All team members should collaborate to bring the best services and supports possible to clients.

Community Voices

Stigma from service providers has a negative impact not only on clients who use substances, but also on staff members who use substances. Organizations need to work to educate staff and build their capacity to reduce stigma and unconscious bias in the workplace.

Although each team is unique, some of the more common concerns brought forward from employees without lived or living experience when first hiring for peer roles include:

Concern: *Will a staff with lived experience be absent more?*
Possible Response: All employees are allocated time off to accommodate sickness or other issues outside of their control. The same respect and opportunity will be given to our new employees. The reasons for time off request are between an employee and their supervisor. In all cases of absenteeism, supervisors will modify schedules or reallocate resources to meet operational needs.

Concern*: Isn't there a higher risk of someone with lived experience using substances and experiencing relapse?*
Possible response: There will always be a risk of relapse once a person decides not to use anymore. However, research consistently shows that people who use

substances are far less likely to begin using again, after a period of not using, when they are meaningfully employed.[35]

Concern: ***Can PWLLE be trusted with administrative demands?*** **Possible response:** Newly hired staff always benefit from a transition period during which they receive specific training and support to position them for success, and PWLLE are no different.[35] Some PWLLE may not have substantial work experience or at times may have limited educational attainment.[35] On-the-job training can give PWLLE the opportunity to learn and thrive at the administrative elements of their position.[35]

Concern: ***Will PWLLE cause harm by breaking client confidentiality?*** **Potential response:** All staff, no matter what program they are hired for, are expected to follow organizational policies and procedures related to confidentiality.[35] As is the organizational practice, supervisors will educate and support staff in developing an understanding of confidentiality within the workplace.

Concern*: Isn't there a risk that PWLLE will say something wrong to clients?*
Possible response: All helping professionals say the "wrong" thing at least once in their careers. There is no reason to believe PWLLE are more likely to say something wrong to clients than any other team member. In contrast, by virtue of their lived or living experience, it may be presumed that PWLLE staff are less likely to say something "wrong" and more likely to accurately assess the emotional needs and use language that will resonate with clients.[35] However, every person's life journey is different, and therefore saying something "wrong" is always possible; supervisors will work with staff on how to move forward with clients in those situations.

Concern: ***Will the addition of a PWLLE make my job more challenging?*** **Possible response**: Many studies have shown the effectiveness of peer support. PWLLE are especially effective in engaging clients and creating a bridge between service users and other team members.[35] Their work will decrease the workload carried by co-workers, enriching the lives of those who they engage with.[35]

Intentionality

Intention must go into hiring any employee who will work with vulnerable and marginalized populations. However, when hiring PWLLE for their expertise based on their personal substance use, extra care and attention needs to go into the hiring process to prevent traumatization or re-traumatization and to ensure their employment is meaningful and not tokenistic. Because there is the potential for power imbalance between PWLLE staff and clients, and because professional boundaries may become indistinct, safeguards need to be put in place before the organization begins to recruit PWLLE. When recruitment begins, policies and procedures need to be clearly stated prior to any new employee working with service users.

Lessons Learned

Many people come to the social services sector with a past history of trauma. There may be staff on your team with a history of substance use or trauma who have not disclosed this history to anyone within the organization. Although these best practices focus on employing PWLLE of substance use where that history is known, consider how these practices may benefit all members of your team.

Final Thoughts from the SafeLink Alberta Team

This toolkit has been a labour of love and a growth opportunity for individual team members and for our organization. SafeLink Alberta has long valued and prioritized the meaningful involvement of people with lived and living experience, but implementation of these toolkit elements elevated us to another level. In the last year, and as a direct result of the research and consultations embarked upon under this toolkit development, we revisited our longstanding advisory committee structure, implemented new policies and practices, intentionally moved program volunteers into employment positions, re-structured our compensation grid for employees and consultants with lived or living experience, adopted an approved Harm Reduction Framework to guide our work, and changed our overall intentionality regarding what meaningful engagement truly looks like. This process also brought about robust conversations that challenged our ideas around harm reduction philosophy and service provision norms and renewed our commitment to leadership in this field. This process was difficult and much more time consuming than anticipated, but at this point it's difficult to envision where our organization would be today without it; it's no exaggeration to say that this one funder output significantly impacted our organizational identity and practices. We are grateful to Health Canada and the Substance Use and Addictions Program for funding this work, and for the opportunity to share these learnings with you.

We would like to acknowledge the significant contributions of our employees, clients, stakeholders, and community partners in the development of this toolkit. Thank you for sharing your expertise and experiences as a service user, as a service provider, as an employee with lived experience, as an employer of people with lived experience, as a policy analyst, as a human rights professional, as an educator, as an advocate, as a content developer, and as a leader. We are honored to walk beside you on this journey.

In alignment with a journey metaphor, we would also like to acknowledge that this is not the end. The logistical implementation of best practices is an ongoing process, and our intention is to continue (to the best of our capacity) this conversation through toolkit content additions and updates. As such, we share this with you in a medium that allows for adjustment; please share the link to this page with colleagues and check back regularly for content updates. We also invite you to connect with our team for support in implementing these practices and welcome you to share experiences and recommendations in the review and use of these tools via the link on our website or by contacting us directly; all feedback welcomed.
Thank you for taking the time to review this content, we hope it helps you on your journey to reduce barriers and enhance pathways to care for people who use substances.

Additional Resources

Organizational Readiness:

- Equip Pathways – Rate Your Organization on Harm Reduction and Reducing Substance Use Stigma - https://equiphealthcare.ca/learn-more/substance-use-and-harm-reduction/rate-your-organization-harm-reduction/
- Canadian medical Association – Organizational Readiness Assessment (Canada Health Infoway) - https://www.cma.ca/physician-wellness-hub/resources/change-management/organizational-readiness-assessment-questionnaire

General

- Naloxone is Not Enough - https://ohrn.org/resources/naloxone-is-not-enough-letters-from-the-heart-of-the-crisis/
- CATIE – Harm Reduction Fundamentals: A toolkit for service providers - https://www.catie.ca/harmreduction

Lived Experience:

- Nothing About us without Us – A manifesto by People who use illegal drugs - https://www.hivlegalnetwork.ca/site/nothing-about-us-without-us-a-manifesto-by-people-who-use-illegal-drugs/?lang=en
- Hear us, See Us, Respect Us. Respecting the Expertise of People Who Use Drugs - https://zenodo.org/record/5514066#.Yxt5iHZMFkx

Crisis Supports for Staff

- Alberta Health Services Mental Health Help Line - 1(877)303-2642
- Distress Centre Calgary - 1(403)266-4357 - www.distresscentre.com
- Canadian Mental Health Association, Alberta South Region - 1(403)327-7905
- Canadian Mental Health Association, Edmonton - 1(780)482-4357
- Crisis Intervention & Suicide Prevention Centre of B.C. - 1(800)784-2433 - www.crisiscentre.bc.ca
- Distress Centres of Greater Toronto- 1(416)408-4357 or text 45645 - www.dcogt.com

Virtual Overdose Response Services

- National Overdose Response Service (NORS) - 1(888)688-6677 - www.nors.ca
- Digital Overdose Response Systems (DORS) - www.dorsapp.ca
- Brave App - www.brave.coop

Staff Development

- SafeLink Alberta Educational Training Modules - https://safelinkalberta.ca/training-resources/

Recommended Trainings for Supervisors

Motivational Interviewing Training:

Agency: The Association for Psychological Therapies[49]
Synopsis: The APT Motivational Interviewing Course will assist individuals in understanding when motivational interviewing should be applied. Each student will learn to generate motivation in staff who may need assistance in becoming motivated, while gaining an understanding of how to respect people's ambivalence about change and how to effectively work with it. This course will teach individuals how to respond constructively when staff is resistant to change and learn how to effectively and ethically give advice and strength-based feedback.

Cost & Format: Individual online and group courses available with fee structure based on choice.

For more information: https://www.aptcanada.com/motivational-interviewing-training-course.html#bookingoptions.

Agency: Centre for Addiction and Mental Health[50]
Synopsis: This course provides an overview of the four-process model of Motivational Interviewing. It is designed to prepare practitioners to implement the four-process model to diverse groups of individuals.

Cost and format: Online, on demand for fee training.

For more information: https://www.camh.ca/en/education/continuing-education-programs-and-courses/continuing-education-directory/motivational-interviewing-introduction-and-application-course

Appendices

Appendix 1: SafeLink Alberta Position Statement on Harm Reduction

Definition
Harm Reduction is the policies, strategies, and programs focused on reducing the harms caused by social, medical, and environmental inequalities which influence how people engage in higher risk activities associated with sexual activity and substance use.

Principles
SafeLink Alberta is grounded in a framework of harm reduction which guides the development and implementation of all programs and services. Although the theory of harm reduction is traditionally rooted in supporting people who use substances, the principles of harm reduction transcend substance use and benefit all members of our community. SafeLink Alberta utilizes this framework to reduce negative consequences or potential harms seen within the lives and experiences of the people we serve while working to build relationships and improve health outcomes.

SafeLink Alberta's framework of harm reduction is based on 7 key principles which shape and inform our work:

1. Harm Reduction is an evidence-based public health approach.
Harm reduction is a public health approach aimed at preventing HIV, hepatitis C, and other sexually transmitted and blood-borne infections. This framework recognizes that complex social structures, such as poverty, classism, racism, white supremacy, colonization, trauma, social isolation, health inequities, sex-based discrimination, and other social inequalities influence health outcomes for individuals. These forces affect people's vulnerability to, and capacity for, navigating the harms that may be associated with their experiences.
As a public health approach, harm reduction implements evidence-based policies, programs, and practices focused on reducing the health, social, and economic consequences often associated with these experiences of harm, while systemically advocating for changes to health inequities caused by social determinants of health.

2. Harm Reduction promotes human rights.
The foundation of harm reduction is rooted in dignity and human rights for everyone, as outlined by the United Nations Universal Declaration of Human Rights. Harm reduction recognizes that agency, choice, and autonomy are basic human rights that are often threatened by larger structural forces. In practice, a harm reduction framework promotes human rights by advocating for basic needs including food, clothing, safety, stable housing, access to health care, education opportunities, and social support and inclusion for all people, without discrimination or prejudice.

3. Harm Reduction focuses on reducing harm.
Harms exist within all aspects of the human experience. A harm reduction framework doesn't focus on abstinence or ceasing certain activities, but rather on working with individuals and their communities to minimize any negative health or social outcomes associated with these activities to improve their overall quality of life. This approach does not seek to ignore or mitigate the realities of harm associated with certain experiences. It does, however, encourage self-empowerment by meeting people where they are at, sharing education and resources, building relationships, and promoting autonomy so people can make informed decisions and lessen potential harms to self and the broader community.

Harm reduction also acknowledges that, due to inequitable social determinants of health, harms associated with sexual activity and substance use are not experienced equally across all populations. Stigma, social and institutional discrimination, and punitive legislation disproportionately impact vulnerable and/or marginalized community members. Harm reduction works to counter these systemic level harms by challenging policies and practices that perpetuate social inequities through community collaboration, education, and advocacy work.

4. Harm Reduction is pragmatic, practical, feasible, safe, and cost-effective.
Harm reduction centres on practical ways to help reduce potential harms associated with individual experiences and behaviours. Harm reduction supply distribution, including sterile syringes and pipes, naloxone kits, and safer sex supplies, combined with accessible education focused on safer ways to use these items, is proven to be an effective strategy to reduce disease transmission within our communities.

5. Harm Reduction prioritizes the meaningful engagement of people with lived/living experience.
Harm reduction is a transparent and accountable, community-driven approach that focuses on the active participation of people with lived and/or living experience, alongside community stakeholders, to shape policies, practices, and programs. Harm reduction recognizes that people are experts in their own lives and their own experiences and that, when offered meaningful engagement opportunities, that expertise can be used to create impactful change within their community.

6. Harm Reduction is non-judgmental and value neutral.
Harm reduction uses a non-judgmental approach that treats every person with dignity, compassion, and respect, regardless of circumstance or condition. Harm reduction does not impose individual values or social ideology related to morality onto others but uses evidence-based best-practice to inform the work.

7. Harm Reduction is adaptive and innovative.
A harm reduction framework recognizes that individual change is not a linear process, but a

dynamic, incremental evolution of self-discovery and transition. Therefore, an adaptive and innovative response from service providers must be continually practiced to effectively meet community members where they are at during each stage of their journey.

The ideas contained within this document have been inspired by the articles below:

Denis-Lalonde D, Lind C, Estefan, A. Beyond the buzzword: a concept analysis of harm reduction. *Research and Theory for Nursing Practice*. 2019;33(4):310–323. doi:10.1891/1541-6577.33.4.310

Hawk M, Coulter RW, Egan JE, et al. Harm reduction principles for healthcare settings. *Harm Reduction Journal*. 2017;14(1):1-9. doi:10.1186/s12954-017-0196-4

United Nations. Universal declaration of human rights. United Nations. 1948. Accessed October 11, 2021. https://www.un.org/en/about-us/universal-declaration-of-human-rights

Appendix 2 – SafeLink Alberta Position Statements

Decriminalization of Sex Work:

Position: SafeLink Alberta supports the decriminalization of sex work and opposes the continued implementation of Bill C-36, Protection of Communities and Exploited Persons Act and sections of the Immigrant and Refugee Protection Regulations in addition to all other municipal, provincial, and federal legislation that imposes violence on sex workers.
As an active member of the Canadian Alliance for Sex Work Law Reform (CASWLR), SafeLink Alberta (identified under the program name Shift, Calgary), supports and continues to advocate for the 49 recommendations for law reform as outlined in the CASWLR's *Safety, Dignity, and Equality: Recommendations for Sex Work Law Reform in Canada (2017).*

Decriminalization of HIV Non-Disclosure:

Position: SafeLink Alberta supports the decriminalization of HIV non-disclosure. SafeLink Alberta believes that people living with HIV and other sexually transmitted and blood-borne infections should be offered support, equitable access to treatment, and provided the resources needed to feel empowered to take control over their sexual health, rather than threatened with punishment under Canada's *Criminal Code* for non-disclosure of their HIV status.

SafeLink Alberta supports the Canadian Coalition to Reform HIV Criminalization (CCHRC), a national coalition comprised of people living with HIV (PLWH), community organizations, academics, and lawyers, and endorses their calls to reform Canada's *Criminal Code* and enact other changes to HIV criminalization as outlined in *Community Consensus Statement: Change the Code, Reforming Canada's Criminal Code to Limit HIV Criminalization.*[51]

Decriminalization of Personal Drug Possession:

Position: SafeLink Alberta supports the decriminalization of drug possession for personal use. SafeLink Alberta believes that substance use should be approached from a public health and human rights lens and that Canada's existing punitive drug laws are causing extreme harms within the community.

SafeLink Alberta supports the Canadian Drug Policy Coalition, and its supporting members, in their advocacy work for decriminalization of substances in Canada as outlined in *Decriminalization Done Right: A Rights-Based Path for Drug Policy.* In alignment with this document, SafeLink Alberta's support extends beyond decriminalization of personal drug possession to include national provision of low barrier access to safe drug supply, expungement of previous convictions related to personal drug possession; equitable access

to harm reduction services including recovery and treatment services, supervision consumption sites, and harm reduction supplies; prevention programs focused on addressing inequities and social determinants of health; anti-stigma and public awareness campaigns to support the shift in social attitudes towards people who use substances; and a National Strategy to address problematic substance use throughout Canada, designed through meaningful consultation and engagement of people with lived and/or living experience and allies.

Undetectable = Untransmittable:

Position: SafeLink Alberta supports the Government of Canada, the World Health Organization, and the global HIV Community in their call for a global declaration of Undetectable = Untransmittable. We acknowledge that the science is clear; an individual living with HIV, when taking their medication as directed by their physician, can achieve and maintain an undetectable viral load. Once an undetectable viral load has been achieved, the HIV virus cannot be transmitted to sexual partners.

Appendix 3 – SafeLink Alberta Language Matters Document, August 2022

SafeLink Alberta acknowledges that language is complex and ever evolving. This document will be updated regularly, annually at minimum, and will include input from agency staff, the SafeLink Community Collective, and people with lived or living experience.

This is not a comprehensive list and language in this document may not always reflect the language used by community members; in all cases, be respectful of those we serve by defaulting to their preferred terminology, particularly if it is requested that you do so. Use person centered language at all times.

USE	AVOID	NOTES
General Terminology		
Condomless sex	Unprotected sex	Condoms are only one way to protect against HIV/HCV/STI's
Key population	High-risk group	
High risk behaviour High risk activity	Risky behaviour	
Participant People we serve Community member	Patient	Avoid clinical language. Acknowledge in our language that participation in programs is voluntary.
Safer sex supplies Safer consumption supplies	Safe sex supplies Safe consumption supplies	Not safe, but safer.
Unhoused Houseless Housing insecure Without housing Street involved	Homeless	Home can be a feeling not a place; a home is much more than a physical space. Naming people as homeless implies that they don't have a place of belonging or community.
Partner	Husband/wife/boyfriend/girlfriend	Using gendered terms is okay when referring to specific individuals for whom identity is known to you, but 'partner' is more inclusive when speaking in generalities.

2SLGBTQIA+ - Two Spirit, Lesbian, Gay, Bisexual, Trans, Queer, Questioning, Intersex, Asexual, + other expressions. Queer Non-Binary Gender Non-Conforming Gender Fluid GBTQ+ cis and trans gay, bisexual, and other men who have sex with men Intersex	Homosexual Transsexual Transgendered gbMSM	Listing 2S (Two Spirit) first is done as an act of reconciliation. Queer has historically been used as a slur and may be offensive to some community members. To others, queer has been reclaimed as a broad term that is considered more inclusive than the acronym. gbMSM is widely used, but not inclusive to the trans community. Intersex individuals are born with sex characteristics that do not fit binary notions of male or female bodies (UN High Commissioner for Human Rights). Transgendered suggests that being trans is something that happens to someone, as opposed to an identity someone is born with.
Cisgender		Cisgender – gender identity matches the sex assigned at birth
Sexual orientation Gender identity	Sexual preference	Preference suggests choice.
Indigenous Aboriginal First Nations Metis Inuit Regional e.g. Blackfoot people	Indian, Native	Indigenous is the term used in the United Nations Declaration on the Rights of Indigenous Peoples and includes Metis, Inuit, and First Nations peoples. Indian is a term that has been a challenge since

		Christopher Columbus arrived in 1492, believing he had landed in India. Often used with negative connotation. Native does not denote a specific ethnicity, has a negative connotation, and is rarely used in respectful conversations. Can be used appropriately and respectfully in some context (e.g. people who are native to this land).
Global North or Global South Members of the Global Majority	First World, Third World	First world / Third world language helps reinforce power differentials in the way we speak about geography.
Sexual and Reproductive Health		
Person living with HIV	Person infected with HIV	
End HIV transmission	End HIV	
HIV transmissions/diagnoses/cases	HIV infections	
Contracted Acquired Diagnosed with	Became infected with HIV	
Died of AIDS-related illness AIDS-related death	Died of AIDS	
AIDS	AIDS virus	AIDS is not a virus. Acquired Immune Deficiency Syndrome is a medical term used to describe a condition caused by the HIV virus
HIV	HIV Virus	HIV = Human Immunodeficiency Virus. HIV virus is redundant.
HIV AIDS	HIV/AIDS	
HIV response	Fighting HIV	

People of reproductive age and ability Birther Parent/Birthing parent	mother, woman	Avoid gendered terms that are not inclusive of trans and non-binary individuals
Baby born to a parent who used drugs while pregnant	Addicted baby	
Chest feed/breast feed		Use both to be inclusive of female identified and trans and non-binary individuals
Front hole/Vulva and Vagina		Use both to be inclusive of female identified and trans and non-binary individuals
Substance Use		
Person who uses drugs Person who uses substances	Drug user Drug addict, Addict Junkie, alcoholic, drunk	Use person centered and non-derogatory language
Substance use	Addiction Drug habit Drug Abuse Drug problem	
Shared or unsterile needles/supplies New or sterile needles supplies	Dirty needles Clean needles	'Clean' contributes to stigmatization by implying that drug use is 'dirty'
Supervised Consumption Services Overdose Prevention Service/Site	Safe injection sites	Not safe, but safer
Sterile equipment Unused equipment	Clean needles	
Person not currently/actively using substances Person who has used substances Person in recovery	Clean Former addict	
Drug toxicity Drug potency Drug poisoning	Strength/Stronger Overdose	Use depends upon context. 'Stronger' has a positive connotation, potency is more neutral, and toxic highlights the danger.

		Drug Toxicity Crisis is used in place of Overdose Crisis to highlight the cause – deaths occur due to a toxic drug supply, not as an inherent side effect of substance use.
Naloxone	Narcan	Naloxone is the drug name, Narcan is a trade name (like Ibuprofen vs Advil)
Mental Health		
Died by suicide	Commit suicide	'Commit' originated when suicide was illegal and connotations of 'wrong', immoral, or offensive behaviour
Suicide attempt	Unsuccessful or failed attempt	Terms like 'unsuccessful' or 'failed' implies that survival is a failure.
Self harm Non-suicidal self injury		
Person living with Schizophrenia	Schizophrenic	Use person first language
Sex Work		
Sex worker People in the sex industry	Prostitute Hooker Victim Girls	Avoid stigmatizing or derogatory terms
Sex industry Sex work	Sex trade Sex trafficking Sexual exploitation	Sex work and sex trafficking are very different; these terms cannot be used interchangeably
Selling a service	Selling their body	Use language that reinforces sex work as work
Acronyms / Industry Terms		
PWLE/PWLLE	People with Lived/Living Experience	Lived experience is past tense, living experience is present – ideally both groups are included

PLWH	People Living with HIV	
PWUD	People who Use Drugs (substances)	
PWID	People who Inject Drugs (substances)	
ACB	African, Caribbean, and Black community	
Living Rough		Person who is experiencing homeless, sleeping outside, or precariously housed
SCS	Supervised Consumption Site	Supervised, not safe.
OPS	Overdose Prevention Site	
TaSP	Treatment as Prevention	The HIV prevention method that involves consistent use of antiretroviral treatment for people living with HIV to prevent forward transmission of the virus.
U=U	Undetectable = Untransmittable	The anti-stigma campaign promoting TaSP. If someone living with HIV takes their medication as prescribed and has an undetectable viral load, they will not transmit HIV to their sexual partner(s).
PrEP	Pre-Exposure Prophylaxis	A medication for people who want to prevent getting HIV from sex or injection substance use. When used correctly, this prescription medication has been shown to be very effective at reducing the risk of HIV infections.
PEP	Post-Exposure Prophylaxis	A combination of three HIV medications that an HIV-negative person takes for four weeks after a potential

		exposure to HIV to reduce their risk of getting HIV.
ART	Antiretroviral Therapy	A combination of medications use to slow the rate at which HIV makes copies of itself in the body. When used consistently, ART can cause a viral load to become undetectable.
iOAT	Injectable Opioid Agonist Treatment	An evidence-based intervention for people with sever opioid use disorder which is injected under medical supervision.
OAT MAT	Opioid Agonist Therapy Medically Assisted Treatment	OAT is an evidence-based intervention for people with sever opioid use disorder which is taken orally. (Examples include methadone, suboxone).
STI STBBI	Sexually Transmitted Infection Sexually Transmitted and Blood Borne Infection	
MIPA GIPA	Meaningful Involvement of People living with AIDS (HIV) Greater Involvement of People living with AIDS (HIV)	

Appendix 4 – SafeLink Alberta Honoraria Policy

Policy

SafeLink Alberta believes that the expertise and knowledge carried by people with lived/living experience (PWLLE) is necessary to create programs and social change which will best benefit the community. As such, the agency intentionally seeks to find meaningful ways to highlight this knowledge throughout our work. Meaningful engagement of people with lived/living experience includes, but is not limited to, program and project consultations, focus groups, speaking opportunities, advisory committee opportunities, and Indigenous elder's engagements.

SafeLink Alberta acknowledges that people with lived/living experience should be acknowledged and compensated for their expertise through appropriate honoraria.
In alignment with best practices, SafeLink Alberta adheres to the following guidelines and honoraria schedule for people with lived/living experience.

Honoraria Schedule

- Indigenous Elders / Knowledge Keepers: $150-$250 depending on the elder and the event.
    - Staff should consult with elders in advance to understand specifics related to that elder's accepted protocol based on the event or request.
    - Customarily, pouch tobacco is given when a request is made for an elder to participate in a ceremonial event such as giving a prayer or blessing.
        - In addition to presenting tobacco, staff should give as many details about the event in which they are asking the elder to engage, as well as the opportunity for the elder to accept or decline the tobacco.
        - Acceptance of tobacco from an elder signifies the acceptance of the request being made of them.
    - For larger events, (Splash of Red, AIDS Walk, etc.) in addition to the honoraria, elders should be presented with:
        - Square metre cuts of cotton broadcloth representing each of the primary colors (blue, red, yellow, and white).
        - A small, non-monetary gift of appreciation like tea, a blanket, or other household goods. Gift cards or gas cards may be appropriate.
    - Honoraria is not considered payment, but rather a gift in exchange for knowledge given and should be presented to the elder on the day the knowledge is shared at the event or ceremony.

- Person with Lived/Living Experience Hourly rate: $25/hour
    - An hourly rate will be provided for PWLLE who engage in focus groups, advisory committees, consultations, education co-facilitation, and project specific work including content contribution, development, or review.
        - PWLLE involved in project specific work may be asked to contribute to project tasks by email; these tasks will be compensated at the rate of $25 per task.
    - Honoraria for co-facilitation opportunities will include 60 minutes preparation time for advance work plus the time the speaker co-facilitated the event.
    - For engagements less than one hour in length, honoraria for a full hour will be provided
- Expert Presenter rate: $100
    - A flat rate of $100 will be provided for presenters sharing their knowledge or lived/living experience.
    - The flat rate amount includes a pre-event discussion plus a post-event debrief all included under the flat rate.
        - For PWLLE who are co-facilitating an event and sharing their lived expertise at the same event, the facilitation honoraria as outlined above, plus the presenter's rate, will be provided.
    - Presenters can also include community members invited to speak on a specific area related to their lived/living experience, learned knowledge, or area of expertise (I.e: medical doctor, wellness professions, grief counsellors, community advocate).
- Expense Reimbursement
    - In addition to honoraria, PWLLE & elders may also be reimbursed for any out-of-pocket expenses incurred through their participation in an SafeLink Alberta event that they have been asked to attend, upon presentation of applicable receipts.
    - Any expenses must be pre-approved by the organization.
    - Reimbursable expenses may include:
        - Parking fees
        - Childcare
        - Registration fees
        - For travel within city limits:
            - SafeLink Alberta may provide transit passes or taxi chits in advance.
            - Mileage would be reimbursed at a rate of $0.59 per km
        - Travel costs for out-of-town events:
            - Hotel or accommodations

- Food (in alignment with SafeLink Alberta's meal per diem policy)
- Airfare

Honoraria Exceptions and Notes

SafeLink Alberta's honoraria schedule is considered the baseline or minimum honoraria provided. Exceptions to this policy may exist at the agency or funder's discretion. Any exceptions to this policy must be pre-approved by the Executive Director.
Honoraria will not be provided to PWLLE or experts who are participating on behalf of their employer on paid work time. Honoraria will also not be provided to PWLLE who are also SafeLink Alberta employees.

PWLLE who are attending SafeLink Alberta events out of their own interest who have not been asked by the organization to participate for a specific engagement purpose will not be provided honoraria.

Canada Revenue Agency and social assistance programs have guidelines and limits related to reportable additional income. SafeLink Alberta does not deduct taxes from honoraria. It is the responsibility of the PWLLE to report any additional income to these organizations as required. Staff should discuss these income related implications with PWLLE prior to any honoraria-based engagement with the organization.

Appendix 5 – SafeLink Alberta Sharing of Lived Experience Handbook

Lived Experience Speaker's Guide

Sharing lived experiences is a powerful form of education and advocacy; one that combats stigma and empowers the speaker.[26] Through the sharing of lived experience, you can further the understanding of your audience regarding situations and experiences that may be new to them or outside of their current understanding. Lived experience sharing allows the audience to connect with knowledge on a deeper level than research alone, heightening their empathy and compassion towards others who may share similar experiences with you.

Additional benefits to sharing your lived experience include:

- **Deeper understanding of yourself and your resiliency**: reflecting on your journey and identifying areas of growth in your life can help you to understand your strengths and abilities.
- **Increase in self-esteem**: telling your story in safe spaces often moves others to express their respect and appreciation for your bravery. You may experience an outpouring of appreciation and gratitude from your audience for the knowledge you have shared with them.
- **Empowerment**: being vulnerable in public spaces is a very brave and intentional action. This type of courage often inspires others to be brave in their spaces, perpetuating a cycle of empowerment.
- **Stigma reduction**: research suggests that teachings and trainings that include the voices of people with lived experience help reduce negative attitudes and biases held by the service professionals who attend the training, thus helping them be more supportive professionals.[52]

Deciding to share your expertise and lived experience is a big step. This guide is designed to help support you in shaping your story while keeping you safe throughout the journey.

Are you ready to share your story publicly?

When you engage in sharing your lived experience, you are sharing personal details about yourself with strangers. Once that information is shared, you cannot control what happens to it. Below are some things to consider when sharing your lived experience to help guide you in telling your story in the way you want it to be told.

Questions to consider when thinking about sharing your story:

- What are you ready to share about yourself and what pieces of your story do you want to keep private?
- Does your story include family members or loved ones?

    - Are they comfortable with being included?
    - How can you help keep them protected?
  - If your family member, neighbor, employer heard your story, how would that make you feel?

Preparing your story for sharing

Preparing in advance for what you want to share is a great way to help you stay on topic within the allotted timeframe you have been provided. It can also help you from sharing things you might not want to disclose. In general, you will have approximately 10-15 minutes to share your story. This is a short amount of time, so advanced preparation is important.

Things to consider when preparing your story:

- Write or type out your story in full.
- Go back and remove any pieces of information you would not want a stranger to know.
- Highlight the most important pieces related to the topics you are speaking about.
- Consider the aspects of your journey that moved you towards healing and/or wellness in your life: *(note: for this topic, healing is considered moving forward in your journey away from something or someone you did not want in your life. Wellness is moving to a place of embracing your identity and feeling you can fully be yourself in all areas of your life.).*
    - What aspects of your story made it hard for you? How did you handle those experiences?
    - What aspects of your story made it easier for you?
    - What did stigma look like in your life? How did that impact you?
    - What did/does healing or wellness look like in your life? What people or resources helped in your healing or wellness journey?
- Consider how you might talk about experiences of trauma (i.e., self-harm, suicide, abuse, etc.)?
    - How will talking about these pieces to strangers make you feel?
    - Could these pieces trigger you and put you in a hurting space?
    - Do these pieces need to be included in what you are sharing?
        - If you choose to include these pieces, how much detail do you think you need to share about them?
        - Chat about these areas with the Facilitator/Education Coordinator in advance of sharing your story so they can help set up safety for you as well as the audience.
- What questions do you think other's might have for you when they hear your story? How might you respond to those questions?
- What parts of your story speak to hope or positivity?

- What is the main thing you want your audience to understand about you and your story?
- What do you want your audience to take away from your story?
    - What positive suggestions do you have for your audience that may help them in supporting others who may have similar experiences to yours?

The PsychHub's Guide for Sharing Lived Experience[53] suggests some additional things to consider when preparing your story:

- **Normalize receiving help**[53] – we often receive help from others throughout our lives. This can be encouragement, support, or love from friends, family, and community, or more formal assistance from service providers. Highlighting what supports you had in your life can normalize receiving help for others.
- **Focus on your own experiences**[53] – your story is powerful. Speaking from your own personal experience, and not the experiences of others, increases that power.
- **Don't give direct advice or tell other people what to do**[53] – there are many ways to support people and to make change. Everyone is different and their circumstances vary. Speaking from your own experience and sharing what worked for you may inspire the listener with ideas on how they can help others without you telling them how to do the work.

Prior to sharing, it is important to practice speaking your story out loud a few times. Practice telling your story to a friend, family member, or the Facilitator/Education Coordinator before the speaking engagement to help you prepare. Practicing will help to:

- Increase your confidence
- Identify any "sticky" points that may be cause you to stumble when speaking
- Identify and prepare for any areas that may bring up emotions for you
- Reduce your nervousness

Additional things to consider:

In addition to preparing your story, there are other logistical pieces to think about in advance. The following should be considered and discussed with the Facilitator/Education Coordinator prior to the speaking event:

- Do you want to use your real name or an alias?
- If the meeting is virtual, do you want to have your camera on or camera off?
- If the meeting is virtual, do you want to participants to be able to put comments in the chat box?
    - This feature can be turned on or off, the decision is yours.
- If the meeting is in person, do you want participants to be able to come and speak to you after the training?

Your Rights at a Lived Experience Speaker

Sharing your experience should be a positive one. You are the expert guest speaker in these situations and the Facilitator/Education Coordinator will do everything in their power to accommodate your needs and keep you safe. You have many rights along this journey, including:

- The right to change your mind about sharing your experience at any time throughout the process, even if you have started to talk. You can stop sharing at any time without repercussions.
- The right to use a different name or different alias each time you speak.
- The right to shut off or turn on your camera at any time.
- The right to not answer questions.
- The right to choose what you share.
- The right to own your story; we will keep your confidence by not telling your story for you.

After you have finished sharing your story

Sharing personal stories can be an emotional experience for people and it is not uncommon for those feelings to continue after you are done talking. You may even find that some emotions are felt hours or days after the event. This is very normal. Practicing self-care and working with the Facilitator/Education Coordinator to help create a self-care plan is a helpful way to process these emotions and to not become exhausted by doing this work.

We recognize that self-care is a very individual practice and may look different for different people, or different for the same person in different situations. Personal practices of self-care may include, but are not limited to:

- Eating something you enjoy.
- Having some quiet time by yourself.
- Taking a walk or exercising.
- Taking a warm shower or bath.
- Curling up under your favorite blanket.
- Connecting with a friend or loved one.
- Listing to your favorite music.
- Reading a book.
- Taking some deep breaths or meditating.

The Facilitator/Education Coordinator will support your self-care in several ways:

- Helping you prepare for the event in advance
- Being flexible and supportive during the event to ensure your needs are met
- Connecting with you immediately following the event to debrief

- Being available in the days and weeks after the event in case you need additional support and debriefing
- Helping you to develop a safety plan to help keep you safe while sharing your story and in the hours/days following

The Facilitator/Education Coordinator will further support your self-care plan by providing you a self-care toolkit in advance. This toolkit may include items such as:

- Coloring books
- Tea
- Mindfulness activities
- Smokes/Gift card
- Snacks
- Information to additional crisis supports (e.g. Distress Centre number)

Sharing your lived experience logistics

Preparing your story and sharing it takes time. We will respect your time by providing you honoraria for sharing your expertise. You will be provided **$100** honoraria for sharing your lived experience.

Honoraria is intended to cover your preparation time, your sharing time, and a post sharing debrief. Honoraria can be paid in cash, by cheque, or by electronic file transfer (e-transfer). Please discuss with the Facilitator/Education Coordinator your preference regarding honoraria payment.

For first time Storytellers, the Facilitator/Education Coordinator will meet with you in advance of the scheduled meeting to help you prepare your story. This meeting will be scheduled for an hour and an honorarium of $25 will be provided in respect of your time.

Thank you for sharing!

Thank you for willingness to be a lived experience speaker. We hope this is a positive and empowering experience for you. We welcome any additional feedback regarding this guide and your experience to make this advocacy opportunity better.

Facilitator/Education Coordinator Checklist for Lived Experience Speaker Engagement Opportunities

Note: This checklist is designed to best support all opportunities for lived experience story sharing throughout the organization including, but not limited to, trainings, panels, and public advocacy events. This list identifies the basic things to implement to help ensure the safety and wellbeing of the lived experience speaker. We welcome you to add more to this list as you see fit within the circumstances. Please connect with the Manager, Education and Capacity Building if you have additional suggestions or considerations to add to this list.

New Lived Experience Speakers:

- Meet with new lived experience speaker to get to know them and to understand their journey and why they want to share their story with SafeLink Alberta communities.
- Work with your supervisor to ensure new lived experience speakers have completed the necessary consultant paperwork.
- Schedule a one-hour meeting with first time lived experience speakers to help them write their story.
    - Honoraria of $25 will be provided for this meeting.
    - Confirm with the lived experience speaker how they would like their honoraria to be paid.
    - Confirm with lived experience speaker if they would like honoraria paid now or to be included with their final honoraria.
- Is there a peer lived experience speaker who you can connect them with that may be willing to help mentor them in this process?
    - Honoraria of $25/hour can be provided to both lived experience speakers in this situation.

Preparation Support for All Lived Experience Speakers:

- Schedule a one-hour meeting in advance of the lived experience speaker event.
    - Share information about the speaking engagement:
        - Who is the audience?
        - Are there any challenges identified within this group?
    - Discuss any potential triggers that the lived experience speaker might experience.
        - Check in on their emotional state – what else might be going on for them at this time that could impact their safety (e.g., emotional safety, physical safety)?

- Confirm with the lived experience speaker what name they would like to be referred to for the speaking engagement.
    - Remind them that they can change their mind, they just need to let you know before you introduce them at the event.
- Create a plan with the lived experience speaker for safety around audience questions – how will you know if they do not want to respond so you can step in to support?
- Does the lived experience speaker need help developing a safety plan or self-care plan to support them after the speaking engagement?
- Confirm with the lived experience speaker how they would like to be provided honoraria and let them know when that honoraria will be provided and in what amount.
- Honoraria should be provided within two weeks of a speaking event. Please ensure you submit an RFE to accounting with enough time for them to process it. This may need to be done in advance of the event.
- Purchase items for the self-care kit and arrange a time with the lived experience speaker for this to be dropped off or picked up. Connect with Manager, Education for more information on self-care gift budget.

Lived Experience Sharing on Virtual Platforms

- Is the lived experience speaker comfortable using the online platforms?
    - Do they know how to log in with the name they have chosen to use?
    - Do they know how to mute/unmute?
    - Do they know how to turn their video on/off?
        - Remind them that they can turn their video on/off at any time prior to or during the presentation.
- Is the lived experience speaker comfortable with the audience putting questions/comments into a public chat?
- Practice on the chosen platform in advance if there are any concerns.
- Create a plan with the lived experience speaker in case their internet crashes or their connectivity is limited.
        - Turning camera off can help with limited connectivity.
        - Return to the meeting link if disconnected.
        - Establish a backup communication method like phone or text.
- Platform logistics:
        - Zoom is our preferred platform as it allows users to change their name.
            - If an organization identifies that they are meeting on Microsoft Teams, they must change their admin setting in advance so that anonymous users can join.

- We will not have lived experience speakers join a virtual meeting if they do not have the option join anonymously.
    - Send the meeting link to the lived experience speaker.
    - Schedule a debriefing session immediately following the training on a different link to respect confidentiality.

In-Person Lived Experience Sharing

- Does the lived experience speaker know where the location of the training is?
    - How will they get to the training?
        - Will transit fare or taxi chits be needed?
        - If driving, parking is a reimbursable expense – let them know to keep the receipt and give it to you.
        - Where at the location will you meet them?
- Is the lived experience speaker comfortable with the audience chatting with them directly after the training?
    - If no, what safety measures can we put into place to stop this from happening?
- Schedule an on-site debriefing with the lived experience speaker in a safe and private place immediately following the event.

Day of Lived Experience Sharing Event:

- Acknowledge that there may be triggers that come up for the audience during the sharing. Establish/re-establish what people can do if triggered by the content.
- Introduce the lived experience speaker by their identified name and pronouns.
- Remind the audience of about confidentiality and respecting the lived experience speaker's right to privacy.
- Verbally state the length of time the lived experience speaker will be sharing (10-15 minutes) and how much time will be left for questions.
- Remind the lived experience speaker of their time at the 10-minute mark.

After the Lived Experience Sharing Event:

- Lived experience sharing will happen at the end of a training so you can move to debriefing immediately after the training has finished.
- Connect with the lived experience speaker through the virtual link provided or in a private space to debrief the event.
- Provide support to the lived experience speaker as needed.
- Extend the invitation for the lived experience speaker to connect with you at any time if they need additional debriefing or have follow up questions.

- Is there a peer or community resource who they can connect with for additional support?
- Ensure all time spent by the lived experience speaker is tracked in the volunteer tracker.

Additional Resources:

Mastering Zoom Basics:

- Zoom Help Center, where you can find a vast amount of step-by-step guides, articles, and short videos all geared towards helping you get started with Zoom. In watching the videos outlined below, you and your team will be up and running on Zoom in no time.
- In-Meeting Basic Controls
- Screen Sharing Basics

Appendix 6 – SafeLink Alberta Fit for Work Policy

The Organization is committed to providing all workers with a safe and healthy workplace. All workers have responsibility for maintaining a safe and healthy workplace by following health and safety rules, procedures, and practices and by reporting accidents, injuries, and unsafe equipment, practices, or conditions.

Workers must understand and adhere to all policies and procedures related to impairment in the workplace. Specifically, workers are required to be fit for work and expected to perform their professional duties in a safe, coherent, competent, and respectful manner.

For this sake of this policy, impairment is defined as the altered state of physical and/or mental functioning that affects a worker's ability to perform their assigned work. Impairment may be caused by a variety of situations resulting in the distraction of a worker from their ability to focus and complete their job requirements in a safe manner, potentially placing themselves, their co-workers, or the public in danger.

Examples of impairment may include, but are not limited to:

- Medical conditions such as seizures or unexplained unconsciousness
- Adverse or unsafe effects of substances including prescription and non-prescription medications, alcohol, or any other substances (legal or illegal)
- Illness
- Fatigue
- Trauma
- Anxiety or depression
- Grief
- Experiencing harassment, bullying, or other forms of violence
- Exposure to extreme temperatures – (i.e. extreme cold could result in lower mental alertness, less dexterity in hands, etc., or extreme heat could result in increased irritability, loss of concentration, loss of ability to do skilled tasks or heavy work, etc.)

Signs of impairment may present as:

- Physical changes such as altered demeanor, slurred speech, or changes in hygiene habits
- Appearance of extreme fatigue or inebriation (i.e. glassy or red eyes, unsteady gait, slurring, poor coordination)
- Psychosocial changes such as difficult focusing on a task, forgetfulness, or sudden changes in mood
- Consistent lateness, absenteeism, or reduced productivity or quality of work

Workers are encouraged to disclose known impairments that may affect workplace health and safety to their supervisor but are not required to disclose the cause of the impairment. Supervisors will respond fairly and without judgement while maintaining the privacy and confidentiality of the worker.

Supervisors are required to make inquiries of workers who are showing signs of impairment in the workplace as part of their responsibility to provide a safe work environment.
Workers and supervisors will take steps to address any unsafe situations and control hazards that may occur, such as not assigning activities to a worker or not allowing them to continue to do the work until the impairment has been addressed.

Appendix 7 – SafeLink Albera Sample Job Description

SafeLink Alberta (formerly HIV Community Link) is an organization delivering services throughout Southern Alberta. As a non-profit organization, we work to reduce the harms associated with sexual activity and substance use. We serve and advocate for priority populations by offering low-barrier, non-judgemental, and informed programs and services. We offer a fun and energetic environment that provide opportunities for you to utilize your talents and develop new skills.

Harm Reduction Outreach Worker/ Peer Support Worker

At SafeLink Alberta, we have a clear vision: to be the place where a diverse mix of talented people want to come, stay and do their best work. SafeLink Alberta's dedication to promoting diversity, multiculturalism, and inclusion is clearly reflected in all that we do. Diversity is more than a commitment at SafeLink Alberta - it is the foundation of what we do. We are fully focused on equality and believe deeply in diversity of race, gender, sexual orientation, religion, ethnicity, national origin, and any other difference that makes us all unique.

We have an exciting new opportunity for flexible and passionate Peer Support Worker who has lived experience (current or former) as persons who use drugs. The Peer Support Worker will use a harm reduction philosophy and non-judgemental approach to provide active street-level outreach at a number of public locations and venues in order to connect with and educate people who use drugs.

The Peer Support Worker will focus on preventing harms related to drug use through informal education, distributing safer drug use equipment, and building meaningful relationships with people who use drugs. In addition, the Peer Support Worker will advocate on behalf of people who use drugs to ensure ready access to HIV and hepatitis C testing and treatment, housing, basic needs resources, and other supports available in the community. The Peer Support Worker will also facilitate immediate access to health and social services available through other SafeLink programs such as overdose prevention and case management services.

Key Responsibilities

- Engaging and building relationships with people who use drugs through street-level walking outreach

- Provide education and information on safer drug use practices and encourage safer behaviours
- Distribute safer drug use supplies alongside information about disease transmission (HIV, hepatitis C)
- Provide people who use drugs with information to assist in accessing community resources such as housing or health services
- Consult and collaborate with the SafeLink Peer Advisory Committee to ensure project activities and strategies are relevant and accessible to people who use drugs
- Complete documentation and data collection
- Daily activities will adapt to meet the immediate needs of service users

Qualifications/ Key Competencies

- Strong emotional self-management skills and self-awareness
- A healthy, solid support system in place and are active in your self-care
- Capacity to set firm boundaries and practice effective communication skills
- Excellent listening skills and the ability to put your own biases aside, working with open mindedness from a nonjudgmental lens
- Lived experience (current or former) as a person who uses drugs
- Ability to draw upon your own personal experience to educate and support others
- Ability to work within the community, open about your lived/living experience
- Capability to work independently and as part of a team
- Knowledge and experience of local community resources and services
- Ability to build supportive relationships with diverse groups of people including people who use drugs and people experiencing addictions and mental health concerns
- Strong comprehension skills and ability to educate others about risk behaviours, HIV and hepatitis C
- Capacity to attend and complete mandatory training
- Willingness to follow and implement policies and procedures and ensure confidentiality and ethical standards are maintained
- Physical capability to allow for participation in extensive walking, moderate physical labour and the ability to lift up to 25 pounds
- Provision of a criminal security check with vulnerable sector search. A positive criminal record check will not necessarily preclude a candidate from being hired – decisions will be made on an individual basis and all information will be kept confidential.

Application Details

We especially encourage applications from communities that are under-represented among our staff, such as people living with HIV, visible minorities, those with lived/living experience, and persons with culturally diverse backgrounds. We value your lived experience, and we encourage you to self-identify in your application should you feel comfortable doing so.

Appendix 8 – SafeLink Alberta Sample Interview Guide

Interview Questionnaire	
Position being Interviewed for	
Interview Date	
Applicant's Name	
Interview Panel	
Name	**Title**

Introduction / General Background

1. Tell us about your understanding of the work we do at SafeLink Alberta in general, and what prompted you to apply for the position. (prompt: ensure they speak to harm reduction, and alignment with their values)

2. What is your understanding of the key responsibilities of this role (clarify if necessary)?

3. How has your education and experience prepared you for these?

Content Knowledge

4. Can you tell us what Harm Reduction means to you and offer some examples?

5. Please share what you know about sexually transmitted and blood-borne infections such as HIV and HCV?

Communication:

6. Tell me about a time where you had to defend or put forward an unpopular opinion or had to stand up for something that others didn't support. How did you handle that?

7. How do you respond to critical feedback? Tell me about a time you were given critical feedback and how you incorporated that feedback into your practice.

8. When you are upset, bothered, or stressed over something in your work life, how would your supervisor know?

9. What support would you need from your supervisor and the leadership team to perform well and be successful in this role?

Role Specific Questions

10. What is your understanding of Peer Work?

11. In your opinion, what are the strengths of peer work? Challenges?

12. How would you use your lived/living experience to support peers in an outreach role?

13. Can you share what you believe is needed to effectively support people who use substances?

14. What may be some challenges in supporting people who use substances? How would you work through those challenges?

15. How might you approach someone you meet on outreach who in engaging in high-risk behaviour to try and connect them to supports?

16. Describe a role or experience that required you to take initiative and work independently to achieve outcomes. What did you enjoy? What were the challenges?

17. How do you handle the impact that some of the stories you see and hear have had on you? How do you incorporate meaningful selfcare into your life?

Critical Thinking and Judgement:

18. A client has stopped by the organization to pick up harm reduction supplies. They decided to hang out in the drop in space to have a coffee and snack. After being at the agency for a while, you notice that they start to prep their drugs at the drop in space table. How might you respond to this situation?

19. A part of your recovery journey, you have stopped associating with people you use to use with/sell drugs to/buy drugs from. One day, a "friend" from your old life comes to the drop in space for harm reduction supplies and support? How do you navigate that interaction?

20. A client has been in the agency bathroom for an extended period. When you knock on the door, they respond, so you know they are not on the nod. However, after a while, you begin to suspect they are using drugs in the bathroom. How might you address that situation with the client?

Cultural Fit

21. Can you give me an example of a time you had a conflict with someone you were working with (co-worker, colleague, service provider)? How did you resolve the conflict?

22. Describe your ideal work environment.

23. Within this organization, there are times when people will need to be able to speak openly about sex, sexuality, substances, and substance use, be involved in conversations on these topics, and work with material of a graphic nature. There may be times when your comfort level is stretched. Tell us about a time when you managed a situation like this.

Appendix 9 – SafeLink Alberta Staff Safety Plan Template

Date:	**Staff Name**:	**Role:**
What are my most noticeable triggers or stressors? (Note: A trigger can be a physical or emotional response to something that may make sense with the event that is happening. Triggers can cause the body to remember a painful memory and react to that memory)		
What happens to me/within me when I start to get triggered? • What thoughts do I think? • What emotions do I feel? (Ex: anger, irritability, sadness) • What sensations happen in my body? (Ex: headaches, stomach pain, sweating, shaking, memory loss) • Does my behavior change? If so, how? (ex: withdrawing, leaving work)		
When I start to feel overwhelmed, what can I do or what I have done in the past to help? (ex: going for a walk, doing a different task, calling a support person, listening to music)		
When I am completely overwhelmed, what helps? (ex: going to a quiet space, crying, connecting with predetermined support person)		
Who can I safely connect with for support?		

When I start to feel overwhelmed, what can my co-worker's or supervisor do to help support me? (ex: listening, validating, encouraging movement)
If I start to feel overwhelmed outside of work hours, how can I keep myself safe?

References

1. Wilson L, Vannice S, Lane AM. Peer worker or client? Conflicting identities among peer workers engaged in harm reduction service delivery. *Addiction Research & Theory.* 2016;26(5):261-368. doi:10.1080/16066359.2017.1410704

2. People with Lived Experience of Drug Use National Working Group, Austin T, Boyd J. Having a voice and saving lives: a qualitative survey on employment impacts of people with lived experience of drug use working in harm reduction. *Harm Reduction Journal.* 2021;18(1):1-12. doi:10.1186/s12954-020-00453-5

3. Godard R. Why organizations readiness assessments are important. I.S. Partners LLC. Updated October 10, 2022. Accessed January 29, 2023. https://www.ispartnersllc.com/blog/why-organizational-readiness-assessments-are-important/

4. Harm Reduction International. Who are we: what is harm reduction? Harm Reduction International. 2022. Accessed September 15, 2022. https://hri.global/what-is-harm-reduction/

5. Lister K. Sex workers or prostitutes? Why words matter. I News. October 5, 2017. Updated July 17, 2020. Accessed December 12, 2022. https://inews.co.uk/opinion/columnists/sex-workers-prostitutes-words-matter-95447

6. Dube SR, Felitti VJ, Dong M, Chapman DP, Giles, WH, Anda RF. Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: the adverse childhood experiences study. *Pediatrics.* 2003;111(3):564-572. doi:10.1542/peds.111.3.564

7. Casey B. Impacts of methamphetamine abuse in Canada. House of Commons Canada. June 2019. Accessed September 15, 2022. https://www.ourcommons.ca/Content/Committee/421/HESA/Reports/RP10533589/hesarp26/hesarp26-e.pdf

8. University of Buffalo. What is trauma informed care? Buffalo Center for Social Research. Updated 2023. Accessed October 11, 2022. https://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-

trauma-and-trauma-informed-care/what-is-trauma-informed-care.html#:~:text=The%20Five%20Principles%20of%20Trauma%2DInformed%20Care&text=The%20Five%20Guiding%20Principles%20are,%2C%20collaboration%2C%20trustworthiness%20and%20empowerment.

9. Canadian Public Health Association, Centre for Sexuality. Trauma and violence informed care tookit: for reducing stigma related to sexuality transmitted and blood-borne infections (STBBIs). Canadian Public Health Association. 2020. Accessed August 7, 2022. https://www.cpha.ca/trauma-and-violence-informed-care-toolkit

10. Waegemakers Schiff J, Lane AM. PTSD symptom, vicarious traumatization, and burnout in front line workers in the homeless sector. *Addiction Research & Theory.* 2019;55(3):454-462. doi:10.1007/s10597-01800364-7

11. Reynolds V. Zone of fabulousness: resisting burnout & shouldering each other up. vikkireynolds.ca. 2019. Accessed August 27, 2022. https://vikkireynolds.ca/opioid-epidemic-responses/

12. Government of British Columbia. Resources on vicarious trauma: self-care and strategies by organizations to support wellness. Government of British Columbia. Updated June 4, 2020. Accessed October 3, 2022. https://www2.gov.bc.ca/assets/gov/health/managing-your-health/mental-health-substance-use/child-teen-mental-health/vicarious_trauma_and_organization_resource_list.pdf

13. Leonard C. TYES frontline workers' toolkit: vicarious trauma & self-care toolkit. Toronto.ca. 2020. Accessed October 3, 2022. https://www.toronto.ca/wp-content/uploads/2020/07/9029-Vicarous-Trauma-Toolkit-2020.pdf

14. Blood Ties Four Directions Centre. Don't be an a**hole: best practices for health and social service providers working with people who use drugs. Bloodties.ca. November 2018. Accessed October 3, 2022. https://bloodties.ca/our-resources/

15. Kingston S. Harm reduction for methamphetamine users. The Body Pro: For the HIV/AIDS Workforce. July 27, 2004. Accessed August 4, 2022. https://www.thebodypro.com/article/harm-reduction-methamphetamine-users

16. Rigoni R, Woods S, Breeksema JJ. From opiates to methamphetamine: building new harm reduction responses in Jakarta, Indonesia. *Harm Reduction Journal.* 2019;16(67):1-13. doi:10.1186/s12954-019-0341-3

17. Dickson-Gomez JB, Knowlton A, Latkin C. Value and identity: the meaning of work for injection drug users involved in volunteer HIV prevention outreach. *Journal of Substance Use and Misuse.* 2004;39:1259-1286. doi:10.1081/JA-120038686. Cited by: Marshall J, Dechman MK, Minichiello A, Alcock L, Harris GE. Peering into the literature: a systematic review of the roles of people who inject drugs in harm reduction initiatives. *Journal of Drug and Alcohol Dependence.* 2015;151:1-14. doi:10.1016/j.drugalcdep.2015.02.002

18. Friedman SR, Maslow C, Bolyard M, Sandoval M, Mateu-Gelabert P, Neaigus A. Urging others to be healthy: "intravention" by injection drug use. *AIDS Education Prevention.* 2004;16:250-263. Cited by: Marshall J, Dechman MK, Minichiello A, Alcock L, Harris GE. Peering into the literature: a systematic review of the roles of people who inject drugs in harm reduction initiatives. *Journal of Drug and Alcohol Dependence.* 2015;151:1-14. doi:10.1016/j.drugalcdep.2015.02.002

19. Kermode M, Devine A, Chandra P, Dzuvichu B, Gilbert T, Herrman H. Some peace of mind: assessing a pilot intervention to promote mental health among widows of injecting drug users in north-east India. *BMC Public Health.* 2008;8:294. doi:10.1186/1471-2458-8-294. Cited by: Marshall J, Dechman MK, Minichiello A, Alcock L, Harris GE. Peering into the literature: a systematic review of the roles of people who inject drugs in harm reduction initiatives. *Journal of Drug and Alcohol Dependence.* 2015;151:1-14. doi:10.1016/j.drugalcdep.2015.02.002

20. Mackenzie S, Pearson C, Frye V, et al. Agents of change: peer mentorship as HIV prevention among HIV-positive injection drug users. *Journal of Substance Use and Misuse.* 2012;47:522-534. doi:10.3109/10826084.2012.644122. Cited by: Marshall J, Dechman MK, Minichiello A, Alcock L, Harris GE. Peering into the literature: a systematic review of the roles of people who inject drugs in harm reduction initiatives. *Journal of Drug and Alcohol Dependence.* 2015;151:1-14. doi:10.1016/j.drugalcdep.2015.02.002

21. Sherman SG, Gann DS, Tobin KE, Latkin CA, Welsh C, Bielenson P. "The life they save may be mine": diffusion of overdose prevention information from a city sponsored programme. *International Journal of Drug Policy.* 2009;20:137-142. doi:10.1016/j.drugpo.2008.02.004. Cited by: Marshall J, Dechman MK, Minichiello A, Alcock L, Harris GE. Peering into the literature: a systematic review of the roles of people who inject drugs in harm reduction initiatives. *Journal of Drug and Alcohol Dependence.* 2015;151:1-14. doi:10.1016/j.drugalcdep.2015.02.002

22. Des Jarlais DC, Semann S. HIV prevention for injecting drug users: the first 25 years and counting. *Psychosomatic Medicine.* 2008;70:606-611. doi:10.1097/PSY.0b013e3181772157. Cited by: Marshall J, Dechman MK, Minichiello A, Alcock L, Harris GE. Peering into the literature: a systematic review of the roles of people who inject drugs in harm reduction initiatives. *Journal of Drug and Alcohol Dependence.* 2015;151:1-14. doi:10.1016/j.drugalcdep.2015.02.002

23. Needle RH, Burrows D, Friedman S, et al. Evidence for action: effectiveness of community-based outreach in pre-preventing HIV/AIDS among injecting drug users. World Health Organization. 2004. Cited by: Marshall J, Dechman MK, Minichiello A, Alcock L, Harris GE. Peering into the literature: a systematic review of the roles of people who inject drugs in harm reduction initiatives. *Journal of Drug and Alcohol Dependence.* 2015;151:1-14. doi:10.1016/j.drugalcdep.2015.02.002

24. Marshall J, Dechman MK, Minichiello A, Alcock L, Harris GE. Peering into the literature: a systematic review of the roles of people who inject drugs in harm reduction initiatives. *Journal of Drug and Alcohol Dependence.* 2015;151:1-14. doi: 10.1016/j.drugalcdep.2015.02.002

25. Touesnard N, Patten S, McCrindle J, et al. Hear us. See us. Respect us: respecting the expertise of people who use drugs. *Zenodo.* 2021;1:1-69. doi:10.5281/zenodo.5514066

26. Marino CK, Child B, Krasinski VC. Sharing experience learned firsthand (SELF): self-disclosure of lived experience in mental health services and supports. *Psychiatric Rehabilitation Journal.* 2016;39(2):154-160. doi:10.1037/prj0000171

27. Greer A, Bungay V, Pauly B, Buxton J. 'Peer' work as precarious: a qualitative study of work conditions and experiences of people who use drugs engaged in harm reduction work. *International Journal of Drug Policy.* 2020;85:1-7. doi:1016/j.drugpo.202.102922

28. Greer A, Luchenski SA, Amalni AA, Lacroix K, Burmeister C, Buxton JA. Peer engagement in harm reduction strategies and services: a critical case study and evaluation framework from British Columbia, Canada. *BMC Public Health.* 2016;16(452):1-9. doi:10.1007/s10597-019-00396-7

29. Boucher LM, Shoemaker ES, Liddy CE, et al. "They're all struggling as well": social and economic barriers and facilitators to self-managing chronic illness among marginalized people who use drugs. *International Journal of Qualitative Studies on Health and Well-Being.* 2022;17:1-13. doi:10.1080/17482631.2022.2082111

30. International HIV/AIDS Alliance. Good practice guide for employing people who use drugs. International Drug Policy Consortium. October 2015. Accessed July 11, 2022. https://idpc.net/publications/2015/10/good-practice-guide-for-employing-people-who-use-drugs

31. Haverfield M, Ilgen M, Schmidt E, Shelley A, Timko C. Social support and symptom severity among patients with co-occurring mental health and substance use disorders. *Community Mental Health Journal.* 2019;55:768-776. doi:10.1007/s10597-019-00396-7

32. Norman T. Homelessness, mental health and substance use: understanding the connections. Here to Help. 2021. Accessed July 11, 2022. https://www.heretohelp.bc.ca/infosheet/homelessness-mental-health-and-substance-use

33. Canadian Centre for Occupational Health and Safety. Impairment at work: policy and recognition. Canadian Centre for Occupational Health and Safety. Updated February 8, 2023. Accessed February 8, 2023. https://www.ccohs.ca/oshanswers/hsprograms/impairment.html

34. Balian R, White C. Harm reduction at work: a guide for organizations employing people who use drugs. Open Society Foundations. December 2010. Accessed July 11, 2022. https://www.opensocietyfoundations.org/publications/harm-reduction-work

35. Philadelphia Department of Behavioral Health and Intellectual Disability Services. Peer tool kit. 2017. Accessed August 25, 2022. Department of Behavioral Health and Intellectual Disability Services. https://dbhids.org/wp-content/uploads/1970/01/PCCI_Peer-Support-Toolkit.pdf

36. Visher CA, Winterfield L, Coggeshall MB. Ex-offender employment programs and recidivism: a meta-analysis. *Journal of Experimental Criminology.* 2005;1(3):295-315. doi:10.1007/s11292-00-8127-x

37. John Howard Society of Ontario. The invisible burden: police records and the barriers to employment in Toronto. Police Record Hub. February 2018. Accessed July 11, 2022. http://policerecordhub.ca/wp-

content/uploads/2018/02/The-Invisible-Burden-Report-FINAL.pdf

38. National Council for Mental Wellbeing. Establishing peer support services for overdose response: a toolkit for health departments. National Council of Mental Wellbeing. March 2022. Accessed August 25, 2022. https://www.thenationalcouncil.org/wp-content/uploads/2022/03/Establishing-Peer-Support-Services-for-Overdose-Response-Toolkit-7-March-2022-Final.pdf

39. Canadian Centre on Substance Use and Addiction. Lived and living. Canadian Centre on Substance Use and Addiction. Updated 2023. Accessed February 1, 2023. https://www.ccsa.ca/lived-and-living

40. Centre for Innovation in Campus Mental Health. Campus peer support toolkit: a guide to implement and operate peer support programs on campus. Campus Mental Health. February 21, 2020. Accessed July 11, 2022. https://campusmentalhealth.ca/wp-content/uploads/2020/02/CICMH-Peer-Support-Toolkit-EN.pdf

41. Greer A, Buxton JA, Pauly B, Bungay V. Organizational support for frontline harm reduction and systems navigation work among workers with living and living experiences: qualitative findings from British Columbia, Canada. *International Journal of Drug Policy.* 2021;18(60):1-13. doi:10.1186/s12954-021-00507-2

42. Prochaska JO, DiClemente CC. Stages and processes of self-change of smoking: toward an integrative model of change. *Journal of Consulting and Clinical Psychology.* 1983;51(3):390-395. doi:10.1037/0022-006X.51.3.390. Cited by: Pacheco, Ignacio. The cycle of change. Social Work Tech. January 9, 2012. Accessed June 7, 2021. http://socialworktech.com/2012/01/09/stages-of-change-prochaska-diclemente/

43. McIntosh J, McKeganey N. Identity and recovery from dependent drug use: the addict's perspective. *Drugs: Education, Prevention, & Policy.* 2001;8(1):47-59. doi:10.1080/09687630124065

44. Canadian Centre for Occupational Health and Safety. Departmental plan. 2021. Accessed February 8, 2023. Canadian Centre for Occupational Health and Safety. https://www.ccohs.ca/ccohs/rpp/2022/default.pdf

45. eMentalHealth. My safety plan. August 16, 2016. Updated April 10, 2020. Accessed

July 11, 2022. eMentalHealth. https://www.ementalhealth.ca/Canada/My-Safety-Plan/index.php

46. Mind My Peelings. Understanding the window of tolerance and how it affects you. Mind My Peelings. April 19, 2019. Accessed October 23, 2022. https://www.mindmypeelings.com/blog/window-of-tolerance

47. Tull MT, Forbes CN, Weiss NH, Gratz KL. An investigation of the effect of trauma script exposure on risk-taking among patients with substance use disorders and posttraumatic stress disorder. *Journal of Anxiety Disorders.* 2019;62:77-85. doi:10.1016/j.janxdis.2019.01.002

48. Kyte A, Pereira J. Peer support toolkit for people living with HIV and/or hepatitis C: peer mentor policy and procedure handbook. Interior Health Authority. 2018. Accessed July 11, 2022. https://www.interiorhealth.ca/sites/default/files/PDFS/peer-mentor-policy-and-procedure-handbook.pdf

49. The Association for Psychological Therapies. Motivational interviewing training. ATP Canada. Accessed July 11, 2022. https://www.aptcanada.com/motivational-interviewing-training-courses.html?gclid=CjwKCAjwu5yYBhAjEiwAKXk_eDkTBcH-RqWRuIZA9f0h-2SAd72RgfVd1o2kcxjrfbahOJSr872yuhoC750QAvD_BwE

50. Centre for Addiction and Mental Health. Motivational interviewing introduction and application course. CAMH Education. Accessed July 11, 2022. https://www.camh.ca/en/education/continuing-education-programs-and-courses/continuing-education-directory/motivational-interviewing-introduction-and-application-course

51. Canadian Coalition to Reform HIV Criminalization. 2022 consensus statement. HIV Criminalization. 2023. Accessed January 5, 2023. https://www.hivcriminalization.ca/2022-consensus-statement/#:~:text=After%20several%20months%20of%20community,Code%20to%20limit%20HIV%20criminalization.

52. Happell BL, Platania-Phung C, Harris S, Bradshaw J, Davies J. (2014). Lived-experience participation in nurse education: Reducing stigma and enhancing popularity. *International Journal of Mental Health Nursing*. 2014;23(5):427–434. doi:10.1111/inm.12077

53. St. Amant E, Asper A. Guide for sharing lived experience. PsychHub. November 2021. Accessed July 11, 2022. https://psychhub.com/wp-content/uploads/2021/12/v3PHLivedExperienceGuideQ42021.pdf