HR Outreach

Community HR Response Teams (CHRRT) project
Street Health

Authors: Ayaka Teshirogi, Jiayi Chen

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What is CHRRT?

The **Community Harm Reduction Response Teams (CHRRT) project** is a 3-year initiative (April 2018 to March 2021) designed to promote low-threshold, Harm Reduction services in Toronto neighborhoods in response to the growing opioid crisis.

Funded by the **Substance Use and Addictions Program (SUAP) of Health Canada**, the project has been designed to mobilize people with lived experience to play leadership roles in community-based Harm Reduction work.

Ten agencies are partnering to train and employ over 25 people with lived experience to become Harm Reduction Support Workers in their communities.

A major component of the project is the mobilization of the community's knowledge about this new model for promoting and resourcing effective community responses to the crisis.

Acknowledgements

With thanks to…

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Janet M. Murray

Monica Forrester

For organizing and conducting the interviews; supervising and contributing constructive criticisms to our work; and granting us relative literatures and background information.

Special thanks to Natalie, Sandy, Charlene, Stephanie, Ben, Iye, and Wade for taking time with the interviews and providing us with first-hand resources of Harm Reduction

Organizations involved

Larger Community Health Institutions:

- Parkdale Queen West Community Health Centre
- Regent Park Community Health Centre

Large multi-service community agencies:

- Agincourt Community Services Association
- Dixon Hall
- Fred Victor
- Sistering

Smaller, specialized social justice and community health organizations:

- Maggie’s
- PASAN
- Ve’ahavta
- StreetHealth (lead agency)

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Section 1: Overview

Methodology

- For this research project, we sat in on the interviews (typically on a three-way ZOOM call) conducted by Monica and Janet from Street Health and took notes about the ideas and experiences surrounding CHRRT Outreach.
- Who did we interview?
  - Interviewees were Harm Reduction workers and program managers from CHRRT partner organizations.
  - Stephanie Moulton (PASAN); Ben (Outreach); Iye (SUAP); Wade (Drop-in); Natalie (StreetHealth); Sandy (Maggie's); Charlene (Maggie's)
- With a total of 7 interviews, we see an alignment in answers for many of the questions. However, in consideration of COVID-19, all interviews were done online and limited numbers of interviews were conducted.
  - Since there were a limited number of interviews, not every voice in the harm reduction outreach department is represented and we may have excluded some important comments or thoughts.
  - Despite the limited time and chances for interviews, answers given by the interviewees provided us with sufficient insight into Harm Reduction Outreach.

What questions did we want to answer?

- How can we describe low-threshold approaches to Harm Reduction?

  (3 modalities: Outreach, Drop-in and Accompaniment/ Systems Navigation)

- What does a typical shift look like? What is involved in the work?

- Is it important to engage people with lived experience in the work? Why?

- What difference does a low-threshold approach make?

  (3 perspectives: service users, organizations and communities)

- What are the outcomes of this HR modality?

Section 2: What is Harm Reduction Outreach

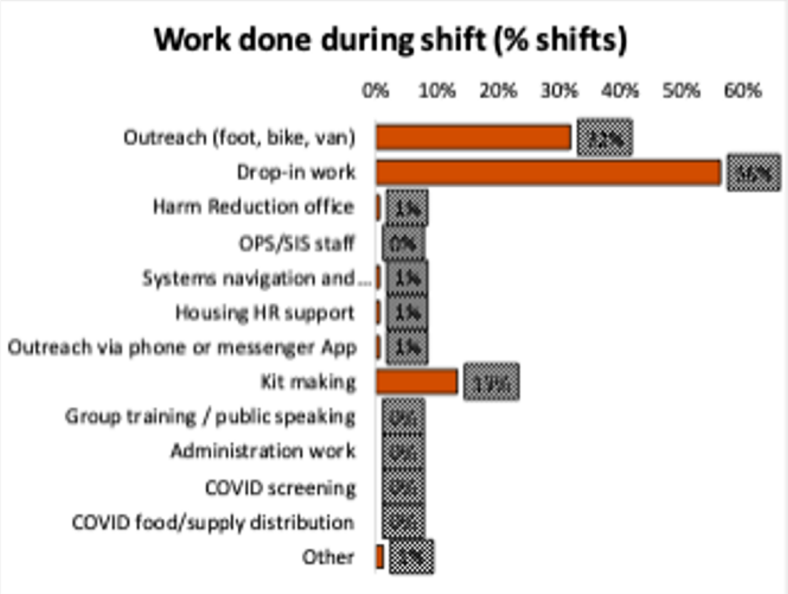
What is Harm Reduction Outreach?

Harm Reduction

- Minimizing harmful risks and reducing stigma, inequalities and discrimination of drug users.
- Individual scale or larger community or societal scale - kit making, distributing supplies, educational sessions (responding to overdose, proper syringe pickups), systems navigations, drug laws and policies, etc.
- Principles of HR[1]
    - Human rights-oriented approach - respecting people's opinions and rights allows them to make their own decisions.
    - Not a focus on prevention, but rather improving the quality of life (society tends to focus on eliminating drug use).
    - Reduce stigmatization of substances and users.

Outreach

- *"Meeting people where they are at" (respondent)* - reaching people that have less access to services or may have difficulty accessing services.
- Increase inclusivity and build a community.
- Going around the city (by foot or vehicle)
    - Making rounds
    - Different route each day: encampments, under the bridge, areas in need



2019 CHRRT Shift Tracking Data Sheet (StreetHealth)
StreetHealth served 7900 clients in 2019[2].

What does a typical day look like?

Shifts can vary amongst different organizations but the overall goal to spread resources and awareness is likewise in all organizations.

- **Daily shift**: ~5 Hours (on the field for 3 hours); shifts vary in time (morning/afternoon)
- **Before going on a shift**: checking emotional status of teammates > peer support
  - Assessments/meeting in the first hour of a shift: discuss the route they are taking and share new information regarding harm reduction outreach.
  - Adjust for weather: appropriate kits and equipment according to the weather.
- **During the shift**:
  - Dedicated routes everyday of the week for 3 hours: different routes taken everyday in order to reach out to people in different areas of the city.
  - Talking to people and handing out supplies.
- **After the shift**:
  - Come back an hour before the shift ends: paperwork on OR tracking sheets and timetable sheets.

Who are the people?

- People living in poverty or homelessness
- People struggling with drug use
- People in the neighborhood
- Transgender and people of color, marginalized populations

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Surveillance and Epidemiology of Homeless Deaths[3]

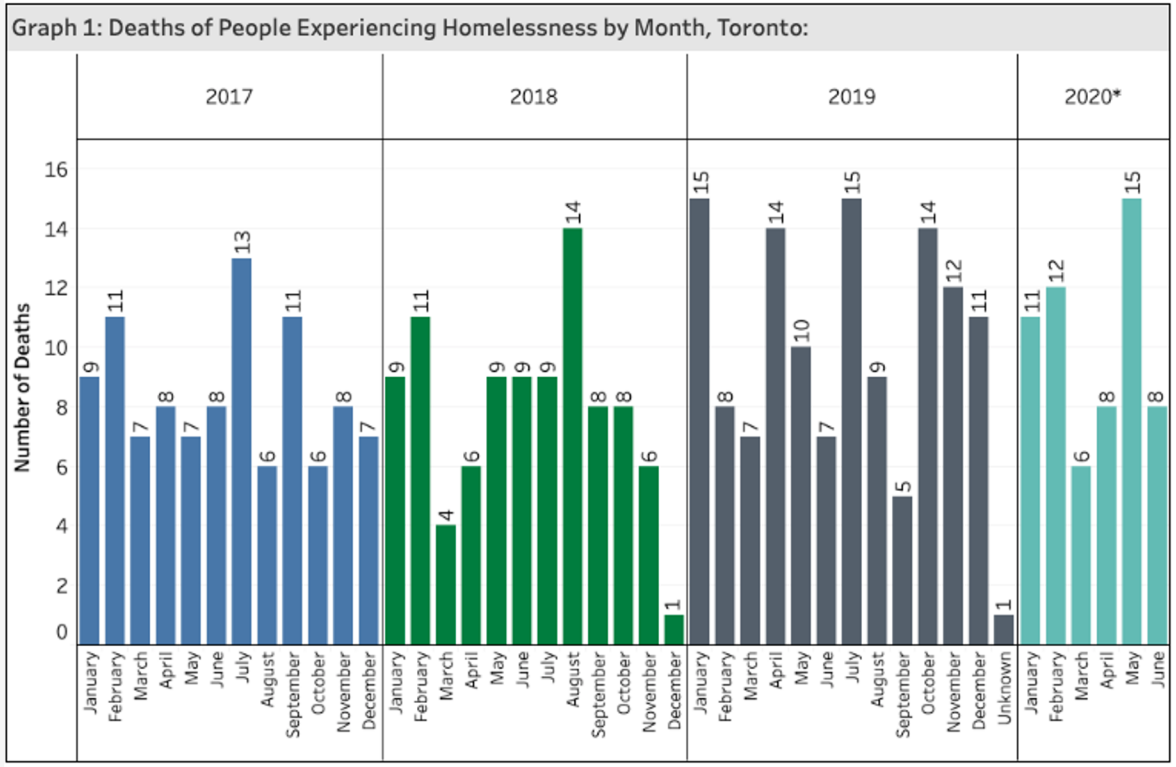


Table 3: Deaths of People Experiencing Homelessness by Cause of Death, Toronto †:

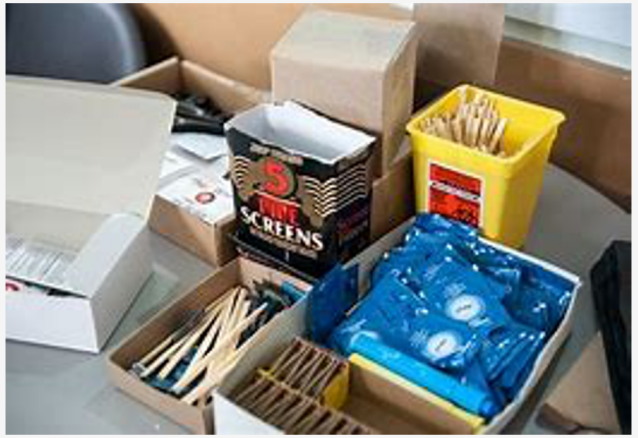
	2017	2018	2019	2020*	Grand Total
Cancer	9%	1%	7%	2%	5%
Cardiovascular Disease	14%	15%	12%	10%	13%
COVID-19				7%	1%
Drug Toxicity	32%	35%	30%	25%	31%
Infection	4%	2%	2%		2%
Pneumonia	3%	4%	6%	3%	4%
Suicide	3%	4%	2%	3%	3%
Accident	5%	5%	7%		5%
Homicide	1%	5%	6%	2%	4%
Other§	4%	9%	7%	2%	6%
Unknown/ Pending	26%	19%	21%	47%	26%

There are many homeless deaths a year, and although not all people that use Harm Reduction services are homeless, this demonstrates a great need to help the homeless population. Within people experiencing homelessness, the leading cause of death is drug toxicity. The majority of HR service users struggle with a combination of homelessness and drug use.

Additional Findings from the literature

Current state of HR in Toronto[1]

- Social service and community organizations are working to raise awareness and to shift from strict law enforcement to a more understanding, unstigmatized approach.
- Over the last decade, there have been more attempts by social service agencies to implement these strategies and develop partnerships with these programs and services.
- Current challenges include:
    - Criminalization, stigmatization and misconceptions of drug use and poverty - difficult to find support and funding
    - Lack of specific support and access to services
    - Insufficient and complex social service delivery - difficult to make the transition out of poverty
- Local community organizations and HR workers play an important role in the advocation of HR approaches and opposing existing stigmatized views and systems but there is still a lot of work to be done.



Outreach and Low-threshold approaches[4]

- *"Access as a policy objective" (respondent)* - less barriers against access to services, more contact and entry points, and adapting from the side of social workers is important for successful HR.
- *"Existing services are not reaching target groups effectively"* and *"services are not adequately based on the needs of target groups" (respondent)* - need to focus on providing access to those that are excluded from services.
- Spearhead practice - leads to further understanding and reflection on the challenges of inclusivity within social work, and the ideas behind social welfare.

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Wider perspective of harm reduction in Ontario in comparison to the whole nation[5,6,7]

- People are afraid of dialing 911 during an overdose as "the presence of police makes people feel vulnerable and at risk of arrest" - this ultimately places lives at risk.[6]
- When comparing across harm reduction services across Canada, policy documents are a decent indication for the state of harm reduction of a specific province. Studies done in 2017,[5] as a part of Canadian Harm Reduction Policy Project (CHARPP), analyzed policies governing harm reduction laws, administrative practices, and services across 13 provinces and territories in Canada comparing 522 documents for screening. The results show:
    - While only BC and Alberta have current stand-alone and provincial-level harm reduction policies, Ontario presents none by only focusing on substance use, addiction, mental health, or sexually transmitted/blood borne infections.
    - Harm Reduction interventions in Ontario are less prominent when comparing to other provinces with regards to meeting program quality indicators despite the fact that Ontario is the most populated province.
- Recent CBC news revealed that since COVID-19, public health officials in Toronto received reports of overdose and death more than ever. Harm Reduction network officials also mentions the same factors that are preventing the spread of the pandemic is the same measurements that are limiting the access of services for drug users.
    - *"We have these two crises where you have the drug crisis intersecting now with another serious public health crisis and the most marginalized folks are the ones bearing the brunt"*, said Nick Boyce.[7]

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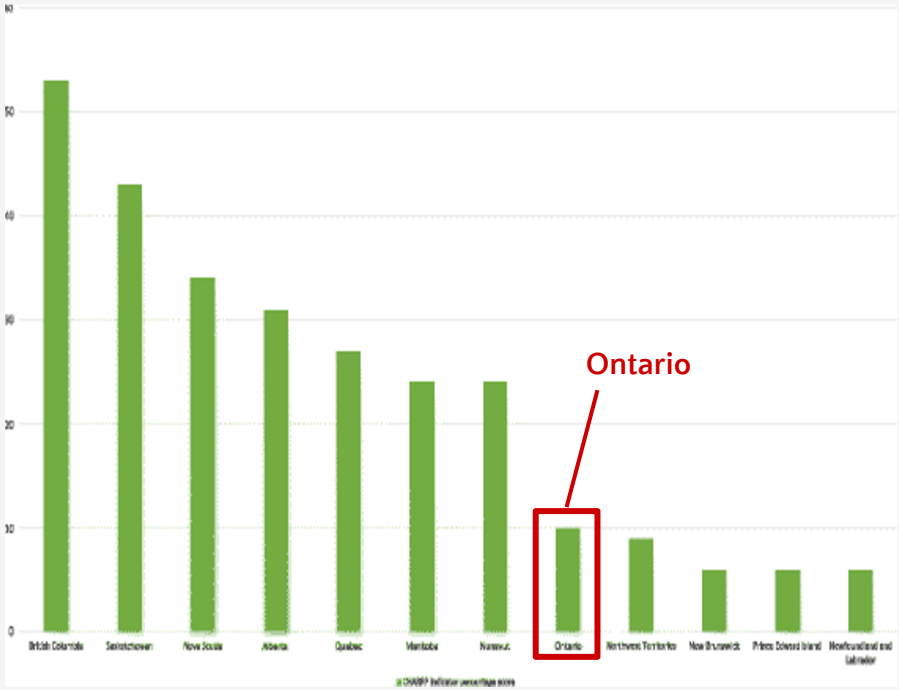
Case	Total no. of current documents (% of Canadian total)	Total no. of pages (% of Canadian total)
British Columbia	10 (19)	447 (15)
Alberta	4 (7)	246 (9)
Saskatchewan	3 (6)	447 (15)
Manitoba	7 (13)	142 (5)
Ontario	7 (13)	336 (12)
Quebec	11 (20)	544 (19)
New Brunswick	1 (2)	24 (1)
Nova Scotia	4 (7)	352 (12)
Prince Edward Island	1 (2)	26 (1)
Newfoundland and Labrador	2 (4)	164 (6)
Yukon	0 (0)	0 (0)
Northwest Territories	2 (4)	72 (2)
Nunavut	2 (4)	91 (3)
Canada	54 (100)	2891 (100)

In this table, we can see the total number of policies in each provinces and territories. Specifically looking at Ontario, the large population is in contrast with its low percentage of total number of pages (Around 12 %).[5]



% scores on CHARPP program indicators: the higher the % by province, the larger the number of documents with high quality harm reduction policies. Ontario is falling behind at 8th position.[5]

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From our research on current literature of the state of harm reduction in Canada and the challenges that it faces, we can see that there is a lot of work that still needs to be done to dismantle the stigma and implement long term solutions. This is a peculiar year where Harm Reduction on the streets are facing more issues and challenges than ever. In our findings, we attempt to address these problems and find out the details of harm reduction on the community level within Toronto regarding what is being done and how lived experience and outreach can make a difference.

Thought Prompts

Before we discuss our findings…

We want to raise the question: What does Harm Reduction mean to you and what are your thoughts when seeing the current state of Harm Reduction in Toronto (Could be something you see in real life, overheard on the news, etc…)?

Section 3: Findings

- **Key takeaways from the interviews**
  - A large part of HR is informing people about services and is not only related to drug use
  - Building relationship and trust is essential
  - Empathy is important
  - More long term accomplishments
- **What difference does lived experience makes in Harm Reduction works?**
  - Allows connections to be more personalized
  - People feel more comfortable opening up
- **What did COVID change?**
- **Challenges**
  - Building a relationship takes time
  - Difficult to achieve desired outcomes
  - Poverty within workers and lack of funding

Accomplishments and outcomes of HR Outreach with CHRRT

A large part is informing people about services and is not only related to drug use

- Providing help is not always related to drug use. Service users often just need to know that services are available and need help navigating systems so they know where they can get resources.
    - E.g. **Maggie's** In-reach strategies - involves going to other organizations and spreading information and awareness of available services. Maggie's is specifically catered for sex workers and can provide certain resources/input that other organizations may not be able to (e.g. questions about sex work, laws, safe sex kits, no judgement surrounding sex work).
- Many stressed the importance of verbal communication in spreading information. A less formal environment allows people to open up and be more comfortable utilizing services.
- Outreach is essential in ensuring that people are aware of the many options they have for different needs and are comfortable accessing them.
- PASAN outreach — an important part of this organization's harm reduction outreach focuses on educational sessions.
    - It is difficult to see how people are newly released (from incarceration) and how the system is built.
    - There is a lack of services provided by the government to support individuals newly released from incarceration. PASAN approaches this community with guiding suggestions of possibilities for employments and services (eg. housing).
- Drop in also provides foot care for people that are not able to take care of their feet.
    - This adds another level of service as some individuals will use the service for meals etc. Not only targeting drug users, Street Health also provides resources for people who have difficulty performing daily life operations within the local community.

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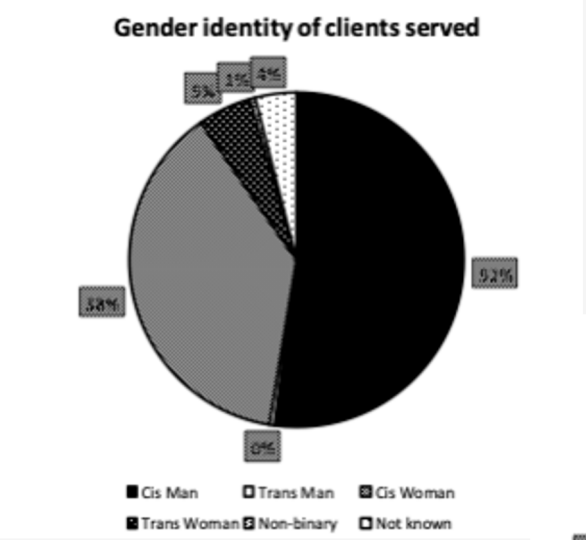
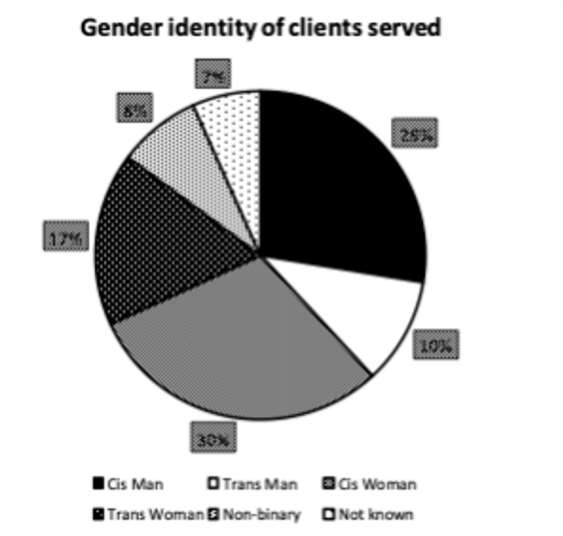
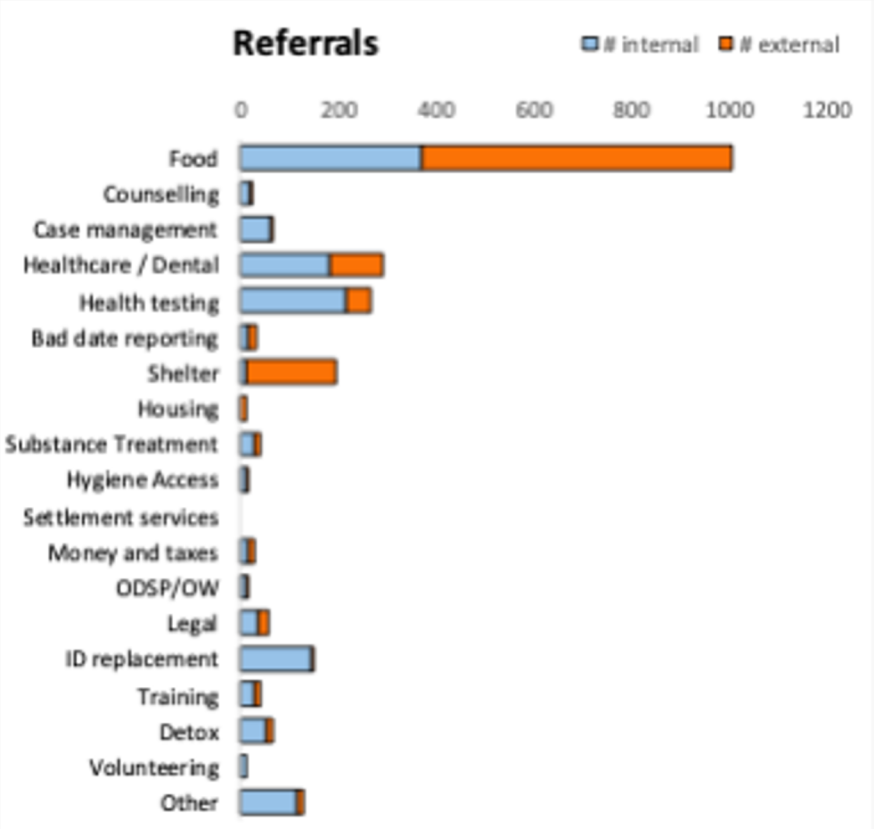
Figures from 2019 CHRRT Shift Tracking Data Sheet[2]





Streethealth (top left)
Maggie's (bottom right)

Demonstrates the importance of outreach and in-reach programs (like Maggie's) to ensure that they can reach a wider demographic.



There is a great range of referrals to different services, both internal and external. It is important to keep clients informed and ensure they have equitable access to the services and care they need.

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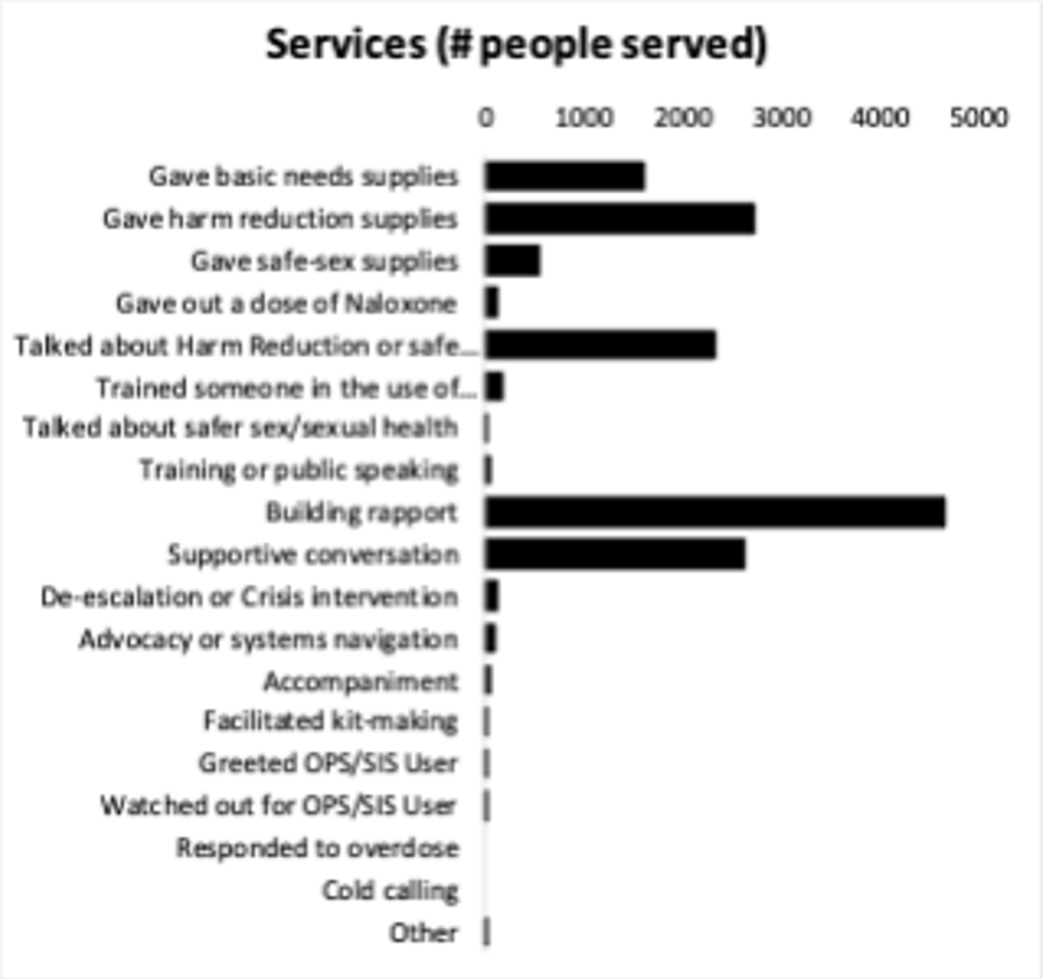
Building relationships and trust is essential

- When asking about what the workers are most proud of in their work, many said that the connections they build with service users is the most fulfilling - meeting people all over Toronto and having them recognize and open up to you. Respondent comments:
  - *"being a friendly face"*
  - *"help people feel not so alone"*
- As well as the relationship between workers and service users, trust among the workplace is also essential — policies addressing code of behavior.
  - *"When teammates are using, there are opportunities to do indoor work" (respondent).*
  - As there are shameful aspects of calling out or sending someone home, such tactful strategy allows workers to feel safe and valued in the workplace thus developing trust and bonds.



2019 CHRRT Shift Tracking Data Sheet[2]

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Empathy is important

- Avoiding empathy gaps — avoid contradicting anyone and prescribing symptoms to the individual seeking help.
    - Acknowledging their voices but approach them by not *"shutting them up" (respondent)*. Do not try to explain their feelings; instead, listening to them evokes trust and mutual respect.
    - Overcoming marginalization and alienation — do not depend on the person's *"middle class behavior"* (respondent).
- Gain a lot of empathy
    - Learn to be very patient with people and just listen to them.
    - Just sat and listened to someone for over an hour - *"they just needed someone to talk to" (respondent)*.

Long term

- Accomplish small goals with people
    - Asking people to share their goals with the workers — little steps ignite passion and objective in life
- Spreading the energy — mentoring and modelling
    - Often, people face stigma and fear over unemployment due to previous drug use, incarceration, etc. However, mentorship and modelling from stories of successful individuals in Street Health encourage people by providing hopes that they can do the same.
- Small steps can lead to longer term solutions.
    - Rather than forcing solutions, it is about overcoming stigma and providing more permanent solutions.

Importance of connection and providing services

(***Respondent***) I have been working with a guy who would come to drop-in sessions for meals and education. He drinks out of sheer depression and would drink until he passes out. But last month, he came in and told me that he is completely recovered and hasn't had a drink in 8 months, he also has a job now.

- The respondent concluded that giving the person time and waiting for themselves to open up by listening and not trying to put them down allows them to overcome the feeling of alienation and marginalization.

(***Respondent***) built a relationship with a service user during outreach work. They started to come into Street Health during drop-ins and gradually began to spend more time there, volunteering and helping out. They now work at StreetHealth together - seeing the transition from being a client to working and helping others in the same position is very fulfilling

Harm Reduction workers

Iye (left) Amanda (right) Tina (left) Natalie (right)

Importance of lived experience and low-threshold approaches

Allows connections to be personalized and for people to feel more comfortable opening up

- *"Everyone wants to personalize with someone" (respondent)*
- All of our interviewees emphasized the importance of being able to connect with service users and providing their own experiences to create an environment in which they can open up and feel safe and unjudged.
- Lived experiences allow workers to approach people with sufficient knowledge and understanding of the individuals in order to proceed as a modelling figure.
- *"Honey I know because we are the same, because I've been there and I am still here, the only thing separating us is the pay check". (respondent)*

Impact of COVID

PASAN

- *"To a person that has been incarcerated, social distancing and self isolation feels like being incarcerated again. This gives people anxiety and fear" (respondent)* since there is a loss of freedom.

Outreach workers are not getting paid properly

- With no government support at this time (no danger pay), some of the workers are overworked due to the absence of volunteers however are still getting paid the same.
- In short hands, there is less time to follow up and report on their work and less time to grief — cannot take a breath.
- *"Feel helpless and like [they] are working at half the capacity" (respondent)*

Increase in drug use and overdose

- People spend more time alone either in hotel programs or at home. This contributes to the increase of overdoses because pre-COVID communities that supported them are now gone.

No kit making or drop ins

- *(Respondent) "number (of people) has doubled since COVID"* meaning more people need supplies, food, and toiletries.
- There was no operation of outreach during the summer — the production and distribution of HR kits were shut down. Less access to services increased overdose rates at the same time, leading to increasing death and suicides.

Social distancing rules are broken

- *"If you are on a bender you're not thinking about a mask" (respondent).* This also relates to the shortage of supplies (masks, hand sanitizer, etc.), less number of workers, and lack of distribution.

Question: Why do you think the government has barely made any moves to support organizations like Street Health during COVID-19? What do you think are the most important things to consider to help people experiencing homelessness or poverty during COVID?

Challenges

Building a relationship takes time

- It is difficult to break through barriers and develop rapport. Often, it will take some time for them to open up and feel comfortable.
- Need to understand that moods will fluctuate and people will not always be at their best. Trauma-informed care is an important aspect of harm reduction.
    - **What is trauma-informed care?** - Understanding how trauma can affect a person's physiology and providing services that allow them to feel safe.[8]
    - Mental Health Action Plan outlines the importance of trauma-informed care.[8]

Safety and wellbeing of workers

- Sexual harassment and stalking of outreach workers sometimes occurred - avoid alleys and work in pairs or groups to ensure safety.
- Some Outreach team workers are living through poverty and unstable housings. Potential prison times and court deals are also difficulties amongst the internal environment..

Spreading the word

- It is difficult to spread information to the community and ensure that all people are aware of the services that are available.
- Spreading awareness to larger governmental organizations is also crucial to gaining support for the HR needs of the community

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Loss and grief in the community

- (Respondent) People are complaining of losses.
  - Since the agency is not equipped with strategies to help their staff members in coping with lost in the community. Many may feel overwhelming grief and need the time to take a breath.
  - There is a need of grief and loss support when death is a constant subject faced by the workers.
  - Trauma informed care, as mentioned previously, also applies in this case as workers witness and experience trauma in the form of loss.[8]
- Need to ensure the mental health and wellbeing of the outreach workers.

Funding

- *"Sucks that they don't get danger pay during COVID-19." (respondent)*
- "*There is not enough budget and everyone is cooking or buying stuff (for the drop in sessions)" (respondent).*
  - Funding has always been an issue to both drop ins and outreach both during and before COVID. With lack of funding, operation becomes difficult due to increased capacity and less materials to work with.
  - In turn, lack of funding impacts workers' feelings as helplessness emerges. There is always limited time and money to offer someone. This also connects to the problems with worker support.

Thought Prompts

What are some of the challenges that you think are important that we have not yet mentioned?

How have these challenges been addressed by the community?

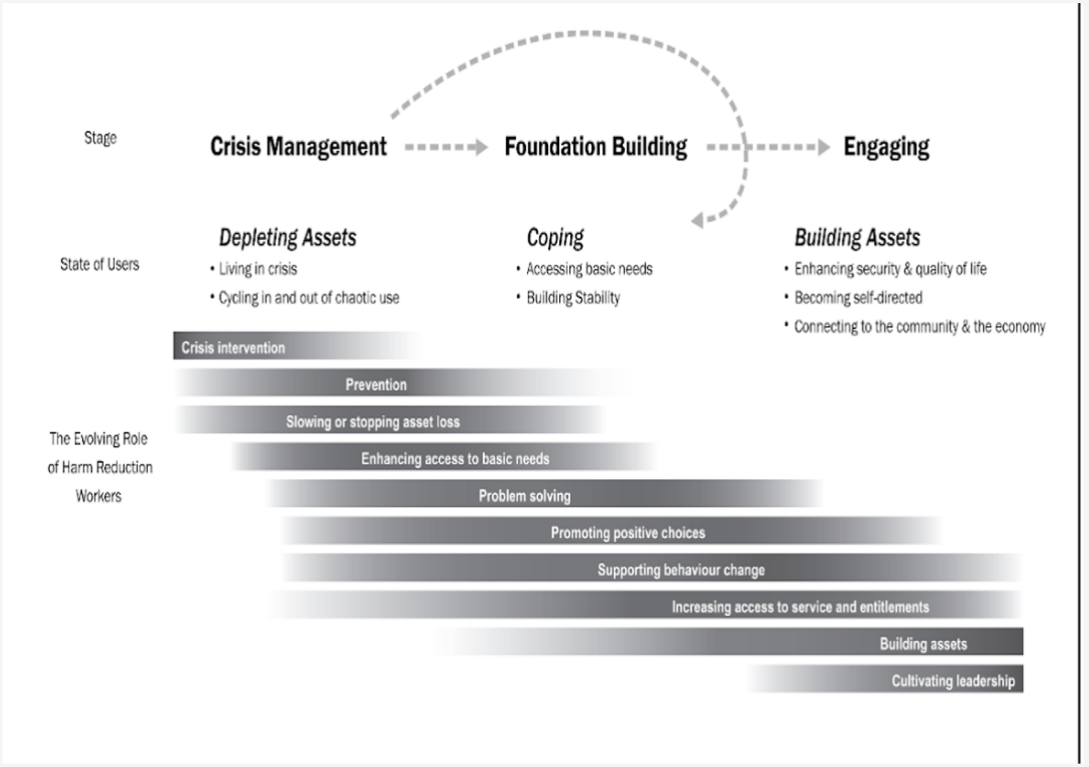
How do you think that these challenges can be overcome?

Section 4: What’s in for the future?

Conclusion

Overall, we observed similar ideas and experiences within the interviewees, with regards to the importance of low threshold Outreach to improve HR and act as a stepping stone towards more permanent solutions. Here are the key points:

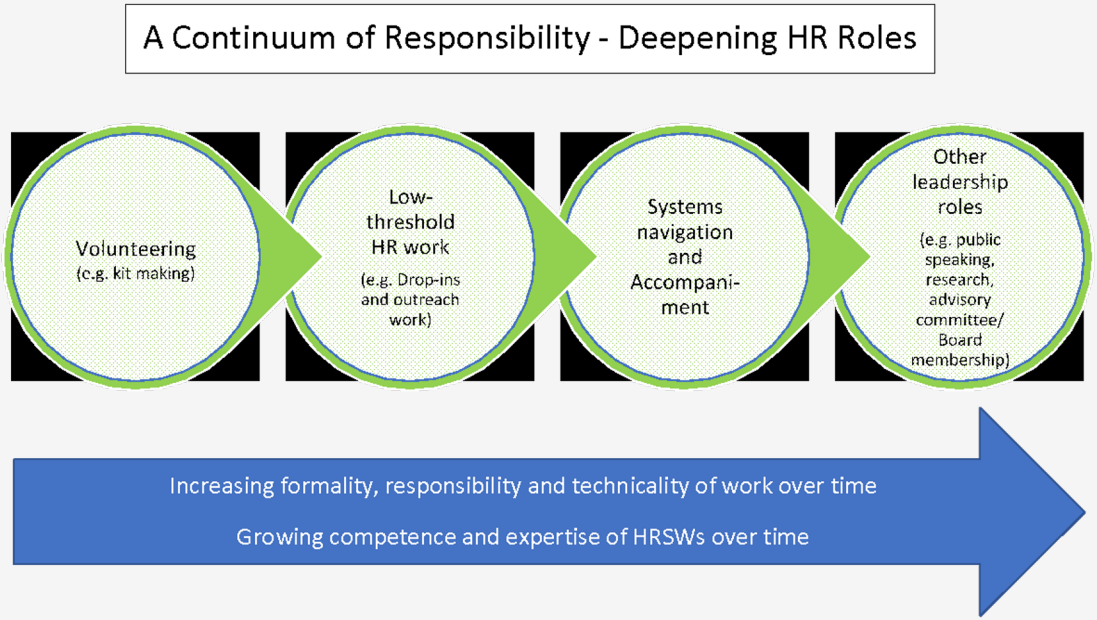
- Overcoming stigma
    - Changing stereotypes of “drug addicts”
- Investing the time necessary to build trust and reporting
    - Patience and hospitality are the keys to allow someone to open up
- Dealing with people in deep poverty and not accessing resources has escalated to a human right violation.
    - Organizations like Street Health send people out because it is *life saving*.



This image suggests the transition steps of individuals seeking harm reduction services. [1]

Expanding experiences of peer workers

- From our interviews and literature, having lived experience is clearly an important aspect of HR - can relate and personalize with clients.
- *(Respondent) "proceed in position of power"*. Directions are coming from authority (top to bottom structure) but would like to see more workers, POC and trans participants involved in executive decisions (bottom to top structure).
- Future steps for respondents inclued: applying for future funding to create an organization at different capacity and structure, going back to school for a degree on social work.
- Continuum of Responsibility (*Figure*) shows the increasing leadership roles over time, as a worker progresses from volunteering into paid work and navigating on a larger scale. Having people with lived experience and a connection to the community is important for upper roles but oftentimes, workers can be questioned about their qualifications/drug use - there is still some stigma associated, which is something we believe should be overcome. It is important to have a mix of both lived experience and credentials for efficient approaches to HR.



(Figure) From CHRRT Research

Problems that we still face

Challenges surrounding workers with lived experience in Ontario[9]

- Lack of support for peer-driven initiatives - persistent stigma surrounding peer workers where they are not seen as equals to other staff, drug use history amongst peer workers may cause health or legal complications.[9]
- Majority of resources are dedicated to intensive and institutional-based care over community harm reduction. “The percentage of community-based mental health budget allocated to Consumer Survivor Initiatives (CSI) is 2%.[9]
- This lack of funding and support, stigmatization, and restriction surrounding peer workers has hindered the implementation of lived experience workers in Ontario
    - “British Columbia and Alberta have prominent, provincially funded user-led organizations” [9]
    - If these barriers can be overcome, it could lead into the establishment of such organizations in Ontario, utilizing the experiences and knowledge of peer workers.

Still need to implement longer-term solutions

- Base level - handing out supplies, saving lives on the streets, providing community.
- Intermediate level - accompanying them to different organizations for different services, getting equitable access to healthcare, etc.
- Long term - preventative aspect, preventing people in worse situation and falling backwards.

While the base/intermediate levels are life-saving and essential to the community, in many ways it is just a **“band aid for problems”.** When looking at the larger picture, it is clear that there are still many problems to be addressed. There is a great lack of initiatives to support the transition out of poverty. Current responses focus on crisis & emergency responses but fail to implement longer-term solutions. While shelters and food banks are helpful and life-saving, more support for a stable living situation needs to be prioritized.

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Inadequacy and complexity of Social Service delivery — Problems with social services failing to address long term issues[1]

- People are not aware of the welfare benefits provided by the governments while people who are forced to rely on welfare are unable to escape poverty. Social injustice has been called out in Ontario for low welfare social benefits which places individuals below poverty lines even though they have received these benefits.
- Organizations other than Street Health (i.e. organizations other than low threshold harm reduction organizations), exclude individuals who do not present "the middle-class behavior" and thus facing discrimination and rejections of services – this means that people are not just stigmatized by society but also by the organizations that are set to help them.
- With referral to the "band aid solution", many organizations concentrate on short-term emergency services assisting long-term users. This is due to the program gaps in transitioning individuals to completely solve the issue from the root — poverty and stigma. Asset-building strategies are relatively neglected because workers are stressed in providing emergency services on the front line.

However, we do believe that low-threshold Harm Reduction approaches, guided by individuals with lived experience, is an important stepping stone to improving people's lives. Alongside many success stories we have heard from Outreach workers about individuals who overcome the stigma, poverty, and drug use, we believe in the future of Harm Reduction in Toronto. Even though Toronto is lagging behind in comparison to other cities nationally, it is improving onto a rightful path.

Thank you for listening

What other future improvements would you like to see in Street Health and Harm Reduction in Toronto?

What do you think are the first steps towards finding longer-term solutions?

How do you think we can raise awareness and start reducing the stigma of drug users and peer workers?

Additional comments? Questions?

Contact

Street Health

338 Dundas Street East
Toronto, Ontario, M5A 2A1
Tel: 416 921 8668
Fax: 416 921 5233

Email: info@streethealth.ca

Website: www.streethealth.ca

Twitter: https://twitter.com/StreetHealthTO

Facebook: https://www.facebook.com/StreetHealthTO/

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