THE ROLE OF KNOWLEDGE BROKERS: LESSONS FROM A COMMUNITY BASED RESEARCH STUDY OF CULTURAL SAFETY IN RELATION TO PEOPLE WHO USE DRUGS

Jane McCall  
St. Paul’s Hospital, Vancouver

Ashley Mollison  
Society of Living Illicit Drug Users, Victoria

Annette Browne & Joanne Parker  
University of British Columbia

Bernie Pauly  
University of Victoria

ABSTRACT
The study explored cultural safety as a strategy to address the stigma of substance use in acute care settings. Two research team members took on the role of knowledge brokers (KBs) in order to liaise between the research team and two distinct research advisory groups: one with people who use drugs and the other nurses. The KBs were instrumental in ensuring that the research process and outcomes reflected the needs, experiences and aspirations of people who use or have used illicit drugs, and the nurses providing care in hospitals as well as bridging differences in power and privilege between team members and advisory groups.

INTRODUCTION
Health inequities are unfair, unjust, and potentially remediable or avoidable differences in health (Braveman & Gruskin, 2003; Braveman et al., 2011; Commission on the Social Determinants of Health, 2008; Dahlgren & Whitehead, 2006). Due to differences in social
positioning, health status is diminished along the social gradient with stigma and marginalization implicated in the production of health inequities and inequities in access to health care (Braveman & Gruskin, 2003; Braveman et al., 2011). Illicit substance use combined with social disadvantages such as poverty and homelessness, for example, are often highly stigmatized and produce inequitable health outcomes and inequitable access to healthcare (Ahern, Stuber, & Galea, 2007; Lloyd & Lloyd, 2013; Neale, 2001; Neale, Tompkins, & Sheard, 2008; Room, 2005). There is a considerable gap between knowledge of the problems of health inequities and implementation of strategies to address them.

Key to closing the know-do gap is the importance of creating relevant knowledge and transferring research findings into practice in order to reduce and prevent health inequities and improve health care through integrated and end of grant knowledge translation and exchange, or (KTE) (Canadian Institutes of Health Research, 2012; World Health Organization, 2004). Davison, Ndumbe-Eyoh and Clement (2015) identified knowledge brokering frameworks and the use of knowledge brokers (KBs) as the most promising knowledge to action strategy for promotion and action on health equity. KBs act as a link between knowledge users and knowledge producers and can play a critical role in the KTE (Lomas, 2007). Key roles and competencies for KBs include acting as a linking agent between academics and knowledge users, capacity building and knowledge sharing (Bornbaum, Kornas, Peirson, & Rosella, 2015; Glegg & Hoens, 2016; Ward, House, & Hamer, 2009).

Populations impacted by health inequities may be over-researched, excluded from research processes, or tokenized (Jansson, Benoit, Casey, Phillips, & Burns, 2010; Lenucha & Kothari, 2010). When included, there are significant power imbalances among researchers, decision makers, and people impacted by health inequities. Thus, it is important to understand KB roles and competencies in such situations in order to ensure that integrated and end of grant KTE is relevant, timely and appropriate to addressing health inequities and access to care. The purpose of this article is to describe the role and competencies used by KBs to bridge power differentials between multiple members of a research team in a community based research study that had an aim to address stigma and improve health equity for people who use illicit drugs.

**Background**

Stigma is a fundamental source of health inequities and has been conceptualized as a difference in power relations in which one group has the power to name differences, label, stereotype and stigmatize another group on the basis of certain characteristics or behaviors, with structural conditions reinforcing and reproducing stigma within interpersonal interactions (Hatzenbuehler, Phelan, & Link, 2013; Link & Phelan, 2001, 2005, 2006, 2014). People who use illicit drugs and are experiencing poverty or homelessness are often subject to considerable stigma and discrimination in society and often have negative and stigmatizing experiences in health care (Ahern et al., 2007; McCoy, Metsch, Chitwood, & Miles, 2001; McNeil, Small, Wood, & Kerr, 2014; Neale et al., 2008; Strike, Myers, & Millson, 2004). They are often socially excluded from the development of policy, services and research (Allman, 2005; Allman et al., 2007). As a result, their
experiential knowledge often goes unrecognized or is overlooked in policy, programming and research even when the aims are to improve the health and social conditions that affect them. Their inclusion in health research, policy development and services ensures that their distinctive knowledge and experiences are recognized and applied to make improvements (Restall, Cooper, & Kaufert, 2011; Southwell, 2010). However, even when included, representatives who are subject to structural inequities may be silenced and tokenized and there may be high levels of distrust due to previous experiences with research and healthcare (Jansson et al., 2010). People who use drugs as a group face many barriers to participating in decisions and research that affects their lives including time, resources, stigma and lack of power. There is a large gap between stated commitments to service user involvement and meaningful participation.

Considerable research has highlighted that health care providers, including nurses, often hold negative attitudes towards people who use illicit drugs, and nurses report that it is challenging to provide care (Happell & Pinikahana, 2002; Merrill, Rhodes, Deyo, Marlatt, & Bradley, 2002; van Boekel, Brouwers, van Weeghel, & Garretsen, 2013). Canadian nurses have a commitment to the provision of safe and competent health care that is compassionate and respects the dignity of patients and a clear position on the importance of addressing the harms of illicit drug use, especially stigma and discrimination, through endorsement of harm reduction as both a philosophy and set of strategies (Canadian Nurses Association, 2011, 2017).

Nurses are often the first point of contact in the health care system and key front line providers in the delivery of care to people who use drugs. While engaging people who use drugs is critically important to ensure their expertise is recognized, involving front-line nurses with the production and application of knowledge for improving health care will ensure that solutions and strategies are not just translated but implemented to improve patient outcomes (Duffy et al., 2015). While nurses use research it is not always clear how it is acted upon (Squires et al., 2011). Thus, we viewed the engagement of both people who use drugs and nurses as critical to the process of the research to improve healthcare policy and practice for people who use illicit drugs and are accessing hospital care.

Community based participatory research (CBPR) is an orientation to research that aims to equitably involve community partners in the process of research, combining knowledge and social action to eliminate health disparities (Israel, Schulz, Parker, & Becker, 1998; McOliver et al., 2015; Wallerstein & Duran, 2006). In CBPR, the research process often begins with a question of interest to the community and seeks to engage or partner with those affected by health inequities who are often excluded from research, to enhance democratization of knowledge. CBPR is specifically relevant to improving health and reducing health inequities by explicitly incorporating experiential knowledge to improve interventions and inform research findings and the value of participation in the research itself (Wallerstein & Duran, 2006). In CBPR, notions of power and group dynamics are explicitly identified and addressed as issues within the research process by creating space for diverse sources of evidence, shifting power through co-learning and decision making, building trust through agreements, long term partnerships and mutual benefits
The Role of Knowledge Brokers
McCall et al

(Wallerstein & Duran, 2010). CBPR is not a specific method per se but an approach within which a variety of research methods may be employed paralleling the integrated KTE process.

Knowledge Brokering and Knowledge Brokers

The term knowledge broker (KB) has been used to describe the role of individuals in bridging the gap between knowledge producers and knowledge users in the process of KTE in the human and social services. KBs are individuals who carry out liaison activities between academic institutions and the outside world acting as facilitators of KTE. In essence, they are central linkages in the KTE platform for fostering both integrated and end of grant KTE. Based on an assessment of 48 KTA frameworks, Davison et al. (2015) scored knowledge brokerage frameworks the highest on health equity considerations including health equity as a value, inclusive conceptualization of knowledge, engagement of stakeholders, interactions across jurisdictions, emphasis on context and applied proactive problem solving (Davison et al., 2015).

Ward et al. (2009) distinguish three different ways that knowledge brokering is useful as an approach to KTE. The first is a management approach whereby the KB facilitates knowledge sharing. The second refers to KBs as linking agents between researchers and knowledge users. The third approach to knowledge brokering involves the training or capacity building of service users in the knowledge translation process. These three areas of work have been affirmed in a systematic review of the literature by Bornbaum et al. (2015) and a review of KTE models by Glegg and Hoens (2016).

Knowledge brokering is a feature of several KTE frameworks. Graham et al. (2006) describes a multidirectional process in which knowledge is created and refined, as part of the knowledge to action process. The Promoting Action on Research Implementation in Health Services Framework highlighted the importance of the human driven facilitation process (Phipps & Morton, 2013). Fernandez and Gould (1994) acknowledge power differentials that exist when brokering processes are carried out by individuals internal versus external to the group in which they mobilize knowledge. The K*Spectrum framework emphasizes the KB role as relational and central to facilitating relationships (Expanding our understanding of K*, 2012).

Jansson et al. (2010) discuss the use of KBs in the context of research with non-profit organizations serving high-risk youth and sex workers. They describe KBs as a necessary part of research with such organizations because of the time and financial constraints of both researchers and agencies for fully engaging in knowledge translation. They discuss possible concerns about one-off or short-term use of front-line workers in recruiting participants – the nature of their relationships with clients could spark concerns about potential coercion. When researchers, with the assistance of KBs, develop long-term relationships with organizations, the groups find ways to work together for mutual gain and to build trust and rapport, thus helping to minimize concerns about this risk. In this
Towards Cultural Safety in Nursing Practice Research Project

Our study, entitled Cultural Safety in Nursing Practice with People who Use Drugs was designed to explore the meaning of cultural safety as a health equity strategy to mitigate stigma associated with substance use in hospital settings with a goal of promoting social change through the generation of collaboratively-developed recommendations for front line nurses, nurse educators, managers and health care leaders. Cultural safety is a nursing concept originally introduced to address the unmet health care needs of Indigenous peoples and the systemic issues that impact access to health care for Maori people (Ramsden, 2000). Some have identified cultural safety as a promising approach for addressing marginalization and discriminatory behaviors or practices in health care that affect individuals and groups experiencing stigma and discrimination associated with age, gender, sexual orientation, ability and socio-economic status (Varcoe & Browne, 2014). For example, nurses at Insite, a Canadian supervised injection facility, identified cultural safety as an important aspect of caring for both Indigenous and non-Indigenous people who used the service (Lightfoot et al., 2009). Two research questions framed the study:

1) What is culturally safe care in acute care settings for people who use(d) illicit drugs and who face multiple social disadvantages?
2) How can nurses enhance the delivery of culturally safe, competent and ethical nursing care to people who are hospitalized and identify as having past or current illicit drug use?

The study drew on a qualitative ethnographic research design within a participatory framework. Details of the study methodology are outlined in Pauly, McCall, Parker, and Mollison (2015).

This research project was conceived through a collaboration of clinical and academic nurses who had extensive experience working with people who use drugs in several settings. McCall, who was the practice co-lead for this study had identified a need to investigate the issues of access to and experiences of healthcare for people who use(d) illicit drugs and were experiencing poverty and homelessness. She approached the academic co-leads (Pauly & Browne) to determine their interest in this project. Thus, the research questions for this study emerged from practice. Pauly had extensive experience in working with peer run organizations of people who use(d) drugs and was aware that the issues had been identified as concerns by peer run organizations of people who use drugs.

In the Cultural Safety project, we engaged both nurses and peers from a drugs user organization to guide the research, analysis, and subsequent development of recommendations, to ensure that the work and its findings would be grounded in the lived experiences and expertise of both groups. Both nurses and both groups who use(d) drugs
were invaluable in crafting the interview questions, analyzing the findings, generating recommendations, disseminating research results and driving the direction of the research. An unanticipated area of learning and finding of the study was the huge benefit of having knowledge brokers (KBs) to engage both people who use(d) drugs and front line nurses in the research process, and the need to bridge power differentials between these two groups and the academic researchers.

**Findings**

In the next section, we discuss the development of the KB role during the project highlighting the roles and competencies needed by KBs to bridge power imbalances and engage populations of people who use(d) illicit drugs and nurses in all aspects of the research process. We discuss practical considerations, benefits and challenges.

**Development of the KB Roles**

In the project proposal, the research team had proposed the development of both a nurse and patient advisory group to guide the research. We envisioned that McCall, as a nurse educator in the HIV/AIDS field would be well positioned to recruit the nurses and patients as advisors for this study. She has worked in the area for over 30 years and has a breadth of experience with the population of interest in this study, especially in the acute care context. She is well known to most of the front line nurses where the study was conducted, which made her an excellent fit for the Nursing KB role in addition to her experience in research and role as practice co-lead of the study. For McCall, this type of research is essential for engaging front line nurses, who historically have been left out of the research processes.

As we looked into the development of a patient advisory group, it became apparent that it would be difficult to organize this within the hospital setting as originally planned. The hospital patient advisory group was not currently active, patients come and go to the hospital and may be experiencing difficult to their health and living circumstances as a result of poverty and homelessness. For this reason, we elected to approach a community peer run organization of people who use(d) drugs to gauge their interest in the research.

One of the principal investigator (Pauly) had developed long-term relationships with SOLID (Society of Living Illicit Drug users) over the past 8 years and had contributed to the development of funding proposals and program evaluation as well as providing advice and board support. SOLID OUT reach is a peer-run harm reduction organization funded by a regional health authority to offer comprehensive needle exchange services, as well as support and educational programming for people who use drugs in a Canadian city. The SOLID board reviewed the project and gauged it to be aligned with their priorities and of interest because of the relevance to their own experiences and that of their peers, as well as the opportunities it provided for members to contribute their ideas and perspectives. We quickly recognized that we would need to engage a second KB who was located locally and well positioned within the community. The second KB (Mollison) was the Program coordinator at SOLID with several years’ experience working in harm reduction and HIV/AIDS and a well-established community advocate and facilitator with considerable
The Role of Knowledge Brokers
McCall et al

research experience. She was extremely well positioned in both the community and academia to act as the Peer KB for this study and to successfully engage people who use(d) drugs. The Peer AG was originally called the ‘Patient Advisory Group’ but we shifted to calling it a ‘Peer Advisory’ as the members were not current patients at the study site, and this was the preferred term at the time within SOLID.

The Peer AG members saw an opportunity to engage and contribute to work that aimed to address an issue they had already identified as a priority. For the front-line nurses, involvement in this project provided an opportunity to participate in research that was directly relevant to their practice. In both cases, the KBs engaged with this project because they wanted to participate in shaping the direction of ‘action research.’ Such academic-practice partnerships allow distinct organizations to identify shared goals and issues, and work together to develop evidence that reflects lived experiences of the populations they serve, with the rigor and resources of academic research. In this project, the academic practice partnerships was tripartite involving people who use drugs, front line nurses and academics with the need for two rather than one KB.

**Recruiting the Advisory Groups (AG)**

The two AGs were developed separately at the start of the project by the Peer and nursing KBs. The KBs proved essential for developing and maintaining connections with the AGs, fostering participation of the two groups at the centre of the research design and analysis, bridging power differences between groups, disseminating research results, facilitating next steps and making the research actionable.

The peer KB Mollison took a lead role in recruiting members of SOLID to join the Peer AG. All were known by the peer KB, and in some cases the lead researcher all had previous experiences with accessing acute care. A total of 10 people with lived experience joined the Peer AG and the majority of these people were engaged consistently throughout the project. It is important to note that stigma and access to health care had previously been identified as a priority for advocacy and action by SOLID. Therefore, although they were only engaged in the project once it had been funded, the project was already aligned with their priorities and those of the nurses who initiated the project.

The nursing KB McCall facilitated recruitment of the Nursing AG from the research site. Initially, a group of nurses was drawn from the two different nursing units, and it was anticipated that they would be a consistent presence throughout the project. While the Peer AG was composed of a consistent group of people from SOLID, it quickly became apparent that this would not work for nurses. Nurses, due to family responsibilities and shift work, had difficulty committing to ongoing projects and attending meetings that did not align with work schedules. Thus, the team had to create a new strategy that would create a more flexible approach for nurses to participate in the AG. Essentially, when the project team had something new to discuss with the nurses, whether it was to seek input on the interview guide, or report on emerging findings, they scheduled unit-based meetings on two different units, at different times, to allow nurses working that day to participate. This revolving group of nurses became the Nursing AG, ensuring a broad range of input in a
way that was flexible and consistent with the reality of nurses’ lives and ability to participate. Scheduling as-needed unit meetings during work hours was a much more successful strategy than regularly scheduled meetings outside of work. Also, it brought a greater number of nurses and a wider range of nurse perspectives to the research process, which was one of the goals of the project.

**Knowledge Brokers’ Contributions**

In our study, KBs carried out all activities described by Ward et al. (2009) for facilitating KTE, including: *linking agents, capacity building*, and *knowledge sharing*. Below, we provide details on how KBs fulfilled the roles described by Ward et al. (2009) first during the process of the research and then as part of end of grant KTE.

**Linking agents.** KBs are important as linking agents to develop positive relationships between researchers and decision makers by acting as intermediaries and using interpersonal contacts to facilitate the development of research and application of knowledge (Ward et al., 2009). Thus, a main objective of the KBs was to link the AGs to the research project. The peer KB, Mollison, led six meetings with the Peer AG over the course of the project, with between 8 to 10 participants in attendance at each meeting. The first two meetings were spent discussing access and barriers to healthcare for people who use drugs, discussing the interview questions, and the process of recruitment and data collection. The next two meetings were for the purpose of getting feedback from the Peer AG on the preliminary findings from interviews and ethnographic observation. The fifth meeting was for the purpose of designing and planning the joint policy forum intended to craft recommendations from the research in collaboration with nurses. The final Peer AG meeting, after the forum, was to review and make changes to the study's recommendations, and to decide on next steps and action items emerging from the research. Food and research stipends were provided at each meeting for participants.

Concurrently, the Nursing KB, McCall, organized several meetings at the study site located in a different city. McCall ensured that the staff working on the unit that day were made aware of the meeting and helped us to select an appropriate time when the unit was less busy. In some cases, McCall herself covered the nurses’ patients so that the nurses on shift had time to talk to the other members of the research team. Attendance was variable, depending on how busy the unit was, but we generally had between 8 to 10 nurses at each meeting. As with SOLID, group discussions ranged from providing feedback on the interview guide to discussing the emerging findings to planning next steps. Food was provided for each meeting. Although rare, in cases where nurses participated during their time off, stipends were provided.

Both of the KBs prioritized building trust and developing relationships between the AGs and the researchers. By linking researchers, decision makers, and the key stakeholders, the KT process can be expedited, promoting opportunities for knowledge exchange (Glegg & Hoens, 2016).
As capacity builders, KBs facilitate the development of positive attitudes towards research, establish a common language among the stakeholders, and provide mentoring and education on both research skills and how to apply research (Glegg & Hoes, 2016). The KBs facilitated research capacity building by engaging people throughout the research process including interview question development, recruitment, data collection, data analysis and KTE. The peer KB was already known and trusted by the peers but also played a key role in bringing the group together and ensuring ongoing communication between the AG and researchers. For the Peer AG the Peer KB’s support was critical to make sense of the research process outside the university setting. For example, in the first two Peer AG meetings, we discussed the research design and reviewed proposed interview questions to determine meaning and relevance for people who use drugs. We made several changes to the questions and, during this meeting, had in-depth discussions about creating non-biased questions, making language accessible, and creating confidentiality and feelings of safety between interviewers and research participants. This significantly contributed to the capacity of the researchers to be sensitive and well prepared for interviews. Many members of the Peer AG had opportunities to engage with the findings and offer their insights both through advisory meetings as well as presenting their views during KTE events which will be described later as part of end of grant activities.

For the Nursing AG, nurses who attended the various sessions held on their units were keen to hear what we had learned from patients as well as other nurses. The sessions included important discussions of how we had asked the questions and how we were organizing the findings – the nurses’ participation in this process added a level of relevance and nuance to the emerging findings, and they in turn expressed interest in learning more about the research process. The nursing KB’s played a key role in making this process accessible to front-line nurses, and in encouraging and engaging them in this work that bridged research and practice. Similar to peer AG members, nurses had opportunities to inform the research as well as take a lead role in sharing of the findings. This work was facilitated by the nursing KB’s existing relationships and credibility as both a practitioner and educator who had extensive experience in practice with the population of focus.

KBs bridged multiple worlds and were able to frame research in a meaningful and relevant way for both knowledge makers and users. This process brought the team invaluable insights into the study topic as well as the process of engaging these specific groups. Their bridging work helped us to tailor the project to be relevant and accessible to the organizations where they worked and to the peers and nurses who participated. It was remarkable to witness the change in the two groups as the research progressed. Both AGs became increasingly engaged with the process and demonstrated an increased understanding of the research questions, process and methods. One member of the Peer AG described the project as being ‘real action research’. The KBs were instrumental in building capacity for research within the two groups as the study unfolded.

The KBs also reported organizational benefits as a result of participating in the research. Research participation, including AG participation, can strengthen and lend credibility to
The advocacy work of community organizations, for example when reporting to funding agencies. The Peer KB emphasized that funding restrictions often limit an organization’s ability to advocate on issues that are meaningful to their staff and clients. Organizations face increasing pressure to collaborate on research and strengthen ties with academic institutions to be viewed as credible and seen as leading. Organizations that participate in research can contribute their practical and experiential knowledge to the latest research, and help to ensure that new evidence is relevant and applicable in real-world settings as well as gain credibility with funders. Furthermore, participation in research can provide opportunities to engage their staff and membership about important issues and build capacity for acting on these issues.

**Knowledge sharing.** KBs act as an information intermediary, a knowledge translator and an innovation broker (Glegg & Hoens, 2016). They act as information managers by creating and sharing knowledge, drawing evidence from primary research and the local context, and by engaging with knowledge users to create a shared understanding of the knowledge. They are the human component in KT strategies (Bornbaum et al., 2015). Their collaborative work with the stakeholders, both researchers and participants, facilitates the transfer and exchange of information in contextually diverse settings (Bornbaum et al., 2015).

Knowledge transfer is a complex, social activity (Ward et al., 2009). The KBs in this study needed to be attentive to ensuring that the AGs were kept abreast of the issues related to the study as it progressed and emerging findings, in part by facilitating meetings between the AGs and the research team. They also made themselves available outside these meetings to explain the research process, including the concept of ethnography, the consent process and the process of data evaluation and interpretation. One of the key objectives of the grant funder was to ensure that front line nursing staff was engaging in the research process. Engaging individuals with first-hand experience throughout the research process is highly relevant if the goal is to address health inequities and inequities in access to care as their involvement can mean greater relevance of the findings. Below, we outline end of grant KTE activities as part of knowledge sharing and the impacts/outcomes of the study.

**A ‘SHARING’ CASE STUDY: TOWARDS CULTURAL SAFETY POLICY FORUM**

The policy forum was an end-of-grant KTE activity that provided a unique opportunity to bring the two AGs together for the first time, to discuss the findings and collaboratively generate recommendations arising from this research. The policy forum was held on March 13, 2013 at the research hospital site. During this event, members of the nursing AG and the peer AG co-led a panel presentation to share their reflections on the research process and study findings.

The Peer KB facilitated the involvement of both the AG and another peer advocacy group based in the same city as the research site in the policy forum by facilitating communications, arranging transportation, driving and otherwise ensuring that their needs
would be met during the trip to the forum. She assisted the peer advisors to prepare for and present their perspectives at the forum. During the policy forum, the Peer KB was the key point of contact for both the Peer AG and the local peer advocacy group, and helped to facilitate relationship building between people who use(d) illicit drugs and other participants at the policy forum. The Nursing KB led the engagement of nurses, managers and other health care providers in the policy forum. She helped to find an appropriate time for the forum to suit hospital schedules, promoted the event throughout the hospital and arranged for a front-line nurse and a nurse manager to take part in the panel presentation.

A key outcome of the policy forum was a set of recommendations for promoting culturally safe care for people who use drugs in hospital settings, developed collaboratively by peers and nurses. The initial recommendations were further refined by the Peer AG, in collaboration with the research team and later highlighted in a research bulletin (Pauly et al., 2013). This bulletin is posted on the CARBC website (www.carbc.ca) and has been used by SOLID to educate others in the provision of culturally appropriate health care and by the study hospital to address the need for changes in substance use and harm reduction policies. Cultural safety has not historically been used to address the needs of this particular population so this bulletin outlined new strategies for care of this group.

Following the success of this event, the Peer AG members requested that we hold a similar event in the city where they are based, to bring some of the findings and recommendations to health care providers at their own local hospital. This second event was smaller than the first but was also a success and kept the momentum going with both AGs. The Peer KB (Mollison) was integral in fostering relationships with the Cultural Safety program of the local health authority, which co-sponsored the second event at a local hospital.

Post grant, this relationship continued and two further Lunch and Learn sessions for nurse managers and educators were offered with the health authority’s cultural safety department in February 2014. Again Peer and Nurse AG members attended to present on study findings and link them to the local context. These forums were opened by an Aboriginal elder, and staff members from the health authority profiled their cultural safety program. In many respects, this set the stage more clearly for presentation of the research and application of cultural safety to address the stigma of illicit drug use. In fact, it unexpectedly created a sense of shared understanding of stigma and discrimination among the two groups. Through these activities, the research project created a bridge between SOLID and the local hospital staff and health authority, which had not previously existed. Whereas the Cultural Safety Program at the local hospital focused on safe and effective care for Indigenous people, the clinical leaders quickly recognized and were interested in the application of this concept for other groups.

**Challenges to the Use of KBs**

Good communication and working relationships between the KBs and the research team were essential. On the *Cultural Safety in Nursing Practice Project*, this was not a significant issue due to pre-existing relationships between academics and both KBs in this project. However, consistent effort was needed to maintain open communication between the
research team based in one city, and the Peer KB and Peer AG based in another city. The research manager (Parker) played an important role in leading team communications and ensuring both KBs were kept up-to-date and had ample opportunities to contribute to planning AG meetings and other collaborative activities as well as fostering their involvement in the research team.

Another important consideration with the use of KBs is the potential for conflict of interest and/or challenges to protecting participants’ confidentiality. In this study, we had to approach data analysis carefully due to McCall’s employment as a nurse educator at the study hospital. Most of the nurses who took part in in-depth interviews were well known to McCall and had various working relationships with her. To protect the confidentiality of these nurse participants, McCall did not have access to nurse interview transcripts. As a research team member, this limited her ability to participate in all stages of data analysis. However, once the data had been cleaned, anonymized, and coded and movement of abstraction, she was able to be actively engaged in higher-level analysis discussions.

**DISCUSSION**

The use of KBs was informed by, and reflected key elements of a cultural safety approach as a strategy for minimizing power differentials between researchers and research participants and facilitating participation. The KBs were able to provide a bridge between the AGs and the research team, and this provided a vehicle for addressing the inevitable differences in power and privilege between the research team and the AGs. The KBs’ existing relationships with AG members promoted the development of trust with the research team, and lent transparency to the research process. These factors proved mutually beneficial, as they improved our collaborative analysis as well as building research capacity among AG members. By facilitating knowledge sharing, building capacity and developing linkages, the KBs were able to develop a sense of safety for both the SOLID participants and the nurse participants. We would argue that KBs are vitally important to meaningful engagement of those impacted by health inequities and can play an integral role in ensuring both knowledge generation and social change.

Research findings are often disconnected from the practice arena. The KBs were crucial in ensuring that the knowledge that was gained as a result of this research was communicated to the most important stakeholders: people who use(d) drugs, policy makers, and nurses. The path to more evidence-informed decision-making is to focus on better linkages between the processes that create the evidence (research) and the processes that incorporate the values and ideas of policy decision making. The strategic communication of research findings to both policy and decision makers as well as front line workers is a key component of implementation and KBs are a solution to bridging the gaps (Canadian Nurses Association, 2008).

Knowledge brokering is a central component of KTE. Knowledge brokering focuses on organizing the iterative process between the producers and users of knowledge so that they can co-produce feasible and research-informed policy. In this study, the KBs and AGs
were both producers and users of the knowledge generated. They were producers in terms of the useful feedback and interpretations that they provided to the research team as the project progressed, but ultimately they were knowledge users who could apply the lessons learned and who could continue to disseminate the key knowledge generated through their own networks.

Informing policy and practice decisions with research is as much a social as a technical task; knowledge circulates through interpersonal networks. Personal two-way communication between researchers and end users can facilitate the uptake and application of research. Knowledge brokers are ideally positioned to provide this communication. Human interaction is the engine that transforms research into practice (Canadian Nurses Association, 2013; Canadian Nurses Association, 2011a).

**CONCLUSION**

Health care decision makers and researchers face challenges in reducing the gap between evidence and practice and promoting a culture of evidence-based health care. Designing practice relevant research and communicating research findings to health care practitioners is an ongoing challenge. Ensuring that those findings transform policy and practice is an even greater hurdle. In this study, the use of knowledge brokers was instrumental in ensuring that the research process reflected the needs and aspirations of people with lived experiences of drug use and social disadvantages and the nurses providing care, that findings were applicable. Knowledge brokers bridge the gap between the producers of knowledge and the users. The KB’s were the source to initiating a process that facilitated changes to policy and practice.

**REFERENCES**


Biographical Note:

Dr. Jane McCall, MSN, RN, is a nurse educator for the HIV/Urban Health Program at St. Paul's Hospital in Vancouver, BC. She has worked with vulnerable populations for 33 years and has a particular interest in trauma, HIV and addiction. Her current research includes a study looking at the prevalence of trauma in the HIV infected population and the relationship between trauma and ART adherence as well as a study examining the experiences and perspectives of patients and staff at Crosstown Clinic, North America's only clinic providing prescription heroin to addicted patients.

Ashley Mollison, MA, is the program coordinator at the Society of Living Illicit Drug Users, which is a peer run organization for people who use drugs in Victoria. She is particularly interested in research, which is participatory and allows for the integration of people who use drugs into the research process.

Dr. Annette Browne, RN, is an associate professor at the School of Nursing, University of British Columbia in Vancouver, BC. Her research focuses on health and health care inequities, with a particular focus on health inequities affecting Indigenous peoples. She conducts research on access to health care, women’s health, cultural safety, and primary health care interventions to improve health outcomes for marginalized populations.

Joanne Parker, MA, is a research coordinator with the Critical Research in Health and Health Inequities at the University of British Columbia. She has previously worked with peer run drug user groups and harm reduction organizations in Nova Scotia.

Dr. Bernie Pauly, RN, is an associate professor at the School of Nursing, University of Victoria, as well as a scientist with the Centre for Addictions Research of British Columbia in Victoria, BC. Her program of research focuses on the study of public health policies and programs that contribute to improvements in health and reducing health inequities especially in the context of homelessness and substance use.