Peers, Paradigms & Parity

The vital role of people who use drugs in the Australian AOD workforce

ACKNOWLEGMENTS

Survival & solidarity and resilience of people who us drugs
Remember those in the drug using community who are no longer with us

The drug war has been as abject failure.
A war on drugs is a war on people

Amongst other things….

- I am a person who uses drugs
- Current & past AOD treatment system experience
- I am a drug user activist – I do local and national activism!
- I strongly believe in the health and human rights of people who use drugs and harm reduction
- I have worked in peer and non peer roles in health and community services for over 20 years or so
- I currently work for QuIHN – QLD Injectors Health Network - a community-controlled organization
- Director of QuIVAA – QLD's drug user organisation
- Being a peer leader is privilege and an honour
- My views. Not the views of QuIHN & QuIVAA
- THANK YOU Brooke RED for having me!

Drug user organisations

- Since the 1980's

- In response to HIV arriving in Australia

- People who use drugs, people in the sex industry & people with HIV mobilised

The Australian Injecting & Illicit Drug Users League (AIVL)

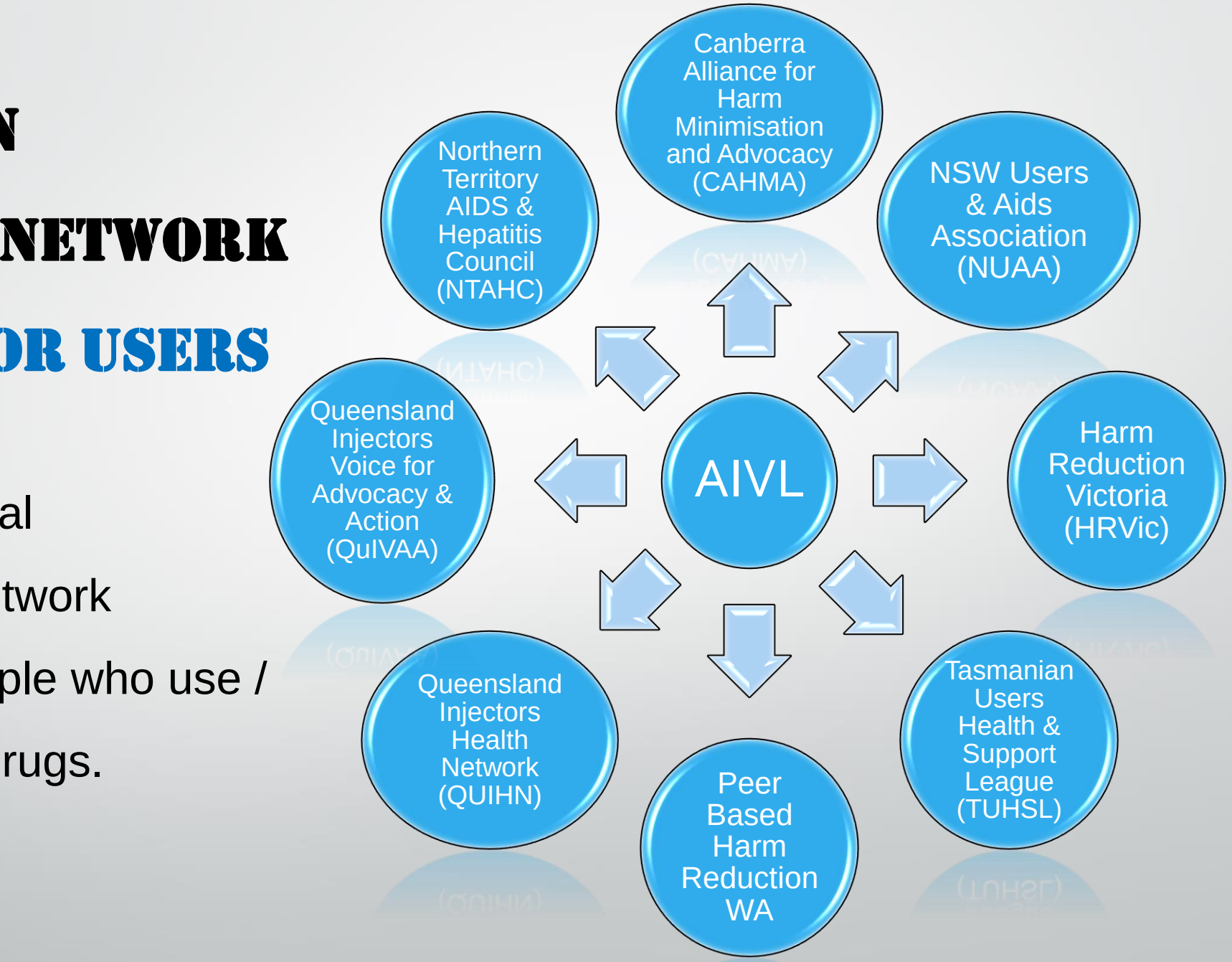
The **primary aim** of AIVL is to promote the health and human rights of people who use or have used illicit drugs. The organisation believes people who use/have used illicit drugs should:

- Have **autonomy** over their own bodies;
- Be treated with **dignity and respect;** and
- Be able to live their lives **free from stigma, discrimination and health and human rights violations.**

AUSTRALIAN DRUG USER NETWORK

BY USERS FOR USERS

AIVL - the national organisational network representing people who use / have used illicit drugs.



Queensland

QLD Injectors Health Network

Brisbane – Gold Coast – Sunshine Coast – Townsville – Cairns

Harm reduction focused health services for people who use drugs

QLD Injectors

Voice for Advocacy & Action

Advocacy

Representation

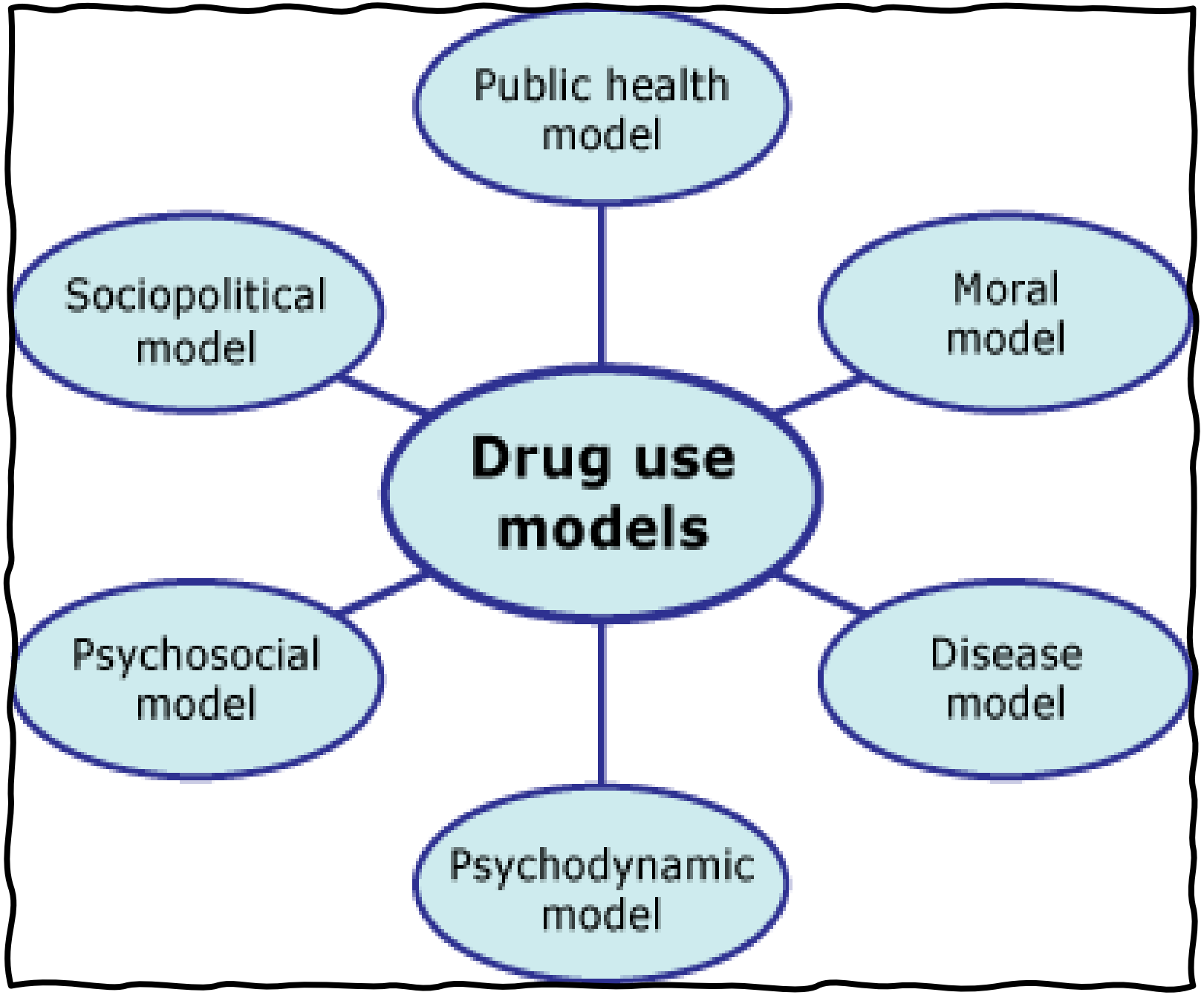
Activism

Community-led organisations

- Community-led organisations are not the same as community-based organisations
- In community-led organisations, decision making is in the hands of people who use drugs
- Self-governing nature, and a commitment to pursue the goals of its members, that makes a genuinely community-led organisation

Social Ways of Looking at Drug Use

- **The evil spirits concept** — the individual is possessed by demons; the problem comes from outside the individual. For example, the '*demon drink*'
- **The moral model** — the result of moral/spiritual impurity, the problem comes from within the individual
- **The disease model** — drug use is a disease and the people who have it are 'addicts'
- **'Addiction'** — from the Latin route 'adictus' meaning 'state proclaim or blind'
- **'Drug abuse'**— drug abuse (dependence) was seen as a medical problem at the beginning of the 20th century with significant consequences


Public health model
Sociopolitical model
Moral model
Drug use models
Psychosocial model
Disease model
Psychodynamic model

Understanding Drug Use

- Drug use is universal
- Drug use is not a moral issue
- Almost all of us use drugs
- The use of mood-altering substances is part of human behaviour
- Illicit drug use in not inherently different to other drug use
- All drug use has a function
- There are costs and benefits of any drug use
- Drugs are here to stay

Understanding Drug Use

Further considerations:

- Recognise that drug use may be the *'solution'* rather than the *'problem'*
- Drug use may not be causing any harm
- Drug use may be a way of coping with past or current traumatic experiences
- Solutions may not be related to drug use
- There needs to be benefits to not using drugs – (what will take the place of drug use?)

Make sure your actions do not create another 'problem' !

DRUG USERS ARE:

INPUD
International Network *of* People *who* Use Drugs

- The most vilified and demonized group in society.
- Often denied their rights and dignity.
- The “junkies” and “crackheads” of the popular media.
- Tagged as “undeserving troublemakers”
- Often sent to prison or compulsory rehabilitation, instead of access to evidence-based prevention, treatment & harm reduction programs.
- Systems of control & coercion
- Excluded from the decisions that affect their lives
- Your sons, daughters, fathers, mothers, brothers and sisters.

VICIOUS CYCLE OF PERCEPTIONS OF PEOPLE WHO USE DRUGS

Language and PWID

- The power of language
- Language use contributes to stigma
- Language of **contamination** and **contagion**
- Disease, illness, sick, cure, clean etc
- Victim & suffering mentality – drug users as victims – no agency
- Language and shame - internalised
- Language and the media

Preferred Language

People first language is vital.

Empowering, strong & positive language

Huge strides in other areas – mental health & disability

eg: Person Living with Schizophrenia –

NOT ‘a person suffering from schizophrenia’

OR a ‘schizophrenic’

- **People who inject drugs (PWID)**
- **People who are dependent on drugs**
- **People with a history of injecting drugs**
- **Clients (of drug related services)**

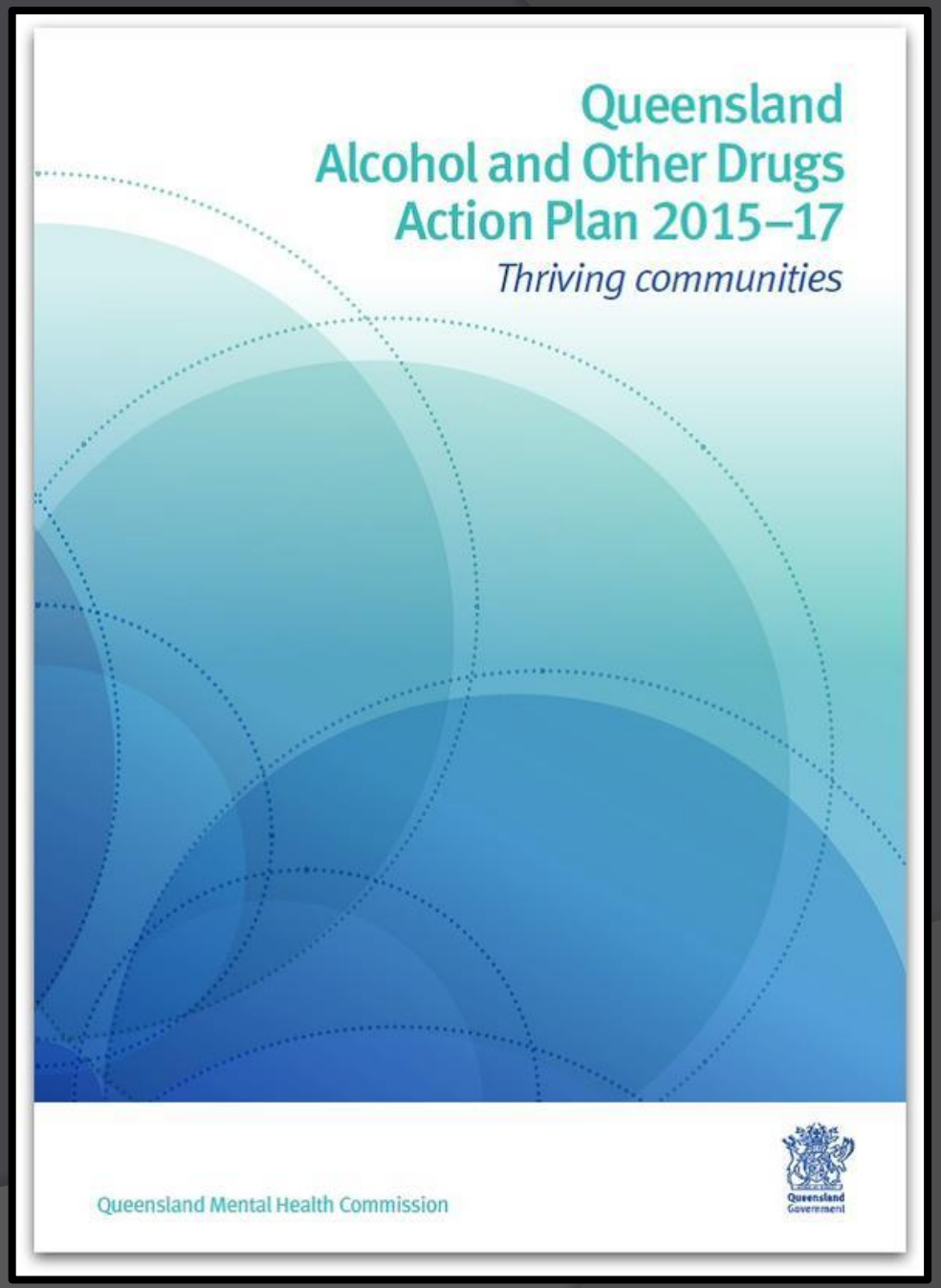
Harm Reduction

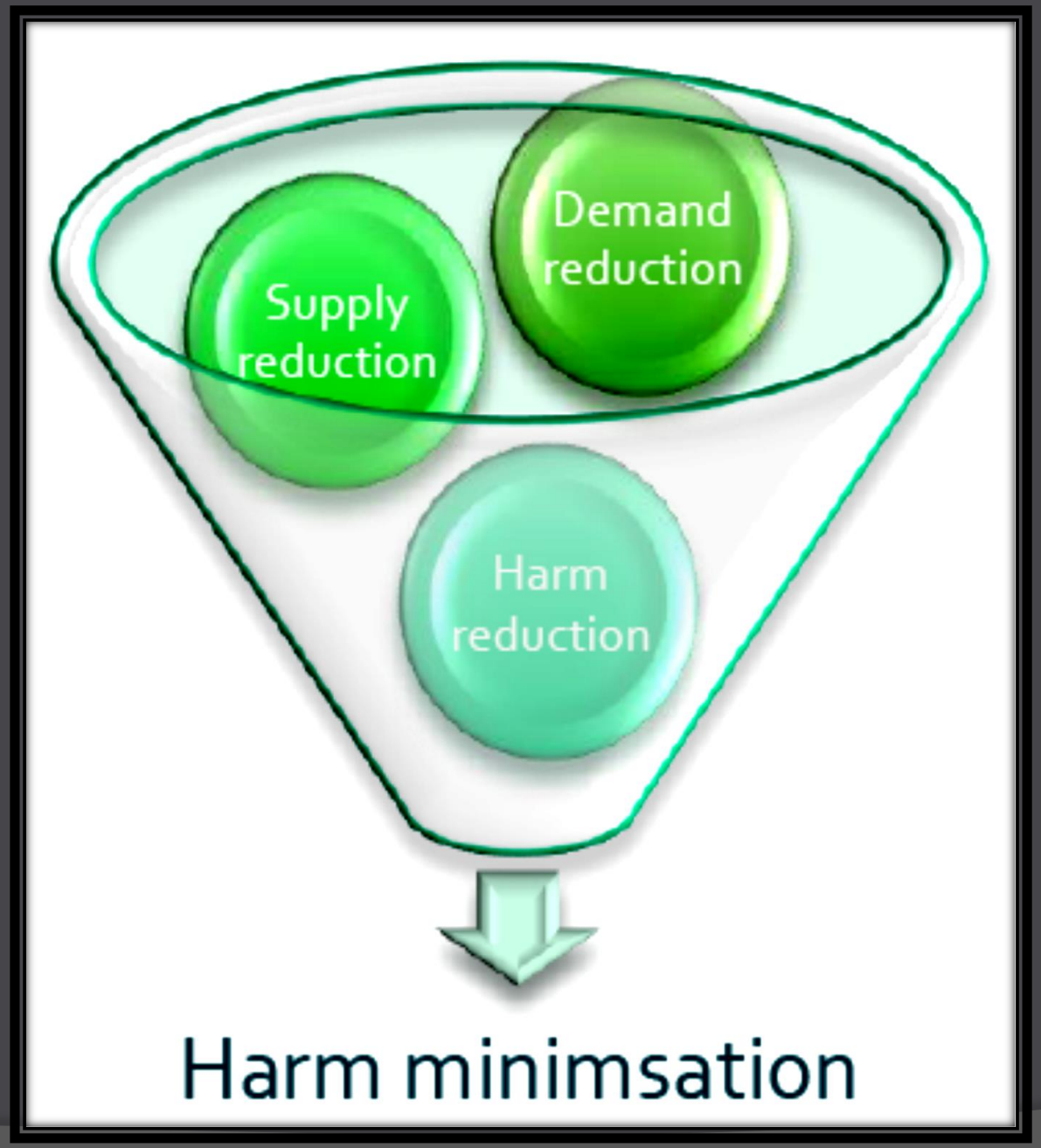
An approach that aims to reduce the adverse health, social and economic consequences of alcohol and other drugs *by minimising or limiting the harms and hazards of drug use* for both the community and the individual without necessarily eliminating use

Australian National Policy since 1985

Fundamental principle of the Queensland Illicit Drug Action Plan 2017

In line with National Drug Strategy 2017- 2026





Harm Minimisation

Harm Reduction

- Needle and Syringe Programs (NSPs)
- Provision of information
- Education
- OST programs

Demand Reduction

- Individual counselling
- Motivational interviewing
- Gov't health campaigns
- Drug education in schools

Supply Reduction

- Interception by Customs
- Seizures by Police

BUILDING POWER AND EQUITY WITH PEOPLE WHO USE DRUGS

through access, advocacy and action

Harm reduction principles

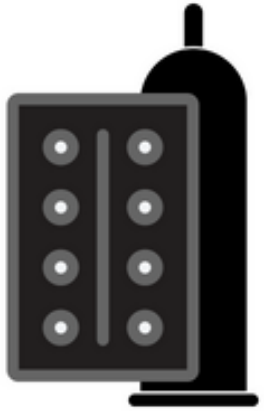
- Targeted at risks and harms
- Evidence based and cost effective
- Nonjudgmental & non-coercive
- Rooted in dignity and compassion
- Acknowledges human rights
- Challenge policies & practices that are punitive & increase harm
- Values transparency, accountability and participation
- Responds to needs of diverse vulnerable groups

EXAMPLES OF HARM REDUCTION IN OTHER AREAS

SUN SCREEN

SEAT BELTS

SPEED LIMITS



BIRTH CONTROL

CIGARETTE FILTERS

Assumptions	Car Related Harm	Drug Related Harm
Pragmatic	People are going to use cars	People are going to use drugs
Values free	Car driving is not evil or wrong	The use of drugs is not evil or wrong
Risk is inevitable	There will continue to be car related harms	There will continue to be drug related harms
Risks can be reduced	Through a combination of measures. E.g. Road rules, car design standards and driver training	Through a combination of measures. E.g. Regulation of drug markets, provision of education and information to inform user behaviour and choices, and the provision of equipment (clean needles) and medications (methadone) that can mitigate risk.

Defining Us….

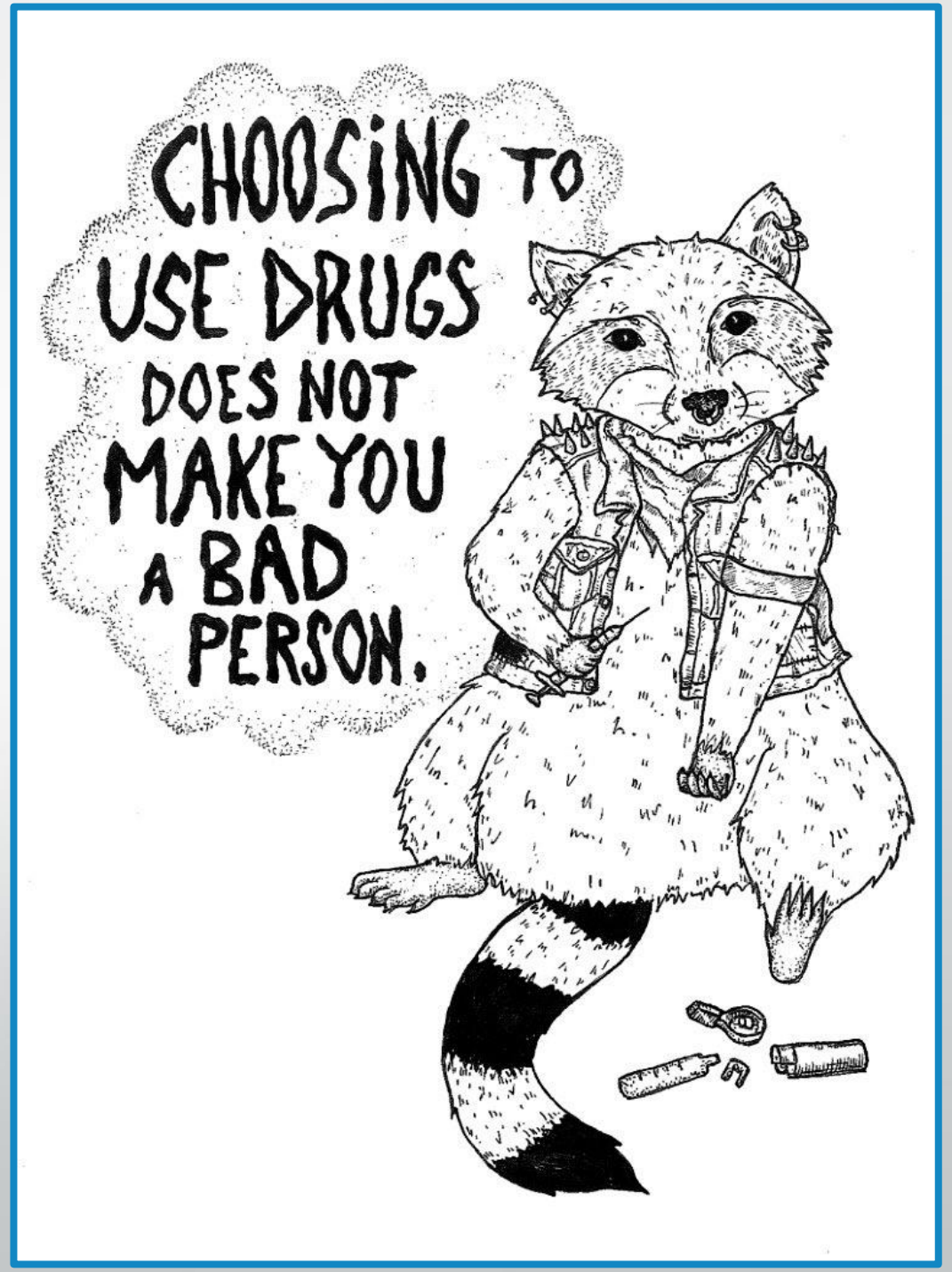
The Australian Injecting and Illicit Drug Users League (AIVL) defines peers workers as '**equals working with equals'.** Good peer workers accept themselves as:

- the **moral equals** of those with whom they work.
- in a position to offer knowledge and information, opportunities for learning;
- in a position to learn themselves

Identify as a member of the drug using community & be identified by the community as a member

What is a peer in Harm Reduction?

- A person who has a lived/living experience of illicit drugs issues
- A person who identifies as a member of the illicit drug using community
- A person who is identified as a member by the illicit drug using community
- Can be using or no longer using (still using is AOK for harm reduction service)

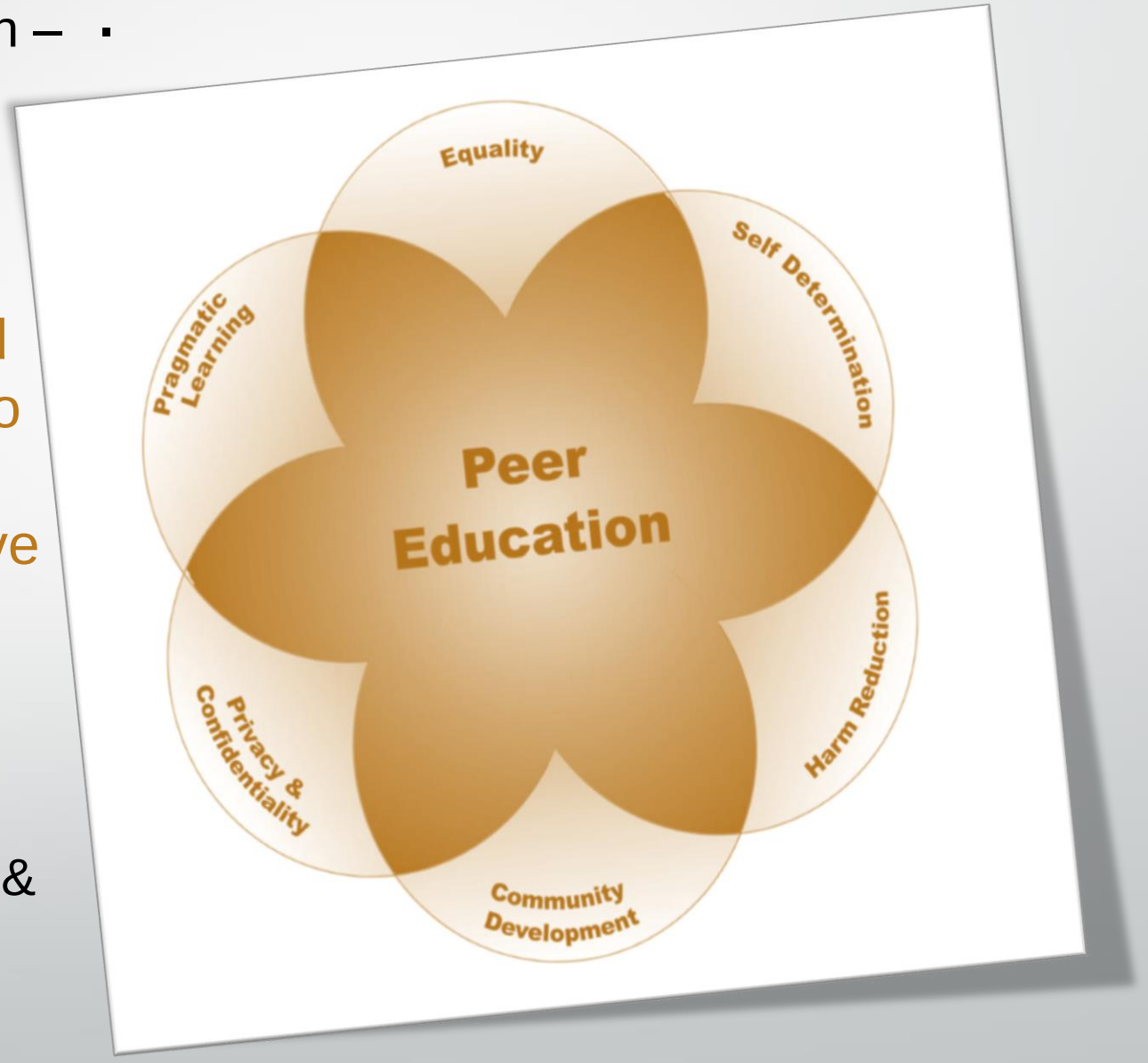


Peer work is **informed by the needs of the people** we work with – not our needs.

AIVL states:

As so **many aspects of drug use are prescribed, regulated & stigmatised**, and people who use drugs are hugely impacted by **systems of control**, we have a responsibility to create an **environment where those pressures are not present**.

To **create ownership** (of process & outcomes)



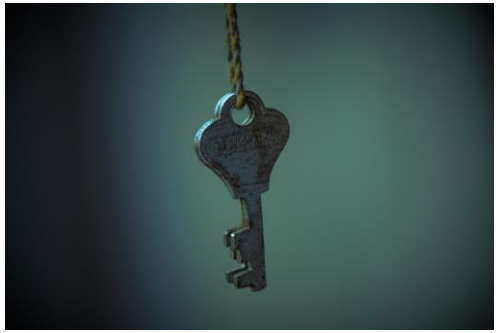
What is AOD Peer Work

- A person who uses their lived/living experience of alcohol and other drugs, plus skills learned in training, to deliver services in support of others.
- Peer support is about social & political change & human rights
- Doesn’t start with the assumption that something is wrong because you use drugs
- Not about HELP – about SUPPORT & CONNECTION
- An important part of service delivery, many organisations include peer work in their service.
- Peer workers usually provide non-clinical assistance; they use their personal experiences to promotes understanding and connection.
- Peer workers understand contexts of community, environment & **systems of control & exclusion**— looking beyond the individual's responsibility for change. (Especially around drug use!)
- Encourages people to live and move towards their goals and doesn’t focus on what we need to stop or avoid doing.

Peers work in Harm Reduction AOD Organisations

- Approach people without bias and judgement
- Intimate knowledge of the 'choreography of injecting,' (or drug use) - to recognise opportunities that arise in diverse scenarios
- Appreciation of injecting as a 'mode of desire,' a personal drive with deep cultural and social meaning (pleasure not just pain)
- Deep insight into their communities, illicit drug scenes, the forces that shape those scenes
- Experiences of criminal (in)justice system / jail / treatment
- Awareness of how stigma influences drug users perceptions of themselves and how they are perceived
- Willingness to apply knowledge and skills in a harm reduction / human rights framework

Peer Workforce – Key Differences



ABSTINENCE

Must be drug free – no longer using substances

Usually this means ANY substance use

Must be committed to abstinence and recovery

Usually active members of AA & NA

Disease model focused peer work

Encourages people to see recovery as abstinence only

When a peer worker uses again, this can significantly impact their work

You need to change

All drug use is problematic

HARM REDUCTION

Peer Workers can be current/active drug users

Can also be no longer using

Must understand harm reduction & passionate about reducing harms and maximising pleasure in drug use

Value people who use drugs

You are worthy – whether you stop or not!

Gives hope to other drug users – just like alcohol, substance use can be managed healthily and without impact.

Encourages people to see recovery as anything a person wants it to be- managed and controlled drug use/ occasional drug use/ no use/ use with reduced harms etc

You have always been ok. You do not need to change unless you want to.

Two worlds collide: Mental Health & AOD

- MH system traditionally does AOD work poorly (can increase harm)
- Lack of AOD understanding / training of MH peer workers
- Often punitive systems to manage or cease drug use
- Peer Workers often must be in “recovery” and not using
- Peer workers are usually abstinence based, not harm reduction focused – Prevents open dialogue
- MH consumers often fulfil AOD representation roles without adequate experiences of substance use
- Whilst lots of similarities and learnings from each other, placing AOD within an MH context is problematic for lots of reasons –
  - AOD poor cousin of MH – underfunded. Often resented.
  - assumption that AOD use is root cause of MH issues
  - “Dual Diagnosis” – most PWUD are not diagnosed nor should be
- Less focus on integration and more focus on **separate but collaborative** work

Where are we at?

- Evidence - employment of peer workers in AOD services = positive outcomes for people with AOD issues
- The AOD peer workforce - an integral part of quality service delivery - some organisations formalising and integrating peer work into their service.
- Despite AOD peer workers & drug user organisations existing since late 1980's.. AOD peer workforce is not yet widespread in QLD - certainly not widespread in AOD sector.
- Some confusion surrounding identified lived experience roles, general lived experience in regular roles and client engagement/representation

Where are we at?

- Funding
- Cultural organisational issues
- System issues- criminal record checks/blue cards
- No formal pathways
- No current analysis or ‘stock take’ of the QLD AOD peer workforce

Where Are We At?

- Recent increase of “peer” positions among harm reduction organisations - from the demands of service users and other affected communities
- Increased recognition of the fundamental value of experiential knowledge
- Acknowledge of the positive impacts of peer involvement in reaching “hard to reach” populations.
- Increasing recognition and integration of peers into harm reduction AOD organizations
- Global austerity and growing budgetary pressures. Employing peers is increasingly attractive as they generally receive below average wages.
- Increasing demands for academic credentials and the professionalization of the community sector means that the role of peers is limited, even though the number of peer positions may be increasing.
- While recognising peer work represents progress, it also highlights issues, - the lack of power within decision-making, and; limited accommodation /understanding within organisational policy
- There is also fundamental tensions with approaches to drug use, HIV, and hepatitis C.

Where are we at?

- We need peer roles to be viewed as credible and legitimate while remaining authentically ‘peer’
- When peer roles are formalised there may be loss of authenticity and there is concern about over professionalisation or coopted or peer drift (esp. if only peer worker!)
- In large organisations, there are risks of peer roles being blurred and people being exploited as ‘cheap labour’ & over ultized.
- The trappings of formality – job descriptions, managers, individual review –provide safeguards as well as risks
- Negative attitudes and stigma. Some people do not value experiential knowledge and expertise. Treated differently

Ethical Issues

- Key ethical issues for the AOD peer workforce
- Dual relationships: dual relationships are generally prohibited in professional ethical codes but are commonplace for peer workers
- Peer workers are embedded in communities - multiple and overlapping relationships, which makes them effective in their work.
- Self-disclosure: sharing life experiences is part of peer work. Can be challenging to navigate the ambiguous territory between friendship and professional relationship.
- Sharing information with colleagues: managing agency and expectations of sharing information can be particularly challenging in peer work
- Physical contact: typically prohibited in professional relationships contact such as sharing a hug can be normative in peer communities.
- There is no clear consensus on when a person is ready to take on the challenges of peer work.

Considerations

- **Employ people who use drugs. Liberation, not oppression.**
- It is not a good idea for racial justice orgs to have all white leadership, or trans orgs with with all cis directors, or a queer org ran entirely by straight people! So why are so many harm reduction / AOD organisations led by people who don't use drugs.
- Stigma, tokenism, workplace discrimination, power and pay inequities are key factors persisting in the everyday experiences of AOD peer workers
- Continued exposure to stigma, power imbalances, combined with impact of high stakes employment (e.g., dealing with overdose deaths), can have significant consequences for PWLE working in harm reduction, including burn out.
- Policy recommendations- structural l changes that address inequities of hierarchical 'peer' employment for PWLE, including increased leadership roles for PWLE, pay equity, as well as more supportive working environments

Considerations

- Intersecting oppressions impede the work capacity of already stigmatized populations who use drugs.
- Working environments need to be attentive to social-structural factors (poverty, criminalization, racism, gendered violence) impacting the everyday lives of PWLE working in harm reduction.
- Peer work loses momentum with insufficient opportunities for new and experienced peer workers or career progression
- Collective organizing is one way we can achieve equity in the workforce
- Opportunities for participation can spark growth within the drug user community.

Considerations

- Coming out as a user / peer worker and the implications for this – career progression & lack of opportunities for higher paid peer roles and external work
- Illegality of drug use – Stigma.
- Implications for personal life & future professional lives
- Drug use and work
- The difference of harm reduction peers in comparison to other approaches
- Equal pay – peer work is not low cost
- Peer workers ≠ consumer/client engagement
- Not co-opting lived experience roles into other roles
- Peer drift
- Living experience v lived experience

How AOD sector can support peer workforce ?

- Belief that the role adds value – protected & nurtured
- Not just the school of hard knocks – need skills building, education.
- Disclosure – negotiating / selective / considerations / management support
- Solid orientation / job description / PEER supervision
- Other peer workers & mentors – connection, networks, opportunities
- Robust self care (& community care) in place
- Recognition of similarity and difference in peer roles
- Welcoming of the imperfect science that is peer work – flexibility
- High level peer roles & leadership – career progression

How AOD sector can support the Peer Workforce?

- Structures & processes - semi-autonomous teams of peer workers
  - peer managers to line manage peer workers
  - peer supervision for peer workers
- Peer work supervision – space for peer workers to discuss their roles. No different than social worker supervision/case conferences
- More awareness, support & dedicated resources needed for peers - Funding, conferences, acknowledgement
- Managing transition from service user to peer worker (formal pathways)
- Training for non-peer workers – organisational culture
- The AOD peer workforce is recognised as an integral part of quality service delivery
- AOD client engagement practice is embedded across organisations
- Clear, formalised pathways into AOD specific training & peer work

How AOD sector can support the Peer Workforce?

- Be mindful of peer drift and cooption
- Stop using peer workers as the voice of service users
- Peer workers do not do your dirty work eg: rapport building
- Disclosure - Don’t ask use to use our story all the time
- Open discussion of substance use in workplace – just like alcohol talk after a weekend
- Stop sanitizing AOD peer workers – trend towards ‘Person with Lived/Living Experience’ rather than a “Person who uses drugs”

How AOD sector can support the Peer Workforce?

- Organisations should maintain a patient and flexible approach to peer work with clear but not rigid work expectations.
- Offering a variety of thresholds for peer involvement to suit individuals at various levels of stability and job readiness
- Adequate training and support means people can negotiate any potential risks such as health care or boundary situations
- Broad qualification criteria, transition timelines, flexible job responsibilities
- Investment in the inclusion of people with lived experience, and a harm reduction framework supports integration of peer workers in the AOD sector.

As drug users, we ask to be…

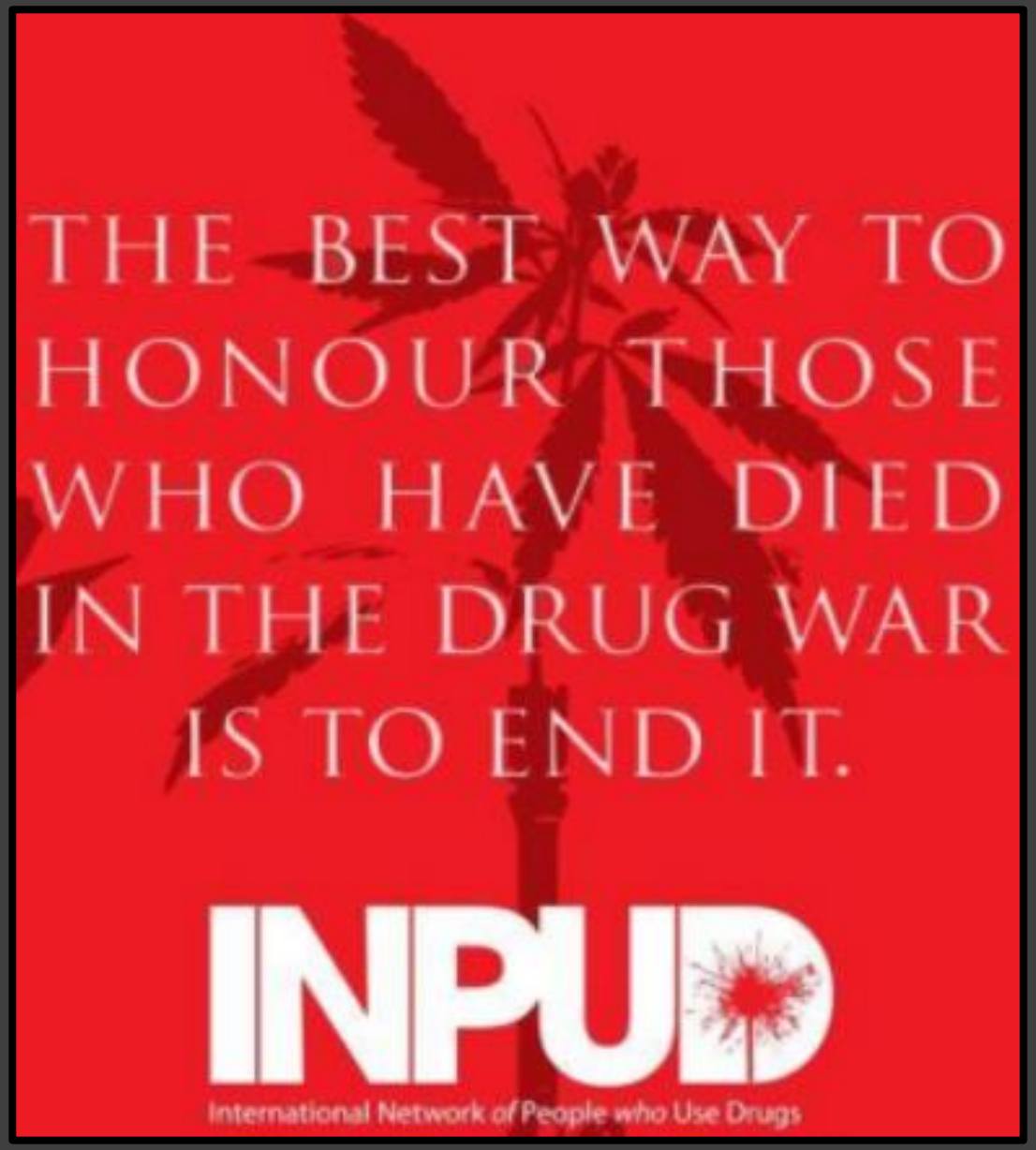
- Treated as equals
- Respected for our expertise and professionalism on drug use
- Recognised for our work, often without funding, to address issues faced people who use drugs
- Supported when demonized & attacked in the media
- Supported to fight the fear, shame and stigma that keep us from fully participating in our communities
- Included in decision-making about the issues affecting us

As drug users, we ask to be…

- Recognized as valid and valued participants in policies and programs about drug use
- Respected in all partnership with governments and organisations
- Supported to develop skills and knowledge to be good peer educators and advocates
- Meaningfully involved at all levels of organisations that provide services to us

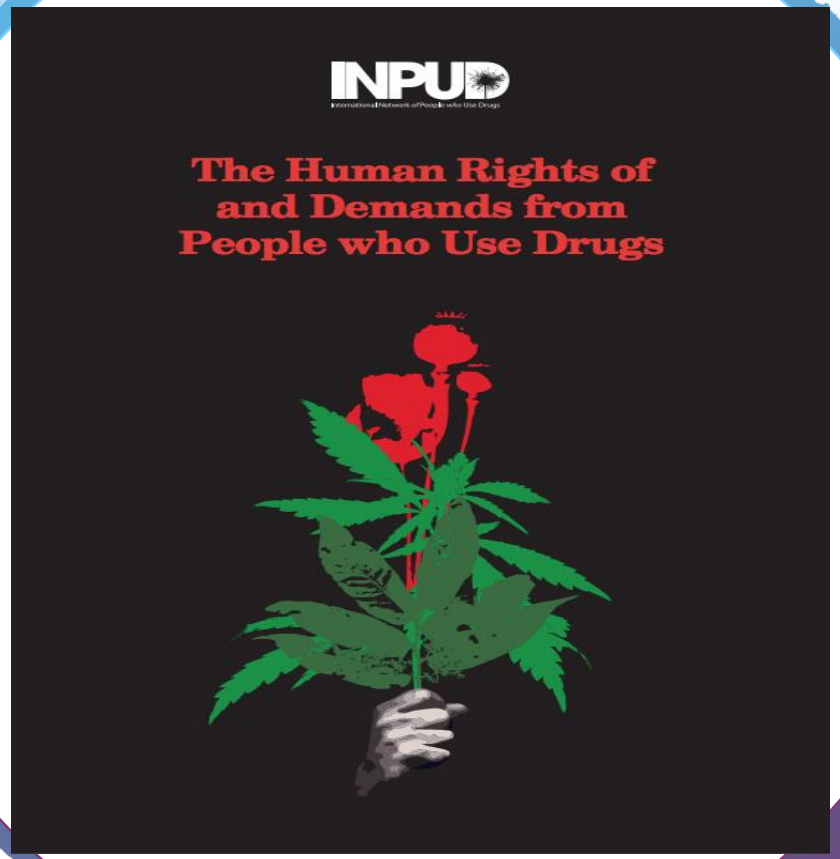
WHAT DO WE WANT?

- Strive to empower and include all people who use drugs
- Meaningfully including womxn and Aboriginal peoples
- Commit to harm reduction, peer work and community development
- Fight for health and human rights of people who use drugs.
- Challenge oppressive drug laws, policies and programs
- **REMEMBER:** Drug users are part of the solution – not the problem.



People who use drugs have identified their values and demands

- The International Network of People who Use Drugs
- The Vancouver Declaration (2006)
- International Network of People Who Use Drugs (INPUD) Declaration of Rights and Demands (2015)



www.inpud.net/consensus_statement_2015.pdf

Broken Record

Change happens incrementally!

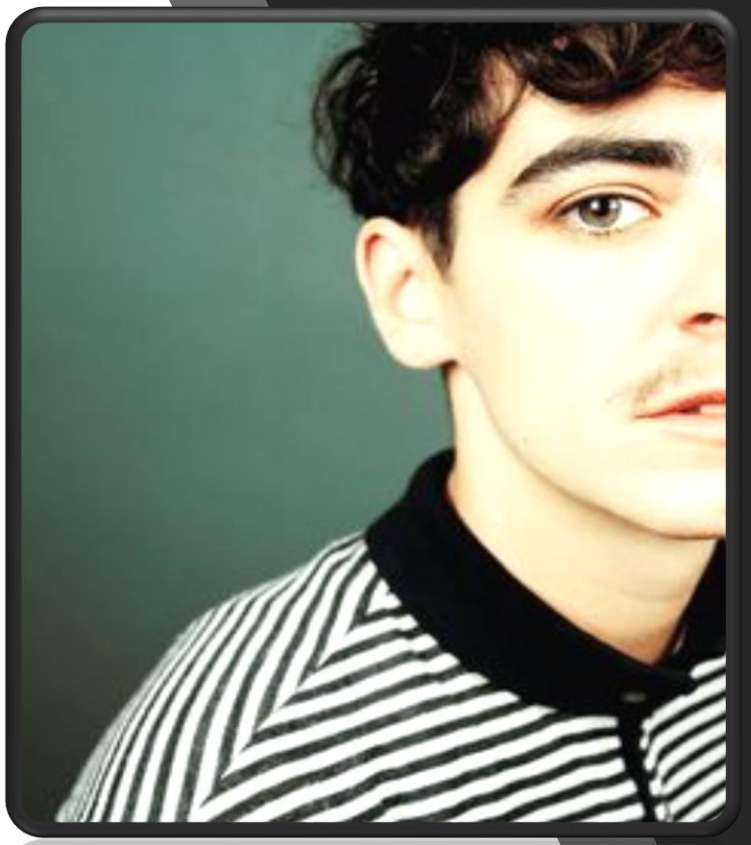
The fight for the inclusion of people who use drugs is worth the long fight. And it has been a looooooong fight!

Successful advocacy requires low-key, detailed and long-term engagement, in-depth knowledge, compromise and strategic timing.

Don’t shout louder,

SHOUT LONGER & IMPROVE YOUR ARGUMENT!

BE THE TOKEN



JD SAMPSON

Feminist
Musician
Gender Queer
Token

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“When there's a sense you're there (on a discussion panel, or at a meeting) as a token, (because they needed a drug user or someone on methadone, or a woman drug user) - it's something that's very complicated both politically and personally, but something I ultimately think is necessary. At least people are thinking of the diversity and representation.

My career in a lot of ways is about being a token. I’m chosen for a lot of gigs because of my identity rather than the work I do. And that can feel depressing, and then at times it can feel really powerful.

There was a moment when I realised I was filling up this space that hadn’t been filled up before, and I took it upon myself to donate myself to my community, to be that token.

Making myself visible is a huge part of what I do! Tokenism has given me a career!”

nparry@quihn.org