# AN EVALUATION PROPOSAL FOR THE DOWNTOWN EASTSIDE SECOND GENERATION STRATEGY PEER INTEGRATION PROCESS

**by**

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## Abstract

Peer integration in health care planning and delivery is an effective strategy to reach out to underserved populations, as it provides opportunities for capacity-building and empowerment. Numerous underserved population groups reside in the Downtown Eastside (DTES), and struggle with complex issues such as poverty, mental illness, drug use, unemployment/underemployment, homelessness and crime. Vancouver Coastal Health (VCH), the responsible health authority has developed a second generation strategy to address these issues and improve the health of DTES residents. VCH also recruited peers to advise and give recommendations on how to implement this strategy. This capstone will focus on developing a comprehensive evaluation proposal for the peer integration process. Evaluating this process will enable VCH discover actions and approaches that bring about community change and empowerment. Process and outcome evaluations will be implemented using a combination of utilization-focused and participatory approaches. An evaluation advisory group will be created, and serve consultative purposes throughout the evaluation process. Findings from the evaluation would provide VCH with pointers to shape and improve future client engagements.



**Keywords**: program evaluation; peer integration; DTES; engagement, participatory

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# 1. INTRODUCTION

Program evaluation can be used as a tool to understand and improve community health services, especially when it is conducted with feasible, proper and accurate methods. This paper will (a) describe the issues and challenges experienced by Downtown Eastside population, (b) highlight the benefits of peer integration in health care, (c) propose an evaluation for Downtown Eastside Second Generation Strategy peer integration process; and (d) discuss implications and recommendations for public health practice. This evaluation proposal will focus on evaluating the projects and activities that a community group (i.e. peers) took part in, and not the entire organization (VCH) or the comprehensive community program (i.e. DTES 2GS).

The peer integration process in the Downtown Eastside Second Generation Strategy (DTES 2GS) involved the recruitment and orientation of peers to advise and inform the implementation of the strategy. The benefits of peer integration are well documented, however the components of the process, as well as the extent to which peer services have an impact are hardly studied. This provides little indication of the potential for peer engagement (Ellison et al., 2016). It is therefore important to study both the extent of engagement and the outcomes of that engagement to lay the foundation for more effective collaboration with peers.

Peer integration in health care planning and delivery is becoming a popular strategy to reach out to underserved populations, as it provides opportunities for capacity-building and empowerment (Guta, Flicker, & Roche, 2013; Hilfinger, Moneyham, Vyavaharkar, Murdaugh, & Phillips, 2009). The traditional paradigm of provider autonomy and control in decision making implies that care is not structured to promote community-oriented partnerships (Anderson & Funnell, 2005; Johnson et al., 2016; Kemper, Blackburn, Doyle, & Hyman, 2013). In a bid to promote consumer centered care, there is a shift in organizational culture towards community and stakeholder participatory practices. There is a growing recognition of the importance of lived experiences as a key part of quality care. Client perspective on the care they receive are valuable sources of information that can be used to shape effective solutions and target practice improvements in health care planning and delivery (Taloney & Flores, 2013).

Peer-led programs have proven effective in extending the reach and outcomes of provider-led services. They have been successful in improving disease management (e.g. obesity, diabetes), reducing harmful health behaviours such as drug use, and improving health outcomes such as uptake and adherence to treatment (Heisler, 2009; Kwan et al., 2017; LaRose et al., 2016). Peers are able to improve the access of disconnected people to health care due to the mutual relationship and shared experiences between peers and the client population (Heisler, 2009).

An evaluation of the DTES 2GS peer integration process should be planned and implemented, where short-term and long term outcomes can be monitored and measured. It may be challenging to study long term outcomes as they may occur several years after the implementation of the project. It would also be difficult to attribute these outcomes to the peer engagement, but we can monitor and measure how well peers' recommendations were incorporated into decisions for this initiative. The DTES 2GS peer integration process presents a rich case that can be followed and studied to understand how peers can drive change in large health systems.

# 2. BACKGROUND

## 2.1 The Downtown Eastside

The Downtown Eastside (DTES) is one of Vancouver's oldest neighbourhoods, and constitutes traditional territories of the Squamish, Musqueam and Tsleil-Waututh First Nations (City of Vancouver, 2013). There are conflicting opinions regarding the geographical locations and boundaries that make up the DTES. For community planning and statistical purposes, the Downtown Eastside is considered a defined area enclosed between the boundaries of Downtown and Strathcona, and includes seven distinct sub-areas: Chinatown, Gastown, Strathcona, Victory Square area, Oppenheimer District and Industrial Lands (City of Vancouver, 2013). This has implications for social and economic diversity among the population groups resident in this area. There is a lack of updated, accurate and comprehensive data for the DTES population. In 2011, the total population of the DTES was estimated to be 18, 477 (City of Vancouver, 2015a).

Roe (2010) argued that the DTES is more of a conceptual community than a physical one; defined in terms of need and the challenges faced in the area. Residents of the DTES are largely seen as clients, classified into service categories and considered vulnerable. These population groups include low income singles and families, sex workers, women, children and youth, homeless, seniors, LGBTQ residents, people with disabilities and mental illnesses (City of Vancouver, 2013).


**Figure 1: Map of the Downtown Eastside** (VANDU, n.d.)

## 2.2 Issues in the Downtown Eastside

The DTES struggles with a lot of complex issues such as homelessness and inadequate housing, poverty, unemployment, mental health, drug use and crime (City of Vancouver, 2013). These are summarized below:

### 2.2.1 Poverty

According to 2006 census data, DTES has the lowest median income of $13, 691 per annum in Vancouver, the rest of the city have a median income of $47,229 per annum. Majority of the DTES population are poor and dependent on charity and social supports, and other forms of financial assistance (City of Vancouver, 2015a). In 2005, 53 percent of DTES residents were considered low income after tax, with residents of Victory Square and Oppenheimer at 79% and 70% respectively (City of Vancouver, 2013).

### 2.2.2 Homelessness and Inadequate Housing

The most common housing type in the DTES are Single Room Occupancy (SRO) Apartments, provided by public and private markets. These SRO units offer the lowest costs for rent, but are still unaffordable for many low income residents on financial assistance. In 2011, majority of SRO (3975) units were privately owned with an average rent of $416 while 1,522 public SRO units were available, all renting at $375 (City of Vancouver, 2013). The units are mostly substandard, suffer pest infestations and in a state of disrepair; they also lack private bathrooms and cooking facilities (City of Vancouver, 2014). In 2015, 1746 people were estimated to be homeless in the DTES, including 488 who are not in shelters and live on the streets (City of Vancouver, 2015b).

### 2.2.3 Food Insecurity

Majority of DTES residents can not afford nutritious and safe food, they also lack access to kitchen facilities and are unable to prepare or store their own food. Despite the proximity to food and grocery stores in the DTES area, affordability and accessibility contributes to food insecurity. There is huge reliance on free and charitable food provided by social service organizations, housing providers, the health authority and faith-based groups (City of Vancouver, 2014).

### 2.2.4 Drug Use and Mental Illness

The DTES suffers high rates of mental health issues and drug use. When compared with the rest of Vancouver, DTES residents have a higher rate of depression and anxiety (VCH, 2013c). Mental illness is often linked with substance use and poverty; co-occurrence of mental illness and drug use is prevalent in the DTES (BC Ministry of Health, 2013). Drug use is also associated with unstable housing and homelessness (BCCfE, 2013). Vila-Rodrieguz et al. (2013) investigated 293 SRO tenants in the DTES, and identified that 95.2% had substance dependence, and 61.7% were injection drug users. 74.4% had a mental illness, the most common was psychosis in 47.4% of the participants.

## 2.3 Health and Wellbeing of DTES residents

According to WHO, health is not only the absence of disease, but a state of complete physical, mental and social wellbeing. Health is largely influenced by social and economic factors, such as education, income, employment, housing, health services, social position, social inclusion/exclusion. These factors are complex and interrelated, and could result in health inequities for certain population groups, like those in the DTES. DTES also has a higher proportion of Indigenous peoples than the entire city (City of Vancouver, 2013); racism, colonialism, history of residential schools and disenfranchisement have an impact on Indigenous health and wellbeing. DTES residents suffer great disadvantages; majority are poor, unemployed/underemployed, homeless, socially isolated with low levels of education (City of Vancouver, 2013). Populations in the DTES lack access to basic needs such as bathrooms, showers, laundry facilities and water fountains. They experience worse health outcomes when compared to the general population. Life expectancy at birth in the DTES is 79.9 years compared to 82 years for British Columbia (City of Vancouver, 2013). Rates of suicide, alcohol and drug related deaths continue to increase for DTES residents compared to the rest of Vancouver (VCH, 2013d).

## 2.4 The Downtown Eastside Second Generation Strategy (DTES 2GS) and Peer Integration

Vancouver Coastal Health (VCH) is the regional health authority responsible for funding and providing health care services in the DTES. Despite the high concentration of health and social services in the DTES, the area still faces a lot of complex challenges, and the health gap between DTES residents and the rest of Vancouver continues to widen (VCH, 2012). To address this issue, VCH conducted a series of consultations with DTES residents, community partners, VCH staff and agencies in the DTES. These consultations led to the development and design of the Downtown Eastside Second Generation Strategy (DTES 2GS). This strategy takes an integrated approach by recognising that there are various interwoven factors that affect the health outcomes in DTES residents. VCH will be collaborating with community agencies and partners working in areas of nutrition, primary health care, housing, harm reduction, mental health services, social welfare in the DTES to design and implement this strategy.

A specialized peer advisory group was recruited to advise and give recommendations regarding the DTES 2GS. This is the first time VCH will be involved in funded peer engagement, and as such, it is a new and exciting learning experience for the organization. More details on the DTES 2GS and the peer integration process is in Section 4.1.2

## 2.5 Benefits of Peer Integration

Peers have been identified to work in various capacities, either voluntary or paid positions, including research, support, administrative, advocacy and advising roles (Jacobson, Trojanowski, & Dewa, 2012). Peer integration improves the cultural appropriateness of public health programs, as well as improve recruitment and participation efforts (Minkler, 2005). The high rates of participation and the general achievements of the PROUD cohort study was heavily attributed to the hiring and training of peers who worked in advisory and research roles (Lazarus et al., 2014). Recruitment of people who use drugs is usually a challenge for studies; by involving peers throughout the stages of planning and implementation, Lazarus et al. (2014) gained access to over 800 people with drug use experience; and reported high rates of consent to HIV/AIDS testing and prospective follow-up. The peers were actively involved in recruiting participants, conducting interviews and carrying out HIV tests (Lazarus et al., 2014). Simoni et al (2011) also found that integrating peers in HIV interventions contributed to positive outcomes such as reduction in risky sexual behaviours, and improved knowledge and attitudes about HIV.

Broadhead et al. (1988) compared the performance of a provider-led AIDS prevention outreach with a similar peer-driven intervention for injection drug users. They found that there were more injection drug users recruited in the peer-led program, and they were more representative and diverse in terms of race, ethnicity, gender and age when compared with the provider-led program. They also recorded a greater reduction in HIV risky behaviours such as sharing of syringes in participants of the peer-led program, and found the peer program to be cost-effective, in comparison to the provider program. Hayashi et al. (2010) found similar results from the study of a peer-run syringe exchange program. The peer program successfully reached a group of high-risk drug users who were homeless or unstably housed. They recorded an increase in access to needles and a reduction in needle reuse in the participants.

Peer engagement has long been identified as an effective resource in minimizing the use of substances in various population groups (Black, Tobler, & Sciacca, 1998). Peer support in mental health services has been identified by Substance Abuse and Mental Health Services Administration as one of the ten components of recovery (SAMSHA, 2012). A peer is defined by SAMSHA (2016) as "a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resilience." Black et al. (1988) examined two existing studies, each comparing the effects of peer-led programs with traditional outreach programs. Botvin (1990) compared peer-led programs with teacher-led and control programs, and discovered that peer-led intervention programs was most effective against cigarette smoking, cannabis use and excessive drinking in high school students. Perry and Grant (1988) reported that participants in a peer-led program demonstrated reduced alcohol use, were more knowledgeable, with improved attitudes about drinking, when compared to a similar provider-led program.

# 3. RATIONALE

The purpose of this paper is to develop an evaluation proposal for the DTES 2GS peer integration process. I will draw upon my practicum experience, and the critical reflection that occurred during and after my practicum with Vancouver Coastal Health (VCH).

## 3.1 Practicum Experience

Community Engagement was a key aspect of my practicum with Vancouver Coastal Health, a provincial health authority in British Columbia, Canada. The organization has a dedicated Community Engagement department that oversees all patient and public engagement affairs. The team works across all the service regions and sectors of care to facilitate participation in health service delivery and planning. They run a large network of patient, family and peer advisors who sit on various committees within VCH referred to as CEAN (Community Engagement Advisory Network).

Community engagement and program evaluation were central pieces of my practicum with Vancouver Coastal Health in BC in 2015, and I am writing my capstone based on my experience, observations and arising questions. My practicum involved conducting an evaluation for the community advisory processes at Vancouver Coastal health, part of a larger effort to shift the organizational culture toward client engagement. The goals of this work were to facilitate and enhance communication between advisors and VCH staff, empower VCH staff to better support patient and family advisors, and identify areas for practice improvement.

During my time at VCH, I worked closely with the Community Engagement team and CEAN (Community Engagement Advisory Network) members. They are patients, family and public advisors who works as volunteers, participating in VCH projects and planning committees. Through surveys and focus groups, I was able to identify facilitators, challenges and areas of improvements for this process.

Another project I worked on was the recruitment and orientation of peer advisors for the Downtown Eastside Second Generation Strategy. This is the first time the Community Engagement team at VCH will work with paid peer advisors from the

Downtown Eastside. These advisors were recruited to bring the voices of clients and residents of the DTES into the planning and implementation of the 2GS. It is expected that their input would improve health services and enhance the health of the DTES community.

## 3.2 Critical Reflection

My presence and involvement during the recruitment and orientation of the peer advisors added to my learning experience during the practicum. I also attended monthly meetings with VCH staff and the advisors, and some of my observations are discussed below:

VCH was conducting a paid engagement for the first time as previous community engagement processes were based on volunteerism; and this area of engagement was new to the organisation. The uncordial relationship between the organization and DTES residents was a common theme that came up during the meetings. There needed to be an establishment of trust and rapport for this collaborative work to run smoothly, and to ease the tension between both parties.

Although a strong level of commitment was shown by relevant VCH departments to the project, participants were uncertain about the genuineness of the engagement process. There was need for further clarity about the level and extent of engagement, especially the level of decision-making/influencing power the peers had. The plans for continuity and sustenance of the peer integration process was also an emerging issue, which probed the commitment of VCH leadership beyond the provision of funds to run the initiative.

## 3.3 The Need to Evaluate the Peer Integration Process

### 3.3.1 To foster trust and communication

An evaluation of the peer integration process will be valuable; it would build and enhance relationships between the stakeholders. It could serve as a tool to foster trust and communication as it would entail a deeper engagement with the peers, by creating an avenue for them to voice their satisfaction or dissatisfaction with the process and the overall health system.

### 3.3.2 Improve health and wellbeing of program participants

The evaluation could also serve as a tool for health promotion, by having a positive unintended effect on the health and wellbeing of the peers. Health promotion is “the process of enabling people to increase control over, and improve their health” (WHO, 1986, p.1). If conducted properly with a participatory approach, their active involvement in the program and its evaluation could contribute to a feeling of control over their lives.

### 3.3.3 Improve VCH’s future engagements

An evaluation could be used as an inquiry that assists in making sense of what happened in a program, it seeks to produce knowledge about the operations, effects and implication of the program (Mark, Henry & Julnes, 2000; Potvin & Goldberg, 2012). Findings from the evaluation would provide VCH with pointers to shape and improve future engagements or interactions with residents of the DTES, as well as other population groups. Evaluating the peer integration process will enable VCH discover actions and approaches that bring about community change and empowerment.

# 4. PROPOSED EVALUATION

The WHO European Working Group (1998) defined evaluation as “the systematic examination and assessment of the features of an initiative and its effects, in order to produce information that can be used by those who have an interest in its improvement or effectiveness” (p. 3).

## 4.1 Program background memo

### 4.1.1 Organizational context: Vancouver Coastal Health

Vancouver Coastal Health (VCH) provides a wide range of healthcare services to more than 1 million BC residents in three communities of care: Richmond, Vancouver and Coastal regions (Sunshine Coast, Bella Bella, and Bella Coola). The area ranges from large urban centres to small, rural communities; and includes 17 municipalities and 15 First Nations communities. Some of the services provided include primary care, community and home-based care, mental health, addiction services and health research (VCH, 2016).

Vision: We will be leaders in promoting wellness and ensuring care by focusing on quality and innovation

Mission: We are committed to supporting healthy lives in healthy communities with our partners through care, education and research.

Values:

- Service: We will provide outstanding service and respond to needs in a timely and innovative manner.
- Integrity: We will serve openly and honestly in a caring and compassionate environment.
- Sustainability: We will focus on effectiveness, efficiency, best practices and health outcomes, holding ourselves responsible for results

Goals: We are guided by four organizational goals to achieve our vision.

- Provide the best care

- Promote better health for our communities
- Develop the best workforce
- Innovate for sustainability

Strategic framework: People First

Our people first strategy shapes how we approach our vision, mission, values and goals.

### 4.1.2 Program description

***The Downtown Eastside Second Generation Strategy (DTES 2GS)***

In 1997, a public health emergency was declared in the DTES due to injection drug use, overdose deaths and high rates of HIV/AIDS and Hepatitis C transmission. Progress has been made, indicated by a reduction in HIV infection rates among injection drug users; from 352 in 1996 to 29 in 2012, as well as improved life expectancy (Montaner et al., 2014). However, the Downtown Eastside is far from well, there are still numerous challenges faced by residents of the DTES. People are now living longer, but with mental illnesses, addictions, chronic conditions like chronic obstructive pulmonary disease (COPD) and poor living conditions such as inadequate housing (VCH, 2012). The health gap between Vancouver residents and DTES residents persists. The lack of proper coordination of health and social services has contributed to this inequity and constitutes a barrier to access care (Nosyk et al., 2015).

In response to this, Vancouver Coastal Health, after consultations with VCH leaders and staff, agency partners, community based providers, clients and residents in the DTES, developed a new strategy to improve health outcomes and respond to the evolving needs of DTES residents. The second generation strategy (2GS) builds upon the success of previous strategies and models in place in the DTES (VCH, 2013a). The Four Pillars Drug Strategy was adopted in September 2000, three years after the health emergency declaration. It was based on the four pillars of Prevention, Treatment, Enforcement and Harm Reduction; and was targeted towards drug misuse and the illegal drug trade (MacPherson, 2001). The action plan included public education, legislative and regulatory control, provision of treatment and counselling intervention, improved collaboration between enforcement and health agencies, and replacement of abstinence-based approaches with harm reduction approaches such as needle exchange programs (MacPherson, 2001). The Four Pillars Drug led to the establishment of harm reduction as

a tool of care for residents struggling with addictions. A direct achievement of this strategy is the opening of InSite, a supervised injection site in the Downtown Eastside, and the first in North America (VCH, 2013a). The operation of InSite and needle exchange programs contributed to the reduction in the number of drug users using openly on streets, overdose deaths, and HIV and hepatitis infection rates (BCCfE, 2010). However, the Four Pillars Drug strategy is considered partly successful; the areas of prevention, enforcement and treatment were not adequately addressed (VCH, 2013b).

The 2GS was developed as a response to changes in the health needs of the DTES population. The 2GS differs from the Four Pillars Drug strategy in a number of ways; it is more comprehensive, beyond the issue of drug misuse and addictions. It takes into account the evolving issues residents of the DTES experience, as well as the ways VCH has contributed to the situation through lack of communication, inappropriate service design and delivery, and insufficient funding (VCH, 2012; VCH 2013a; VCH, 2014). With the 2GS, VCH seeks to support the evolution of health services towards the provision of cost effective, evidence based care within a cohesive network of community based health services (VCH, 2013a).

Overall (Public Health) Goal: To improve the health and wellness of residents of Vancouver Downtown Eastside by reshaping the delivery of Vancouver Coastal Health services.

2GS Program Goal: To support operational excellence at every level of VCH and among our contracted health service partners; to work deliberately and measurably towards improved health outcomes for vulnerable residents living in the DTES; and to foster more open and synergistic partnerships among our health service partners as well as with other agencies, organizations and orders of government active in the DTES.

The 2GS design involves a series of coordinated actions in five broad approaches, with specific actions associated with each:

- Strengthening relationships with community partners
- Expanding care teams and skill sets
- Integrating health services to better coordinate care for clients
- Aligning services with client demand
- Achieving performance excellence

Target Areas: Addictions and Mental Health Services, Primary Care and Addictions Medicine, Supported Housing, Nutrition, Communicable Disease Prevention, Specialized Harm Reduction, and HIV Treatment Supports; and Low Barrier Gateway, Navigation and Social Support Services.

### *Peer Integration for the DTES 2GS*

Through out the development of the 2GS, the importance of peer involvement was acknowledged. The commitment to peer work within the 2GS provided an opportunity to increase awareness, understanding and support for peer roles within VCH.

In May 2015, 12 peers were recruited to take up paid advisory roles within VCH for the DTES 2GS. For this purpose, a peer is defined as

> "a person with a role within a VCH service where their lived experience is identified and central to their role. In this case, this lived experience is similar to the client population in the Downtown Eastside. This could mean experiences with mental health or substance use issues that has had a significant impact on their life and/or a shared culture, Aboriginal, First Nation, Metis identity, gender, sexuality, experience with sex work, experience living or accessing services on the Downtown Eastside, and/or with other identities or experiences" (VCH, 2015).

The various operational agencies and service providers involved in 2GS are required to request for one or two peers to sit on their committees to discuss and give recommendations on the target areas of the DTES 2GS (i.e. nutrition, housing, mental health services, etc.). Monthly team meetings are held with the peers, where they all discuss and give updates about their roles on the committees they advise. The Community Engagement (CE) team, service providers, VCH staff and other stakeholders are usually well represented at these meetings.

Program Activities: Completed activities include recruitment, orientation and training of peers, development of DTES Peer Framework, development and distribution of educational materials for peer and staff, capacity building of non peer staff, and identification of peer allies. Ongoing activities include peer request and contract management, committee advising, and attendance at monthly team meeting.

### 4.1.3 Theory of Change (Logic model)

The theory of change, otherwise known as logic model outlines the activities involved in the development and implementation of the DTES 2GS peer integration, as well as the expected outcomes from the initiative. The logic model explains what the organization is hoping to achieve with the initiative, and is useful in identifying evaluation questions. The theory of change can be tested in the evaluation; indicators to measure the outcome of the initiative can be identified as the logic model outlines outcomes that indicate success or areas for improvement, as well as the overall effects of the strategy.

The theory of change for the DTES 2GS and the process of identifying evaluation questions is shown in Tables 1 and 2 respectively. The components of the logic model are explained below:

**Inputs** are human, financial and material resources that were used for the initiative

**Activities** are the actual interventions that the program implements in order to achieve outcomes

**Outputs** are direct products obtained as a result of program activities

**Outcomes** are the changes, impacts, or results of program implementation (activities and outputs). This is the effect that the initiative had on participants. Outcomes could be short-term, intermediate or long-term.

- Short-term outcomes are immediate changes that are largely influenced by the program
- Intermediate outcomes (also medium-term or mid-term) are changes that are anticipated to occur from short-term outcomes. The program has less influence on these changes
- Long-term outcomes (also referred to as impact) are expected after short and medium term outcomes. They include large scale population changes and are significantly influenced by events outside the program.

**Table 1: Logic Model - DTES Peer Integration**

| Inputs | Activities | Outputs | Short-term outcome | Medium-term outcome | Long-term outcome |
|---|---|---|---|---|---|
| Financial resources<br><br>Operational and support human resources<br><br>Collaboration with community agencies/partners | Engage stakeholders<br><br>Recruit peer advisors<br><br>Orientation and capacity building of peers<br><br>Online survey administered to VCH staff<br><br>Monthly meetings and Committee advisory meetings | Peer Integration Work plan<br><br>DTES Peer Framework<br><br>DTES Peer Advisory Group<br><br>Pre-test data available from staff responses | *Peers feel supported and part of the team<br><br>*Staff have improved knowledge and ability to work with peers<br><br>Clients have access to peer support<br>, | *Peers stay in position for over a year<br><br>*Staff have improved clarity of peer role<br><br>Clients have reduced experience of stigma | At-risk people are engaged in care<br><br>*Clients have access to patient-centered care<br><br>Peers and Clients have unbroken attachment to care<br><br>*Staff have increased perception of the values of peer<br><br>Overall health improvement |

Adapted and modified from: VCH. (2016). Theory of Change - DTES Peer Integration [Internal Document].

* - Evaluation will focus on outcome components that involve peer advisors and VCH staff

**Table 2: Identifying Evaluation Questions**

| Logic Model Component | Identified Evaluation Questions |
|---|---|
| Resources (Input) | What are the cost or benefits associated with implementing this initiative, compared with previous strategies? |
| Activities/Outputs | Were all the components of the peer integration initiative implemented, as planned? |
| Outcomes | Do peers feel supported and part of the team?<br><br>How many peers are still in position till date?<br><br>To what extent do staff understand the role and value of peers?<br><br>What direct actions have been implemented based on peer recommendations?<br><br>What knowledge, attitudes, skills and behavior changes have occurred among VCH non-peer staff, partner agency staff and peers since the implementation of the initiative?<br><br>To what extent has client access to care improved as a result of this initiative?<br><br>How has this initiative contributed to the establishment of trust and rapport with the Downtown Eastside community? |

## 4.2 Evaluation Design Memo

### 4.2.1 Evaluation Purpose, Type and Questions

***Purpose of the evaluation***

The purpose of the evaluation is to assess the genuineness of the engagement process, outcomes of the peer integration and identify areas for improvement to guide VCH's future engagements.

The peer advisors and VCH have identified that intent and reason for the peer integration process, as well the level to which the peers would be engaged and related decision-making/influencing power could indicate the genuineness of the initiative.

### *Types of Evaluation to be conducted*

Both process and outcome evaluation will be used in this evaluation. Process evaluation "is an ongoing check of the implementation of an initiative; it provides information on the extent to which program is being implemented as planned" (Harris, 2010, p. 94). By using process evaluation, we can look at the implementation processes/activities of the peer integration, and identify successes and areas for improvement. Process evaluation will provide insight into the resources being used to implement the initiative, and help to identify VCH's capacity to achieve the desired outcomes from this initiative (Linnell, 2014).

Outcome evaluation "assesses the effectiveness of the fully implemented and stabilized initiative and measures the extent to which the initiative made a difference to those who were exposed to it" (Harris, 2010, p. 94). The DTES 2GS peer integration process is still ongoing, however, an outcome evaluation will be used to assess the effectiveness of what has been rolled out to date. An example of this will be to review some of the progress that has been made in the overall DTES 2GS program and identify the contributions the peers have made towards this. Expected as well as unexpected outcomes will be measured during this evaluation.

### *Evaluation Questions*

The following are suggested evaluation questions:

Process Evaluation Questions:

- Were all the components of the peer integration initiative implemented, as planned?
- What are the costs or benefits associated with implementing this initiative, compared with previous strategies?

Outcome Evaluation Questions:

- Do peers feel supported and part of the team?
- How many peers are still in position till date?
- To what extent do staff understand the role and value of peers?
- What direct actions have been implemented based on peer recommendations

- What knowledge, attitudes, skills and behavior changes have occurred among VCH non-peer staff, partner agency staff and peers since the implementation of the initiative?
- To what extent has client access to care improved as a result of this initiative?
- How has this initiative contributed to the establishment of trust and rapport with the Downtown Eastside community?

### 4.2.2 Evaluation Approach

VCH has identified a number of concrete changes it hopes to see as a result of this initiative, which will be measured during this evaluation exercise. Some of these changes include improved staff- peer working relationship, a positive impact on rapport, trust and communication with the DTES community, increase in number of at-risk people engaged in care. VCH has also identified that the evaluation results will be used to request for a provision of funds to continue with the peer integration initiative. In order to best support VCH to achieve these goals, participatory and utilization-focused approaches will be used to evaluate the peer integration process.

Adopting a participatory approach will foster a partnership with stakeholders at each stage of the evaluation process, and aims to build stakeholders' evaluation capacity. Stakeholders will be play active roles in developing and implementing the evaluation. The evaluation process will represent the perspectives of the most affected stakeholders and beneficiaries of the program (Zukoski & Luluquisen, 2002). Incorporating a utilization-focused approach will ensure that the evaluation process and its outcomes are useful to VCH and its stakeholders. Patton (2008) defined utilization - focused evaluation as "evaluation done for and with the specific intended primary users for specific intended uses" (p. 37). This will increase the likelihood that the evaluation outcomes will be useful to VCH, especially in deciding whether to continue the initiative or not; and how to improve the integration process and future peer engagements. This approach will increase buy-in from intended users and build a better understanding of the evaluation process and results (Patton, 2008; Knowlton & Phillips, 2009).

Challenges that may arise from both approaches include possible conflicts among the individuals involved due to differences in class, culture, social location and job roles. It is also time-consuming and costly, as the process will require commitment from various

actors. (Patton, 2008; Zukoski & Luluquisen, 2002). To address these challenges, financial resources available for the evaluation will be clearly reviewed and stated, time availability will be negotiated right from the beginning of the evaluation process. A term of reference will also be developed and used as a tool for conflict resolution, and can be revisited throughout the evaluation process. Refer to Appendix B for a proposed budget.

A combination of these approaches enables the evaluator assume a facilitating role, rather than an expert role. This will enhance a sense of ownership of the process and product of the evaluation among the stakeholders. As a facilitator, the evaluator will coordinate the various stakeholder groups involved, manage relationships, and negotiate between the many players and competing agendas (Poland, Krupa & McCall, 2009; Zukoski & Luluquisen, 2002). The evaluation of the peer integration process must be well-facilitated to avoid reinforcing power differentials that may exist between the peer advisors and VCH.

### 4.2.3 Evaluation design

This evaluation will use an observational pre/post and post-only design. To determine the effectiveness of the initiative, a pre/post test design will be used where baseline data is available; and a post test only design where applicable. A major threat to the validity of an observational design is the delay of time effect, some programs may actually be effective but require more time than the evaluation timeframe allows to induce detectable changes (Fink, 2005). This can lead to an underestimation of the actual effects of an intervention.

### 4.2.4 Stakeholder Engagement Plan

To ensure that evaluation results are well understood and used, it is necessary to involve key stakeholders, especially the end-users in the evaluation process. An evaluation advisory group that will serve consultative purposes through the course of the evaluation process will be formed. The individuals in this advisory group will bring in insight, wide and varied experience, and knowledge and skills to the evaluation process. They will provide opinions, suggestions and information throughout the evaluation (Harris, 2010).

The benefits of working with an evaluation advisory group include:

- Engaging stakeholders from the beginning will increase buy-in and support of the evaluation
- Ensuring that information is collected, analyzed, and reported in an understandable manner for the intended users
- Ensuring that the results from the evaluation process are used

The various avenues for input from this advisory group include:

- Refining and making necessary changes or additions to the evaluation questions listed above
- Identifying key indicators *to* measure the outcomes of DTES 2GS peer integration initiative
- Assisting with data collection - selection of data collection methods, pretest data collection tools, identify and/or act as key informants, promote responses to surveys, etc.
- Analysis and interpretation of data
- Dissemination of evaluation findings - timing, expectations and formats (CDC, 2011)

The stakeholder analysis matrix, shown in Table 3, is necessary to identify people who were involved in the planning and implementation of the Peer integration initiative, people who are affected by this program, as well as the intended users of the evaluation result. As these stakeholder groups would have varied interests, they will be involved in the evaluation process in various ways.

**Table 3: Proposed Stakeholder Analysis Matrix**

| Stakeholder organization, group or individual | Potential interests in the evaluation | Involvement in the evaluation |
|---|---|---|
| **BC Ministry of Health** | • Commitment to VCH<br>• Interested in the outcomes of the program<br>• Evaluation findings can inform future health care policies | • Access to files, reports and publications |
| **VCH Leadership** | • Commitment to the DTES 2GS<br>• Distributes funding to the various components of the DTES 2GS, including the peer integration<br>• Interested in the outcomes of the initiative, evaluation findings could influence future decision-making and budgeting | • Funding for evaluation – cover costs associated with data collection and analysis, provide incentives for participants<br>• Administrative and logistical support<br>• Discussion |
| **Community Engagement Team** | • Facilitate involvement of other stakeholders<br>• Interested in genuine and meaningful engagement<br>• Findings from evaluation will guide further engagement processes | • Administrative and logistical support<br>• Access to other stakeholders -necessary for data collection<br>• Access to files, reports and publications<br>• Data Analysis |
| **Planning committee for the Peer Integration process** | • Interested in evaluation results, could inform future planning/expansion opportunities | • Provide implementation details<br>• Provide guidance in framing evaluation questions<br>• Data collection |
| **DTES 2GS committee chairs** | • Requests for peers to sit on their committees<br>• Evaluation findings could impact quality improvement and future collaborations with peer advisors | • Data source – Interviews<br>• Data interpretation |
| **Peers** | • Evaluation provides opportunity to voice satisfaction/dissatisfaction with the integration process<br>• Evaluation findings could influence future work with VCH | • Data source - Interviews/Feedback<br>• Review data collection tools<br>• Data interpretation<br>• Discussion |

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|---|---|---|
| **Peer Allies** | • Support peers in their work<br>• Findings from evaluations will influence future work with peer advisors and organization leaders | • Data source - Focus group participants<br>• Data interpretation |
| **VCH staff** | • Evaluation findings could improve working relationship with peers | • Survey respondents<br>• Discussion |
| **Agencies/Service providers** | • Results from evaluation could be used to improve quality of health care services provided | • Data source - Interviews/Feedback<br>• Provide feedback regarding evaluation methods and tools<br>• Discussion |

## 4.3 Data Collection and Analysis memo

### 4.3.1 Evaluation Plan

The evaluation plan is an important tool to facilitate the evaluation process. The plan encompasses: the evaluation questions to be answered, a description of the indicators pertaining to each evaluation question, the types of data sources and data collection methods that will be used, a timeframe to collecting data, and an outline of who is responsible for collecting the data. This tool would facilitate an understanding of the overall evaluation process among stakeholders, making it easier to advocate and allocate resources for the evaluation.

Different types of data will be collected in order to answer the evaluation questions. Both qualitative and quantitative data will be required to comprehensively answer the evaluation questions. Using mixed methods i.e. both qualitative and quantitative methods allow for corroboration of findings from the individual methods. Overall, it provides a comprehensive approach to answering the evaluation questions. The evaluation guide for the DTES 2GS peer integration is included in Table 4.

### 4.3.2 Data Collection

Data will be collected with a number of tools, and various methods depending on the stakeholder group, and at various times throughout the initiative.

***Document review:*** Data pertaining to community service utilization by DTES residents, cost of running the initiative, progress in implementing the peer integration process and the overall 2GS project will be collected on a continuous basis throughout the project. This data will be collected from service provider reports, organizational documents and budget/allocation papers.

***Observation***: Participant-observation will be done at committee and briefing meetings, and will entail observation of verbal and non-verbal interactions between peer advisors and VCH committee members. Observing the physical setting and the events that go on can also provide context to the evaluation process (CDC, 2008b). Observations will be recorded as field notes.

***Interview:*** Two semi-structured interview guides will be developed and administered to the peer advisors and VCH/agency committee chairs respectively, after their committee work has been completed. Interview guides will cover questions regarding outcomes of engagement, level of satisfaction with advisory process, barriers and challenges faced, and level of decision-making/influencing. Using a semi structured style of interviewing allows one to use both a structured approach as well as a conversational style in order to answer the evaluation questions. The interviews will be recorded because of the need for accurate transcription in improving the reliability of this data collection method (Green, 2014). Interviews also serve as a good follow-up to other evaluation methods (CDC, 2009a). Using interview and observational data together adds depth, by combining data on "what goes on" with the accounts of how people describe and understand what is happening (Green, 2014)

***Focus group:*** A focus group discussion will be facilitated for peer allies. This will provide an opportunity for peer allies to share their perceptions of the peer integration process, and any arising challenges they had to resolve during the integration process. A focus group will work for this group of stakeholders, because they are few in number and all have experience of working with both peers and VCH committee chairs. A focus group guide will be used to facilitate the discussion.

***Survey:*** Pre and Post - test assessment will be conducted for VCH staff to explore changes in attitudes and perceptions of relevant VCH employees, related to working with peers. This is an efficient method to maintain privacy as responses will be collected anonymously (CDC, 2008a). The survey will include few demographic questions about the departments where the respondents work and other close-ended questions with predetermined answers. A sample survey questionnaire is included in Appendix A.

***Feedback forms:*** Forms will be provided at committee and monthly meetings to all attendees. This will provide an opportunity for stakeholders to communicate about general concerns, give feedback and input frequently.

Information on how data will be collected can be found on the evaluation guide (Table 4).

**Table 4: Proposed Evaluation Guide**

| Evaluation Questions | Indicators | Data sources (Who/where will you collect data from) | Data Collection method | Timeframe | Responsibility for data collection |
|---|---|---|---|---|---|
| Were all the components of the peer integration initiative implemented, as planned? | - Description of process steps, actions and strategies | - Records of program implementation process<br><br>- Past evaluations | - Document reviews<br><br>- Key-informant interviews | Pre- and post-implementation period | - Program implementation team |
| What are the cost or benefits associated with implementing this initiative, compared with previous strategies? | - Resource allocations<br><br>- Working hours for managing initiative | - Budget<br><br>- Administrative expenditure records<br><br>- Working hours' log | - Document reviews<br><br>- Self-administered/ telephone surveys | Pre-implementation<br><br>6 months' post implementation<br><br>1-year post implementation | - Hired evaluator<br><br>- Evaluation Advisory Group |
| Do peers feel supported and part of the team? | - Self-reported accounts | - Peer advisors | - Interviews<br><br>- Feedback forms | 3 months' post implementation<br><br>1-year post implementation | - Community Engagement Team<br><br>- Hired evaluator |
| How many peers are still in position till date? | - No of peer advisors present in initiative<br><br>- No of peer advisors currently serving advisory roles | - Planning committee for the Peer Integration process | - Document reviews | Pre-implementation and 1-year post-implementation | - Community Engagement Team |

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|---|---|---|---|---|---|
| To what extent do staff understand the role and value of peers? | - Self-reported accounts | - VCH staff<br>- Committee/Agency chairs | - Surveys<br>- Interviews | Pre-implementation, 6 months' post implementation | - Hired evaluator<br>- Evaluation Advisory Group |
| What direct actions have been implemented based on peer recommendations | - Actions implemented<br>- Materials produced | - Committee/Agency chairs<br>- Peers and allies | - Interviews<br>- Document review | - 6 months and 1-year post-implementation | - Evaluation Advisory Group<br>- Community Engagement team |
| What knowledge, attitudes, skills and behavior changes have occurred among VCH non-peer staff, partner agency staff and peers since the implementation of the initiative? | - Staff and peers report a change in knowledge, attitudes and behavior | - VCH Staff, peer, service providers | - Survey and interview questions<br>- Feedback forms<br>- Observation | - 3 months, 6 months and 1-year post-implementation | - Hired evaluator |
| To what extent has client access to care improved as a result of this initiative? | - Healthcare service delivery indicators | - Computer software/patient information software<br>- Patient charts<br>- Service providers | - Patient information on admission rates, service use rates<br>- Chart audit<br>- Interviews | 1-year post implementation | - Health records personnel<br>- VCH staff (data analyst) |
| How has this initiative contributed to the | - Increased two-way | - Feedback from peers | - Interviews | Pre and post | - Evaluation Advisory |

| | | | | | |
|---|---|---|---|---|---|
| establishment of trust and rapport with the Downtown Eastside community? | communication<br><br>- Improved integration of services<br><br>- Improved coordination between VCH and Police department<br><br>- Issues brought forward by the peers | - Service providers<br><br>- VCH leadership<br><br>- Community agencies | - Feedback forms<br><br>- Observation | implementation | Group<br><br>- Hired evaluator |

### 4.3.3 Data Analysis

Data analysis will be done by collaborating with the evaluation advisory group. Stakeholders will be engaged during the exploratory analysis of the data to ensure the focus of the data analysis suit the interests of the stakeholders.

Data was collected using mixed methods approach and will be analyzed with both quantitative and qualitative techniques. Quantitative data will be analyzed using basic descriptive statistical methods. Automatically generated as well as custom made reports will be downloaded from the online survey software used. Information will be represented using frequencies and percentages; analyzed data will be reviewed to identify patterns, similarities and differences. Tables and charts will be used to summarize and illustrate findings (CDC, 2009b).

Qualitative data will be analyzed with an inductive and exploratory approach. Exploratory analysis involves performing coding for interview scripts and identifying patterns and themes that emerge. Data from interviews, focus group and observation will be transcribed firstly into a word processing document. The main computer software program that will be employed for this analysis is Nvivo, to ensure data is properly organized and labelled. Inductive coding techniques aimed at discovering the codes from within the data itself will be used. A thematic content analysis will be conducted, the themes will be grouped and organized to develop a coding scheme (Green, 2014)

Afterwards, the relationship between cases and themes that emerged from the content analysis will be examined. Cases will be categorized based on the roles of the participants (peer advisor /peer allies/VCH staff), and further stratified based on the specific committees they sat on. The data will be rearranged by charting to allow for comparison between peer advisors and VCH committee chairs/staff. Data will be organised under themes and across cases, with annotations of page references to the interview transcript, so that the original data can be easily retrieved if needed. The charts will then be used to compare across cases and codes, relationships will also be identified.

All of these emerging themes and relationships will be presented to the stakeholder advisory group; they will be involved in the interpretation of the findings. Their input will be incorporated, and matched with the indicators for the evaluation questions.

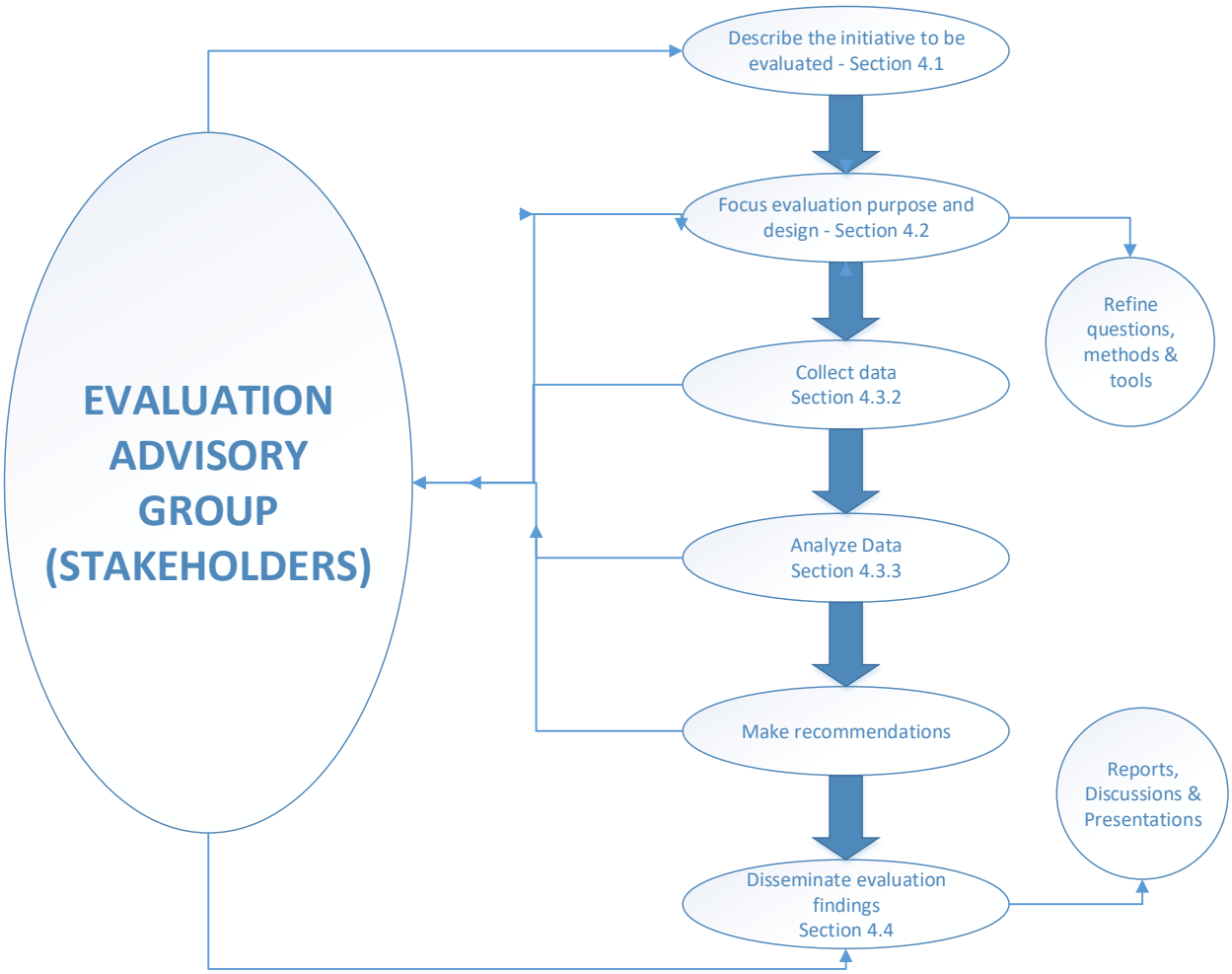
## 4.4 Reporting and Dissemination of Evaluation Results

After data analysis and prior to writing the final report of the evaluation, the evaluator will meet with the evaluation advisory group to present and discuss the findings from data analysis. They will also use the evidence provided to give new recommendations, as well as refine existing recommendations from the evaluation team. Input will also be collected on appropriate timing, expectations and preferred formats to consider in disseminating the evaluation findings.

The final findings of the evaluation in the form of a formal report will be presented in two forms: an executive brief (maximum 3 pages) and a full report. The executive summary will use graphics and charts to highlight the evaluation questions, methods, findings and recommendation. The full report will describe the evaluation purpose, questions, methods, findings from each data source, recommendations and appendices with data collection tools and additional information (CDC, 2011; Harris, 2010). A presentation session will be held with the target audience and intended users of the evaluation - VCH staff and leadership, and possible funding agencies. This information will also be available to all participants, relevant community agencies, VCH and all collaborating partners in the DTES 2GS initiative.

The process for this evaluation is summarized in Figure 2 below. The evaluation will be carried out in a series of steps, this does not imply that the actions are always linear. An evaluation is an ongoing process, and might require a back and forth effort along the outlined steps.

**Figure 2: Proposed evaluation process and activities**



# 5. IMPLICATIONS/SIGNIFICANCE

## 5.1 Measuring the impact of engagement

It is widely recognized that stakeholder engagement contributes to quality improvement of health care. However, the impact and effectiveness of engagement has been difficult to establish in part due to limited measures to quantify or define the outcomes of the engagement process. Some commonly available metrics are client satisfaction and experience data. Instruments such as surveys are usually designed and used to capture opinion of the quality and safety of health care services based on a recent health care service encounter. Gathering information from those most impacted by health care processes is valuable, but the data from surveys alone lack the context often needed to improve health care system design, and it is usually not clear how to use the information to drive change (Kemper et al, 2013). Data collected this way may not necessarily depict how client engagement has improved clinical and health outcomes.

Assessing the influence of engagement requires in-depth information which surveys might not provide. As satisfaction surveys became more common, there is increasing concern that the concept of satisfaction does not accurately represent the process of evaluation (Peikes et al., 2016; Staniszewska & Henderson, 2005).

## 5.2 Level of engagement

The pinnacle of client engagement is shared decision making (Barry & Edgman-Levitan, 2012). The very common question is usually how much decision-making or decision-influencing power do the peers have. There are frameworks that outline the decision-making role of the public at different engagement levels. The IAP2 public spectrum of participation outlines five levels of participation, with differing roles. The spectrum highlighted the increasing impact the public has on decision across an Inform-Consult-Involve-Collaborate-Empower continuum. The highest impact is at the Collaborate and Empower levels where peer recommendations are maximally considered in decision making (International Association of Public Participation, 2014). Davis et al. (2016) also identified 5 similar levels of participation, and highlighted that all levels of participation are valuable, as different levels meet different needs.

Most engagement strategies practised in health care are usually at the lesser decision-making/influencing levels (Peikes et al., 2016; Roblin & Becker, 2009). Carman et al. (2013) developed a framework that advocates for a substantive partnership role that goes beyond consultation and involvement to co-leadership, organizational governance and policy making.

## 5.3 Genuine engagement

Hahn et al. (2016) suggests that it is necessary to consider the level to which tokenism exists in engagement processes in health care. They made a clear distinction between tokenistic and genuine engagement, and identified three domains to consider: (1) Structure (2) Intent (3) Relationship building. More emphasis was placed on intent and they assert that 'the intent to engage needs to be genuine', which is demonstrated by the level of collaboration on decision making. Another key component that emerged was involving consumers of care right at the onset and planning stages, and throughout the project. Group composition, appropriate scheduling, communication and feedback were identified as components of structure that are essential to genuine engagement.

Leonhardt et al. (2006) reported that structure and format of the engagement process has to be designed to facilitate exchange of information between clients and providers. Using in-depth interviews, Peikes et al. (2016) identified similar factors to consider when engaging with the public through advisory councils. Key considerations identified include: size and membership, provision of feedback to clients, shared purposes and well-articulated guidelines. Johnson et al. (2016) also identified similar key considerations, as well as compensation, confidentiality and privacy.

For engagement to be genuine, peer integration efforts must be coupled with programs for staff so that they are prepared to actively reinforce and support these behaviors. In the absence of this dual education, peers are at risk of being ignored. Active support from staff increases the likelihood peers will continue to initiate and engage in care decisions. Financial commitment and administrative support from the leadership of the organisation is also critical to a successful engagement (Kemper et al., 2016; Leonhardt, Bonin, & Pagel, 2006; Taloney & Flores, 2013).

# 6. CONCLUSION

Peer engagement provides a lot of opportunities that could improve the way health care is planned, designed and delivered. Evaluation when done properly can illuminate the untapped potentials of peer engagement and guide our focus towards the big picture. Peers can stimulate and drive improved health care services through their involvement at the clinical/point of care, policy/design, and governance levels of the organization (Kemper et al., 2013). This approach could hold a lot of promise in dealing with persistent public health issues, especially in underserved populations.

The implementation and impact of peer engagement at large health care system level and in their population's overall health have been understudied (Roblin & Becker, 2009). More evaluation studies are required to explore ways in which peer engagement can be productive and meaningful in higher levels of decision making in health care, its impacts on high level policy and decision making at large health care systems and organizations need to be further explored.

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# Appendix A.

## Proposed Data Collection Tool (Sample of Pre and Post Assessment Survey for VCH staff)

Timeline and Process
Baseline – June 2016, prior to initial team conversations (first of two training sessions), survey link and paper copies handed out at first team conversation, absent staff will receive email

Comparison – December or Jan 2017, survey link emailed out to all participants

Respondents
Baseline – current non-Peer VCH staff and physicians at DTES CHCs, stratified by site

Comparison – Integrated non-Peer VCH staff and physicians on Integrated Care Teams (ICT)

Purpose
Evaluation – this is one component in the evaluation plan for the DTES Peer System Work Stream, and the only process that will measure the staff piece of the intervention (others will address client outcomes and peer satisfaction).

Quality Improvement
Baseline – site-specific findings will provide guidance on tailoring and allocating training and support resources

Comparison – ICT-specific findings will provide guidance on tailoring and allocating ongoing training and support resources, identifying team/peer-specific issues etc.

Survey Questionnaire

PART A: EXPERIENCE WITH PEERS AND PLACE OF WORK

1. Baseline: Do you have experience working with Peers now or in the past?
   Comparison: Had you worked with a Peer prior to May 2016?
   *Y/N*

2. Where do you currently work?
   *(Baseline: drop down of sites for, comparison: drop down of ICTs)*

   Comparison only: Where did you work in June 2016?
   *(Drop-down of sites)*

PART B: VALUE, ROLE AND CAPABILITY

3. I believe Peers have a unique and valuable role to play on clinical teams
   *(Strongly disagree to strongly agree scale 1-5)*

4. I am clear about what specific roles and responsibilities Peers should have on clinical teams

   *(Strongly disagree to strongly agree scale 1-5)*

5. I feel confident in my ability to support a Peer colleague on my team

   *(Strongly disagree to strongly agree scale 1-5)*

PART C: PERCEIVED BENEFITS AND RISKS

6. I wonder whether individuals with lived experience can be productive and accountable as service providers

   *(Strongly disagree to strongly agree scale 1-5)*

7. I think Peers are in a unique position to inspire hope and model recovery and healing

   *(Strongly disagree to strongly agree scale 1-5)*

8. I see value in Peers talking about services and resources with clients from the perspective of having used them

   *(Strongly disagree to strongly agree scale 1-5)*

9. I feel that in having Peers working on our clinical teams, my own qualifications are being undervalued

   *(Strongly disagree to strongly agree scale 1-5)*

10. I worry that a peer colleague will be more like having another client – they will increase my workload by requiring a lot of support

    *(Strongly disagree to strongly agree scale 1-5)*

11. I think Peers can help teams be more client-centered and trauma-informed

    *(Strongly disagree to strongly agree scale 1-5)*

12. I am concerned that peers do not have skills necessary to do the job

    *(Strongly disagree to strongly agree scale 1-5)*

Adapted from: VCH. (2016). DTES 2GS Peer Work Stream [Internal Document].

# Appendix B.

## Proposed Budget

| Evaluation Activities | Days of work | Cost ($) Daily rate = $650 |
|---|---|---|
| Review literature & background documents | 2 | 1300 |
| Evaluation Advisory Group meetings | 4 | 2600 |
| Identify and recruit participants for data collection | 2 | 1300 |
| Incentives for Data Collection participants | Gift cards | 450 |
| Data collection | 8 | 5200 |
| Data analysis | 3 | 1950 |
| Data interpretation and development of recommendations with stakeholders | 0.25 | 165 |
| Final report compilation | 3 | 1950 |
| Dissemination of findings – Knowledge translation | 0.5 | 325 |
| Miscellaneous expenses | | 400 |
| **Total** | **22.75 Days** | **$15640** |