ATLAS INSTITUTE FOR VETERANS AND FAMILIES

ENGAGING WITH VETERANS AND FAMILIES

Creating a new approach to collaboration

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Glossary of Terms

- **Civilian life/post-service life/life after service**: Various terms are used to refer to a Veteran's life after they transition from active service in the Canadian Armed Forces (CAF) or Royal Canadian Mounted Police (RCMP), such as "civilian life," "post-service life," and "life after service." For simplicity's sake, the term "Veteran" or "post-service life" will be used throughout this document unless explicitly quoting an external source.
- **Client/consumer/patient:** Atlas Institute recognizes that various terms are used to refer to those who receive mental health services and supports, such as "client," "consumer," and "patient." For simplicity's sake, the term "client" will be used throughout this document unless explicitly quoting an external source.
- **Co-development/co-production**: These include equal participation of one or more people to produce a desired product that benefits both parties.[1]
- **Engagement:** includes active listing and partnership, and having a two-way conversation. At Atlas Institute, we believe an optimal mental health system embeds engagement practices at a systems level, at the organizational level, and within research and service delivery.
- **Intersectionality:** Veterans and Families are not a homogenous group as they have multiple and diverse intersecting identity factors that impact how they understand and experience the world around them. Identity factors include race, ethnicity, religion, age, ability, gender identity, sexual orientation, and socioeconomic status. Intersectionality recognizes the multiple facets of an individual's identity that impact their experiences.[2] Within Atlas' context, this could also include across CAF and RCMP service and rank.
- **Lived experience and expertise:** For the purpose of this Framework, "lived experience" refers to direct knowledge gained from first-hand experiences of mental health problems and illnesses, and substance-related issues. "Lived expertise" refers to the use of these experiences to bring about change to positively impact systems.[3] Within Atlas' context, we also refer to lived experience as having served as an RCMP or CAF member, and RCMP and CAF Family members.
- **Trauma-informed practice:** A strengths-based approach to understanding the whole person, including past traumas that may influence their behaviours and ways of coping. Being trauma-informed can also involve being aware of and sensitive to historical, intergenerational trauma (i.e., trauma experienced by cultures and family systems over multiple generations), and its relationship to substance use.
- **Veteran:** Former or retired CAF (Army, Navy, Air Force) regular or reserve force or full-time, part-time, or auxiliary member of the RCMP (i.e., no longer in service or those in transition to post-service life).[4]
- **Veteran-centred/Veteran Family-centred:** Based on human-centred design, focused on generating solutions to problems and opportunities, driven by the context, needs, and desires of Veterans and Veteran Families.
- **Veteran Family member:** Atlas Institute defines Veteran Family as parents, siblings, partners/spouses, and dependent and adult children, as well as carers (related or not), friends, and peers, taking into account who the Veteran identifies as significant to their mental well-being.[4]

1 Government of Canada. (2003). *Co-development in the Public Service of Canada*. Working Group on Co-development, Public Service Commission Advisory Council. https://www.njc-cnm.gc.ca/a8/co-dev_e.pdf

2 Government of Canada. (2021, April 14). *Introduction to GBA+: Introduction to Intersectionality*. Women and Gender Equality Canada. https://femmes-egalite-genres.canada.ca/gbaplus-course-cours-acsplus/eng/mod02/mod02_03_01a.html

3 Throughout this document, references to mental health problems and illness are inclusive of substance-related issues, including addictions. Similarly, mental health and illness services include the full continuum of substance and addiction-related services, even when the latter are not explicitly named.

4 Atlas Institute capitalizes "Veteran" and "Veteran Family" as a way to demonstrate respect.

Executive Summary

Atlas Institute for Veterans and Families ("Atlas Institute") envisions a mental health system with services and supports for Veterans and their Families where they stand at the centre.

The mental health system can better respond to Veteran and Family needs when guided and informed by their voices, experiences, and expertise. This Framework provides a foundation for defining and understanding Veteran and Veteran Family engagement within the mental health sector in Canada. Accordingly, engagement and involvement of Veterans and Veteran Families is one of seven key guiding principles in Atlas Institute's blueprint for a transformed Veteran and Family-centered mental health system (Phoenix Australia and the CoE-PTSD, 2020).

To co-develop this Framework with Veterans and Families, Atlas Institute relied on the expertise of an external Advisory Committee comprised of Veteran, Veteran Family, research, and service provider perspectives; consultations with Atlas Institute's Reference Groups and the Lived Experience team at Atlas Institute; and existing literature on engagement within the Veteran context and more broadly.

As a result, the contents of this resource include various key components, complemented by real-world examples and quotes from Veterans, Family members, researchers, and service providers engaged in policy development, service planning, research, and practice within mental health services. The first section of this resource sets the stage by exploring the context for mental health engagement in Canada with reflections on Veteran and Family engagement. This section highlights our ever-evolving understanding of what mental health engagement looks like and what it means for Veterans and Families to be heard and influence Veteran mental health programs and practices.

The second section introduces the Veteran and Family Engagement Framework in a graphic depiction with each level on the continuum explained through the lens of the organization seeking to engage Veterans and Families. Recognizing that each level of engagement holds merit and may be the most appropriate approach at any given time, organizations may travel from left to right or right to left (or anywhere in between!) across the continuum—demonstrating the non-linear nature of engagement.

Embedded within the Framework are emerging principles and practices of mental health engagement with Veterans and Families. The principles and practices were inspired by existing literature, the work of peer organizations, and the voices of Veterans and Families. Each principle and practice is unpacked to better understand its relevance and application within Veteran and Family engagement with strategies to support organizations engaging with (or seeking to engage with) Veterans and Families.

In the final section, we explore the benefits and outcomes of engagement, including for Veterans or Family members, the organization, and the mental health system in Canada. Though this Framework is not focused on direct mental health care, within our engagement for this Framework, Veteran and Family members stressed the importance of being *actively involved* in treatment decisions rather than having those decisions imposed on them. There is a need for organizations and systems to understand this as they influence delivery of direct care.

Background and Purpose of Framework

Atlas Institute for Veterans and Families ("Atlas Institute") envisions a mental health system with services and supports for Veterans and their Families where they stand at the centre—the focal point. The mental health system can better respond to Veteran and Family needs when guided and informed by their voices and experiences.

This Framework provides a foundation for defining and understanding Veteran and Veteran Family engagement within the mental health sector in Canada. **While the concept of engagement in mental health systems, services, and research is not new, we found this to be a new concept within the Veteran and Veteran Family mental health literature**. We hope this Framework serves as a starting point—one that we continue to unpack and understand together over time.

The process for building this Framework is as important as the content within. This Framework was born from Atlas Institute's desire to build an organization centred on the principles and practice of lived and living experience and expertise. As described within this document, "the process is the practice." The following steps were taken to create this Framework:

- An Advisory Committee (external to Atlas Institute) was convened, including Veteran, Veteran Family, research, and service provider perspectives. This group came together at various milestones throughout the project to guide and inform the content of the Framework.
- Atlas Institute Reference Group members were consulted, and they provided input on how and why to engage Veteran and Veteran Family members in policy development, service planning, research, and practice within mental health services.
- Atlas Institute has a Partnerships and Stakeholder Engagement team, whose work is focused on amplifying the voice of lived experience and those who study and support them. We also have a Lived Experience team who brings their lived experience as a Veteran or Veteran Family member to Atlas Institute. These portfolios worked together to create this Framework, bringing their respective skillsets and expertise to the work.

Geared toward organizations and systems while recognizing the interconnected impacts on direct care, we hope this Framework will help enhance understanding of how Veterans and Veteran Families want to be engaged, and provide guidance and thought-leadership to organizational leaders, policy-makers, service providers, researchers, and others within the mental health sector. **Together, we can transform the mental health system to one that is guided by the voices and experiences of Veterans and Families**.

Atlas Institute is committed to adopting, embedding, and championing meaningful and authentic engagement practices. We believe that, through an active partnership focused on listening and engaging in a two-way conversation, we can shape mental health research, policies, and service delivery to better meet the needs of Veterans and Veteran Family members.

The Context for Mental Health Engagement in Canada

There is wide agreement among people (clients) who access health care services, the general public, health care providers, leaders, researchers, and policy-makers in Canada that involving clients and families as partners is essential to ensuring safe and quality care (Canadian Patient Safety Institute, 2017).

In addition, new knowledge and tools are accelerating engagement practice, and its evaluation continues to evolve (Bombard et al., 2018; Baker et al., 2016; Manafo et al., 2018).

In the mental health sector, Canada and other countries such as Australia and the United Kingdom are developing policies, standards, and best practice guides to strengthen client, family, and caregiver involvement in mental health service delivery, planning, and evaluation (Mental Health Commission of Canada, 2019).

Early advances in patient and public engagement practice grew out of consumer advocacy in the mental health system (Franco et al., 2021; Bombard et al., 2018; Vojtila et al., 2021). People with lived experience (PWLE) are considered experts based on their own experience of their diagnosis or health condition or caring for someone living these experiences (CIHR, 2014; Forsythe et al., 2019; Vojtila et al., 2021). The advocacy phrase "nothing about us without us" conveys that decision-making about policies, programs, and services should be made with participation from those affected.

PWLE are using their own "experience as knowledge" in the Canadian mental health and addiction system (Vojtila et al., 2021) by:

- Being a decision-maker in their own care;
- Helping others navigate the mental health system, providing advocacy, empowerment, and support;
- Being active partners in mental health research and caring for peers with the same condition, as volunteers and paid workers;
- Helping develop new processes of client-centred care; and
- Holding leadership roles in health and social policy, treatment development, and education.

Clients are no longer viewed as passive recipients of a service but as integral members of teams redesigning health care, and in governance and decision-making (Bombard et al., 2018). Collaborative efforts are advancing the practice of partnering with clients and the public in health care quality improvement. For example:

- The Ontario Centre of Excellence for Child and Youth Mental Health (OCECYMH; now known as the Knowledge Institute on Child and Youth Mental Health and Addictions) is advancing quality standards for partnering with youth and families to improve quality of care in the child and youth mental health system (OCECYMH, 2021a; OCECYMH, 2021b). The standards are an example of co-production with youth and families at the system level.
- The Mental Health Commission of Canada (MHCC) co-developed a guide of promising practices for engaging caregivers in mental health and addiction services and has partnered with HealthCareCAN to advance quality mental health care. Clients and families are engaged in these and other initiatives, such as research, to identify structural barriers and improve equity in access to mental health services for racialized and underserved groups (MHCC, 2021; MHCC, 2019).
- Accreditation Canada, Healthcare Excellence Canada, and several provincial Health Quality Councils are working with clients and the public, health care providers and

administrators, academics, and government policy-makers to identify, share, and translate best and emerging engagement practices and to build engagement-capable environments in health care (Baker et al., 2016; Bombard et al., 2018; Canadian Patient Safety Institute, 2017).

In health research, there is an expectation of co-production with the involvement of multiple stakeholders to improve research relevance and outcomes (Bird et al., 2020). Community-based participatory research is an approach that involves community partners in all steps of the research process, working as equal partners to researchers, with the goal of bringing about social change (Tremblay et al., 2018). By example, the Canadian Institutes of Health Research (CIHR) Strategy for Patient-Oriented Research (SPOR) has been advancing patient partnership in research (CIHR, 2011; CIHR, 2014):

- Capacity-building strategies and tools are being developed and implemented through regional SPOR SUPPORT units and networks across Canada (CIHR, 2018; CIHR, 2017).
- PWLE are working together with researchers to learn by doing and to share what works. A new national training platform for patient-oriented research will support these efforts (CIHR, 2021).

Still, there are gaps in knowledge about how to "do" meaningful engagement, with recent attention to inclusive engagement processes and using engagement as a tool to advance structural equity in health care and health outcomes (Eichler, 2021). Many engagement efforts are limited to one-way information-sharing from participants to decision-makers, or vice versa. There are good examples of collaboration and partnership with clients and citizens, but practices are not widely understood or used (Bird et al., 2020).

In summary:

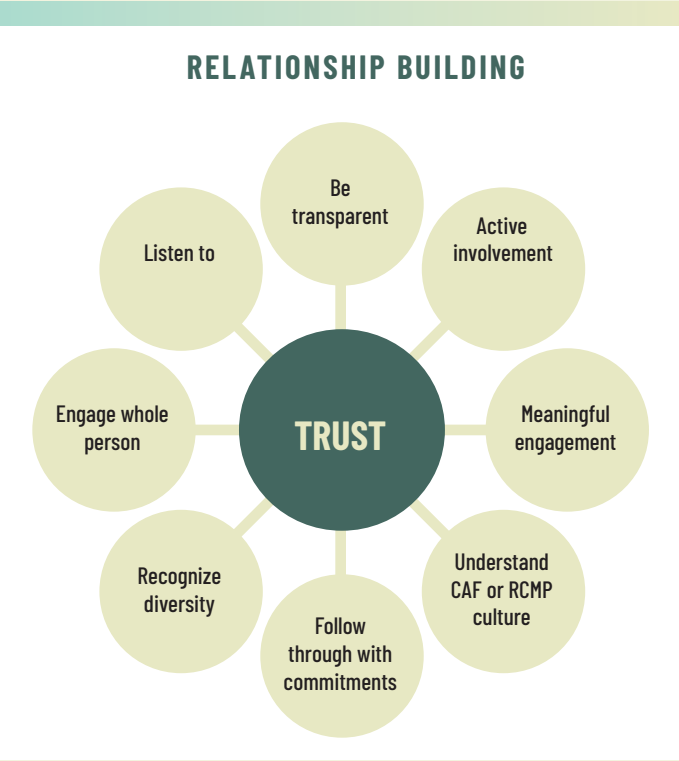
- Engagement practice is evolving, with active sharing of what works to advance effective partnerships and collaboration.
- Engagement practice is "a work in progress" with gaps in knowledge and capacity to do it in a real-world context.
- Some policies and standards are in place to help embed client and public engagement in health research and health care practice.
- The evidence base supporting client and public engagement in research continues to grow..

Reflections on Veteran and Family Engagement

To understand the current Veteran and Family engagement landscape in Canada, Atlas Institute consulted with its four interrelated Reference Groups (Veterans, Veteran Families, service providers, and researchers), consisting of individuals from across Canada who bring various perspectives. The Reference Groups provide Atlas Institute with strategic advice and expertise on specific initiatives and priority areas—including the co-development of this Framework with Veterans and Families.

During the consultations, each group was asked a series of questions to understand their experience with organizational and systems-level engagement. As a key component to the creation of this Framework, we heard directly from Veteran and Family members, as well as those who study and support them, about what engagement means, their engagement experiences (both good and bad), the ways they would like to be engaged, what supports or gets in the way of their engagement, and what motivates them to engage. Even though the conversations took place individually (separated by group), several themes emerged from the consultations, many of which overlapped and were shared across all four Reference Groups. The themes informed the Framework and the contents of this resource.

At the heart of many of the Reference Group consultations—especially for Veterans and Family members—was the notion of trust, including barriers and facilitators to establishing trusting relationships that encourage initial or prolonged engagement. Service providers and researchers echoed the sentiments around trust and the importance of investing the time and energy necessary to foster trusting relationships with Veterans and Families. As depicted in the graphic, additional themes build on trust and speak to what is important to Veterans and Families and those engaging with them within the mental health sector.



Below is a snapshot of what we heard about Veteran and Family engagement in Canada:

- Veteran and Family engagement requires a high level of trust. Veterans and Families want to be sure that what they share will be treated with respect, kept confidential, and result in real action.
- Recognizing that those who seek to engage Veterans and Families are well-intentioned, engagement with service providers, in particular, can be frustrating due to a lack of understanding of Canadian Armed Forces (CAF) or Royal Canadian Mounted Police (RCMP) culture and the needs of Veterans. Having to continually "teach" the service provider or organization about military or RCMP basics can deter Veterans and Families from engaging.
- Though this Framework is not focused on direct mental health care, Veterans and Family members stressed the importance of being actively involved in their own treatment decisions rather than having those decisions imposed on them. Being engaged in the process—including a two-way discussion about treatment options—is important from the start.
- Efforts by service providers and organizations to understand Veterans, including their Families, and learn all they can about the best ways to support them, do not go unnoticed.
- **Engagement needs to be *meaningful*. The first question organizations should ask themselves before engaging Veterans and Veteran Families is why they want to engage these groups. If the organization doesn't know why or doesn't have a thoughtful response, they are usually engaging to "tick a box," which deters Veterans and Families from engaging.**
- Veterans and Family members are often motivated to engage if they believe their input will help others. (This is evidenced by the number of Veteran and Veteran Family peer support programs.)
- Veterans and Family members need to be comfortable bringing their whole selves to the table, not just the piece of them that is a Veteran or Veteran Family member.
- Organizations looking to engage should recognize that not all Veterans and Families are in the same place mentally and emotionally, and they will not all be willing or able to engage at the same level at any given moment. Organizations need to be prepared to meet Veterans and Families where they are, even if that varies from person to person and from day to day.
- Organizations should assess their readiness to engage Veterans and Families. The assessment should be completed before any new engagement, as organizational changes can affect readiness over time. The self-assessment could be validated by Veterans or Family members to ensure they are truly achieving what they sought out to achieve.
- Engagement is a key element of program and service development. Veteran and Family engagement can inform the types of services offered and quality improvement efforts for existing programs.
- One of the most effective ways to build trust with Veterans and Families is to follow through on your commitments. Unfortunately, the reverse is also true: failing to follow through is a very quick way to lose that trust. It takes time and effort to build trust, and care must be taken throughout to ensure it is not eroded or broken. Treating everyone as equals, sharing their own humanity, and using plain language are keys to developing trust.
- Veterans and Families are not a homogeneous group. They are diverse and have different needs, perspectives, and experiences that must be considered.
- Stakeholder consultations often inspire lofty ambitions, which are not always achievable. Be *transparent* about what is possible and why you are seeking the expertise of Veterans and Family members. Action what you can and acknowledge items that are less feasible, offering alternatives where possible.
- With research, in particular, Veterans and Family members can be engaged in every stage of a research project, not just as study participants. Furthermore, a community-led approach often produces better research by focusing more on the questions that are relevant to the community—such as the Veteran community—and less on the questions that happen to pique the interest of a researcher.
- **When engaging Veteran Families, consider the definition of "Family." In the Veteran context, it oftentimes conjures an image of a spouse and young children. But there are other family members, including siblings, parents, and adult children, who also face challenges related to the Veterans' mental health and should not be excluded. Indigenous definitions should be considered, which usually include cousins, aunts, uncles, and grandparents as part of a person's immediate Family. The role of chosen Family—including other Veterans—should also be considered.**

The Veteran and Family Engagement Framework (Table 1) is a depiction of levels of engagement that span from "Passive" (i.e., recipients of information) to "Active" (i.e., as decision-maker). Adapted from a model created within the context of patient and research engagement in health research (Vandall-Walker, 2017), the levels of engagement are depicted across the continuum, ranging from "Inform" to "Partner and Shared Leadership," as it relates to mental health system roles, including "policy," "research," "organization," and "direct care." The continuum along the bottom is meant to demonstrate that any position within the framework can be suitable, depending on the interests, experience, ability, and desire to contribute at a given time, and an organization's matched needs and ability to engage (taking into account possible constraints).

Table 1: Veteran and Family Engagement Framework

	INFORM	PARTICIPATE	INVOLVE	PARTNER AND SHARED LEADERSHIP
	Communicate knowledge or resources	Contribute to priorities and initiatives	Collaborate to shape priorities and initiatives	Partner as equals with influence, shared leadership and decision-making
POLICY RESEARCH ORGANIZATION DIRECT CARE	**Veterans and Families…** ■ are informed of policy changes that impact them. ■ are informed of research findings and what they mean for the community. ■ receive updates by email or through social media. ■ receive information about treatment, services, and supports.	**Veterans and Families…** ■ participate in consultations to discuss new or existing government policies. ■ participate in studies through interviews, surveys, and other methods. ■ participate in consultations about priorities and initiatives. ■ participate in discussions related to treatment, services, and supports.	**Veterans and Families…** ■ are involved in shaping policies through advisory or working groups. ■ serve on advisory groups to help shape research goals, priorities, and design. ■ serve on an advisory council to shape priorities and initiatives. ■ share their preferences for treatment options.	**Veterans and Families…** ■ partner with government to envision, and design, new policies. ■ partner with researchers to co-investigate or co-lead research projects. ■ co-lead an advisory council to shape priorities and initiatives. ■ partner with service providers to make treatment decisions.
	PASSIVE			ACTIVE

Adapted from Vandall-Walker (2017)

Engagement Principles and Practices

Existing literature includes several credible sources describing evidence-based best practice principles and strategies for engaging PWLE, families, and the public in mental health system improvement. Some sources focused specifically on the Veteran context. This section summarizes emerging principles, practices, and strategies with relevant Veteran and Veteran Family examples.

Two primary sources helped generate and organize the principles, practices, and strategies presented in this section:

- **The quality standards for youth and families developed by the Ontario Centre of Excellence for Child and Youth Mental Health** (OCECYMH, 2021a; OCECYMH, 2021b). The quality standards for meaningful engagement of youth and families include co-development, commitment, communication, diversity and inclusion, ongoing learning, research, and evaluation. Additional principles for youth include accessibility, authentic relationship, and safe spaces, whereas empowerment and partnership were identified as principles for families.
- A 2019 report by the Australian Government National Mental Health Commission, *Sit Beside Me, Not Above Me*, on safe and effective engagement of PWLE (Australian Government NMHC, 2019). The report identifies essential ingredients for safe and effective engagement and participation: strong leadership, a culture that recognizes engagement and participation is everyone's responsibility, values of kindness, respect and understanding, freedom from stigma and discrimination, enhanced health literacy, continuous quality improvement, training and skills development for all involved, and ongoing research and evaluation.

We modified and identified other principles and practices based on:

- Veteran-specific sources: understanding military culture and trauma-informed practice (Cheney et al., 2018; Brintz et al., 2020; Botero et al., 2020; Lane et al., 2021; Alhomaizi et al., 2020);

> "Real engagement is about engaging people in creating an intervention, creating an educational component, creating whatever it is you are trying to do, and to have the community members—for example Veterans—actively involved in this."
>
> **HAMILTON & FINLEY (2016)**

- Evolving anti-oppression practice that takes into account diversity of voices, intersectional identities, structural barriers, and advancing systemic equity (Eichler, 2021; SFU Centre for Dialogue, 2020); and
- evidence-based engagement principles from the Patient-Centered Outcomes Research Institute: reciprocal relationships, co-learning, partnership and trust, transparency, and honesty (Sheridan et al., 2017).

Table 2 describes emerging principles and practices for Veteran and Family engagement in the mental health system. Strategies and examples in the following sections draw from a range of other identified sources. The principles, practices, and strategies, when put into action, work together as a whole to set up for meaningful engagement and productive outcomes. Their use can minimize the risk of unintended harmful outcomes. Strategies can be thought of in five broad areas (Bombard et al., 2018):

- Designing engagement processes;
- Recruiting participants;
- Involving participants;
- Creating a receptive context; and
- Providing active leadership.

Table 2. Emerging Principles and Practices for Veteran and Family Engagement[5]

Principle	Description
CONNECTION	Engagement processes promote relationship-building, communication, shared experience, and empowerment. Veterans and Families connect with others who can validate their experiences.
CULTURAL AWARENESS	Engagement processes consider CAF and RCMP cultures and subcultures, values, organizational and leadership structures, service experience, and experience of transition from service to post-service life.
DIVERSE AND INCLUSIVE	Veteran and Family engagement practices are inclusive. Diversity is valued and representative of various identities within the Veteran and Veteran Family community.
LEADERSHIP AND COMMITMENT	Organizational leadership is committed to Veteran and Family engagement. Leaders are accountable for embedding this commitment in research, policy, service planning, and quality improvement efforts.
RESPECT AND RECIPROCAL RELATIONSHIPS	All acknowledge and value each other's expertise and experiential knowledge. Veterans and Families are considered experts based on their own lived and living experience.
SAFE AND TRAUMA-INFORMED	Engagement processes are designed to create a safe, non-judgemental, stigma-free space for Veterans and Families. The impacts of trauma are recognized, and supports are consciously embedded.

Practice	Description
CLEAR AND TRANSPARENT COMMUNICATION	Communication is timely, clear, transparent, respectful, and accessible. Communication is a two-way exchange of information, perspectives, and experience.
CO-LEARNING	Veterans, Families, and organizational partners learn together by doing. Organizations invest in training, capacity-building, and knowledge-sharing.
CO-PRODUCTION	Veterans and Families develop activities and processes in mental health system research, policy development, service planning, and improvements, and have opportunities to be engaged.
CONTINUOUS EVALUATION	Continuous evaluation can support co-learning and help manage the complexity and unpredictability of collaborative engagement. Veterans and Families are involved in evaluating engagement processes and developing evaluation approaches.

5 Adapted from OCECYMH (2021a) and OCECYMH (2021b).

Engagement Principles

CONNECTION

Engagement processes promote relationship-building, communication, shared experience, and empowerment. Veterans and Families connect with others who can validate their own experiences.

Engagement processes that build in opportunities for social connection have the potential to contribute to positive mental health and recovery for Veterans living with PTSD or other mental health conditions (Albright et al., 2020, Barnett et al., 2021; Fogle et al., 2020; Franco et al., 2021; U.S. Department of Veterans Affairs HSR&D, 2021a). Social connection is a reported positive outcome of engagement in health research and other processes designed to improve mental health policy and service improvements (Bird et al., 2020).

The First Nations Mental Wellness Continuum Framework is a complex model that is rooted in culture, with layers and elements that are foundational to supporting First Nations Wellness. It spans the lifespan, and demonstrates the interconnectedness between mental physical, spiritual, and emotional behaviour, and their contribution to purpose, hope, meaning, and belonging. A balance between these, and other elements described within the Continuum, lead to optimal mental wellness (Health Canada, 2015).

The transition to post-service life can have a negative impact on social group engagement and Veteran well-being (Barnett et al., 2021). Getting involved with supportive social groups can help with the transition, for example, through volunteering or participating in Veterans' support organizations (Barnett et al., 2021). Veteran college students who participated in civic engagement[6] activities reported experiencing reduced feelings of depression and increased use of mental health services (Albright et al., 2020).

Other studies have identified benefits to Veterans of civic engagement and volunteering: increased social connection and access to social support networks; higher likelihood of successfully transitioning from military service to post-service life; better overall health; lower rates of post-traumatic stress disorder (PTSD) and depression; less social isolation; and other positive physical and mental health outcomes (Albright et al., 2020).

Peer support was identified as an essential tool to provide social support in engagement processes. The principle of peer support is based on "being there," for and with others (Australian Government NMHC, 2019). Peer support for participation can include outreach to encourage involvement, providing advice or helping to prepare (e.g., reviewing background information, talking through ideas or strategy, providing feedback on planned input or presentation, emotional support), participating as an ally/buddy at a meeting, debriefing, and helping connect to supports, when needed.[7] Peer support can be provided formally or informally to PWLE, their families, and other support people to be linked into networks.

Peer support can be provided in a range of ways: one-on-one or in a group; by volunteers or paid employees; peer-led or facilitated; in-person, on the phone, or via the Internet; through workshops or social activities; in ad hoc or ongoing formats (e.g., advisory group, network) (Australian Government NMHC, 2019).

Facilitation by peers with lived experience has proven effective in activities designed for positive mental health and recovery (Lane et al., 2021). Health systems are shifting toward the employment of PWLE at all levels of engagement in the mental health system (Byrne et al., 2019).

Beyond connections with peers, Veterans and Veteran Family members have identified connecting more broadly with the community and professional networks as benefits of engagement, for example, through community-based participatory research (True et al., 2021; Franco et al., 2021; Hyde et Ono, 2017). Engagement through ongoing groups or networks also supports social connection, such as Veteran-led groups or multi-stakeholder Communities of Practice (CoPs) (Australian Government NMHC, 2019; Woodward et al., 2021).

6 The term "civic engagement" was used to describe the extent to which a person is involved in shaping and improving their community.
7 Communication with Kelli Dilworth, December 2021.

> "Both law enforcement and the military have a culture and it's got its own set of rules and values that is completely different from the civilian life."
>
> **VETERAN OF THE RCMP**

STRATEGIES FOR FOSTERING CONNECTION IN ENGAGEMENT

- Working with Veterans or Veteran Family members to strategize about building peer support and connection;
- Involving two or more Veterans or Veteran Family members on a multi-stakeholder advisory group or governance body, as opposed to including only one Veteran or Family member, which may be tokenistic and result in added pressure on the Veteran or Family member to represent all voices from the Veteran community;
- Facilitating connections between an experienced Veteran or Veteran Family member as an ally/buddy for someone new to sharing lived experience;
- Providing a mechanism for Veterans participating in an engagement to connect informally or outside of structured engagement activities;
- Offering training and skill-building that brings together Veterans and Veteran Family members to learn on their own (e.g., how to approach sharing lived experience, what to expect at a meeting and how to prepare) or with other stakeholders to learn together (about the content of the engagement, the engagement process, specific skills for collaboration);
- Working with community-based Veterans groups to build relationships and connections with their members or groups they serve (e.g., partner to bring people together for an informal information session or activity related to the focus of engagement); and
- Sharing information and facilitating connections between Veteran or Veteran Family members and community-based Veteran groups (e.g., in follow-up after meetings).

CULTURAL AWARENESS

Engagement processes consider CAF and RCMP cultures and subcultures, values, organizational and leadership structures, service experience, and experience of transition from service to post-service life.

Canadian military (CAF) and RCMP culture are significantly different than civilian culture, with unique language and terms, values and belief systems, attitudes, goals, and sets of norms and courtesies that can impact the choices around participating in mental health services and experience of service use (Greendlinger & Spadoni, 2010; Brintz et al., 2020). Adaptations that consider military culture can increase relevance and support participation for Veterans and Veteran Family members (Brintz et al., 2020; Wendleton et al., 2019; Alhomaizi et al., 2020; Barnett et al., 2021).

Unique characteristics of military culture include (Brintz et al., 2020; Government of Canada, 2009; Wendleton et al., 2019):

- Highly structured chain of command structure that emphasizes regimentation and conformity;
- Clear hierarchy and strict rules leave little room for questioning authority figures;
- Being part of a cohesive team/unit over individual autonomy;
- Expectation of efficient, structured organization and execution of tasks;
- High value on emotional strength and resilience, particularly in stressful situations; and
- Positive values, such as teamwork, altruism, and being in service to others (Barnett et al., 2021).

Respect for authority figures can extend to showing deference for civilian professionals (e.g., researchers, clinicians, health leaders) (Brintz et al., 2020). In the context of engagement, care is needed to reinforce that everyone's experience is valid and helpful, regardless of former military or RCMP rank. Engagement design needs to use techniques that bring in all voices, such as choosing methods, facilitating discussions, or making decisions about who to include.

CAF and RCMP cultural awareness (also referred to as cultural competency) means understanding the issues, problems, values, and language associated with serving in today's military or RCMP (Greendlinger & Spadoni, 2010; Botero et al., 2020; Brintz et al., 2020). Anyone without military or RCMP experience who interacts with Veterans will communicate more effectively if they have CAF or RCMP cultural awareness.

Engagement practitioners can create a more comfortable and welcoming environment if they are aware of the CAF or RCMP context when designing engagement processes, with a focus on removing barriers to participation. For example, Veterans with PTSD often feel isolated, which can be compounded by having the additional task of translating military lingo or explaining military structure to others (Greendlinger & Spadoni, 2010). Veterans say they do not want to "waste time explaining military basics to the person who was supposed to be able to help them with issues derived from that military experience" (Committee to Evaluate the Department of Veterans Affairs Mental Health Services, 2018, p. 228).

For work focused on improving mental health policies and programs, it is also important to understand the health care, social, and financial supports available to Veterans and Veteran Families. Notably, CAF Veterans transition to civilian health care when they leave service. As such, there can be significant differences in the services available to them in their home province or territory. Former regular force CAF members may still be engaged as reservists with access to different types and levels of care depending on the class of their employment contract. Though RCMP Veterans do not experience the same transition to civilian health care as CAF Veterans, they may need to seek out new service providers following the end of their service due to relocation (e.g., an RCMP member relocates from northern Canada to an urban centre upon retirement, or vice versa).

STRATEGIES FOR CULTURAL AWARENESS IN ENGAGEMENT INCLUDE:

- Involving Veterans and Veteran Family members from the beginning to design the engagement in a way that makes sense for them, in developing recruitment strategies and reaching out to others to promote their involvement;
- Aligning the engagement with CAF or RCMP cultural values, such as a strong sense of service, altruism, giving back to the community, and helping those who will serve in the future (Barnett et al., 2021; Lahey, 2015);
- Learning the language and terms used in the CAF and RCMP to understand the different processes and structures that Veterans and Veteran Families use for mental health and financial support to access services (Cheney et al., 2018; Brintz et al., 2020);
- For meetings or discussion groups, choosing a facilitator familiar with the CAF or RCMP environment and common terms (Brintz et al., 2020);
- Using group facilitation techniques that level the power dynamics across CAF and RCMP ranks/chain of command—for example, with their permission, using personal names instead of titles in introducing participants; inviting people into the discussion to give equal voice; using real-time anonymous polling tools; reinforcing the value of each person's perspective in identifying challenges and the best solutions; and creating a separate forum for input from higher-ranked vs. other personnel to increase safety (e.g., focus groups);
- Developing CAF and RCMP cultural awareness for those involved in collaborative engagement processes who do not have CAF or RCMP experience (e.g., clinicians and researchers, engagement practitioners, and staff in the organization) (Botero et al., 2020; Cheney et al., 2018; Wendleton et al., 2019);
- Involving CAF and RCMP leaders in the engagement to share their own experiences accessing mental health services or positively promote service use and improvements (Hinton et al., 2021);
- Designing engagement activities that build shared understanding of experiences, including awareness about PTSD and the experience of Veterans and Families living with PTSD; and

- Paying attention to the complexities and differences in access to mental health supports experienced by Veterans and Veteran Families—for example, living in different parts of the country or transitioning in their employment relationships with the CAF or RCMP (e.g., in deciding who to include in designing engagement questions and in analyzing and reporting findings).

PRACTICE EXAMPLE:
Adapting to military culture context (INVOLVE)

CONTEXT:
A program for active-duty Army personnel experiencing chronic pain in the U.S.

The process used to adapt the evidence-based mindfulness-based stress reduction program to the military context is a good example of applying military cultural competence to design (Brintz et al., 2020). Military-related adaptations included military culture, language and terminology, and practical implementation factors. A four-member Veteran Advisory Group tested the adapted program in the early design stages for acceptability, fit within a military context, and other refinements. Changes were made based on their feedback to strengthen the program design..

Examples of adaptations included:

- To maintain the chain of command, the facilitator presented the course material in a directive manner to help participants view them as credible and trustworthy.
- The sessions included military-relevant examples to help define mindfulness and demonstrate its use in the military context.
- Addressing the military's emphasis on regimentation, sessions were highly structured, with brief and efficient presentation of materials.
- To address military literacy, the chosen facilitator was familiar with the military environment and common terms.
- Time and format matched the realities of Veteran participants (e.g., evenings, virtual).

DIVERSE AND INCLUSIVE

Veteran and Family engagement practices are inclusive. Diversity is valued and representative of various identities within the Veteran and Veteran Family community.

Veterans are not a homogeneous group, nor are their Families. Instead, they have diverse experiences across generations and identities, all of which are valid and need to be represented in engagement processes (Shimmin et al., 2017). Examples of factors to consider in understanding the range and diversity of experiences include those related to:

- Their military service experience, including their rank, branch of service (e.g., army, navy, air force), and military cohort (based on when and where they were in active service), all of which have their own unique internal cultures;
- Age, sex and gender identity, sexual orientation, race, ethnic and cultural background, socioeconomic status, and geography, as well as life experience and life circumstances that shape education, income, living arrangements, and social supports, and how these intersect; and
- The intersection of their Veteran identity with their other identities connected to experiences of exclusion and systemic oppression (e.g., racism, colonialism, classism, sexism, ableism, homophobia) (Shimmin et al., 2017).

> "There isn't a sole voice of representation."
>
> **RESEARCHER**

Equity in public engagement exists when resources and opportunities for participation are designed in a way that pays attention to historic and ongoing disadvantages faced by marginalized groups (SFU Centre for Dialogue, 2020). Engagement processes that do not consider systematic exclusion of voices and power imbalances can increase inequities in access to health services and health outcomes for affected groups by shaping services to meet the needs of the dominant culture (Shimmin et al., 2017).

In the military context, the focus has been more on the experience of white, cis-gendered, predominantly high-ranking men, and less on the experiences of Veterans who are women, LGBTQ+, racialized, Indigenous, living with a disability, or economically disadvantaged (Eichler, 2021). As a result, Veterans with these identities can be invisible in health research and policy development, resulting in unmet needs and structural barriers to accessing services (Chen et al., 2017; Crone et al., 2021; Hamilton & Yano, 2017; Woodward et al., 2021). Inequities can be magnified by systemic oppression and past trauma (Shimmin et al., 2017).

In the U.S. VA health system, challenges have been identified in bringing diverse voices into health research and service planning (e.g., women, Veterans experiencing homelessness, Veterans living in underserviced rural areas) (Frayne et al., 2013; Greendlinger & Spadoni, 2010; Fehling et al., 2021). Efforts are underway to understand the different needs of these groups through active engagement in research and service planning processes, outreach, listening, and purposeful design.[8]

According to the SFU Centre for Dialogue (2020), the aims of equitable engagement are to:

- Be mindful of power and privilege within engagement processes, institutions, and broader systems; and
- Provide opportunities for diverse people from marginalized groups to contribute for mutual benefit (i.e., working with, not "doing for").

STRATEGIES FOR DIVERSE AND INCLUSIVE ENGAGEMENT INCLUDE:

- Inviting Veterans who are already involved to be connectors who help reach others; involving them in a "seed" committee to identify and recruit others; and extending reach into the community (Wendleton et al., 2019);
- Applying an intersectional, anti-oppression lens to the early stage of engagement design to purposefully include diverse voices and use processes that equalize power;
- Including the voices of marginalized Veteran groups (e.g., women, LGBTQ+, Indigenous, people of colour, Veterans experiencing homelessness);
- Using open, non-traditional definitions of the Veteran Family in deciding who to engage,[9] and recognizing the Veteran Family could include heterosexual or same-sex partners, a new or different spouse, children from blended families, single Veterans, parents of a Veteran, adult children of a Veteran, and other members of a circle of support;
- Considering diversity in age and military service experience, and involving Veterans from different branches and military cohorts and their Families in early discussions about how best to engage these groups;
- Reviewing sex, gender, and intersectionality reflective questions for military and Veteran researchers (see Eichler, 2021 for questions);
- Engaging the internal diversity of the group by including multiple voices (SFU Centre for Dialogue, 2020) – individuals who share one aspect of their identity or experience may hold very different perspectives on an issue and may face different barriers to participation;
- Building ongoing relationships with diverse Veteran groups (e.g., women, LGBTQ+, racialized, Indigenous, older, living with a disability, experiencing homelessness); listening to their priorities and working together to create mutually beneficial, reciprocal engagement processes; and asking how they see your

8 Communication with Dr. Eva Woodward, November 2021.

9 Communication with Dr. J. Don Richardson, November 2021.

organization's work advancing their concerns or how to approach partnering to enable change (SFU Centre for Dialogue, 2020)—to engage a new community, it's important to meet people where they are at, and not try to fit them into a prescribed role you need them to fill;

- Tailoring engagement to context rather than using a one-size-fits-all approach to engagement activities;
- Involving members of diverse Veteran groups on an engagement project team to advise on or lead activities within their community—for example, this approach has been used successfully to recruit more diverse research participants in the U.S. VA health system (U.S. Department of Veterans Affairs HSR&D, 2021b);
- Using participatory design processes that level the power dynamic (e.g., participatory action research, to include the voice of Veteran groups that have been left out of health research and design of care processes); and
- Requiring training in gender-based analysis to inform the design, implementation, and evaluation of engagement processes;[10] and
- Questioning long-standing norms, structures, and power relationships, and working to advance diversity and equity in the system and leadership (SFU Centre for Dialogue, 2020).

PRACTICE EXAMPLE: Building capacity to include the voice of rural Veterans (INVOLVE)

CONTEXT: Inclusion of rural Veterans in research in the U.S.

To strengthen mental health services for rural Veterans in the U.S., the Center for Growing Rural Outreach through Veteran Engagement (GROVE) is developing the capacity of VA researchers and staff to be more inclusive of rural Veteran populations (Fehling et al., 2021). Because researchers are typically located in urban regions with medical centres and academic institutions, much of the research has not benefitted from the formal input of rural Veterans. GROVE supports projects interested in including rural Veteran engagement in their research approach.

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Much of GROVE's work is consultation, outreach, and partnership building between rural communities, rural Veterans, and VA researchers.

Expert consultation for researchers has resulted in concrete changes early in research design on specific research projects, such as hiring a Veteran with expertise in the subject matter to assist with the recruitment of other rural Veterans; clarifying critical points for shared decision-making with Veteran partners, using Veteran feedback when interpreting qualitative findings; and using innovative ways to reach out and involve rural Veterans.

- Sharing best practices with a research network (the VA Access Research Consortium) resulted in greater collaboration with diverse Veteran groups. Changes in the engagement approach included:
- Seeking input on research priorities from more Veterans to include diverse perspectives (beyond existing Veteran Engagement Groups);
- Including Veterans from underrepresented groups with greater access needs to increase sample sizes and address equity issues;
- Engaging lesser-known Veterans groups and other partners to help strategize research questions more deeply at a systemic level; and
- Creating more opportunities for Veterans to inform dissemination efforts.

Other strategies to building capacity for engagement of rural Veterans include:

- Setting up informal jam sessions to provide a "community of practice" forum where interested Veterans and professionals have opportunities to learn from others' experiences; and
- Developing a virtual platform to facilitate connections between rural Veterans and researchers.

10 The Government of Canada has a GBA+ online learning module for those involved in policy and program development; the Canadian Institutes of Health Research has learning modules on unconscious bias, how to integrate sex and gender-based analysis in research, and research involving First Nations, Inuit, and Métis People.

LEADERSHIP AND COMMITMENT

Organizational leadership is committed to Veteran and Family engagement. Leaders are accountable for embedding this commitment in research, policy, service planning, and quality improvement efforts.

Strong leadership drives a culture of meaningful engagement and is a key facilitator of successful engagement that drives Veteran-centered care (Locatelli et al., 2015; Khodyakov et al., 2017; Hamilton & Yano, 2017). A supportive organizational culture

- Understands and supports engaging lived experience in collaborative processes;
- Provides practical supports for engagement: infrastructure, time, and resources to support collaboration (Shippee et al., 2015; Baker et al., 2016; Hyde & Ono, 2017); and
- Can influence, through organizational leaders, the engagement culture from the top down (commitment at the institutional or executive level) or from the bottom up (leadership or promotion by local champions in the community) (Bombard et al., 2018).

Leaders can:

- Ensure that expectations for engagement are clear and supported by a well-articulated vision, policies, and supportive structure (Mulliez et al., 2018);
- Foster a sense of empowerment and commitment among clients (e.g., when managers and executives recognize and advocate for the importance of lived experience in the organization's work, PWLE feel more empowered) (Baker et al., 2016);
- Identify engagement as everyone's responsibility in the organization;
- Plan the right time for engagement to ensure results influence decision-making;
- Align and embed engagement findings or recommendations in the organization's strategic plans and policies; and
- e well-defined organizational expectations for meaningful engagement, build trust, and demonstrate commitment. Organizational policies can make engagement a strategic priority, describe expected outcomes, and help set targets for engagement that can be monitored and evaluated (MHCC, 2019; Baker et al., 2016).

Organizations that are new to engagement may fear negative outcomes. A certain element of vulnerability is necessary to be authentic and open to acting on input from PWLE and other stakeholders.[11] It is not necessary to have a perfect process or clear path forward (Attygalle, 2019), as "the process is the practice."[12] To learn engagement, it is important to start. The more experience partners gain from working together, the more productive the process will be.

Assessing readiness and learning best practices can help manage risk. Leaders can signal engagement as a stretch opportunity for learning and extending skills (Attygalle, 2019).

This spirit of engagement as collective learning can be built into organizational principles and modelled by leaders. It can help equalize power and set up for creative thinking and productive results (Redman et al., 2021). Being open about the challenges and the "messiness" of authentic engagement can reinforce trust in the engagement process.[13]

11 Communication with Kelli Dilworth, December 2021.
12 Ibid.
13 Ibid.

STRATEGIES FOR LEADERSHIP AND COMMITMENT IN ENGAGEMENT INCLUDE:

- Building messaging into organizational mission, goals, and strategic plans that commits to meaningful engagement with Veterans and Veteran Family members;
- Assessing organizational readiness for collaboration, taking into consideration skills and experience of involved staff and volunteers (communication, facilitation, collaboration, working through conflict) and the available time and resources;
- Investing in practical supports for meaningful engagement—for example, honoraria or other financial compensation for Veterans and Veteran Family members; dedicated staff time and resources to organize and support engagement in governance; and other collaborative activities;
- Developing a policy that promotes hiring Veterans and Veteran Families as staff, including in leadership positions, to embed lived experience and/or involve them in staff hiring processes;
- Building realistic timelines that allow for meaningful involvement of Veterans, Veteran Family members, and other partners;
- Tracking and sharing engagement activities and results of engagement for accountability purposes and to celebrate successes;
- Investing in developmental evaluation of engagement processes that include regular progress checks and time for reflective feedback with Veterans, Veteran Family members, and other partners; and
- Considering how to formalize the role of Veterans and Veteran Family members in governance and advisory structures as co-chairs or members.
  - For organizational governance, this could be participation on the Board or an advisory body to the Board, either multi-stakeholder or Veteran- or Veteran Family-specific.
  - For major system-level initiatives, this could be participation on a multi-stakeholder steering committee, project team, or expert panel.

PRACTICE EXAMPLE: Supportive leadership and organizational practices (INVOLVE)

CONTEXT: Veteran mental health councils in U.S. Veteran medical centres

Veteran Mental Health Councils promote recovery and contribute to improvements in mental health services in U.S. VA medical centres. Important factors contributing to the success of Councils included (Beehler et al., 2019):

- The general openness of the medical centre culture to client participation;
- The willingness of the medical centre to provide practical support to Councils over time (e.g., refer members, endorse the mission, and include members in relevant discussions and decisions);
- A designated and trained staff liaison who is well-supported with a clear job description and structured processes for working with the Council;
- Setting up regular, structured communication between the Council and medical centre decision-makers;
- Having clear Council policies in place that support full, active participation of members (at meetings; between meetings) and effective operation;
- Building strong internal and external relationships—for example, with clinical and department staff in the medical centre—with community-based services that could help Council members in their role as "eyes and ears" of the Veteran community (mental health clinic, suicide prevention services, military sexual trauma programs); and
- Taking time for mutual appreciation and feedback.

RESPECT AND RECIPROCAL RELATIONSHIPS

All acknowledge and value each other's expertise and experiential knowledge. Veterans and Families are considered experts based on their own lived and living experience.

The principles of respect and reciprocal relationships are front and centre in engagement frameworks supporting health research and health system improvement work (CIHR, 2014; Health Quality Ontario, 2017; British Columbia Ministry of Health, 2018).

Mutual respect is an attitude and way of relating. British Columbia's Patient, Family, Caregiver and Public Engagement Framework describes this principle as having "a deep commitment to respect, dignity, and listening to understand" (British Columbia Ministry of Health, 2018).

Respect and reciprocal relationships are connected. Main characteristics of reciprocal relationships in partnership with PWLE include:

- Clarity in the roles and decision-making authority of all partners;
- A shared understanding of the capacities and goals of all partners;
- Value placed on the time and contributions of partners bringing lived experience, with fair financial compensation and reasonable time commitment requests;
- Knowing how to work through conflicts together; and
- Recognizing that not all Veterans or Veteran Family members may be interested in participating in higher-level engagement activities (e.g., in multi-stakeholder processes or as leaders). It is important to support people to contribute at the levels they would like to contribute and to offer different ways to bring their voice into engagement processes (Sheridan et al., 2017; Shippee et al., 2015; CIHR, 2014; Brys et al., 2018; Gierisch et al., 2019).

Maintaining relationships over time is an ongoing challenge, such as between engagement initiatives. Any efforts to maintain open communication and dialogue can help with relationship-building and trust.

STRATEGIES FOR RESPECT AND RECIPROCAL RELATIONSHIPS IN ENGAGEMENT INCLUDE:

- Setting a tone of friendliness, mutual support, and working toward shared goals;
- Putting organizational policies in place to create an expectation for mutual respect and partnership, and fair compensation for Veteran and Veteran Family members for their time (e.g., honoraria; costs of child care or transportation);
- Involving Veteran and Veteran Family members in developing fair compensation policies (e.g., honoraria; reimbursement of expenses);
- Reinforcing the value of lived experience as part of evidence-based practice (e.g., in internal and external communications; in terms of reference for projects; in introductions at meetings to create a level playing field);
- Offering more than one way to participate (e.g., option to complete a written questionnaire instead of joining interactive activities; doing one-on-one interviews; inviting discussion in informal settings about issues of concern);

> "Let people know that we're valuing their voice and wanting to learn from their voice and to empower them to have a greater voice."
>
> **RESEARCHER**

- Being aware of the potential impacts of Veteran and Family mental health conditions on their ability to participate in engagement activities at a given point in time and being prepared to mitigate them (see the section on safe and trauma-informed engagement);
- For collaborative processes, planning early opportunities for Veterans and Veteran Family members to meet other partners, to learn about their respective roles, and to build working relationships;
- Working with an external facilitator with experience to create a positive working environment based on mutual respect and equal partnership;
- Acknowledging when different perspectives create tension and supporting partners to constructively resolve conflict; and
- Considering strategies that keep communication and dialogue open with Veterans and Families between discrete engagement initiatives (e.g., formal or informal dialogue sessions to check in on top-of-mind issues or new ideas; one-on-one calls with volunteers or key partners in Veteran-led groups; creating opportunities for social connection in-person or virtually).

> "Stigma is a barrier to engagement."
>
> **VETERAN FAMILY MEMBER**

SAFE AND TRAUMA-INFORMED

Engagement processes are designed to create a safe, non-judgemental, stigma-free space for Veterans and Families. The impacts of trauma are recognized, and supports are consciously embedded.

General engagement principles stress the importance of creating a safe, welcoming, non-judgemental environment. This is especially important for Veterans who experience post-traumatic stress and the challenges of adjusting to post-service life after their military experience (Botero et al., 2020).

Negative stigma related to mental health treatment and concern about not being understood are significant barriers for Veterans seeking support (Botero et al., 2020; Koenig et al., 2014) and a likely barrier to organizational and system-level engagement. Attitudes of military leadership and warrior culture can perpetuate stigma and get in the way of seeking mental health care and support (Hinton et al., 2021). Fears related to stigma include being viewed as weak, labelled as "those people," not being capable or belonging in the unit, or having negative career consequences (Hinton et al., 2021).

Sharing personal stories and exposing vulnerability requires courage and trust in others. For collaborations with Veterans living with PTSD or other mental health conditions, it is important that the process design minimize the risk of retraumatizing participants, in addition to ensuring a safe, stigma-free environment (LaMonica et al., 2019; Greendlinger & Spadoni, 2010). Traumatic memories or emotional distress could resurface in the retelling of personal experiences or hearing the experiences of others.

Traumatic events set up a situation where an individual, a system, or an event has power over another (Shimmin et al., 2017). Feelings of powerlessness, guilt, shame, betrayal, or silencing often shape the experience of this event. Therefore, care is needed in designing engagement processes to not reproduce feelings of powerlessness but instead build relationships and create space for safe, empowering interpersonal interactions.

There is a large body of evidence on trauma-informed, non-medical approaches to care (Van der Kolk, 2015; Treleavan, 2018). Trauma-informed strategies can guide the design of safe, meaningful Veteran and Veteran Family engagement initiatives grounded in values of kindness, respect, and understanding, and freedom from stigma and discrimination (Australian Government NMHC, 2019).

STRATEGIES FOR SAFE AND TRAUMA-INFORMED ENGAGEMENT INCLUDE:

- Communicating strong, clear messages upfront that empower Veterans and Veteran Family members to speak about their lived and living experiences;
- Taking time to establish safe, authentic, and positive relationships with Veterans and Veteran Family members;
- Involving Veterans and Veteran Family members in creating engagement opportunities or research questions, and framing questions in a way that creates safety and sets up for authentic sharing;
- Collaborating with Veterans and Veteran Family members in design and agenda-setting to identify and sensitively frame difficult discussions or activities, as sharing power and decision-making builds trust and can help address trauma by giving control;
- Being clear about how their information will be used, where it is going, and who will have access to it;
- Establishing confidentiality agreements to respect privacy (e.g., information shared during meetings);
- For meetings or discussion groups, embedding mental health supports into the design (LaMonica et al., 2019), including:
  - Assigning engagement team members, facilitators, peer volunteers, or health professionals the role of monitoring participants for any signs of distress and offering support, as needed—for virtual engagement, this includes monitoring the chat and video displays;
  - Having ready access to professional mental health support during and after the engagement activity (on-site or virtually)—identified resources should have experience with assessing suicide risk and safety planning; and
  - Having a protocol in place for accessing additional crisis intervention or mental health supports, if needed;

- Checking in with participants before engagement, including:
  - Sending out the invitation well enough in advance that Veterans or Family members have time to think through their participation and talk it through with their circle of support;
  - Having a conversation about what the engagement activity will look like and flagging complex topics, and inviting questions, feedback, or concerns about what is planned;
  - Reinforcing respect for their choice about whether or not to participate and how to participate (either sharing personal experiences or being part of broader discussions on making change)—for example, it may not feel like the right time in their mental health journey to talk about broader concerns like health policy or service delivery changes; having the option to opt out of formal participation but remain informed could be suggested as a way for the Veteran or Family member to remain engaged, if appropriate;
  - Asking about their accessibility needs to help them feel comfortable, safe, and supported, and paying attention to barriers to participation and potential changes to engagement design to remove them. Examples of accessibility needs could include being buddied with a peer support person, knowing who else will be participating (in-person, virtually), having easy access to an exit if they feel they need to leave, turning off their video during virtual meetings, doing a detailed walkthrough of a session agenda ahead of time to understand the intent and how they might contribute, offering coaching on how to share their personal story, and considering the meeting room set-up and how a Veteran's seat within the room might impact their comfort level (i.e., preference not to have their back to the door; open circle set-up). If travelling, choosing a venue away from the airport and other noise, and near grass if a service dog is accompanying the Veteran.
- Early in the engagement activity, identifying available mental health supports to participants if needed (on-site, virtually), including who they are and their professional expertise (e.g., experience supporting Veterans, understanding of military or RCMP culture and PTSD), and how to contact them; and
- After an engagement activity, structuring intentional debrief/check-in, both with participants and staff, to provide emotional support, identify immediate follow-up steps, and capture lessons learned.

PRACTICE EXAMPLE: Veteran readiness to share lived experience (PARTICIPATE)

CONTEXT: Self-reflection of a Canadian woman Veteran

Research and practice reinforce the potential negative impact on participants sharing their lived experiences. A Veteran who has publicly shared their lived experience of military sexual trauma talked about individual readiness to share. For them, the opportunity to help others in the future gave them the strength and motivation to share their story. They credited years of therapy and time to heal as key in preparing them to move from anger toward sharing their lived experience and advocating for change.

At the same time, the retelling still brings up difficult memories and emotions, including anger and bitterness. It is impossible to control the reaction of others to the sharing, even when a safe space is consciously created. Skills are needed to be present with others and stay focused on the goals of raising awareness and learning together. A strong network of peers and other supports is a source of strength.

Based on their experience, each person needs support to reflect on their recovery and readiness to share to avoid reliving the trauma, such as by reverting to a feeling of powerlessness or being harmed. Strategies are being considered to provide more safety in sharing stories of trauma, such as through the use of avatars during virtual meetings.[14]

14 Communication with M.E. Sam Samplonius, December 2021.

Engagement Practices

CLEAR AND TRANSPARENT COMMUNICATION

Communication is timely, clear, transparent, respectful, and accessible. Communication is a two-way exchange of information, perspectives, and experience.

> You don't have to speak my language, but if you're making an effort, I'll meet you halfway.
>
> **VETERAN OF THE CANADIAN ARMED FORCES**

Meaningful engagement is based on trust, transparency, and honesty (OCECYMH, 2021a; OCECYMH, 2021b). Trust-based relationships are critical to achieving individual, community, and system goals (British Columbia Ministry of Health, 2018). Setting up clear communication processes builds mutual trust and collaborative relationships over time. Key process elements include a two-way exchange of information and inclusive decision-making.

STRATEGIES FOR CLEAR AND TRANSPARENT COMMUNICATION IN ENGAGEMENT INCLUDE:

- Clarifying engagement objectives, realistic expected outcomes, and time commitments;
- Explicitly discussing and documenting the roles and expectations of all partners;
- Identifying the points in the process where shared decision-making will occur and how it could be done;
- Building in structured feedback loops throughout the process for Veteran, Veteran Family members, and other stakeholders to share progress;
- Reporting back on how the input of Veteran, Veteran Family members, and other stakeholders have been used and how it has shaped actions;
- Being open about challenges and new information that impacts the process;
- Co-developing a dissemination plan, involving diverse voices in the planning, and considering partnering with Veteran-led groups or community-based services to reach diverse sub-groups (Greendlinger & Spadoni, 2010).
- Involving Veterans and Veteran Family members in preparing or reviewing communication materials to ensure language is clear, terms are in plain language that resonates, and messages are stigma-free;
- Creating communication roles and offering training for Veterans and Veteran Family members in outreach, media events, or other knowledge-sharing with other partners (on panels, in presentations, at conferences, and in public consultation meetings).
- Designating a contact person for Veteran or Veteran Family members to provide information and support for engagement; and
- Sharing information in advance of meetings or other engagement activities to give time to prepare.

CO-LEARNING

Veterans, Families, and organizational partners learn together by doing. They seek opportunities to continually enhance their knowledge and skills. Organizations invest in training, capacity-building, and knowledge-sharing.

Doing authentic, meaningful engagement through collaboration and partnership is not easy (Redman et al., 2021). The openness needed for true collaboration brings risks and can generate fear for organizations and stakeholders involved (Attygalle, 2019). Veterans and service providers need to become comfortable working together (Wendleton et al., 2019).

When engagement is not done well, it can create more harm than good (Redman et al., 2021). Reported negative outcomes often stem from a disconnection between the goals and expectations of the different stakeholders participating or not having the skills and support to work together productively (Oliver et al., 2019). This can result in token participation or inauthentic relationships that create disappointment and conflict for everyone involved.

Co-learning is a key strategy to help manage risk, based on (OCECYMH, 2021a; OCECYMH, 2021b):

- Learning together and learning by doing;
- Being clear on the process for working together;
- Building capacity for working together (knowledge and skills for collaboration); and
- Evaluating collective progress and readjusting to improve processes.

The engagement design should include an explicit discussion to bring risks and fears into the open (Attygalle, 2019). As a result, these concerns become visible, and strategies can be put in place to manage the risks (Oliver et al., 2019).

From the perspective of the Veteran or Veteran Family member, fears can be rooted in past experiences of institutional betrayal, stigma or not being heard, not being in a safe place in their recovery journey to participate, not feeling empowered to make a change, not having experience sharing their lived experience, or not having the knowledge and background in the focus area of engagement (Australian Government NMHC, 2019). Providing training and creating learning opportunities can support participation.

> "There is merit in conveying the learning process in itself to engage people who wish to be engaged."

VETERAN FAMILY MEMBER

STRATEGIES TO SUPPORT CO-LEARNING IN ENGAGEMENT INCLUDE:

- Working with Veterans and Veteran Family members to understand and support their readiness to engage by discussing expectations, goals, and options for engagement, as matching skills and interests to the requirements of the engagement process sets up for a positive experience;
- Providing training, orientation, and coaching for Veterans and Veteran Family members so they feel prepared to participate on a level playing field with the right information and skills—for example, preparing for a governance meeting or learning about research or evaluation, the mental health system; or a policy process;
- For a Veteran or Veteran Family member with less experience engaging with organizations, exploring their interest in being paired with a peer or ally/mentor to build skills and confidence and provide support, attend workshops or conferences, or participate in other learning opportunities;
- Providing joint training for all partners on inclusion of lived experience, collaboration, and empowerment of the Veteran and Family voice as an integral part of strengthening evidence-based practice;
- Creating opportunities for all partners to learn together about the content of the engagement—for example, webinars to learn about current research on the topic or to hear about lived experiences from Veterans or Veteran Family members;
- Checking in at each stage to collectively evaluate how the process is working—for example, to ensure Veterans and Veteran Family members are comfortable providing feedback, consider one-to-one check-in calls or a small group discussion, and be open to adjusting the process based on their feedback;
- Setting up ongoing learning forums, such as formal or informal Communities of Practice, where Veterans and Veteran Family members participate alongside researchers and service providers to share experience and advance a particular issue; and
- Leveraging existing capacity-building tools, learning opportunities, and resources, such as the new national training institute for patient-oriented research announced by CIHR's Strategy for Patient-Oriented Research (CIHR, 2021).

CO-PRODUCTION

Veterans and Families develop activities and processes in mental health system research, policy development, service planning, and improvements, and have opportunities to be engaged.

Co-production is both a principle of how to work together and a process. As a principle, co-production puts "nothing about us without us" into action. It aims to bring people together in a way that lived experience perspectives are heard, valued, and brought into planning, implementation, and evaluation. A culture is deliberately created to value all expertise and knowledge, particularly those most affected by the problem and the solution (Australian Government NMHC, 2019).

As a process, it has been studied extensively, particularly in health research and health care system improvement (Redman et al., 2021; Bombard et al., 2018; Shippee et al., 2015). The focus is on setting agendas for change together and identifying ways in which diverse voices can be involved in decision-making processes.

- Co-production of knowledge means working together along the research cycle to identify research questions; develop the research design; and interpret, disseminate, and implement the findings (Redman et al., 2021; Shimmin et al., 2017). Engaging people with lived experience from the start of the research process allows them to steer agendas and outcomes and provides a values context (Shippee et al., 2015). Early involvement improves study design, applicability, and research relevance, and ensures PWLE perspectives can impact the research process.
- Co-design in the mental health system brings lived experience into improving care processes, programs, and service pathways or developing new innovative approaches. Engagement techniques that actively involve all stakeholders in co-design of health care services (employees, clients, families, caregivers, managers, providers, leaders, citizens, and health-sector organizations) help ensure that services meet their needs and are usable (British Columbia Ministry of Health, 2018).

At its heart, co-production is a sharing of power, influence, and decision-making. For meaningful engagement to happen, it is necessary to create an environment in which Veterans and Veteran Family members can work side by side with partners, including clinicians, researchers, service providers, and policy-makers (OCECYMH, 2021a; OCECYMH, 2021b).

Power-sharing is a challenge because it goes against traditional, hierarchical decision-making structures, where decision-makers hold authority (research principal investigators, clinicians, health service directors, government policy-makers) (Redman et al., 2021). Typical practice has tended to invite stakeholders, such as Veterans and Veteran Family members, to provide input or advice rather than actively participate in decision-making.

Enabling engagement can often take the form of doing "to" people rather than doing "with" or doing "for" people. Successful co-production is supported by building trust, encouraging flexibility, and balancing these power dynamics by setting up for equal voice and shared decision-making (Redman et al., 2021; Australian Government NMHC, 2019; Bombard et al., 2018; Wendleton et al., 2019). Ideally, the relationship should be two-way, with clear guiding principles to get results acceptable to all partners (Australian Government NMHC, 2019).

The design process helps all partners understand their respective contributions and can build confidence and comfort with the team process. Actioning these broad strategies requires a supportive organizational culture and practical supports.

STRATEGIES TO SUPPORT CO-PRODUCTION IN ENGAGEMENT INCLUDE:

- Working with Veteran and Veteran Family members to identify priority issues they would like to see advanced;
- Involving Veterans and Veteran Family members in discussions about strengthening their involvement in shared decision-making and governance structures, and creating roles and opportunities;
- Working with Veterans and Veteran Family members to identify roles that fit their interests and skills, and bringing them into a formal structure, such as a steering committee, advisory board, or working group;
- Recruiting experienced Veterans or Veteran Family members to co-chair or co-facilitate meetings, as co-chairs of advisory or governance bodies, or as co-principal investigators on a research project;
- Hiring Veterans or Veteran Family members to lead or support a project;
- Including Veteran or Veteran Family members in Communities of Practice or system-level planning tables (e.g., for a research project, mental health program evaluation, or policy review);
- Including more than one Veteran or Veteran Family member in structures and processes to avoid tokenism and diverse voices to support more balanced input;
- For specific projects, inviting participation in an authentic engagement process that does not have a predetermined conclusion or expected outcome;
- Involving Veterans and Veteran Family members in all (or most) stages of the project planning, implementation, and evaluation; starting with early involvement in setting the goal, creating governance documents, the agenda, and the process to build shared ownership and empowerment; and being flexible and ready to revise goals and adapt the process based on the feedback received;
- Providing structured orientation for all partners involved in the process to clarify expectations, roles, and processes for working together;
- Using guidelines for discussion that set up for productive, respectful dialogue; and
- **Creating a clear container for the engagement** (Attygalle, 2019)
  - **Key criteria: what the solutions are trying to address;**
  - **Constraints: what can't be changed;**
  - **Process: where you are at in the process—for example, working to understand the problem, identifying the possible solutions, selecting a solution from a shortlist; and**
  - **Resources: sharing the time and financial resources available**.

PRACTICE EXAMPLE:
Bringing diverse voices into co-design of Veteran resources (PARTNER and SHARED LEADERSHIP)

CONTEXT:
U.S. Veterans engaged in developing and testing a wellness guide

A project of the U.S. Department of Veterans Affairs Health Services Research & Development's Center for Innovations in Quality, Effectiveness and Safety (Center for IQuESt) and the South Central Mental Illness Research, Education, and Clinical Center co-developed the "Veterans Wellness Guide" with U.S. Veterans (U.S. Department of Veterans Affairs HSR&D, 2021d). The intention was to create a self-guided resource with goal-setting and evidence-based interventions for Veterans, which incorporate self-kindness, gratitude, breathing techniques, and mindfulness.

The project was intentional about including diverse voices in creating the resource. A Veteran Engagement Group with seven Veterans from the Houston area provided focus group input.

Following the initial feedback and revision of the "Veterans Wellness Guide," six Veterans pilot-tested the guide and participated in interviews two weeks later. An early evaluation showed the guide was viewed as relevant and useful to Veterans (based on the number of downloaded guides and evaluation feedback). Other articles posted on the U.S. VA Health Services Research and Development e-publication *Veterans' Perspectives* show increasing attention to including diverse voices in developing Veteran health care services, supports, and resources. For example, a March 2021 article describes the engagement of a diverse 13-member Veteran group to bring lived experience to developing evidence-based approaches to opioid use (U.S. Department of Veterans Affairs HSR&D, 2021c).

CONTINUOUS EVALUATION

Continuous evaluation can support co-learning and help manage the complexity and unpredictability of collaborative engagement. Veterans and Families are involved in evaluating engagement processes and developing evaluation approaches.

Working in organizations and systems is complex and includes an element of unpredictability (Attygalle, 2019; Baker et al., 2016). Every engagement context is different, depending on who is involved, the readiness of the organization, the skills of staff and partners, and the external conditions that bring opportunities and constraints.

Planned, continuous evaluation can support co-learning and help manage the complexity and unpredictability of collaborative engagement (OCECYMH, 2021a; OCECYMH, 2021b).

STRATEGIES FOR CONTINUOUS EVALUATION IN ENGAGEMENT INCLUDE:

- Building in regular progress checks and feedback loops with Veterans, Veteran Family members, and other partners through developmental evaluation to identify gaps (e.g., missing diverse voices, emerging priorities to bring forward, and creating a space for identifying new challenges and solutions);[15]
- Involving Veteran and Veteran Family members in developing engagement evaluation questions and processes (OCECYMH, 2021a; OCECYMH, 2021b);
- Tracking how principles of meaningful engagement are being implemented and sharing results of engagement, which can build confidence and help advance the culture and practice of meaningful engagement; and building on evidence-based engagement evaluation approaches and tools, and adapting them to the context of the engagement work (Abelson et al., 2018; Boivin et al., 2018; Dukhanin et al., 2018; Abelson et al., 2016; Mulliez et al., 2018);
- Including metrics that track diversity in engagement, which can prevent inequities, such as by bringing attention to how diverse voices are being engaged in issue identification, understanding challenges, and developing solutions (Shimmin et al., 2017);
- Using an anti-oppressive lens to develop evaluation questions and metrics, and considering the diversity of voices and barriers to participation in the mental health system and engagement processes; and
- Continuously evaluating the engagement process to help clarify roles and expectations, and assessing how well the principles of meaningful engagement are working in practice and identify barriers.

15 Communication with Kelli Dilworth, December 2021.

Benefits and Outcomes of Engagement

This section summarizes outcomes of engagement, drawing from a mosaic of evidence sources to build an understanding of the benefits of Veteran and Veteran Family engagement.

To identify the benefits of engagement, we supplemented available outcome studies specific to Veteran and Veteran Family engagement with broader systematic reviews focused on outcomes of engagement. These systematic reviews identified outcomes of client engagement in health care, health, and health service research (Bombard et al., 2018; Manafo et al., 2018; Bird et al., 2020; Forsythe et al., 2019).

In some cases, studies also reported negative outcomes of engagement. Negative outcomes are summarized below. However, many sources emphasize that the risk of negative outcomes can be mitigated or minimized by applying best practices in engagement (see Engagement Principles).

Positive outcomes of engagement

Outcomes of active client engagement in service planning, design, and evaluation to improve quality of care have impacts on products and care process or structural outcomes, equity in service delivery (through engagement of diverse voices [Woodward et al., 2021; Shimmin et al., 2017; Eichler, 2021]), and changes in organizational culture.

The following types of quality of care outcomes have been reported (Bombard et al., 2018):

- Enhanced care or service delivery (e.g., creation of a new family-integrated program in an inpatient care unit; redesign of an outpatient clinic, development of a new care pathway);
- Enhanced governance, specific policy, or planning documents (e.g., new organizational priorities; revisions to roles and responsibilities of an Indigenous community-controlled health service and a local health service); and
- Development of educational materials or other tools (e.g., electronic medical record for mental health service users, a new hospital discharge tool).

Outcomes of Engagement in Health Research

There is a growing body of evidence demonstrating positive outcomes from partnering with PWLE in health research. Analysis of 126 projects of the Patient-Centered Outcomes Research Institute found that clients and others (including Family members) were engaged as consultants and collaborators in determining research study design, selecting study outcomes, tailoring interventions to meet patients' needs and preferences, and enrolling participants (Forsythe et al., 2019).

Most evaluations of client and Family engagement measure impacts on the research process more than on research outcomes (Boivin et al., 2018). Client and Family involvement as research partners can make a contribution throughout all stages of the research cycle (Brett et al., 2012; Concannon et al., 2014; Domecq 2014; Forsythe et al., 2019; Manafo et al., 2018; Vojtila et al., 2021), helping to:

- Target research questions to be more relevant and important to clients and family, based on real-world needs and concerns;
- Improve feasibility, acceptability, and rigour of research;
- Develop more user-friendly information, questionnaires, and interview scripts;
- Realign research processes and outcomes to be more client-centred (e.g., selection of interventions to compare, choice of study outcomes and how they are measured, strategies for recruitment);
- Provide client-focused interpretation of data, and implementation and dissemination of study results;
- Better translate knowledge into clinical practice;
- Create meaningful change in patient outcomes and health systems; and

- Support more collaborative, holistic approaches to mental health care and supports—looking beyond traditional medical-based lenses to take bio-psychosocial factors into consideration.

Benefits to people with lived experience

When engaged as research team members or throughout the research process, client research partners reported the following positive impacts of their involvement (Bird et al., 2020):

- Learned practical skills (e.g., computer use);
- Gained knowledge about research processes and topics;
- Gained confidence as an expert and advocate;
- Felt empowered by using their voice to make change;
- Gained a social network of supportive peers;
- Developed ongoing personal and professional relationships, beyond the project;
- Provided positive experience (e.g., laughter, connection); and
- Motivated future involvement in research as patient partners.

Positive client experiences are reported in studies that that formally evaluate the experience of being engaged in service planning, design, or evaluation to improve quality of care (Bombard et al., 2018). Positive experiences are linked to feeling empowered and independent as a result of skills development and positive recognition. The following positive outcomes have been reported by clients and Family members:

- Satisfaction with the engagement processes;
- Interest in continuing involvement in the longer term;
- An educational experience;
- Attention to issues that have been historically ignored;
- Increased self-esteem from contributing or improved self-efficacy and self-sufficiency; and
- Encouragement to pursue formal training.

Similar findings were identified in some Veteran and Veteran-specific primary studies (Franco et al., 2021; True et al., 2015; Hyde et Ono, 2017; Wendleton et al., 2019).

Several Veteran-specific studies reported on improvements in care processes and structures as a result of Veteran engagement (Alhomaizi et al., 2020; Botero et al., 2020; Brintz et al., 2020; Clair et al., 2021; Dobscha et al., 2021; Fraser, 2017; Gnall et al., 2020; Goodyear-Smith et al., 2021; Gould et al., 2020; Hamilton & Yano, 2017; Jacobs et al., 2018; LaMonica et al., 2019; Silvestrini et al., 2021; Smits et al., 2021; Sorrentino et al., 2020).

Reported improvements in organizational culture from engagement and co-design in non-Veteran mental health and other settings included (Bombard et al., 2018):

- Promoting further patient participation in service design and delivery;
- Achieving collaboration and mutual learning;
- Sharing or neutralizing power among patients and providers or staff;
- Developing new competencies; and
- Negotiating for service changes.

Benefits of including lived experience in the Veteran context

Program and facility leadership within the U.S. VA health care examined facilitated engagement of Veterans and their Families in client-centred care transformation. The study reported on the benefits of engagement (Locatelli et al., 2015):

- Awareness of client needs and preferences can bring about positive changes to strengthen client-centred care.
- Involvement in the design and implementation can generate client-centred care innovations.
- Hearing stories of lived experience can shift attitudes and culture, laying the foundation for changes in care practices. Sharing one's story can increase the safety of the care environment for Veterans.

> "Families matter in their own right; they have their own needs independent of the Veteran."
>
> **RESEARCHER**

- Feedback can bring new information that increases the chance of achieving desired outcomes.
- Engagement builds relationships between providers, Veterans, and Families.

Negative outcomes

Potential negative outcomes to engagement in health research, health care, and more broadly are reported elsewhere (Oliver et al., 2019; Bombard et al., 2018; Attygalle, 2019). For example, Attygalle (2019) identified risks from the perspective of organizations undertaking engagement initiatives, including:

- Harm to individual participants or the community (e.g., through potential conflict, unintentionally offending people, or retraumatizing individuals who participate);
- Not having all the information or knowledge needed or the skills to manage sensitive or contentious issues;
- Opening up for public criticism or verbal attack or drawing attention to problem areas in policy or service delivery; and
- Investing time and resources that could potentially be better used elsewhere.

Studies that looked at negative client experiences of engagement in health care imporovement have reported: (Bombard et al., 2018):

- That the engagement demanded considerable energy and time;
- That involvement was tokenistic (because decisions had been made in advance or engagement was used to justify decisions already made);
- That requests were denied or managerial support was lacking; and
- A sense of dissatisfaction with their lack of involvement in analyzing the findings and creating the final report.

> "Sometimes it [engagement] can be triggering to the Veteran."
>
> **VETERAN OF THE CANADIAN ARMED FORCES**

PRACTICE EXAMPLE:
Maximizing benefits of PWLE engagement (PARTICIPATE)

CONTEXT:
Evidence-based practice based on Australian research and experience

The report *Sit Beside Me, Not Above Me* identifies essential ingredients for safe and effective engagement and participation (Australian Government NMHC, 2019). The report was based on a literature review and interviews with 90 key informants, including many PWLE of mental health challenges.

Evidence-based practices are summarized for PWLE wanting to maximize the benefits of their engagement and participation. The report suggests they should be supported and encouraged to:

- Be clear with themselves and others as to why they want to engage, what the decision-making process is, and what they aim to achieve;
- Determine where they want to focus their time and energy: individual engagement, advocacy and support, service and organizational change, and/or strategic systems and policy levels;
- Ensure they have (or develop) the skills and capacities to engage and contribute at that level (which will often extend beyond their own lived experience);
- Be prepared to demonstrate those skills through formal selection, appointment, and performance review processes;
- Practise self-care and awareness, including the ability to be informed by the experiences and knowledge of others;
- Ensure they are linked into networks and other supports;
- Treat others with respect and understanding—just as they would expect to be treated; and
- Engage and participate in respectful, civil debate, recognizing the potential different views and experiences of other people.

Conclusion

This Veteran and Veteran Family Engagement Framework was co-developed with lived experience perspectives, with the engagement of an advisory committee, and with consultation with Atlas Institute's Reference Groups. We supplemented this information with a rapid review of the literature that investigated outcomes of Veteran and Veteran Family engagement and identified evidence-based principles for meaningful engagement in the mental health system, along with practice examples.

Through these points of input, we learned that outcomes of Veteran and Veteran Family engagement mirror outcomes reported in the broader engagement literature in areas of health research and mental health system improvement. Veteran and Veteran-Family member engagement has the potential to strengthen Veteran mental health care and can support recovery if done safely by building social connection and empowerment.

Applying evidence-based engagement principles and practices can minimize risks to organizations and to Veteran and Veteran Family member participants and support meaningful engagement. In addition, designing engagement opportunities should take into account military cultural context; create a safe, trauma-informed environment; facilitate equal sharing of power; and intentionally bring in diverse Veteran voices.

Engagement practice continues to evolve. There is a current focus on building capacity and tools to support equal partnership and the evaluation of engagement processes and outcomes. A Veteran and Veteran-Family centred mental health system where power and decision-making is shared is a paradigm shift that will require collaborative effort and ongoing learning, with active involvement of system partners, staff, and Veterans and Veteran Families. This shift is crucial to creating a mental health system that revolves around, and is responsive to the needs of Veteran and Veteran Families.

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