AIVL

Australian Injecting
& Illicit Drug Users League

PEER WORKFORCE CAPACITY BUILDING TRAINING FRAMEWORK:

Peer processes among injecting drug users –

Indicators of best practice in peer based and mainstream organisations

1a Introduction

"A peer is someone who considers themselves a member of a specific community and that community recognises them as a member of its community"

A framework for peer education by drug user organisations (AIVL) 2006

Over the last three decades the community of people who inject drugs have borne the brunt of three major blood borne viral (BBV) epidemics, HCV HBV and HIV. One common problem or theme running through any literature discussing this issue is the profound reluctance of people who inject to engage with the medical profession or any other mainstream organisation. This 'unavailability' makes testing and estimating affected numbers almost impossible and providing adequate BBV treatment services difficult. The number of programs and projects based on modelling in the IDU sector is extensive, and it has had a profound effect on the number of prevention, treatment programs and any other health programs targeting the community. One method that has been globally acknowledged as successful in the HIV/HCV prevention literature related to contacting and educating disaffected communities is peer education/processes.

Peer processes have been a feature of communication between individuals for centuries, more formally the influence of peers on education and learning has been of interest for several centuries, in the first instance in relation to how children learn. Both the Russian Len Vygotskian and Jean Piaget's work speaks to the influence of peer interactions on learning. Since then many disciplines and experts such as di Clementi Bandura and Rogers (1900's) have provided insights to how peer influences can be most effectively harnessed to enable positive social learnings. The HIV (1980s) crisis response resulted in whole campaigns being based on the utility of peer processes among affected populations in a public health viral elimination program. The drug and alcohol sector (1980s) provided a different focus on peer processes with a number of papers on peer processes most often discussing the negative impact deviant peers have on their friendship networks in terms of providing modelling for others to initiate papers.

Peer processes are acknowledged globally as a successful method of harnessing the organic and natural communication networks and structures that exist among injecting drug using communities. Peer processes enable the diffusion of education/prevention messages into parts of the community that mainstream organisations struggle to interact with. Peer based programs like many community programs of this ilk have an element of altruism connected with them. People from stigmatised communities come forward and to work with others to ensure their people have the information they need to prevent transmission. People with an intimate understanding of the traditions, rituals and lives of disaffected communities are able to quickly, efficiently and effectively disperse prevention education and other materials to enhance the health and wellbeing of their community.

1b The development of peer processes: Australia

In Australia, the definition and purpose of peer education processes for BBV prevention became unclear very early on in use. This is partially the result of an historical coincidence. The Government announced and implemented a very different looking drug strategy known as the Australian Harm Minimisation Response in 1985. This occurred alongside the announcement and implementation of the critically important HIV prevention strategy. Due to the critical nature of the AIDS epidemic, programs were rolled out very quickly and peer processes were central to Australia's response. This fast-paced process didn't allow the sector to develop a sound conceptual framework or a common understanding that became the best practise for these interventions. This lead to people and organisations putting their own interpretations on the process to fit their various agendas. Two very new concepts for the drug and alcohol sector - harm reduction and peer education - were outlined as processes under the Harm Reduction Pillar, one of the three pillars that underpinned the Australian Harm Minimisation Strategy:

- Harm reduction;

- Demand reduction; and

- Supply reduction.

Before the implementation of the new drug strategy the response had been an abstinence based approach, which had resulted in very little contact or knowledge of the injecting community. Necessarily the drug and alcohol sector's implementation of peer processes looked very different to those of a public health BBV elimination program. After the HIV epidemic had been arrested, HCV became an epidemic that required government intervention. The development of NSP and OST spaces had resulted in a network of services that were aimed at the injecting community. Unlike HIV, the HCV response had a readymade network of places some sections of the injecting community accessed.

The use of drug and alcohol services and staff to develop and implement peer processes in a BBV elimination context, when some are constrained by the philosophical basis of their sector, does not necessarily allow for the most effective BBV prevention peer interventions to be utilised.

1c Peer based drug user organisations

Drug user groups in Australia evolved in response to the HIV epidemic and to the potentially catastrophic development of a "third wave" of HIV infections, which would be driven by communities of people who inject drugs infecting the wider community through sexual transmission. Drug user groups were funded to develop and implement peer education and other peer processes to facilitate the diffusion of prevention education messages and assist in the familiarisation of safer using practises among their peers. The response was so successful that the utility of peer based user groups became apparent and as the gradual realisation of the extent of HCV epidemic among the injecting community was understood, drug user groups now struggled to implement appropriate HCV prevention peer processes within the sector.

1d A description of Peer initiatives

Peer initiatives can be incredibly diverse, depending on the sector involved and the outcome required. The numbers involved range from "36 different roles that can be grouped into 5 categories". Initiatives can range from peer based drug user organisations whose board and staff are all members of the drug using community through to mainstream drug and alcohol services who employ peers to help clients navigate HCV testing and treatment or other outcomes. The way that peers are involved in an organisation is also shaped by external factors which impact on the ability of peer processes to be implemented; the current political and social attitude to drug users particularly is front and centre of these.

Peer programs encompass a diversity of styles and processes in a range of organisational structures. Examples of peer programs and peer-led action include:

• **Peer-based organisations:** the most engaged and firmly embedded in the injecting community are those organisations whose governing body and staff are members of the local drug using community. Drug user groups in Australia illustrate this notion. Examples of these include the NSW Users and AIDS Association (NUAA), the Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) and Harm Reduction Victoria are peer based organisations delivering peer based projects.

• **Peer-based programs:** community organisations employing peers to deliver interventions, these organisations already have some connection with the community and provide programs to various groups. These organisations are usually connected to that community. Typically, mainstream service delivery organisations are staffed by people from the health and medical sectors and funded according to government and funding body requirements. The culture of service delivery organisations and the culture inherent within communities of people who use drugs often clash.

Peer education is acknowledged globally as a successful method of harnessing the organic and natural communication networks and structures that exist among injecting drug using communities. It enables the diffusion of messages into parts of the community that mainstream organisations struggle to interact with. People with an intimate understanding of the traditions, rituals and lives of disaffected communities are the only peer workers who are able to quickly, efficiently and effectively disperse information and other materials. A variety of research illustrates the effectiveness of peer-led action in achieving public health goals. A meta-analysis of peer-led action in the context of HIV illustrates that peer education increased HIV knowledge, increased condom use and assisted in reducing sharing of injecting equipment amongst people who inject drugs.[1] As noted above, the efficacy of peer-led action has been demonstrated through its early incorporation into Australian HIV policy.

Employing peers indicates a commitment to the health and wellbeing of the drug using community and often acknowledges the discrimination they face in the wider community. It also provides access to previously unreachable groups to both promote prevention education but also to provide intelligence to the organisation which assists in policy development and program initiatives. It also allows for an understanding of the context of an individual's potential risk episodes.

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[1]   Medley, A., Kennedy, C., O'Reilly, K., & Sweat, M. (2009). Effectiveness of peer education interventions for HIV prevention in developing countries: a systematic review and meta-analysis. *AIDS Education and Prevention*, *21*(3), 181-206.

Peer-led projects and peer based service delivery are receiving increasing emphasis from various sectors, particularly the HCV viral elimination sector, as the need to contact people for testing and possible treatment ramps up. Interventions so far aimed at contacting our community have been less than stellar. We have not developed a method of evaluating our programs that works across all organisations nor have we developed a means of evaluating different programs for different outcomes - resulting in a lack of clarity in reporting.

AIVL has developed the following guide based on two very important documents that should be read in conjunction with this tool.

1. AIVL (2006) A framework for peer education by drug user organisations, AIVL, Canberra http://www.spen.org.uk/mymedia/files/resource_pdfs/hepatitis_C/Framework%20and%20research%20 forPeerEducation%20with%20drugs%20users.pdf

2. Brown, G. (2018) W3 Framework Toolkit, Australian Research Centre in Sex, Health and Society, Melbourne http://www.w3project.org.au/

2. Indicators for Best Practice

Peer-led and community-led projects and service delivery are receiving increasing emphasis within health and social sectors from funders but also in recognition that these initiatives work best when community members are invested in services and programs and have ownership over their outcomes.

But what does this mean for organisations that want to employ people who use drugs in the context of BBV or alcohol and drug programs? How do organisations employ and best support people whose lives are shaped by legal and criminal forces and who often experience stigmatising and discriminatory attitudes?

This guide aims to support organisations in creating an organisational environment where people with lived experience of drug use can be employed and make significant contributions to organisational goals. It has been written by people who use drugs and have considerable experience being employed in peer worker roles and in peer-led programs, and draws from this unique knowledge and expertise.

To do this, this guide adapts the *What Works Why* (W3) peer programs framework developed by Dr Graham Brown and applies this to the specific context of working with people who use drugs. It provides a practical tool which organisations can use to improve their organisational practice and improve outcomes in peer-based programs

2a   The *What Works and Why* (W3) framework[2], developed by Dr Graeme
Brown and colleagues at the Australian Research Centre in Sex, Health and Society (ARCHS), has developed a new process to evaluate peer-based activities among the communities involved in the BBV response in Australia. This is a process focusing on the factors that need to be in place to most effectively undertake peer programs. Some factors, such as the ongoing criminalisation of drug use, constrain the ability of peer-based programs to operate effectively, however regardless of this, the indicators can be used as goals to strive for.

The *What Works and Why* (W3) project has developed a set of principles that have been found to underpin successful peer initiatives and situates them firmly within the broader health network and part of the systems evolution.

W3 opens the way for another level of understanding of peer processes to be incorporated into peer programs which move beyond the quite limiting questions in this context of "who is a peer" (current, past, occasional drug user, which drugs and when?) to "what skills does a peer worker need to bring to do that job and work within the system"? This moves to focus on the skill of drawing on personal expertise and community knowledge as well as the ability to interpret social research and epidemiological research through a peer lens, in order to engage with peers whose experiences may differ from their own. W3 research has resulted in the development of a framework that assists in the articulation of peer processes while providing the structure to support effective evaluation. The research project undertook a comprehensive literature review and extensive community consultations over several years, combining the resulting information and understandings with the outcome of applying systems thinking and participatory methods to peer based programs and a new way of viewing these interventions developed. This framework situated peer initiatives as part of a larger system of public health programs and working within the current environment including constraints and barriers. Previous evaluations had looked at peer processes in isolation to community attitudes and government agenda and they had often been evaluating different aspects or degrees of peer initiatives.

W3 applies systems thinking methods to bring together the day-to-day understandings of how peer workers in outreach, community development, workshop facilitation, policy reform and leadership management and governance navigate these systems- where everyone has part of the picture but the pieces are rarely bought

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[2]   Australian Research Centre in Sex, Health and Society. (2015) Using the W3 Framework in Practice. La Trobe University, Melbourne. Available at http://www.w3project.org.au/.

together. W3 conceptualised peer based processes and the communities and policy environments they engage with as complex fluid systems. The input of information to either the community or policy system is filtered by peer processes, which refine government education messages into the community response to enhance current policy positions.

Four elements were found to be essential for the successful implementation of peer processes - they were interlinked and interdependent:

1. Engagement;

2. Alignment;

3. Adaption; and

4. Influence.

Engagement - how the program maintains connection to the diverse community's experiences and understandings of its targeted communities.

Alignment - how the program picks up signs from the policy/community sectors as to what is changing and what thinking's are emerging and uses the knowledge to enhance program visibility.

Adaption - how the program changes its approach refining activities as new information or research comes to light from engagement and alignment insights.
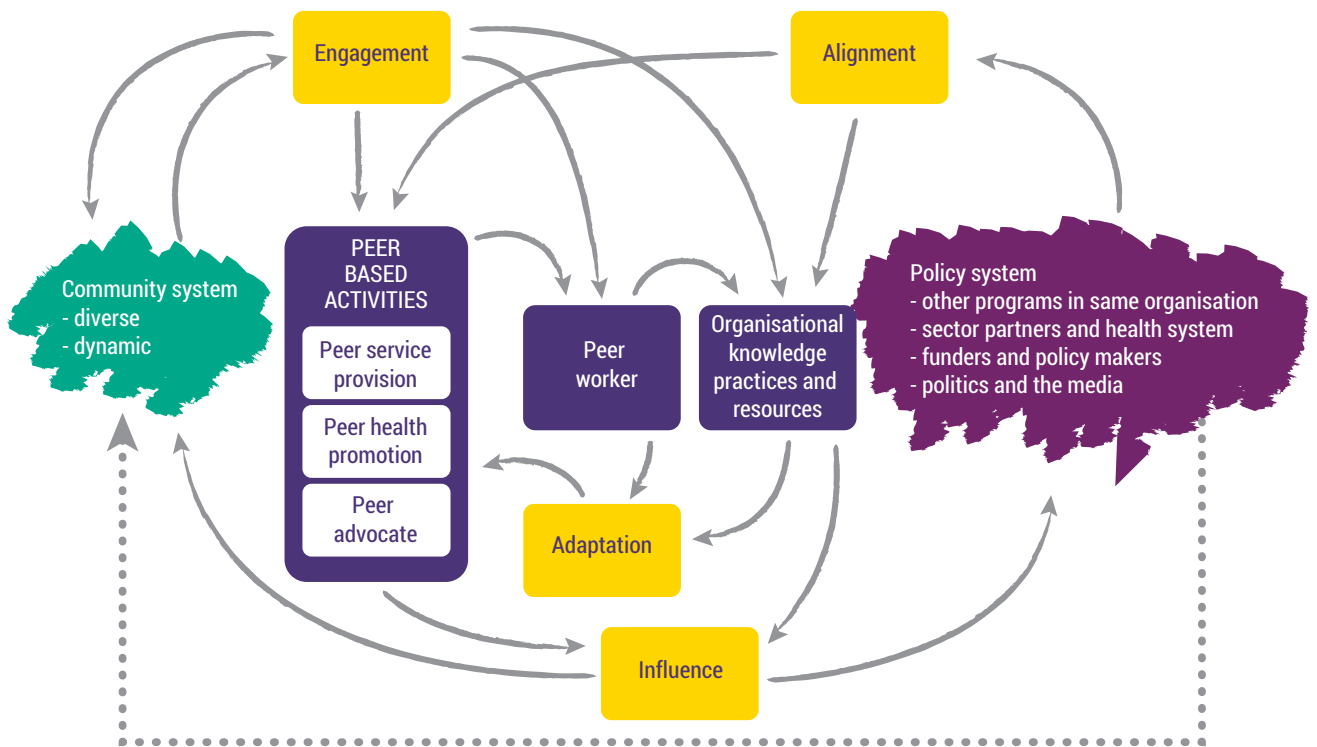
Influence - how the program uses existing social and political processes to influence and achieve improved outcomes in both the community and policy sectors.

Engagement and alignment elements working side by side adapting accumulated information, data and community responses to evaluate and enhance current strategies while simultaneously massaging government strategies and programs into tailored community information messages and influencing each of them. The way in which these elements are processed and utilised to enhance and expand programmatic activity and policy direction are a direct indication of the integration and information flow of these elements.

As well as the four elements working within the peer process there are other factors that will assist or hinder the implementation of successful peer process among injecting drug users. All these factors impact on the successful interrelationship of the four elements and can be used as a means of assessing the level of an organisations commitment to peer process within public health response to a viral epidemic.

The focus of this guide is on the latter parts of this understanding. While individual peer worker skills are critical, the environment that the peer worker operates in or where the peer-led program is positioned within the organisation is equally as important. Therefore, the best practice principles within the guide focus on how a supportive environment can be created in the organisation to enable peer workers and peer-led programs to have the best chance of success and influence.

According to the research of W3, peer led programs operate within and between two interrelated and constantly changing systems, the community systems and the policy system. Four functions are required for peer led programs to be effective and sustainable in such a constantly changing environment:

Domains	Definition
Engagement *Plugged into injecting drug using community*	The depth and variety of the programs responses to the dynamic cultures in the injecting community including anticipating their needs, understanding their experiences and how to most effectively interact.
Alignment *Plugged into government agenda*	The peer program's effectiveness in picking up signals from the policy sector and integrating policy directives into programs.
Learning and adaptation *Picking up intelligence and refining it to use in an organisation*	The effectiveness of the program and peer workers in capturing insights from peers and other organisational workers to refine knowledge and fine tune community processes.
Influence *Shaping community practice and attitudes and shaping policy*	Community: How the program uses the communities existing ways of doing things to promote new ways of doing things. Policy: How the program achieves or mobilises influence on processes and outcomes within its policy environment.

This section provides an overview of best practice indicators to enhance the effectiveness of peer-led programs, both within peer-based organisations and mainstream health organisations.

It draws from and adapts the W3 framework and provides guidance on how organisations can improve the effectiveness of their peer-led programs.

W3 Framework	Definition (What is it?)	Indicators (What does it look like?)	Outcomes (What changes?)	Ideas for Best Practice (How do we create it?)
Engagement *Plugged into the injecting drug using community*	The depth and variety of the programs responses to the dynamic cultures in the injecting community including anticipating their needs, understanding their experiences and how to most effectively interact.	• The peer worker and program ensure the community have access to the latest information and technologies while expanding their reach and influence with other relevant networks. • Community members recognise the program as a part of their networks and cultures and feel a sense of ownership over its work. • Peer workers use personal experience as well as cultural knowledge to communicate and work effectively with community. • The peer program identifies emerging practises and unintended consequences of changes on policy or services.	• Clients feel they are welcome and have a valuable contribution to make to the shared sense of ownership of the program. • Strategic opportunities created with new relationships with people and organisations; strategic opportunities taken at every opportunity to enhance communication and cross referral. • Increased willingness of community to engage in sector consultation and leadership opportunities.	• The organisation recruits and supports diversity of peer workers that reflect the community's populations. • Programs encourage input from community in a number of ways and at a number of organisational levels such as workshops, meetings and casual conversations. • Programs work from a variety of locations to maximise community interactions. • Peer workers have a professional network of peer workers (within the organisation or outside the organisation) to collect and share stories of success to sustain broader momentum. These are communicated within the network and outside the network. • Peer workers attend internal committees and meetings and are supported to contribute to the broader organisation. • Peer workers are supported to undertake a variety of training to support them in their job.

W3 Framework	Definition (What is it?)	Indicators (What does it look like?)	Outcomes (What changes?)	Ideas for Best Practice (How do we create it?)
Alignment *Plugged into the government agenda*	The peer program's effectiveness in picking up signals from the policy sector and integrating policy directives into programs.	• Peer workers actively seek out and use knowledge from partners and stakeholders with different perspectives and emerging issues within the sector. • Other sector stakeholders adapt their approach to support the effectiveness of the peer program. • Policy system demonstrates it values and supports the peer leadership role of the peer program. • Peer leaders communicate with sector partners to improve each other's understanding of responses to emerging issues. • Peer leaders are made aware of changes to policy or services to assess their implications for the community.	• Performance indicators and funding mechanisms reflect the complexity of the service provided. • The broader sector and policy system includes and values peer initiatives and the insights they generate. • The organisation has strategic and supportive relationships with key players within its sector, policy and funding environment. • Peer workers are seen as peer advocates and a valuable source of knowledge within the sector.	• Peer workers are supported to establish partnerships and relationships with key stakeholders in the sector. • Peer workers attend external committees, meetings and platforms where policy decisions are made or discussed, and peer workers are supported to undertake this role through training, supervision and comprehensive orientation to the organisation and its work. This includes presenting at seminars and conferences. • Mechanisms established to communicate the policy agenda into the organisation and feed peer insights back to policy makers.

W3 Framework	Definition (What is it?)	Indicators (What does it look like?)	Outcomes (What changes?)	Ideas for Best Practice (How do we create it?)
Learning and Adaption *Picking up intelligence and refining it to use in an organisation*	The effectiveness of the program and peer workers in capturing insights from peers and other organisational workers to, refine knowledge and fine tune community processes.	• Organisation supports continual learning within peer program and facilitate the capture and packaging of knowledge from peer insights as an organisational and strategic asset. • The program supports members to acquire skills in leadership and policy participation. • Insights from on the ground peer programs update and strengthen the peer leader's understanding of the diverse experiences and adaptation in the community.	• Service quality and outcomes improve as information acquired by peer workers turns into organisational knowledge and is used and adapted into service provision. • Peer principles become embedded into organisational practice as organisational leadership supports a peer approach in workplace culture and organisational strategy.	• The intelligence from peer activities is written into strategic understandings and direction of the organisation. • Organisation provides higher learning opportunities for all workers and runs workshops for the community members to upskill. • The organisation adapts policies and processes to support peer worker employment. Organisation should consider: what peer workers need to do to perform their role effectively. How are the principles of harm reduction embedded into organisational policy and practice? • The broader organisation and staff understand the role of peer workers and goals of the peer program, and are supported to be inclusive of peer workers and peer practice. Specific training on harm reduction, blood borne viruses or the effects of stigmatising attitudes towards people who use drugs supports this.

W3 Framework	Definition (What is it?)	Indicators (What does it look like?)	Outcomes (What changes?)	Ideas for Best Practice (How do we create it?)
Influence *Shaping community practice and attitudes and shaping policy*	Community: How the program uses the communities existing ways of doing things to promote new ways of doing things Policy: How the program achieves or mobilises influence on processes and outcomes within its policy environment	*Community* • Community trusts peer processes to provide information and translate knowledge into community practice and community issues such as safer injecting; or information on real world outcomes of hepatitis C treatments in our community. • Confident peer leaders are visible in the communities. • Expanding community influence is reflected in new and diverse networks in the community engaging in peer initiative opportunities. *Policy* • The broader sector and policy system values peer approaches and trusts the insights they generate. • Readiness and responsiveness of peer workers opportunities for policy participation. • Policy services and funding environment support (or do not impede) innovative and culturally relevant peer led approaches.	*Community Indicators* • Reducing the gap between readiness to inject (skills, knowledge and equipment) and the short and long term pressures that impact on that readiness and the ability to practise safer behaviours. • Reinforce and contribute to community empowerment whilst sustaining an ongoing culture of safer use. *Policy Indicators* • The contribution of peer workers in consumer representation and policy advocacy is recognised and sought after. • Knowledge resulting from peer worker's interaction is shared and used in the broader sector and policy environment. • Policy advice with peers resulting in the improved quality of services in the community. • Sustaining and strengthening policy support for peer and community based approach in harm reduction and BBV prevention.	These indicators consider how actions from the Engagement, Alignment and Adaption domains can be leveraged into Influence, and in turn, feedback into these other domains. Consider how existing programs can be scaled up through organisational practice to both capture community insight but also build community ownership over the peer work. In the policy arena, what relationships need to be built or what platforms need to be engaged with to turn peer insights into policy influence? How do peers become indispensable and essential parts of the policy system?

3. Understanding your organisation and making change

This section provides a template tool based on the best practice indicators provided in Section 4.

The tool is designed to be flexible and used by organisations for a number of purposes such as:

- Identifying areas for adaptation to create an enabling environment for a new peer-led program
- Monitoring current peer-led programs
- Identifying areas for change to enable current peer-led programs to be scaled up and expanded
- Evaluating the effectiveness of the organisation in supporting existing peer-led programs
- Auditing organisational practice as part of broader organisation quality and risk management processes

This tool is not designed to evaluate the effectiveness of peer-led actions and programs in and of themselves. Rather, it is used to scan the organisational environment as to the organisation's strengths and weakness in relation to peer-led actions. The tool, however, can be used in conjunction with specific peer-led action evaluation processes.

The application of the tool is also designed to be flexible. Organisations are encouraged to consider how best this tool can be implemented. Some ideas include:

- Completing the questions within the tool as a full staff group. This may be done through written survey or discussion.
- Interviewing existing peer workers as a group or individually to understand their experiences and what is working well and where things can change.
- Auditing written documents, policies and processes as to how effective organisational practice is in relation to the indicators.
- For mainstream health organisations wanting to establish a new peer program, partnering with a drug user organisation in your local area and working through this tool can help develop a supportive organisational culture and successful peer program.

This tool also contains a number of questions for consideration in each domain. These are designed as prompting questions – don't feel limited to only responding to these.

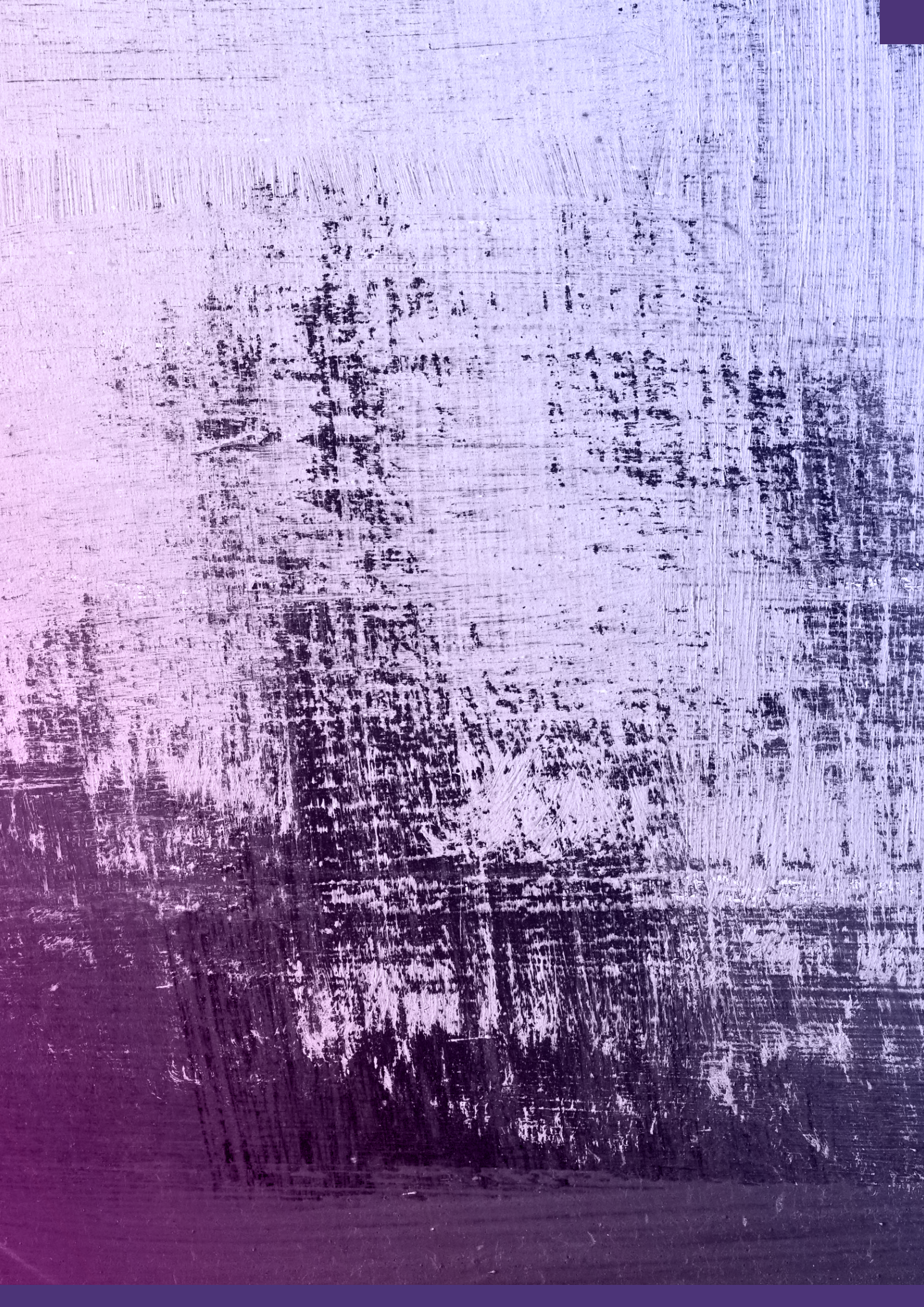# Peer-Led Programs with People Who Use Drugs

Best practice tool

Description

(What is the peer-led action within our organisation?)

Vision

(What do we want to achieve with our peer-led action?)

W3 Framework	Definition (What is it?)	Indicators (What does it look like?)	Action (What practices do we undertake that demonstrate the indicators?)	Change (What organisational change do we need to undertake to achieve our vision?)
Engagement *Plugged into the injecting drug using community*	The depth and variety of the programs responses to the dynamic cultures in the injecting community including anticipating their needs, understanding their experiences and how to most effectively interact. In practice, through peer worker's involvement, new trends, behaviours and beliefs within the community are quickly identified and responded to by organisation, and fed into the policy arena	• The peer worker and program ensure the community have access to the latest information and technologies whilst expanding their reach and influence with other relevant networks. • Community members recognise the program as a part of their networks and cultures and feel a sense of ownership over its work. • Peer workers use personal experience as well as cultural knowledge to communicate and work effectively with community. • The peer program identifies emerging practises and unintended consequences of changes on policy or services.	*Consider:* • *How are peer workers and peer programs connected with their communities?* • *How are peer workers and peer programs connected with other peer workers/programs within or outside of the organisation?* • *How do we know that community members feel ownership over our peer-led actions?* • *How is peer knowledge used and applied in our organisation?*	

W3 Framework	Definition	Indicators	Action	Change
	(What is it?)	(What does it look like?)	(What practices do we undertake that demonstrate the indicators?)	(What organisational change do we need to undertake to achieve our vision?)
Alignment *Plugged into the government agenda*	The peer program's effectiveness in picking up signals from the policy sector and integrating policy directives into programs.	• Peer workers actively seek out and use knowledge from partners and stakeholders with different perspectives and emerging issues within the sector. • Other sector stakeholders adapt their approach to support the effectiveness of the peer program. • Policy system demonstrates it values and supports the peer leadership role of the peer program. • Peer leaders communicate with sector partners to improve each other's understanding of responses to emerging issues. • Peer leaders are made aware of changes to policy or services to assess their implications for the community.	*Consider:* • *How are peer workers and peer programs connected to the broader environment and stakeholders that our organisation works in/with?* • *Is the peer-led knowledge produced by our peer workers and programs used by other stakeholders? How? What do we do that makes this happen?* • *What does our organisation do to communicate broader system changes to our peer workers and programs?*	

W3 Framework	Definition (What is it?)	Indicators (What does it look like?)	Action (What practices do we undertake that demonstrate the indicators?)	Change (What organisational change do we need to undertake to achieve our vision?)
Learning and Adaption

Picking up intelligence and refining it to use in an organisation | The effectiveness of the program and peer workers in capturing insights from peers and other organisational workers to, refine organisational knowledge and fine tune community processes. | • Organisation supports continual learning within peer programs and facilitates the capture and packaging of knowledge from peer insights as an organisational and strategic asset.
• The program supports members to acquire skills in leadership and policy participation.
• Insights from on the ground peer programs update and strengthen the peer leaders understanding of the diverse experiences and adaptation in the community. | *Consider:*

• *What policies/practices/ processes do we use that reflect the unique lived experience of our peer workers? How do we know if/ what needs to change in our policies/practices/processes?*
• *What actions have we undertaken to integrate peer-led programs and peer workers into our organisation mission and every day work?*
• *How do we incorporate peer insight into our practice? What mechanisms do we use? E.g. training, meetings, policy change etc* | |

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W3 Framework	Definition	Indicators	Action	Change
	(What is it?)	(What does it look like?)	(What practices do we undertake that demonstrate the indicators?)	(What organisational change do we need to undertake to achieve our vision?)
Influence *Shaping community practice and attitudes and shaping policy*	Community: How the program uses the communities existing ways of doing things to promote new ways of doing things Policy: How the program achieves or mobilises influence on processes and outcomes within its policy environment	*Community* • Community looks towards peer leadership to provide insights and translate knowledge into changing meanings relevant community issues such as safer injecting; or that hepatitis C treatments based on the reality of their shared experiences. • Confident peer leaders are visible in the communities. • Expanding community influence is reflected in new and diverse networks in the community engaging in peer initiative opportunities. *Policy* • The broader sector and policy system values the peer approach and trusts the insights it generates. • Readiness and responsiveness of peer workers to create opportunities for policy participation. • Policy services and funding environment support (or do not impede) innovative and culturally relevant peer led approaches.	*Consider:* • *How do we identify current community practice? What processes do we use to evolve practice and how do we know if it changes?* • *How do we define 'community ownership' over the program? What does it look like and how do we measure it?* • *How do we develop leadership amongst our peer workers? What does 'peer leadership' mean and look like to us?* • *How can existing programs be scaled up through organisational practice to both capture community insight and build community ownership over the peer work.* • *In the policy arena, what relationships need to be built or what platforms need to be engaged with to turn peer insights into policy influence? How do peers become indispensable and essential parts of the policy system? What do we need to do to support this?*	

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