WHACK

#48
HR23 ISSUE

HARM REDUCTION PEER WORKFORCE ISSUE

FOR HR23, MELBOURNE,AUSTRALIA

WHACK©

#48
Harm Reduction Peer Worker Issue
Produced Especially for HR23
By FUSE Initiatives- a program of Harm Reduction Victoria

WHACK magazine is produced by Harm Reduction Victoria- a not-for-profit, community organisation for Victorians with a living/lived experience of drug use.

WHACK aims to serve as a vessel for our community- to provide a safe, non judgemental forum for debate and for sharing relevant and up to date harm reduction information, education and comment on the issues affecting us- People who use drugs in Victoria.

This Special Harm Reduction Peer Worker Issue is brought to you by Fuse Initiatives,

a program of Harm Reduction Victoria for HR23

The contents of this magazine do not necessarily represent the policies and/or views of Harm Reduction Victoria.

Harm Reduction Victoria (HRVic) does not condone nor condemn drug use. HRVic does not promote illegal activity. HRVic recognises and acknowledges that drug use happens and as such, focuses on drug safety and harm reduction messages.

HRVic seeks to reduce the potential harms that are sometimes associated with drug use through the provision of factual, useful information, peer education, support, advocacy and referrals.

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WHACK© Magazine is your magazine and as such we want your stories, your artwork, your hard hitting articles etcetera!

- & YOU'LL GET PAID *(if your work is published)!*

Do you write or draw/ paint/do digital artwork or take photos?

OR Are you interested in learning to do any of those things?

WHACK is a lot of work. To keep it coming out regularly, we would like to put together a **Production Team** made up of **community members with living/lived experience of drug use-** to put together WHACK magazine.

If you are interested in hearing more about this volunteering opportunity, please email

samj@hrvic.org.au

HRVic respect and acknowledge the Wurundjeri people of the Kulin nation as the traditional custodians of these unceded lands and waters on which WHACK is published and read.

We respectfully acknowledge all Elders past, present & emerging who may read this publication and throughout so-called Victoria & Australia where this magazine is distributed.

www.hrvic.org.au

INTRODUCTION

SIONE CRAWFORD
PEER CEO,
HARM REDUCTION VICTORIA

Welcome to this Special Edition of WHACK!

Harm Reduction Victoria is proud to be the local partner for the 27th Harm Reduction International Conference here in Melbourne in 2023.

We are a peer-based organisation of people who use drugs and were formed in 1987 as part of a broader affected community response to the HIV crisis.

At that time our focus was on people who inject drugs in particular, and as we all know, there was no effective medication or medical treatment for HIV back then.
Harm reduction and blood-borne virus prevention education, and organisations of peers, like HRVic (then VIVAIDS) were crucial to engage our communities, to deliver peer education around safer injecting practice and self-care, and to ultimately ensure HIV rates remained low amongst people who inject drugs in Victoria.

Peer work is important to us and for many years organisations like ours - drug user organisations - were the only places a person who currently uses illicit drugs and who were embedded in communities of people who use drugs could work and be open about our illicit drug use.

This has always had advantages and disadvantages. We know how fortunate we are to have an organisation and work those values, rather than stigmatises our experiences. We can be who we are in our workplace and we can work with our community on things that are important to us. On the other hand being known in the sector and sometimes, the media, as an illicit drug user can lead to difficulty finding other work, the loss of friends and family and a tricky balance of being valued for something that is still illegal, and can endanger the workplace.
Over the years our organisations, while never perfect, have striven to be places of safety for our peers who work with us and to be supportive as well.
I suppose what I am saying is that it isn't simple to be a living experience peer worker and nor is it simple to be an organisation of living experience peer workers.

But when peer education and engagement works - it is one of the most powerful, empowering and exciting forces for change there is.

The peer workforce outside of blood-borne virus work: across mental health, carer, and drug treatment and recovery and in harm reduction has grown over the years as this fundamental truth has become clear.
Slowly, funded programs outside peer organisations has increased and this is the case for our harm reduction peer work as well. There are a small number of people working in harm reduction identified current peer positions in Victoria, outside of the

good thing, we are also very clear that care is needed. As long as illicit drug use itself remains illegal, it is not possible for any workplace to offer a current, living experience peer worker a completely safe workplace.

Here in Victoria, the Department of Health has supported us in building systems and processes that we hope will help to make things safer for our peers who work in more mainstream organisations.

This Special Edition of WHACK, put together for the International Harm Reduction Conference in Melbourne, is our way of celebrating our amazing harm reduction peer workforce - whether in identified positions, or in positions where they cannot openly use their living experience, or in leadership and management or in volunteer roles.

Really, we are all doing the same thing - using our personal, up to date experience and knowledge of a criminalised marketplace and of the communities who thrive and survive around this marketplace to deliver or improve services and to improve or change policies that affect us.

WHACK has reached out to peer workers who use drugs all over the world and in our own backyard. Giving HRPWs a platform to speak and let us and you know what they do and why they do it.

Harm reduction is so central to our work and our lives that releasing this issue to coincide with the conference and ensuring that every attendee gets a copy is a no-brainer. We are proud to be associated with the conference but more than that are proud to be associated with the people in this issue, and with every other peer worker or volunteer out there who didn't have the time to respond and we want to thank you for helping make harm reduction the success it is.

Photo Left: Baden, Pharmacotherapy Support Peer

THE QUESTIONS

Throughout this issue you will encounter one by one, page after page, the replies to 4 questions.

Our global peers were asked 4 questions-based on whether they identified as a Peer Worker or are a Peer in an 'official' management or leadership role- even though I feel we are all in leader role if we are a peer worker:

Questions for living experience / harm reduction peer workers:

Q1 What does it mean to you to be a peer worker?

Q2 Why are peer workers so important?

Q3 What is the climate for peer workers where you work or in your country?

Q4 What can you do as individual to flip the current paradigm when it comes to the need for drug law reform & the fact most peer workers are forced to work in unsafe workplaces?

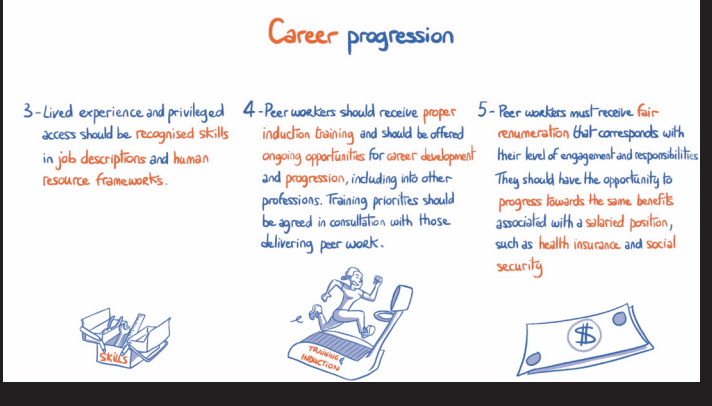
Question for living experience / harm reduction peers in management or leadership roles:

Q1 Why is it so important to have living experience/ current peers in management/ leadership roles?

Q2 What do you think you bring to your roles that maybe different to other managers or CEOs without living experience?

Q3 Are you 'out' as have living experience? Do you think you can be an 'out' PWU/ID in a management or leadership role, if you work outside of a drug user org or network?

Q4 What can you do as individual to flip the current paradigm when it comes to the need for drug law reform & the fact most peer workers are forced to work in unsafe workplaces.?



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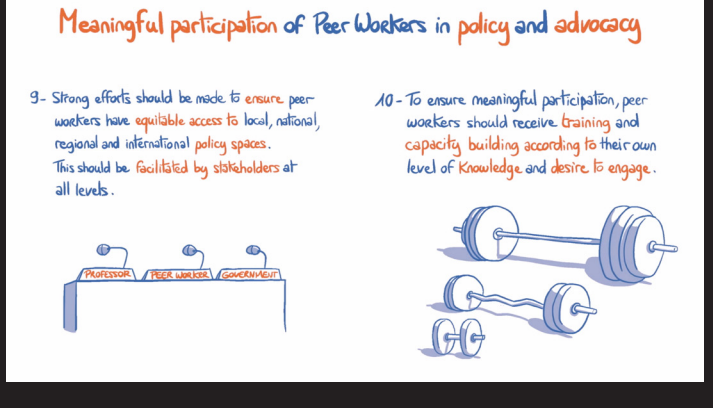
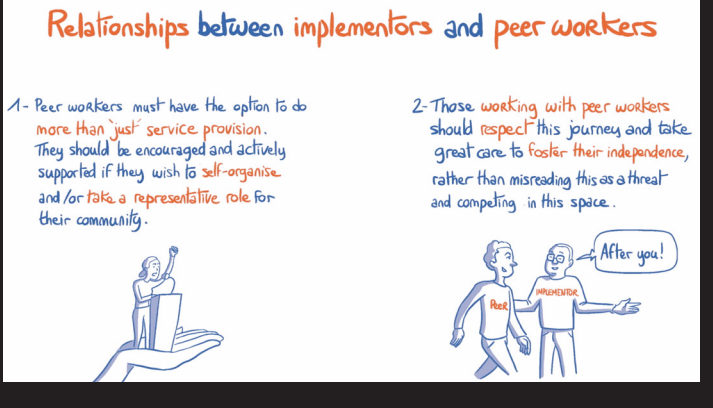
SPECIAL PEER STORIES





CAROL
PEER LEADER
SOUTH AUSTRALIA

Q1.

Having current peers in leaderships roles shows peer workers that there are opportunities to advance their careers and that people with lived/living experience don't have to hide their peer status to be employed in a role beyond 'peer worker'.

Peers in leadership roles can be role models and mentors for peer workers and can actively support and assist peer workers in their professional development.

It is also important to have peers in leadership roles because it shows non-peers that people with lived/living experience can take on leadership/management roles and excel in them.

Q2.

Well, obviously that shared experience means that I can empathise with my peer staff and their experiences.

As someone with living experience I know the challenges of using or being on OMT/OST/OAT while working in a job where it feels like my every move is scrutinised and I can understand the pressures that the peers face.

I know what it's like to struggle to get through the day because I've used all my TAs on the weekend for example. If a peer worker is having a rough time they know they can be honest with me about what's going on and they know that I have their back.

Q3.

Yes, I am quite out as having living experience.

Although I find it interesting that regularly other (non-user) workers in the sector have a sort of memory lapse or are in denial about my living experience. I don't hide my peer status and at times will mention something or make a comment that clearly indicates my experience is current, yet there will always be some people for whom that doesn't register.

I think being out in a leadership role outside of a DUO/network can be done discreetly, slowly and selectively.

You might need to be in the role for a while first, develop professional relationships/ networks, show people how damn good you are at your job. Then select who you might disclose your current peer status to. It also depends where you are working, what your employer's stance on drug use is.

But I think there is still so much stigma associated with injecting drug use that to be completely 'out' in all work related situations is likely to present barriers - maybe you won't get that funding you applied for, or that position on a key committee etc.

Q4

Peer work doesn't have the recognition that it should. There is a stigma associated with drug use, and therefore AOD peer work. Because peer workers' core knowledge comes through life experience,

the role of peer worker is undervalued, their contribution is often unrecognised and peer workers are often regarded as an 'add-on' rather than an intrinsic part of the AOD sector.

As long as the current paradigm continues, and until meaningful law reform occurs, peer workers will continue to be underpaid, undervalued and working to the point of burnout.

"Laws won't change while drug users are vilified, and drug users will continue to be vilified while legislation places injecting drug use outside the law."

What can individuals do?

They can speak out, they can get involved in law reform campaigns. But I think the foundation of it all is the stigma that goes with injecting drug use and the resulting discrimination directed at people who inject drugs. The stigma goes hand-in-hand with drug legislation, and both need to be addressed concurrently.

NADIA
PEER LEADER
MELBOURNE

Q1 It is so important to have living experience/ current peers in management/ leadership roles as we move into spaces outside of the safety of Drug User Org's, where people who are currently using and/or injecting drugs are being hired, specifically to be 'out' as having living experience in peer worker roles in mainstream harm reduction services, in Victoria.

This is when the importance of management having their own living experience is absolutely necessary.

They/we know the issues that peer workers face as they have generally managed to hold down jobs with their own living experience.

This may have meant they have maybe either needed to be under the radar and not known by the upper management of an organisation and/or made their way to their management role with the upper managements knowledge, either way it isn't easy but they have now made it and are at a management level.

I would say that most PWU/ ID in management roles, don't talk about their current use especially if they are working for a mainstream harm reduction services, they are more than likely still not 'out', because disclosing means you are open to be discriminated against, because what we do on a daily basis is illegal, so there is no safety net for you, but due to the fact that we all seem to be guided by the same values and we are all extremely community minded, we will swipe any risk to ourselves to the side and focus on making

sure our community members who are accessing services get the best possible outcomes and make sure their needs met.

We work with PWU/IDs where they are at & in a meaningful non stigmatising manner.

So, then the benefit of having living experience peers in management roles is to help the organisation to:

- **Engage with the benefit of peer workers.**
- **Learn about the experiences that HRPW bring to their roles**
- **Make sure the org is being inclusive, and work with peer workers in a meaningful way**
- **Educate organisations & encourage not to impose discriminatory policy & procedures as knee-jerk reactions to having peer workers in the workplace**
- **Help role model to HRPWs as well as non-peer colleagues that peer workers have a role to play in service delivery.**
- **They can be exponents of the training needs of the whole of their orgs to understand the benefits of peer roles,**
- **Work towards team cohesion in mixed multidiscipline teams.**
- **PWI/IDs who manage peer workers are more aware that being a peer worker is a 24/7 job and that there is an extremely fine line between work life/ home life balance and that it is easy to say that your work ends at 5.30pm or at the end of their shift and is a big ask to expect peer workers to not live and socialise within their community,**
- **Provide support to peer workers & discuss the benefits and share wisdom.**

Q2 Peer leaders/managers bring an intimate understanding of the expectations of an organisation from a peer perspective. I speak the shared language of my community.

I provide support, am able to be a mentor and role model. If a non- peer manager supports living experience peers they need to be a harm reductionist and be understanding of the benefits living experience peer workers bring to a service and they need to be supportive of the needs of living experience peer workers and not push recovery focused harm reduction.

I will never say things to peer workers like, "you should be just happy you aren't dead." I will never say "it's just a job". I am passionate about my role and all of our roles.\

I have lost and grieved more than most people.

You can not teach the empathy that living experience peer managers bring to their roles. We understand the passion that drives us and that it comes from a place of loss and desperation to stop that loss from happening to others.

We won't treat our peer workers like they are 'troublemakers' because they ask questions about our methods. I am understanding of the discrimination that my staff have experienced because I have experienced discrimination myself I want to make our work not only mean something ,but for it to be restorative.

Q3 It can be dangerous to be an out user in a mainstream org but I think some organisations have a big enough appetite for risk to deal with it even though I would say that peers in those management roles have usually already proved their worth and would never put their organisations reputation at risk out of respect. I work for a drug user organisation so I do have the luxury of being able to be out about my drug use, but that doesn't mean that it isn't without its risks. I haven't always felt fully comfortable with disclosing to everyone. I am much more comfortable with disclosing as my son gets older. I feel less pressure about when, where, and who I out myself to, but for a long time I didn't ever want my son to be discriminated against for who I am or something that I had done or was perceived to have done.

Ultimately I realised we won't have change until we start to disclose that there are PWIDs as part of ALL communities and we have always been here but because of our own safety you may not ever know that we are here.

Q4 If we want to flip the current paradigm when it comes to drug law reform & address the fact that most of us peer workers are

forced to work in unsafe workplaces, we need to write to our local members of parliament or find allies inside & out of the harm reduction sector and constantly advocate for drug law reform.

In over 35 years of harm reduction in Australia, funding has never increased passed the 2.1%

Let people know that only 11-12% of PWU/IDs (nationally & globally) will every access or need to access treatment, which means that 88% to 89% of PWU/IDs will never run into issues where they need treatment, this also proves that so-called recovery is not the only answer, yet Demand Reduction still gets far more funding than Harm Reduction.

In over 35 years of harm reduction in Australia, funding has never increased passed the 2.1% that is allotted from the overall Harm Minimisation funding, which has been the Australia National Drug Strategy. When we know that NSP (needle & syringe programs) have been really well researched and is still the most cost effective health measure, for every $1 spent, there is a $26 return on investment.

If we were able to get researchers to listen to PWU/IDs and ask the right research questions, we need more research to be funded to find out what we know anecdotally, that:

- **Living experience peer workers can access hidden marginalised communities**
- **We are for the preservation of life, we want to save your life, not 'fix' you**
- **We make services much more service user friendly,**
- **Service users have better outcomes from organisations with living experience peer workers.**
- **Organisations benefit from hiring Peer workers because we make services more credible.**
- **We work with our community where they are at,**
- **We speak the same language, so we can act as a bridge between services and service users.**

Peer education has always been a grassroots and organic activity, because we only trust the information we hear as credible if it is from other peers and so peer workers are able to provide formalised peer education that is current, best practice and research based. We are not judgemental and understand that not all drug use is problematic.

We need allies and proponents that will help to lobby to get more funding for living experience peer workers who have proven that they can access hidden hard to reach marginalised PWU/IDs like women who inject drugs. Women who inject drugs only make up for 15% of clients accessing NSP, and 25% of safe injecting facilities, when living experience peer workers do outreach, their client contacts are 55% women who inject drugs and this is the same for other peer led approaches like peer networkers who provide secondary distribution of sterile needles & syringes, provide education and information on blood borne virus prevention & treatment, naloxone training, overdose prevention education.

We want our expertise to be valued and acknowledged. We need to change societies views about who and what we are.

We need to encourage positive PWU/ID role models to be seen by the media and be written about in a positive light.

The only way we are going to change views is if people in society see us as human beings.

We need to dispel the idea that people who use drugs have nothing to offer, we have so much to offer and if people could actually be out about their drug use, you would know we are everywhere -in all strata's of society and we have a right to experience the same degree of safety in the workplace as every other worker.

"Women who inject drugs only make up for 15% of clients accessing NSP, and 25% of safe injecting facilities.

When living experience peer workers do outreach, their client contacts are 55% women who inject drugs and this is the same for other peer led approaches like peer networkers..."

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by sex workers, for sex workers

MAUREEN
PEER WORKER
NEW SOUTH WALES

" There are 2 things my AOD colleagues say to me that makes me feel like I am doing a good job; "I never looked at it that way before" and "that hadn't occurred to me."

Q1

Like most people, I would like to leave this planet feeling like I helped make it a better place than it was when I arrived. And working for the rights of my own community, particularly to protect the rights of community members less empowered than me, seemed to be the right thing to do.

I worked for NUAA from the early 1990's into the 2000's. But it is only recently that government AOD services have started to employ peer workers. So doing peer work outside the DUO sphere appealed to me. I think if you really want to change a system, it can only happen from the inside. And after working in harm reduction for so many years, I thought it might be interesting to give "demand reduction" a go, by which I mean, drug treatment services.

My hope is to help PWID/UD who are in

treatment, to not feel so alone and not feel defeated. While everyone's experience of drugs and their drug treatment journey is totally different to the next person's, I think it can help to share common experiences. When someone is in the withdrawal unit at the hospital, and talking about their life spiraling out of control, you can't overestimate the value of a peer worker saying "Yeah! Me too! I did that!"

For a lot of us, it makes damn good sense as to why we use too many drugs, we have been traumatised, neglected, abused, and drugs are great emotional painkillers. But, for some of us, our drug use gets out of control, and causes us problems, and peer workers can help make an incredibly isolating drug treatment experience feel a little less isolating and a little less stigmatising.

Q2

There are 2 things my AOD colleagues say to me that makes me feel like I am doing a good job; "I never looked at it that way before" and "that hadn't occurred to me." and good on the ones who are willing to say that. Peer workers can act as a conduit between staff and service users so that they better understand each other.

Generally, PWID/UD don't trust AOD service staff (and staff often don't trust patients). Part of my role as a peer worker is to let PWID/UD know that the staff are doing what they can within the limitations of the system. In other words, they do care.

Some AOD service users think the people working in AOD are "doing it for the money." I recently witnessed a client who made a young nurse cry. So, I walked over to him and tried to say in a jokey kind of way "Hey, what's going on for you? Are you having a bad day or something?" And the client is now upset, and he says, "I had no idea you guys gave a shit about us...I swear, I had no idea." I thought it was sad that this guy had been treated so badly by the system, that he had gotten that cynical of the people in it.

I think there is a lot of miscommunications on both sides. PWID are scared to be honest with clinicians and clinicians take offence when users lie to them. But it is hard to have an honest therapeutic relationship with a service provider when you know honesty could mean a detrimental outcome for you.

I can show PWID to "navigate the system" and how to self-advocate, and also, what are reasonable expectations. Hopefully through this process people will gain an understanding of the system, and also learn that they can trust it for the most part, but also learn how to manage your own personal goals when they are in conflict with the stated goals of the treatment program.

For example, if I meet a PWID/UD who is telling me that they are not ready to stop using drugs yet, but they are on suboxone because their drug use became unmanageable, I feel that they have been forced into an impossible, and potentially risky, position. People feel pressured to tell their family and treatment providers that they "never want to use drugs again," so suboxone appears to be a logical choice. Most OTP clients are receiving buprenorphine products rather than methadone, making the use of opioids a fraught proposition, with timing and lack of tolerance being just two factors to consider. Ultimately, methadone is the better choice for someone still using opioids but it seems that suboxone is pushed instead.

Q3

Upper management are supportive of peer workers in AOD as they put the role in place. But peer and consumer workers are managed by middle management, who are often clinical staff without a lot of knowledge of allied health workers, let alone peer workers. They tend not to see the value in peer work, and they don't know how to manage peer workers.

And when they finally gain an understanding, they leave the role, and the peer worker invariably starts over with a new, inexperienced manager.

Some staff who work in drug treatment do not have a nuanced understanding of harm reduction or peer work principles. They do not recognise the value of peer or consumer workers as the service existed without them previously. All AOD staff need to attend ongoing training about the role of peer and consumer workers and why they are important. Training in AOD is often lacking prior to people joining the AOD workforce, for example, it is not covered well in nursing. This means that some staff begin their AOD careers with information gleaned from high school drug education, the media and friends and family. Job descriptions in the AOD field should include a competency related to a commitment to peer work and to supporting, and undertaking, consumer participation activities.

Q4

Drug User Organisations were funded in most states/territories in Australia the late 1980's and 1990's in response to HIV. And then in the late 1990's we started seeing jobs for mental health peer workers, usually a day a week, based in hospitals or within a local health district. The AOD field was very late in coming on board with employing peers within local health districts in NSW, and these jobs have really only come into existence over the last 10 years or so.

Public AOD services in NSW have mostly followed the mental health model for peer workers and employ a team of peer workers working 1 day a week. This helps ensure that the peer workforce is representative of as many people and issues as possible. Another option for AOD services is to employ fewer peer workers, but for more days per week. While this might result in a less representative peer workforce, it gives the peer or consumer worker the opportunity to become involved in more time-consuming activities such as contributing to policy development and co- designing research projects. Ideally, it would be great to have a team of peer and consumer workers who could cover all the above-mentioned activities and be managed by someone with lived experience.

And, as an aside, "Consumer participation" and "peer work" are often used interchangeably though they can be quite different. Peer workers help people to achieve their goals throughout their patient journey. Consumer participation workers aim to ensure that the consumer perspective is represented in service planning delivery and evaluation. It would be great to have a team of peer and consumer workers who could be representative of different client needs and contribute to policy

Q5

Workplaces need to support peer and consumer workers in many ways that are currently lacking. If peer and consumer workers are paid to draw on their lived experience as part of their work, what happens if that "lived experience" becomes problematic? Surely the workplace has a duty of care towards peer workers, especially if the workplace has contributed to triggering a period of "instability?" Peer workers also deserve an Award rate of pay similar to the Health Education Officer award, and ought to have relevant degrees recognised.

"It is hard to have an honest therapeutic relationship with a service provider when you know honesty could mean a detrimental outcome for you."

YATIE
PEER LEADER MALAYSIA

"It's not easy to reform drug policies, it involves moves on a jurisdictional levels, Drug law reform -also at a high level, its hard, so the least that I can do as a drug user myself, in my community is to advocate amongst my immediate friends & network that I can reach to. Things like sharing safer using info or overdose education or having spare new needles and other equipment to give out if someone needs. The very basics of harm reduction. To work to save our lives, those who are using drugs- and being forced to use in harmful ways.

Rather than trying for bigger things and feeling like nothing really helps. this is the least I and we can provide our own local communities."

Q1

There's no money can buy living experiences. Being a person who has living experiences in a managerial position is critically important in lots of situations specifically in the agency's/organisation's strategic planning that includes the implementation, the monitoring and evaluation process. Not forgetting the passion and commitment from those individuals with living experiences will help the agency/organisation to achieve its goals by creating a comprehensive and needs oriented approach.

Q2

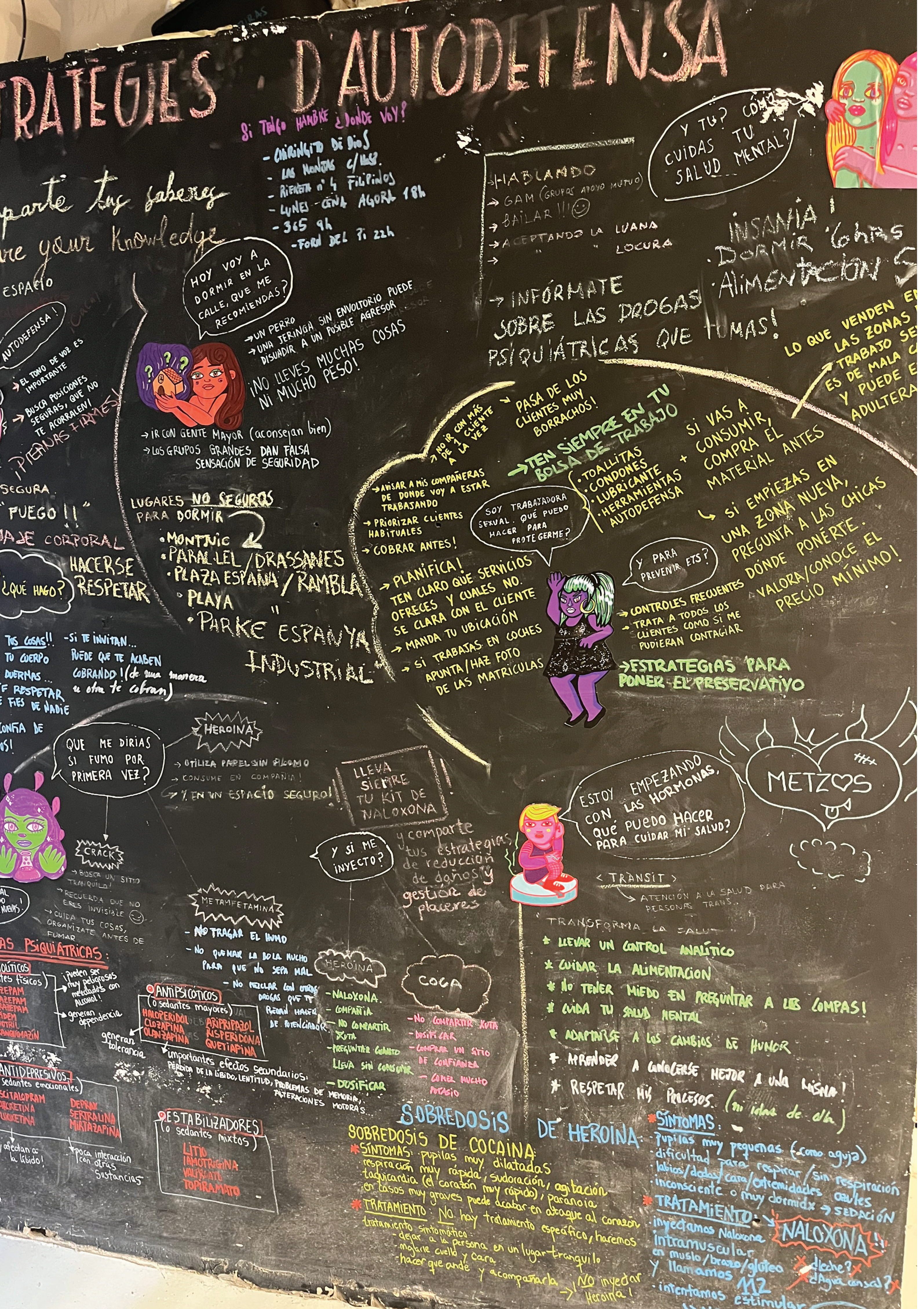
Being able to bring a few people abroad to attend regional/international meetings and conferences. That's actually what I've experienced with my former colleagues. How those precious first-time regional meetings opened my mind and eyes and I take it as a lesson that I will definitely repeat by sharing it with my current newly met colleagues. Hoping that it will inspire them to do the same in their respective years working.

Q3

Yes, I had been working with the biggest HIV NGO in my country for around 3 years, my substance use didn't stop me from working. Unfortunately, due to my own principles, I had been digging into the organisation transparency issues and how funds were being allocated for redundant work and being vocal in supporting the grassroots organisation rather than the organisation itself, I was sidelined by the top management by not renewing my yearly basis contract. Note that there's no way any agency/ organisation want to recruit me over 45yrs & also a substance user to work at companies.

Q4

As a person who is using substances, I've been proactively pushing myself to get any tasks done even if I have to work late nights. Being punctual in any work schedule is the way I show others I'm doing my hardest in supporting and complementing the organisation's objectives. Hence why there's so much more we can do in the future from the mistakes that we have gone through. Creating a non-judgemental workplace and to create more opportunities to increase capacity will help the organisation grow. The goal is to utilise the resources at its best which will get ROI from there. I'm open about everything to my family members and friends, my colleagues -all are well informed about my everything as the first thing to do and seeing how I lived on without being a burden to anyone actually reflects as my personal accomplishment that I used to brag about with everyone around. "



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- Riereta nº 4 Filipinos
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- 365 9h
- Forn del Pi 22h
...parte tus saberes
...re your knowledge
Y TU? ¿CÓMO CUIDAS TU SALUD MENTAL?
HABLANDO
GAM (grupos apoyo mutuo)
BAILAR!!
ACEPTANDO LA LUANA LOCURA
INSANIA!
DORMIR 6hrs
ALIMENTACIÓN S...
INFÓRMATE SOBRE LAS DROGAS PSIQUIÁTRICAS QUE TOMAS!
LO QUE VENDEN EN LAS ZONAS DE TRABAJO SE... ES DE MALA C... Y PUEDE E... ADULTERA...
HOY VOY A DORMIR EN LA CALLE, QUE ME RECOMIENDAS?
UN PERRO
UNA JERINGA SIN ENVOLTORIO PUEDE DISUADIR A UN POSIBLE AGRESOR
¡NO LLEVES MUCHAS COSAS NI MUCHO PESO!
IR CON GENTE MAYOR (aconsejan bien)
LOS GRUPOS GRANDES DAN FALSA SENSACIÓN DE SEGURIDAD
LUGARES NO SEGUROS PARA DORMIR
MONTJUIC
PARAL·LEL / DRASSANES
PLAZA ESPAÑA / RAMBLA
PLAYA
"PARKE" ESPANYA INDUSTRIAL
AUTODEFENSA!
EL TONO DE VOZ ES IMPORTANTE
BUSCA POSICIONES SEGURAS, QUE NO TE ACORRALEN!
¡PIERNAS FIRMES!
SEGURA
"FUEGO!!"
...JE CORPORAL
¿QUÉ HAGO?
HACERSE RESPETAR
NO IR CON MÁS DE 1 CLIENTE A LA VEZ
PASA DE LOS CLIENTES MUY BORRACHOS!
TEN SIEMPRE EN TU BOLSA DE TRABAJO
TOALLITAS
CONDONES
LUBRICANTE
HERRAMIENTAS AUTODEFENSA
SI VAS A CONSUMIR, COMPRA EL MATERIAL ANTES
SI EMPIEZAS EN UNA ZONA NUEVA, PREGUNTA A LAS CHICAS DÓNDE PONERTE.
VALORA/CONOCE EL PRECIO MÍNIMO!
AVISAR A MIS COMPAÑERAS DE DONDE VOY A ESTAR TRABAJANDO
PRIORIZAR CLIENTES HABITUALES
COBRAR ANTES!
SOY TRABAJADORA SEXUAL. QUÉ PUEDO HACER PARA PROTEGERME?
Y PARA PREVENIR ETS?
CONTROLES FRECUENTES
TRATA A TODOS LOS CLIENTES COMO SI ME PUDIERAN CONTAGIAR
PLANIFICA!
TEN CLARO QUÉ SERVICIOS OFRECES Y CUALES NO. SE CLARA CON EL CLIENTE
MANDA TU UBICACIÓN
SI TRABAJAS EN COCHES APUNTA/HAZ FOTO DE LAS MATRÍCULAS
ESTRATEGIAS PARA PONER EL PRESERVATIVO
...TUS COSAS!!
...TU CUERPO
...DUERMAS...
...F RESPETAR
...E FIES DE NADIE
-SI TE INVITAN... PUEDE QUE TE ACABEN COBRANDO! (de una manera u otra te cobran)
QUE ME DIRÍAS SI FUMO POR PRIMERA VEZ?
HEROÍNA
UTILIZA PAPEL SIN PLOMO
CONSUME EN COMPAÑÍA!
Y EN UN ESPACIO SEGURO!
LLEVA SIEMPRE TU KIT DE NALOXONA
CRACK
BUSCA UN SITIO TRANQUILO!
RECUERDA QUE NO ERES INVISIBLE
CUIDA TUS COSAS, ORGANÍZATE ANTES DE FUMAR
Y SI ME INYECTO?
y comparte tus estrategias de reducción de daños y gestión de placeres
METANFETAMINA
NO TRAGAR EL HUMO
NO QUEMAR LA BOLA MUCHO PARA QUE NO SEPA MAL
NO MEZCLAR CON OTRAS DROGAS QUE TE PUEDAN HACER DE POTENCIADOR
HEROÍNA
NALOXONA
COMPAÑÍA
NO COMPARTIR RUTA
PREGUNTAR CUÁNTO
LLEVA SIN CONSUMIR
DOSIFICAR
COCA
NO COMPARTIR RUTA
DOSIFICAR
COMPRAR UN SITIO DE CONFIANZA
COMER MUCHO POTASIO
ESTOY EMPEZANDO CON LAS HORMONAS, QUÉ PUEDO HACER PARA CUIDAR MI SALUD?
METZOS
< TRANSIT >
ATENCIÓN A LA SALUD PARA PERSONAS TRANS.
TRANSFORMA LA SALUT
LLEVAR UN CONTROL ANALÍTICO
CUIDAR LA ALIMENTACIÓN
NO TENER MIEDO EN PREGUNTAR A LES COMPAS!
CUIDA TU SALUD MENTAL
ADAPTARSE A LOS CAMBIOS DE HUMOR
APRENDER A CONOCERSE MEJOR A UNA MISMA!
RESPETAR MIS PROCESOS (mi idea de ella)
...AS PSIQUIÁTRICAS:
ANTIPSICÓTICOS (o sedantes mayores)
HALOPERIDOL
CLOZAPINA
OLANZAPINA
ARIPIPRAZOL
RISPERIDONA
QUETIAPINA
generan tolerancia
importantes efectos secundarios: pérdida de la libido, lentitud, problemas de memoria, alteraciones motoras.
¡pueden ser muy peligrosas mezcladas con alcohol!
generan dependencia
ANTIDEPRESIVOS (o sedantes emocionales)
...CITALOPRAM
...OXETINA
...OXETINA
DEPRAX
SERTRALINA
MIRTAZAPINA
afectan a la libido!
poca interacción con otras sustancias
ESTABILIZADORES (o sedantes mixtos)
LITIO
LAMOTRIGINA
VALPROATO
TOPIRAMATO
SOBREDOSIS DE HEROÍNA
SOBREDOSIS DE COCAINA
SÍNTOMAS: pupilas muy dilatadas, respiración muy rápida, sudoración, agitación, taquicardia (el corazón muy rápido), paranoia, en casos muy graves puede acabar en ataque al corazón
TRATAMIENTO: No hay tratamiento específico, haremos tratamiento sintomático
- dejar a la persona en un lugar tranquilo
- mojarle cuello y cara
- hacer que ande y acompañarla
NO inyectar heroína!
SÍNTOMAS:
pupilas muy pequeñas (como aguja)
dificultad para respirar / sin respiración
labios/dedos/cara/extremidades azules
inconsciente o muy dormidx → SEDACIÓN
TRATAMIENTO:
inyectamos Naloxona intramuscular en muslo/brazo/glúteo
NALOXONA!!
y llamamos 112
¿leche?
¿agua con sal?
intentamos estimular...

METZINERES

WOMXN ONLY

OVERDOSE PREVENTION SITE & INFO CENTRE

El Raval, Barcelona, Spain

By Nadia Gavin

When we arrived in Barcelona, it felt so different to Paris, where we had just left. Driving away from the El Prat airport you could smell the Mediterranean Sea, the light was so different from north-western Europe, it was lighter, warmer and I know this may sound strange, but it felt way more welcoming. Straight away I exclaimed “I really like it here and I haven’t even gotten out of the taxi.”.

The architecture in Barcelona is beautiful. Even their footpaths are adorned with Flor de Barcelona (Rose of Barcelona) or other patterns. We came around past the port and port authority buildings on our way to the gothic quarter where we were staying. The taxi could only take us so far, because the gothic quarter is made up of very small alleyways that normal sized vehicles just cannot drive down, so we got out of the taxi, said "Gracias" (thank you) followed the driver's rudimentary directions and actually made it to the hostel we were booked to stay in.

Immediately we decided to drop our bags off and go adventuring. Every few blocks there seemed to be a little town or village centre that had restaurants and bars, and bars and restaurants ...so we sat and had a few drinks, people watched, marvelled at our ancient surrounds, ate good food, listened to locals singing and playing music as you would imagine the same way people have for centuries in these same squares and gathering spaces.

We weren’t in any great hurry to do too much that night and being that pretty much all of Europe only gets brown (heroin) that you need to add citric acid to turn it and my veins are long past being able to put crap in them, if it’s not the white, we are accustomed to and being on physeptone, there wasn’t any great urgency to get on, so we chilled and took in the ambience.

Day Two.

Our first full day in Barcelona. We

Photo: Roman walls of Barcelona 4th century

Photo: Village square

Photo Left:
The community Message Board-for harm reduction messages, drug warnings, & other messages

Photo: The main room Metzineres

thought we would go adventuring and eventually find our way to Metzineres. We checked out the local neighbourhood, by then I'd definitely fallen in love with the huge old buildings, their big wooden doors and all the amazing street art everywhere you looked, everywhere you looked there was something beautiful to see- wrought iron balconies, ancient forts from the 4th century, graffiti.... Barcelona intrigued me.

We got to Metzineres and one of their workers was already waiting for our prearranged visit. We all eyed each other off- not recognising each other immediately from Glasgow. But immediately realising we all had a certain 'something' in common and found eachother in no time.

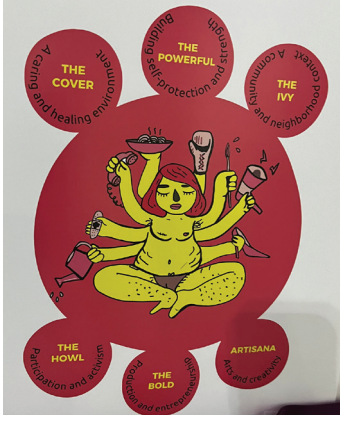
They rolled up the big roller door and in we walked, it was an amazing space that obviously had lots of input by WWUDs (womxn who use drugs) that work in and access the service. We were Introduced as other workers came in. Metzineres is mainly staffed by peer workers. The local community legal service lawyer came in as it was the day that she comes in to offer legal support to the womxn with legal issues.

Metzineres started filling up pretty quick and there were Womxn smoking crack out the back in the courtyard and doing their laundry, we were shown where you could get new sterile equipment and where to inject your drugs.

There was a really nice vibe. A home type vibe.

It felt 'normal'. No stainless steel booths to sit separately in, no nurses in white coats or scrubs presuming to show you how to inject yourself after 30 years of injecting yourself. Some were cooking breakfast, some just checking in for the day. Like I said- Home vibes.

We'd been there for a little while, talking to the womxn who spoke some english. I always feel strange that I only speak 1 language fluently, and I hate how english speakers go somewhere else and expect those residents to speak english when the visitors don't really try to pick up the language of the country they're in.



We tried furiously to communicate using a translation app, struggled as we butchered the spanish language, but worked out what the going cost of cocaine per gram was and sussed out , via some peer workers who recommended the most appropriate service user to ask that wouldn't rip

us off.

We stepped outside away from the service and asked our trusted person, a trans woman a year or 2 younger than Sam & I, that I will call N, if they could score for us, none of us really being able to communicate the best, it was pretty funny, but we managed to convey what we wanted, how much and that we would give them enough cash to make sure they were going to be sorted as well. We continued to find out about Metzineres how it started and future plans. Some of the gals were trying on outfits and general socialising with each other, it didn't feel like a service, it felt more like a mate's house and you could tell the womxn that accessed the consumption room, felt they had ownership inside those 4 walls, I loved the vibe, everyone was really accepting of each other in this shared space.

Photo: Mama-im fine.


Photo: View from our hostel

I guess it worked out as N came back and wanted to shout us a shot as well, so we spent the next hour or so chatting, well it actually was more like charades, had a few shots with N, she was pretty surprised that we were both long term WWIDs & used both heroin & cocaine on the regular, had jobs and were able to travel overseas, later I realised I probably should've said that we were both on methadone and that allowed us the opportunity to travel, N thought we were the nicest people that they had met in a long time. She also warned us to be careful of some of the other women as they were starting to talk about us and thought that as travellers we had money and were drug tourists. I don't ever begrudge peoples opportunism, it is a hard life and being a street user is even harder. But all in all, we had a great time the day we went to check out Metzineres.

Barcelona was my favourite place we visited on this trip, and I really want to go back again someday and see more of the architecture and the street art that brings the city alive but most of all if given the opportunity I would love to do some work with Metzineres, I love that this safe consumption room isn't based on a medical model, it is a peer led model, so doesn't discriminate against us like many medical model, safe injecting facilities still seem to.

Metzineres is a non-profit cooperative based in the neighbourhood of El Raval (Barcelona), which provides sheltered environments for womxn and non-binary gender people who use drugs. Their mission is to promote communities that guarantee full access to the rights, well-being, and pleasure of womxn who are surviving violence, intersectional vulnerabilities, and that are affected by the war on drugs.

As you may have noticed Metzineres use the word womxn to make cis & trans women visible as well as people of fluid and non-binary gender, I have chosen to use womxn in solidarity with Metzineres in this article.
Their approach states:

"In the face of a war on drugs that continues to result in the widespread and systematic violation of the rights of womxn who use drugs, and who survive multiple situations of violence and vulnerability, Metzineres works for justice based on three cross-cutting themes: Intersectional feminism, embedding peers & harm reduction."

I just want to focus on the fact that they embed peers, and this is what they say about why,

"Because people directly impacted by the war on drugs are experts in their realities and therefore must be an essential part of the design, implementation, monitoring, and evaluation of all those policies and practices that condition their life paths".

I found the quote below on their website, and I don't think there has ever been a saying that resonates so much with me as a peer.

"Never doubt that a small group of thoughtful committed citizens can change the world: Indeed it's the only thing that ever has"
-Margaret Mead

If you are ever in Barcelona and are a WWUDs it is definitely a safe comfortable space to check out.

Metzineres is open 6 days per week 2-9pm most days except for Tuesdays when it is open from 4-9pm and is closed on Sundays.

Check out their website- https://metzineres.org or email metzineres@metzineres.org

"Because people directly impacted by the war on drugs are experts in their realities and therefore must be an essential part of the design, implementation, monitoring, and evaluation of all those policies and practices that condition their life paths".

ELE
PEER LEADER
AUSTRALIA

Q1

There are loads of reasons why having living experience is important for management and leadership as well as peer roles. In my experience, people who have personal experience are more likely to employ peers even in non-peer roles, can have honest and supportive relationships with peers working with them, and are able to demonstrate to other managers, staff and people who use services that people who use drugs are capable of doing different roles within an organisation including management roles. There are still a lot of people who believe people who use drugs can't be trusted.

Q2

PWUD in management have a lot to offer, not just to peer workers. We are able to work with people who use drugs in different ways, ways that are truly person-centred. If you've been able to manage illicit drug use and a professional life, you tend to have some good strategies for how to do that. You also know it can be done. I've noticed a lot of managers think supporting peer workers involves a willingness to talk to them about going into rehab as soon as they mention current drug use.

Q3

I've worked in drug user orgs and mainstream orgs so the cat is out of the bag in terms of my "history" of drug use. I've not really ever hidden my drug use from colleagues. But at the same time, in many of the mainstream organisations where I've worked, I've found it safer to let people assume what they want to assume unless it was someone I trusted who I thought would benefit from knowing more about me. In most cases, that is people from our community. I definitely wouldn't recommend telling everyone about current drug use in workplaces because it leaves you very vulnerable. The minute you look tired or annoyed, people start talking about their "concern" for you and your drug affected state. And that's the best-case scenario.

Q4

I would really like to see changes to the way we recruit PWUD in the workplace, with recognition of the barriers faced by people with criminal records and periods of time where they haven't worked. We can develop position descriptions and roles that are less discriminatory including peer specific roles, but also, we can be much more proactive in encouraging people from our community to apply for a range of positions. There are people using our services and in our community who would be brilliant if they were given a chance.

I also think we can do more to support peers when they are working in services, whether that be finding other peers who they can work alongside, support peer workers, whether they are in identified peer roles or not, to develop networks within the service and in other services, provide peer supervision and get their ideas for what they think will help them in their work.

Finally, managers can do more to make sure peer workers are treated well by their non-peer colleagues. We can provide training for other workers about stigma and discrimination and the value of peers and have zero tolerance for stigmatising comments and practices. If we make it clear peers are equal to "non-peers" employed in the organisation, and make sure peers get the same opportunities for training and movement into other roles if they want to, a culture of safety where stigma and discrimination is called out will create a better environment for all the workers and the people who use the service.

EMMA
PEER LEADER
QUEENSLAND

Q1

The benefits of including the living experience voice in program design and delivery are well documented and are finally being reflected in best practice models. The inclusion of this voice in policy development, managerial and leadership roles has also been proposed in the literature, though has yet to be adopted widely in Australia. Without the ability to contribute at these levels the inclusion of the living voice can be seen to be simply tokenistic and without the influence required to make the necessary and sustainable changes our organisations require. The voices of our community are an important component in bringing about change though if they cannot be heard at all levels there is not likely going to be any real change.

Q2

I bring my own experiences and understanding of a system that discriminates against PWUD. I also bring the experiences of stigmatisation and vilification from the community that QuIVAA represents. This informs my work practice and motivations as a CEO and helps to guide my decisions around how to best advocate for this community. This experience does not provide anything more than an authentic understanding of the community I work to represent, and an ability to readily identify practices that perpetuate the stigma they face.

Q3

The focus on people's experiences with drugs, or eliciting their story, begins to define us by our drug use rather than as individuals with valuable contributions to make. This has, and can, lead to further stratification and fracturing amongst our community. I believe that no one person can represent the complete diversity of people who use drugs, rather I believe that an individual's unique journey is important and should be valued equally whatever their story. The focus needs to be drawn towards a person's acceptance amongst their community. Peers should be able to demonstrate their participation within this community, recognising that it is these bonds and shared experiences that is what provides value, rather than their story. As the CEO of QuIVAA, I bring an extensive personal history of living experience with drugs, though this story is one that I share sparingly and only when there are specific benefits in doing so.

Our community is still the most stigmatised population in the world. Despite the recognition that the policy landscape here in Australia has contributed to this and despite awareness and changes slowly being made, this stigma is still pervasive across the wider community. It is demonstrated everyday across the media and through the rhetoric of political leaders. It is further reflected in the direction of funding made available to the sector and the unwillingness of governments to fund peak peer bodies representing drug users as they would other sectors. I know firsthand that many individuals with living experience of drug use already successfully occupy managerial or leadership roles outside of the AOD sector. Though I do not believe that many could declare or 'out' themselves without the associated stigma impacting on their current or future roles. Unfortunately, this means that many valuable voices remain silent in challenging the stigma we face.

Q4

My work with QuIVAA has been extensively advocating for reform at

QMHC advisory council, on Qld AMA advisory boards, through multiple submissions and input at sector reform meetings. This has contributed to the recent law reforms here in Qld with the introduction of expanded diversionary measures and approved drug testing facilities. Continued advocacy remains at the core of our work here at QuIVAA and we continue to call for further reforms to challenge the stigmatisation and discrimination that our community face.

We are conscious of the inherent dangers that AOD peer workers face in the workplace and as an organisation we are actively providing measures that work to ensure the safety of this valuable workforce. QuIVAA offers a range of peer supervision services including evidence-based peer to peer professional supervision and a community of practice space for lived/living experience workers where they can reflect on the challenges and success they encounter in their roles. As this sector continues to develop we will continue to advocate for the best practice approach of ensuring all LLEW are offered external peer supervision.

ESHA
PEER WORKER/LEADER QUEENSLAND

PEER LEADERSHIP ROLE

Q1

I think it is very important to have peers in these roles because we are the best to understand and relate to peer as staff.
Also, to be able to advise and teach non peer staff on how to work with peers.

Q2

The way we manage staff, how we communicate etc

Q3

I have always been out as a PWID, but I think it would be really hard to find a job being a person who is out about this!!

Q1 PEER WORKER ROLE

Being a peer worker mean a lot to me, being able to connect to my community with no judgement, stigma and discrimination.

Q2

Peer work are a important part of an organisation and to our clients. Being able to connect to client in a way that feels normal to them. Because most peer workers understand as we have walked in their shoes.

Q3

Our organization has a group supervision once a month for all identified peer roles and staff using there lived experience in their work.

Q4.

The climate for peer works where I work is developing, we have employed a peer to develop the framework for peers at our organisation.

Within Australia the climate for peer works is expanding, in some states they are great with having organisation with only peers working for them.

Q5

What I have put myself out there by doing lived experience talks at national and international conferences. Got myself on our national peak bodies board of directors (AIVL). Joined any advisory panels or committee to advocate for PWID etc

CULTURAL SENSITIVITY WARNING

Aboriginal & Torres Strait Islander readers are advised that the following article/post contains images and names of people who have passed into the dreaming.

VERONICA'S STORY

By Meghan Fitzgerald, Special Counsel, Fitzroy Legal Service
with the Blessing of Veronica's mum Aunty Donna Nelson
and Veronica's partner Uncle Percy Lovett

Veronica Nelson, a proud Gunditjmara, Dja Dja Wurrung, Wiradjuri, Yorta Yorta woman, died whilst on remand in a woman's prison on 2 January 2020.

Her charges were minor and non-violent.

On 30 January 2023, Coroner Simon McGregor published his decision following a lengthy inquest into Veronica's passing.

He determined the cause of Veronica's death to be 'complications of withdrawal from chronic opiate use and Wilkie Syndrome in the setting of malnutrition'.

Veronica weighed 33 kilograms at the time her passing, and had used the intercom 49 times to request help.

He determined her death was preventable.

Coroner McGregor also found that, had the recommendations from the Royal Commission into Aboriginal Deaths in Custody 1991 been successfully implemented,

Veronica's passing would have been prevented.

Background

When Veronica Nelson died in a prison cell on 2 January 2020, picked up on shop theft allegations, a gaping hole was torn in the heart of Collingwood, Melbourne, and in all of the Countries where her family and community live.

Rumours travelled quickly of her cries for help before she passed.

When the announcement was made in the papers some months later that she had died from a rare disorder "Wilkie Syndrome", no one believed it. Intuitively the collective belief from where I stood was that she had been in rapid forced withdrawal, and that the prison had treated her as they do; as a person to be punished and denied treatment because of the criminalisation of her health condition, substance dependence.

"**The hole Veronica left has not closed. She is not forgotten, and what has happened never will be. I want to pay respects to her mother Aunty Donna Nelson, partner Uncle Percy Lovett, her family, and her community.**"

Veronica lived in the same neighbourhood I live in. I would see her most days buying smokes or milk or whatever she needed.

Then she was gone.

The visceral loss and mourning continues because of the gravity of the injustice. Veronica was greatly respected as a holder of culture, stories, principles, and kindness. I would look out my window and think of Veronica's death for shop-theft, assumed to be driven by drug use, and consider all that had been taken from her – all that she may have been trying to forget or manage.

The injustice of our justice system knows no bounds. Sitting on and exploiting stolen land under legal sanction, with no recompense or genuine reckoning, Country scarred by generations of massacres, the violence of being dragged on and off missions, peoples collectively denied the right to practice language and culture, generations upon generations of children taken into institutions – experiencing all manner of harm – and now, the traditional and rightful owners of this country are the most imprisoned population in the entire world.

There is a pathological denial and shame that continues to drive the war on First Nations people, including through the war on drugs. It enables a collective and bloody mindset that is homicidal, genocidal, and profoundly immoral, keeping our society sick to the core.

Coroner's Court proceedings

The coronial jurisdiction is a truth-seeking jurisdiction led by families of those who have passed away, predominantly in the custody of the state. The Coroner is empowered to make findings of fact, comments, and recommendations. There are two key features to the Coroner's role: firstly, to reveal and speak to factors that played a role in causing Veronica's death; secondly, to recommend changes to systems operations, practice, policy, and law that could prevent future deaths.

"That Veronica was separated from her family, community, culture, and Country at the time of her passing is a devastating and demoralising circumstance."

Coroner Simon McGregor,
30 January 2023.

As an independent intervener, Fitzroy Legal Service ('FLS') were not directly instructed by Veronica's senior next of kin and were confined n our role to systemic concerns and prevention matters. Because of the risks associated with the intervention, I sought the counsel of local elders through talks with Uncle Frank Hayes (Veronica's

uncle), the late Uncle Jack Charles, and the late Aunty Viv Malo, each of whom carried deep knowledge of intersectional discrimination and associated harms.

FLS is grateful for their guidance. The application ultimately filed as an interested party was supported by Veronica's senior next of kin and was unopposed by any parties in the court proceedings.

What FLS did:

FLS was given standing as a result of our drug outreach lawyer program (which has operated for 21 years), our prisoner legal advice clinic (which has operated for 25 years), and our 'women transforming justice' program, which involved a leadership program of women with lived experience of imprisonment, driving our work on gendered injustice. FLS had also recently published research on the specific drivers of incarceration for women,1 and holds deep knowledge of the specific ways in which legal processes disadvantage people with complex and multiple health conditions (inclusive of substance dependence), socio-economic deprivation, and severe trauma first-hand and intergenerational. As such, FLS was able to contribute in its' capacity as a legal service with unique long-term harm reduction expertise in the justice system.

Within our harm reduction mandate, we felt it was critical to share our knowledge and expertise on intersectional discrimination and stigma, stigma against people who use drugs (PWUD), the contextual drivers of criminalisation for PWUD, and the cumulative harms imposed by criminal justice processes, from policing, through to the courts, and into the prison environment. FLS undertook from the outset a framing and use of language that was respectful of PWUD, seeking to integrate and share an overtly de-stigmatising framework through our participation in the proceeding.

FLS was at all times deeply driven by our internal data, which showed the gross over-representation of first nations people and refugees in the prison population (survivors of war) – often on remand because of the 'reverse onus' bail laws and procedural breaches – in the context of homelessness, low-level offending, and highly complex health issues.

FLS briefed a range of experts that included lived peer experience, long-term front-line workers, and Aboriginal elders with a lengthy lived engagement in harm reduction, health, and human rights.

These were:

Aunty Vickie Roach – Yuin elder, poet, author, scholar, and lived-experience expert in the areas of prisons, drug dependence, health care in prisons, intersectional stigma and discrimination, specific processes and impacts of criminalisation on Aboriginal women

Aunty Marjorie Thorpe – Kurnai elder, Djab Wurrung and Gunditjmara woman, previous worker at the Victorian Aboriginal Health Service and Victorian Aboriginal Legal Service, Commissioner for Victoria in the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from the Families, Aboriginal activist, with expertise in the areas of intergenerational trauma, health, and substance dependence

Adjunct Professor Ted Wilkes OA – Noongar elder, long-term director of the Aboriginal Health Service in Perth, champion of Justice Reinvestment, Harm Reduction Australia, previous chair of the National Indigenous Drug and Alcohol Committee, previous board member, Australian National Council on Drugs, member of the National Aboriginal Health Strategy Working Party on behalf of Western Australia, which published its findings and recommendations inclusive of a comprehensive harm reduction framework for Aboriginal communities in 1989

Scientia Professor Carla Treloar, UNSW Sydney – Director, Centre for Social Research in Health, Director, Social Policy Research Centre, Associate, Australian Human Rights Institute, Adjunct Professor, Australian Research Centre in Sex, Health and Society, La Trobe, Deputy Dean, Faculty of Arts and Social Sciences (2019); leading expert in the field of stigma and discrimination experienced

by people who use drugs in the health care and justice settings

Nico Clark MD MPH, MB.BS, GradDipClinEpi, FAChAM – Head of Addiction Medicine at Melbourne Health, Medical Director of the Medically Supervised Injecting Centre, North Richmond Community Health, Melbourne Associate Professor (University of Adelaide), previous Director World Health Organisation Collaborating Centre for Research on the Treatment of Drug and Alcohol Problems, Clinical Director – Drug and Alcohol Services South Australia (DASSA), Medical Officer – World Health Organisation

Adam Wilson – Senior Drug Outreach Lawyer at FLS (6+ years of service with people who use drugs 'PWUD'), accredited criminal law specialist, and executive committee member of the Yarra Drug and Health Forum

FLS is profoundly indebted to the courage and generosity of these witnesses, who gave their time and energy in a highly respectful, focussed, and impactful way.

Findings of the Court

The Court heard from over 50 witnesses. The scope of inquiry included analysis of multiple systems and systemic failures, underpinned, and enabled by laws and policies, and a comprehensive review of the cumulative, compounding nature of discrimination and stigma experienced by people facing multiple barriers to equality before the law.

Coroner McGregor's findings identified that the markers of identity under consideration – gender as a woman, Aboriginal identity, criminal history, and substance dependence - radically increase the likelihood of engagement with criminal justice systems and compound harms at each stage, rather than proffering protection for those affected, in this case with fatal consequences.

Stigma & human rights violations

For the first time in a legal proceeding, the Court, adopted the experience of 'stigma' as a conceptual tool for the inquest.

'Stigma is the result of social power relations, that drive four processes: (a) distinguishing and labelling differences; (b) associating negative attributes to those identified differences; (c) separating and distancing of 'us' and 'them'; (d) culminating in status loss and discrimination. Stigma occurs when elements of labelling, stereotyping, status loss and discrimination occur together in a power situation that allows them.'[2]

On behalf of the Medical Conclave, Professor Treloar expanded the definition of stigma, stating:

'stigma is a multi-level phenomenon that can be embedded in organisational structures and policies, and in laws and media representations (structural stigma); manifest during interactions between people (interpersonal stigma); and individuals can internalise social messages about them or people like them, resulting in feelings of lower self-worth (internalised stigma); stigma towards people with multiple stigmatised identities (intersectional stigma) results in multiple and severe disadvantage; intersectional stigma in relation to people who inject drugs (especially women who inject drugs) and First Nations people is well-described; and stigma has been accepted as a fundamental cause of population health inequalities.'[3]

Coroner McGregor acknowledged that:

'[t]he World Health Organisation has described people who use injectable drugs as the most stigmatised community on the basis of their health condition.'[4]

Findings were made that Veronica's treatment – including the failure to provide treatment – both by medical and corrections staff was negatively influenced by stigma, that stigma was inherent in the Justice Health policies governing her treatment, and that drug use stigma casually contributed to Veronica's passing.

"Normalisation of the suffering of women experiencing drug withdrawal results in the

desensitisation of both Corrections Victoria and Correct Care Australasia staff to this presentation. Desensitisation to suffering rendered Corrections Victoria and Correct Care Australasia staff virtually unresponsive to Veronica's pleas for assistance and blind to her clinical deterioration. They collectively and continually failed to recognise she was in need of urgent medical care. I am satisfied that this phenomenon is evidence of pervasive stigma at Dame Phyllis Frost Centre towards women who use injectable drugs."[5]

Coroner McGregor found the failure to adequately treat Veronica's withdrawal symptoms by medical staff, and her treatment by some prison officers, constituted cruel and inhumane treatment in breach of Veronica's human rights protected under the Charter of Human Rights and Responsibilities Act 2006 (Vic) (the Charter)[6] (This finding has implications in mainstream health settings.)

Coroner McGregor found that, given the greater risk of fatal overdose upon release from prison, restricting access to pharmacotherapy involves a systemic infringement of the protected right to be treated humanely while deprived of liberty and the right to life under the Charter.[7]

It was held that the failings by Correct Care Australasia and Justice Health to deliver health care equivalent to that available in the community and the public health system causally contributed to Veronica's death.[8]

Coroner McGregor also found that the absence of a subacute medical facility in the women's prison (which exist in men's prisons) breached the human right to equality.[9]

Discriminatory impacts of bail laws in Victoria

Evidence was provided to the coroner on the discriminatory impacts of the 2018 reforms to the Bail Act (designed to target violent offenders) on First Nations people, resulting in grossly disproportionate rates of remand – the most egregious of which affect Aboriginal and/or Torres Strait Islander women.[10]

The coroner found there were successive failures to give adequate consideration to Veronica's identity as an Aboriginal woman, and to consider the specific vulnerabilities that should have influenced decision makers to grant Veronica bail, as opposed to remanding her in a prison system which was ill equipped to provide her with the culturally safe and medically appropriate care she needed.

Failures extended from the arresting police to remand procedures, police training, legal representation, prosecutors, to the under-resourcing of the Courts to provide adequate cultural support – infringing the right to equality and cultural rights.

Coroner McGregor found that changes to the Bail Act particularly devastating to PWUD and people experiencing intersectional discrimination and marginalisation, were not compliant with the Charter.[11]

"The criminalisation of bail offences, the reverse onus regime, and the unacceptable risk test have separate and mutually reinforcing effects that increase the likelihood that an accused will be remanded in custody. The effects of are widespread but disproportionately experienced by individuals already marginalised and vulnerable, particularly Aboriginal women. The repercussions include erosion of the presumption of innocence, indirect effects on pleas of guilty and sentencing outcomes, pressure on the legal and correctional systems and entrenchment of disadvantage."[12]

Both Aunty Donna Nelson (Veronica's mother) and Uncle Percy Lovett (Veronica's partner) have asked that the repeal of these laws be called "Poccum's law" in honour of Veronica.

In a clear and determinative ruling for Victoria, Coroner McGregor endorsed that: **'[s]ubstance use disorder is a recognised diagnosable mental disorder. It is a condition that falls with the definition of 'disability' in s4 of the Equal Opportunity Act.'[13]**

– and noted that -

"in the criminal justice system, therapeutic interventions are often coercive, with

'non-compliance' having the potential to contravene court orders and attract further criminal penalties. In short, drug dependence is not universally regarded as a health condition and the correctional system becomes a proxy for appropriate social service supports in the community."[14]

It is now open to advocates to argue that substance use disorder should be a factor weighed in favour of bail, as opposed to a risk factor that might contribute to further low-level offending. Advocacy for treatment within custody equivalent to that available in the community is also supported by Coroner McGregor's findings, particularly with respect to withdrawal and access to opiate substitution therapy.

Looking forward

A range of recommendations have flowed from these findings, and it will be critical for advocates, peers, allies, and the broader community to ensure the government responds meaningfully to measures that can stem the tide of deaths in custody, in particular, black deaths in custody.

We encourage you to lend your voice and experience to the call for justice for Veronica Marie Nelson and in that way honour her life, your own, and pay respects to all those who have lost their lives to the ongoing war on first nations people and the war on drugs.

FLS and I are grateful to Aunty Vickie Roach for sharing her lived experience of criminalisation and incarceration as a cultural expert, an unprecedented recognition by the court of this expertise, and close with her words:

'My story can be regarded as a stereotypical story of an Aboriginal woman in prison. Including how you get there. Or maybe a stereotypical story of an Aboriginal woman during occupation colonisation and genocide.

We are in jail for breaking a white man's law who has no right to be making this law anyway.

Our law should have been the dominant law in this country. Which is why they plead terra nullius, so they can make their own laws and outlaw us. It's like we are refugees on our own country, on our own land. Hunted by coppers. And we remember how our ancestors must have felt as we live through it. They say history is written by the victor. But we have to make our story so big it can't be written out of history.'

MAT
PEER LEADER
UNITED KINGDOM

"I recently visited a drug user organisation undertaking peer-led harm reduction where peer workers were paid $70 per month-

ten years AFTER working in the organisation."

Q1.

Having people with living experience in management and senior management roles is key to sensitising the organisation and ensuring that management understand the work and have the community empathy to support peer workers on the frontline.

When managers have graduated from these roles themselves then this also demonstrates that peer work is an entry point to the staff team and a glass ceiling doesn't exist-that people with living experience are truly welcomed in the organisation

Q2.

I work half-time for two community-led organisations:
1) Project Executive for the European Network of People who Use Drugs (EuroNPUD) - a regional drug user rights network and part of the INPUD global family

2) Managing & Technical Director for Coact Technical Support LTD a peer-led technical support private company.
The two roles allow me to have impact in my country and region while also working globally. My living experience underpins my commitment, resilience and dedication to deliver my roles. It means I have been involved in the initiation phase of 3 drug user rights networks working through the hard set up years when money is short and work is demanding. Glad to be working with organisations becoming more established but understanding of why drug user activists will commit to work that others would see as unfunded, under-resourced or too demanding.

Peer work is something I committed to doing through the P2PNSP / P2PN scheme that I run with my wife with the peers in Bath and championing technically with resources and technical support.

Q3

I came out on a BBC TV documentary in 2001. It ended my career in the NHS and closed down my consulting company training the criminal justice system in Motivational Interviewing. It led me to build drug user rights networks using my NHS management training. I was previously a publicly undisclosed drug user in an NHS organisation that had an employment policy that welcome people who use drugs as employees and valued lived / living experience. The Healthy Options Team in East London was the first in the UK to positively employ people on methadone and active drug users and to foster and work with drug user groups.

Q4

A key advocacy point from the Global Peer Work Consultation was the need to create a proper peer development structures and also to manage work in high-risk settings.

Another Harm Reduction Victoria Initiative

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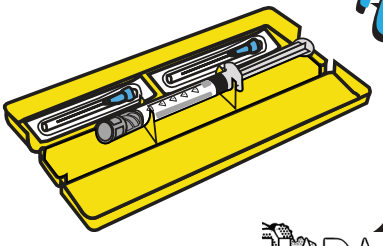

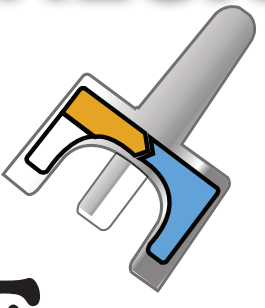

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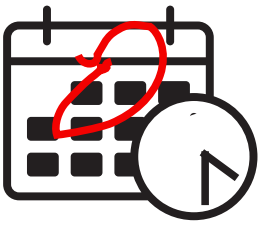

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The Ugly Side of a one dimension 'Peer Workforce'

An experience of 'Peer Support' in Arizona, USA

Written By Danielle Russell & Experienced by Many

As someone who has spent many years as a client at U.S.-based methadone clinics, when I hear the term "peer support", I hate to admit it, but a rather clear and unpleasant image comes to my mind.

The clinics tend to culture and hire a very specific type of individual to work in this role. In fact, fellow drug user activists have even joked with me that the fastest way to find out if someone has problematic personal politics is to just ask them what they want to do for a career, and if they say they want to work in drug treatment, that is a big red flag.

This is not to take away from the very admirable tendency of some folks to want to give back to the community after they have struggled. Emphatically, this is a red flag because of who the clinic generally selects for these roles and the behaviors that they culture and reward in their employees – especially the ones with 'lived experience.'

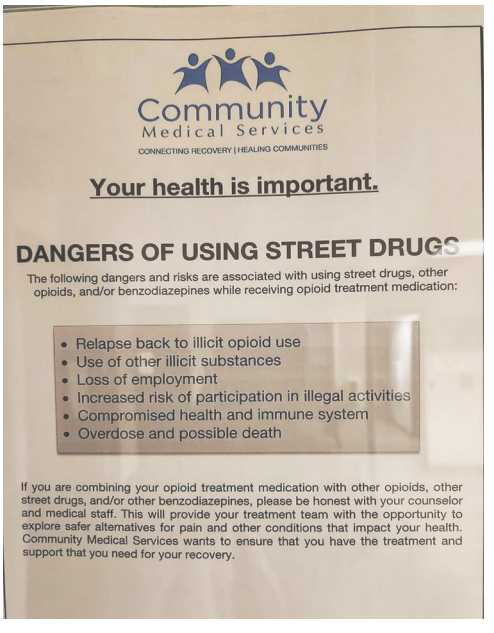
I also recognise that methadone clinics exploit the experiential knowledge of peer workers who are often the lowest paid, lack training, placed under intense pressure, and are denied opportunities for career growth. Hiring 'peer support staff' is one way that clinics pretend that they value lived experience and are "patient centered" without having to actually change anything substantial about their service provision. They deliberately ensure that the peer workers hired are not going to push them to change either.

One way they maintain the status quo of the clinic is by requiring total abstinence from illicit drugs. Not only is this policy unethical, but it is also quite dangerous because it isolates peer workers even more than they otherwise would be. As much as some people really lean into the idea of 100% abstinence, drug use is generally along a continuum – with abstinence reverting to use back and forth over the course of a person's lifetime. But with their job at stake, depending on them maintaining at least a public image of sobriety, peer workers in this situation are often pushed by these sobriety policies into hiding their use and using alone, which increases their risk for an overdose event.

"Hiring so-called peer support staff is one way that clinics pretend that they value lived experience and are "patient centered" without having to actually change anything substantial about their service provision."

The kind of person that the clinic seeks to hire as a so-called peer worker is also someone who can regurgitate a recovery narrative with a clear and uncomplicated transcendent arc – the "I once was lost, now I'm found" story that I know I have also often felt social pressure to perform.

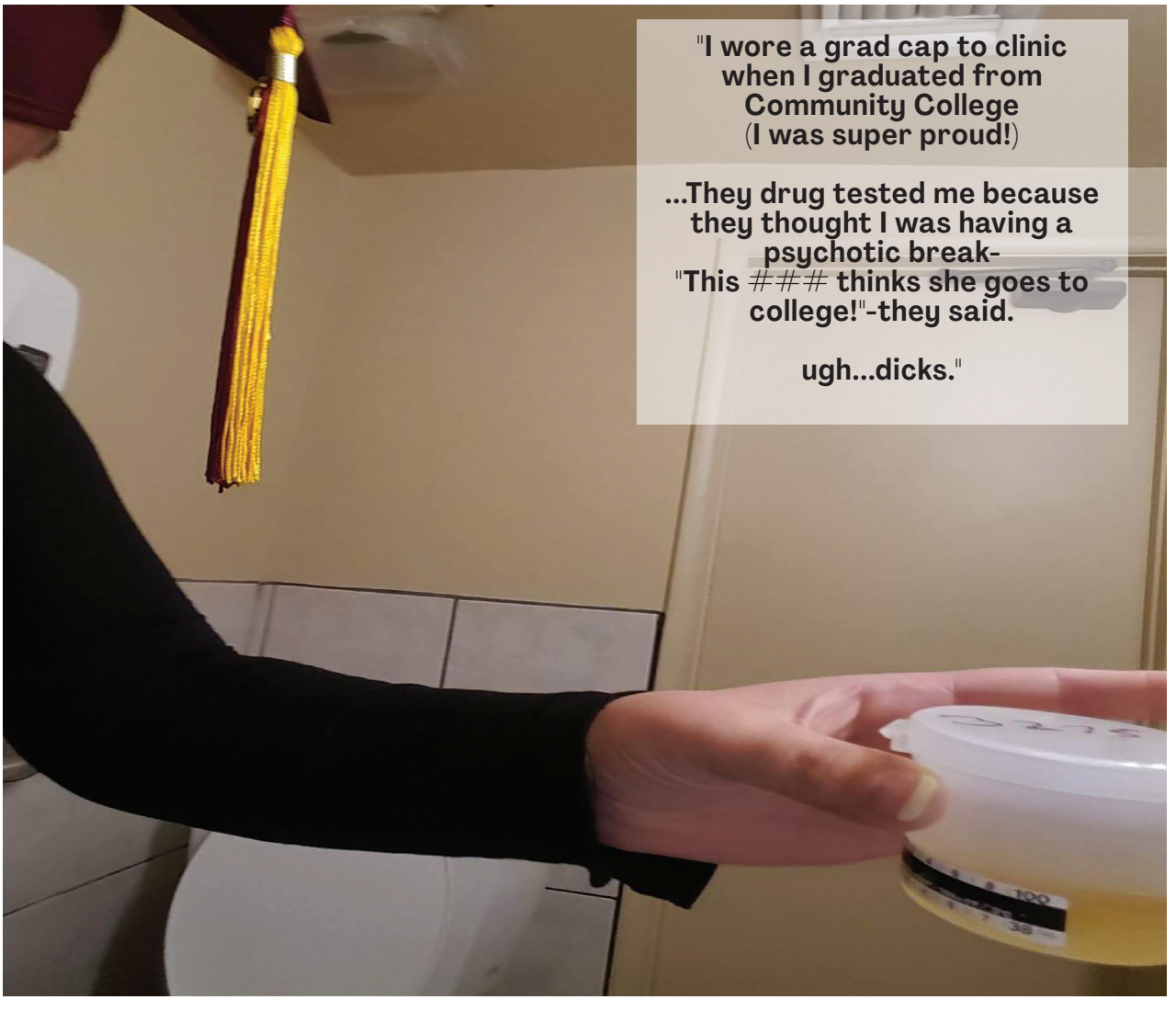
The clinics also tend to want an individual who will generalise their own experience onto everyone else and be willing to serve up shame to anyone who can't seem to fit their life and experience into this tidy recovery narrative. My sense is that because the clinic puts intense pressure on peer workers to project this tidy narrative and image of recovery from a past deviant self into a new, reformed, wholesome self, peer workers in this context also tend to be some of the



most judgmental clinic staff towards individuals who are still struggling with their relationship to intoxicants or who have made peace with their use and are satisfied with a maintenance existence.

"It is not unusual to overhear peer workers at the clinic talking about how "disrespectful" it is for someone who is still using to come into drug treatment spaces whilst obviously under the influence, and also to mock people who use drugs who are experiencing structural violence like homelessness, as if these issues are the inevitable result of their own personal failure to maintain sobriety and not failure of service provision to meet individual needs."

Within a treatment industry that makes no room for any goals other than total abstinence, hiring peer workers who are militantly committed to enforcing rules and convincing others that "one shoe size really will fit everyone" is a priority. Therefore, I am less than enthusiastic when I hear the term "peer support". I also don't want to make the mistake of generalising my own experience onto everyone else, so fully admit that this is perhaps only true for my own very limited experience of professionalised peer support within the methadone clinical setting in Arizona, U.S.A.



Jason
PEER WORKER
AOTEAROA/NEWZEALAND

Q1 I feel really fortunate to have the opportunity to work as a peer for the Needle Exchange Services Trust, which is part of the New Zealand Needle Exchange Programme as the National Harm Reduction Lead. Working in the harm reduction space as a peer is quite unique in that my lived experience using/injecting drugs and all that entailed is considered highly desirable, useful experience, rather than it being a negative thing to hold against me like most of mainstream society would view it.

I came to work for the NZNEP 17 years ago, initially by way of a 400-hour community service sentence for importing drugs for my own use. I already had a long list of convictions for drug related offending at that stage and it limited my employment options. After completing my community service I had the opportunity to volunteer as a way to get out of the house whilst on home detention, which was also part of my sentence. Eventually volunteering turned into a part-time job and now 17 years later it's become a career in peer-based harm reduction. I've continued to work in this role because I get the chance to use my lived experience to contribute to a service that makes a difference in people's lives. People will always use drugs, it's important that people can be as safe as possible in doing so and working in peer-based harm reduction helps keep people safe, it saves lives, and that's really important.

Q2 Peer workers can connect with people who use drugs in ways that others can't. Some things simply can't be learnt by reading a book, you've either done it or you haven't. People who use drugs are such a stigmatised, discriminated against group of people, we often don't trust health professionals who are often one of the sources of stigma and discrimination, when you talk to a peer worker you don't have to fear being judged, stigmatised, or discriminated against, they can provide insights and understand things in ways that other people can't.

When I was considering going onto OST, I asked the peer workers at the needle exchange about it, not my GP. My GP was completely against OST, and only supported abstinence-based approaches, which I wasn't interested in. Peer workers at the NEP were the best source of information because they could speak from experience!

Q3 Yes, I have access to supervision or coaching, if I wished I could find a peer to provide that support.

Q4 The New Zealand Needle Exchange Programme is peer-based, we estimate that approximately 90% of our staff either do or have injected drugs. As such, the climate within the NZNEP is very supportive of peer workers, it's a cornerstone of the program. More broadly New Zealand is going through a period of growth in peer-based roles within the drug & alcohol sector. Lived experience is increasingly being recognised as legitimate and valuable experience. Overall, the climate is pretty supportive of peer workers, though it is still developing, and many services don't really know how to make the best use of peer workers, so we still get a bit of tokenism, where a service employs a peer-worker because it's the fashionable thing to do but they don't know what to do with them. It's important that we continue to educate people on the importance and benefits of peer workers!

Unfortunately, as using drugs is still illegal, it's not always that easy to be open about currently injecting or using drugs. Overall, in New Zealand as a whole, I would say that there is much greater acceptance of peer workers who are perceived to be abstinent from using drugs than there is of peer workers who still use drugs. For people on OST it can be difficult, as OST services can be somewhat punitive, for example, if a peer worker was really open about using drugs whilst on OST, they might find that they lose take-home doses all of a sudden.

Q5 I think as much as possible, if and when safe to do so people who can, should talk about using drugs, and why they use drugs. People need to understand that people use drugs for all sorts of reasons and that they aren't just negative reasons. There needs to be a shift in the narrative to focus on some of the "benefits" of drugs use as all too often drug use is viewed as something people do for negative reasons. I think more effort needs to be put into gaining support from the average person in society, often advocacy efforts are wasted on those who are already supportive. We need to continue to humanise people who use drugs, people need to see them as regular everyday people, not just some stereotype you saw in a movie.

Peer workers should be safe in their workplaces, they should be able to freely talk about their lived experience without fear of being stigmatised or discriminated against. I think there needs to be focus put into educating organisations on the benefits of peer workers and why their experience is valuable. Organisations that employ peers need to have supportive policies in place that support peers if they are struggling. Good employers will acknowledge that sometimes peer workers might struggle with their drug use and peers need to know they can be honest about things with their employer without getting fired or told to harden up.

KOKETSO
PEER WORKER/ LEADER
SOUTH AFRICA

Interviewed By Nadia (Fuse Initiatives)

N- What does it mean for you to be a peer worker?

K- "For me being a peer worker currently means everything to me. Because it has given me a second chance at life where by before there was no hope, because everyone had thrown in the towel on me, so now I am able to make a positive impact and a positive difference in my community.

I love being a peer worker because I can help people in similar situations that I went through.

N – So you have pretty much said why you do the work and community is a pretty important thing for us. Being able to share the things that we have learned. Do you have a specific role based around a specific topic or do you do everything?

K- "Previously I used to be a peer educator in an organisation that offers harm reduction services, helping others get OST and psychosocial services, but for the last 2 years I have been working for SANPUD (South African Network of People who Use Drugs) as the Community Engagement Officer- now my role is more advocacy. I am advocating for people who use drugs with specific issues.

Even those peers working at the service where I used to work need support too because we know sometimes when you're working but you are depressed because we are never valued and not getting salaries where we can sustain our lives, people expect it to change, but how will you change when the money you receive to work only covers your transport?!

So yeah I am working for people who use drugs specific issues. I am also a part of the Global Funds CCM, which is the Culturally Coordinating Mechanism because in my country there is civil society forum but no peer led sector. So right now I am in the process of helping formalise the sector and I am also a prevention leader.

N – Excellent. Why do you think it's important that peer workers are involved in the work that we do?

K- "For me I think peer work is an integral part of the work that we do, I think if they had non peers doing what we do it would be of minimal importance but when we are there we can lead with our fellow peers and our fellow peers can look up to us and think "if Koketso can do this so can I " and also be an inspiration to them.

N – Beautifully put.

Before you went to work at SANPUD, when you were in a peer educator role, did the organisation provide you with adequate support by other peers?

K -" The organisation -for me they tried. Even though the harm reduction thing was a new thing in our country, they tried because we had our peer meetings, we had our monthly engagement with a psychologist, so they looked after our mental wellbeing, they tried to get as much as they could from us, they knew to get much from us they had to try because peer education is a new thing in my country, they knew that if we were healthy we would be able to deliver more in our roles so we also had our monthly peer meeting and our peer coordinator used to be Angie.

N – Angela McBride-Executive Director of SANPUD? I met her in Glasgow at the same time I met you.

Now you are at SANPUD do you get external supervision?

K. "Yes previously at SANPUD we used to receive that but currently we don't. A service used to provide it from the Netherlands. "

N. So what is the climate for peer workers in your country? How many organisations outside of SANPUD hire peer workers.

K- "I would say I only know of 3 maybe 4 organisations, yeah!

N. Are you ever asked to provide support to those peer workers?

K- " No, but we do provide training. I do provide support to the peers at the previous organisation I used to work for. Sometimes they may come to me for their specific issues, so recently they were going through a wage dispute with their employer, so I was the mediator."

N-Excellent, so you were giving industrial relations support to the peer workers.

K- "Yes, Yes!"

N - Amazing, so in Australia it is illegal to be a drug user but there has been a push towards living & lived experience peer workers here, but it is basically illegal, is it the same climate for peer workers in South Africa in terms of being an 'out' drug user?

K- "For me, in my own country, at SANPUD it is a lot better than what I have seen at other organisations where it can be dangerous even for the client to say they are using, so everyone is always trying to hide their using, which means peers can end up using in a destructive way. At SANPUD everyone uses freely and there is support there, and what I have seen with their using and our using there is continuity and so even though we are still using we can hold down our jobs. We are 'functional'. So if a peer at another organisation is seen to be using, they will be too scared to go back to work the next day, will say he had some health issues and starts using more. He will end up back on the streets."

N- I think it is similar for a lot of us-especially peer workers working outside of drug user org's. As long as we still have prohibition it is dangerous for us to be 'out' in our jobs- remembering to use apps like Signal or other end to end encrypted apps and being aware of using their work phones -even outside of work hours -as we are under more scrutiny from the police because we are 'out'.

N. Ok last question, so what can you do as an individual or what can be done to flip the current paradigm when it comes to the need for drug law reform?

K- "The thing that's causes the most harm to us as drug users is the stupid drug laws. Prohibition causes more harm to our lives so for me, I will fight for law reform, because what I know is that if the laws change that stigma & discrimination on us will stop and our lives will become much better, we are just like the next person who is on medication but ours isn't tested, so if we could test our drugs and then we would know what we are using, right now they get mixed with these other harmful substances because people want to increase the quantity, so if we can check the harm wont come from the heroin or the coke, it comes from all these factors combined, it is like cancer at the moment with prohibition and if we could just get rid of it our lives would be a lot better."

N. In the time you have been a peer worker have you seen any laws change in SA?

K- "They have decriminalised Dagga (Afrikaans for marijuana) This is the only law that has changed. We are now pushing for decrim for the other substances. Methadone (OST) is now on the essential medicines list."

N – Thanks so much for taking time to let me interview you. Take care.

K- "No problem!"

DANIELLE
PEER WORKER
UNITED STATES AMERICA

While in Scotland for the 2022 Glasgow INHSU conference, Nadia & Sam from HRVic caught up with one of the Jude Byrne Emerging Female Leader Award winners, Danielle Russell from Arizona, USA.

While visiting Edinburgh we figured while we were surrounded by a street scene straight out of Harry Potter or Jack the Ripper that we should hunker down in a gothic graveyard and get the skinny on what it means to be a peer worker in the AZ and find out just what that experience looks like.

N: Do you think there'd ever be potential for peer workers with living experience to be meaningfully employed with appropriate salary and funding in America?

D: It depends, so many of the services that have funding to pay peer workers are so deeply toxic-like I think of my methadone clinic – they talk a good game when it comes to harm reduction, even when I met with their research team to talk about this study I'm working on with people from University in Tucson, we talked about getting patient-centred care at the methadone clinic, and he (the man in charge) said "We already do that." It's amazing because they're so far off from being patient-

centred anything. The fact that they are so delusional they think there's no room for improvement. I think if anyone came in (to work) with good intentions they'd burn out -it wouldn't be fair to the peer worker to have to work in that environment.

N: You did mention there was peer workers, are those people with lived experience?

D: Yeah, they (peer workers) are either people in recovery and very vocal about being in recovery, and often it feels patronising to be an almost 40-year-old woman and have some 21-year-old white boy recovery bro who used heroin for like 2 months and then stopped, that's what it feels like. It feels so condescending the way they implement it, at least in the spaces where it's been offered. Or forced upon me and it's not even an option, they're put around you to use their lived exp more to snitch on you, it's not a support it's more like an intrusion on you.

N: Yeah and it's totally ironic because you said they're harm reduction services but are staffed by recovery [people]
D: Yeah, that's what they call it. And even how they give you Narcan- say you test positive (for heroin) right -they have a checklist and on the checklist they ask you "Do you have naloxone at home?" They say -"we're taking your privileges (takeaways) away and ask if you have naloxone, they're basically fucking you in the ass, taking away your take homes and giving you Narcan. It just feels gross the language they use to talk about it, like access to care is a privilege. And that's how they see it.

S: Do you reckon it affects other peers from being honest about their living experience because the lived exp people in rec are so vocal and full on and gatekeeper about HR?

D: Yeah, I think you would get fired, in those spaces if you were open and you weren't repentant about it, cuz that's what they really wanna see, like even the stories they tell, have to follow this narrative arc of like, was bad, reformation, transform and recover, and if you deviate from that for one you wouldn't get hired. Cuz the clinic grooms a certain type of person, one who won't challenge them,

".. their (peer workers) are usually people in recovery and very vocal about being in recovery.

It often feels patronising to be an almost 40-year-old woman and have some 21-year-old white boy, recovery bro who used heroin for like 2 months and then stopped, declaring to be my peer..."

that's gonna be thankful just to be included or have a job it all. They expect the fact that most, have criminal records and can't get job anywhere else. "Oh, look we're doing this good thing", but they have this captive disenfranchised workforce that they can exploit that's not gonna demand much from them. You can tell they have no upward mobility; they just do peer support and that's it, unless some have high ed, but they have no power to change anything and that's obvious even to me, as a client. They don't tell me jack shit but it's obviously the peer workers are very low in there. Even during covid, the people that were in person

were the people who didn't matter – the clients, peers and front desk staff; the nurses were locked away in a sealed room with no contact, the lower ones just left there.

N: You were talking about the lack of ability to getting new sterile needles & syringes, so where, how far is the nearest service or pharmacy where you could get new equipment?

D: If it wasn't the pharmacy about 45 min from my house. And there's none in the areas were people actually shoot dope. They're really far away. The only one that was peer run just popped up in the parking lot of another service, so its hit or miss whether you get there when they're actually handing stuff out. The other one is an hour away in North Phoenix, and they're also not open very much. You gotta just try the pharmacies that are friendly, or try another one til you find one that'll sell you a 10 pack.

N: So how much do they cost with tax?

D: $3.50. Or you can go to Walmart that's 13.50 for a box of 100, but you have to go to a friendly one. Then there's one place that's always friendly but they charge 8 bucks for 10, I've never tried to buy a case from them

N: So, do you get swabs or prep pads? No water or spoons? With the syringes

D: Just syringes. I didn't even know what the other stuff was for until I was in Sydney, and they kinda explained it. Yeah, I've seen stuff at some of them, but they're not given you. Even if you go to where they're handing it out as only one bag per person, if you ask for them for someone else, they're dicks about it and ask to see them. I was even on their governance board and I couldn't even get extras!

N: SO, you just said you're on the board for a HR service. Are there any other current users on the board?

D: Hold on – one of the lobbyists from the ACLU on the board informed me they were living experience, cuz they'd been to burning man. Like they'd had some mushrooms or something. So I was like yeah whatever, you've been to burning man...

"One of the lobbyists from the ACLU on the board informed me they were 'living experience' cuz they'd been to Burning Man. Like they'd had some mushrooms or something. So I was like , "yeah whatever, you've been to Burning Man... "

N: In the drug user movement globally, we kinda identify Living Experience as being people who currently inject drugs ... I don't know if taking mushies once a year really counts as they can identify with the issues, struggles or barriers for PWID

D: Even the fact that, that person can say this with a straight face... that they've got a similar experience to mine while like I've got pus dripping in my shoe while you tell me this. Like sorry we're not the same, you're gonna go home to your nice house and be safe, they're not gonna get arrested and detox in jail. The fact that's not understood by then is hurtful. Plus their whole board was made up out of a lobbyist, a surgeon, a lawyer, they just want people who can donate money. I feel like I'm the token gesture, like I'm the pottery barn of heroin users, like I'm safe to put on.

N: How did you get put on the board?

D: I read something about HR online, and it blew my mind to know they were doing things like handing out sterile syringes, like I was like we need this! And so I reached out to Harm Reduction Coalition, stuff about HR, I said

I'm in phoenix I don't see this stuff anywhere I can't find stuff anywhere, and they're like oh it's definitely happening in Phoenix, and they gave me the name of … Prevention Works so I sent them a msg, didn't hear back from them, I finally sent them a mean message saying how can you say you're doing this, I've been using here for ages and I've never seen any of it, like just once there were these bleach bottles being passed out from another org called Teros, I've seen the bleach bottles I've never seen any of your shit and finally they got back to me, they started talking to me, and I started talking to the executive director, started volunteering and handing out stuff, volunteering for years. And eventually I realised that everyone else was getting paid, only those of us who were using were volunteering and doing all the work, none of us were paid – and I feel like I ignored all these red flags for so long because I was happy to get stuff and get syringes. But I'd have to drive all the way to Nort Phoenix to get on. And then they started getting more stingy with supplies, still a lot of gatekeeping around access to the resources and stuff.

N: So, when you say volunteer, you mean just volunteer, no stipend, no measly lazy $20 for expenses etc…

D: As a board member I never got paid. When I was co-facilitating the drug user union, I did get a few hundred dollars. And it was for like buying cigarettes to bring, and some was for me, so over all the years I did I probably ended up with $400.

N: Wow. And then I guess you've gotta find other ways to support yourself!

D: Yeah, definitely was like, well once I got disability too it was like I got disability coming in, and my partner pays for most of our living. And most other people had jobs and it was just like a thing that we did. And it's weird cuz it's like the people that don't do the work, it is their job, and those of us that do the work it isn't our job, we have to have other jobs. So, it's interesting

N: I guess it's that community mindedness where you wanna try make things better for your fellow users and people will go above and beyond… so you're doing your PHD a the moment, you've had the opportunity to meet other Harm Reductionists and see what's happening around the world, do you think you'd be able to get support from any donors to implement any changes when you go back to Arizona?

Photo: Fit bin in graveyard, Edinburgh

D: I'm def gonna try especially with drug testing, I'm going to reach out to Thermo who do the FTRs and stuff, testing. I'll see if they'll donate something, don't know if it'll work but that's the plan. That's the issue with OD, we don't have any insight into our drug supply. We have no idea what's in it, especially with Fentanyl, we need to know what we're getting.

N: So talk about drugs in AZ?

Photo: Black tar heroin, Arizona

D: Yeah, we can get pretty much anything, we're right on the border. Depending on where in the city In North Pheonix I see meth, then white people, at uni, fentanyl pills and ecstasy, club drugs, south side its coke, crack and heroin, and Eastlake is pcp and crack. But that's the drug geography of Phoenix!

N: If you were able to do drug testing do you think that southside would be the place that'd be serviced first?

D: that's where I would like. I know the neighbourhood is interestingly conservative, it's like Latino…

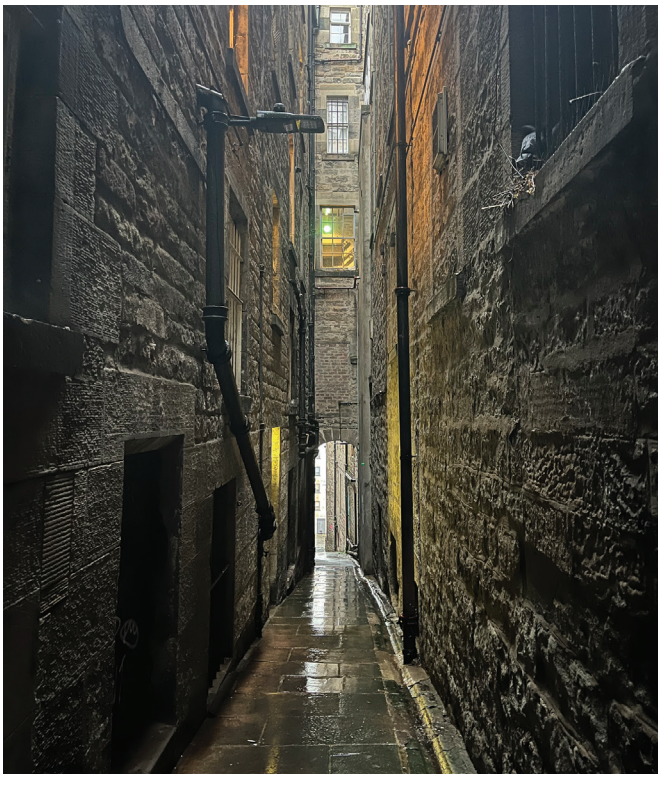
S: Culturally religious and stuff?

D: Yeah, really religious, and that's the excuse services make for not being southside? Like it's a desert for services. And even when I would ask "how come we have nothing

in southside where nothing is", it's like they're waiting for an ambassador to come ask them, they're like we're not from that neighbourhood, but that's where there's a need. That's where I'm gonna be going, like when I moved to Phoenix that's where I moved cuz it was cheap, so that's where all my friends and personal network is still at is in southside there so I'm hopeful that especially people who sell drugs, like smaller scale, maybe they can make better choices about who they buy from, like if they're getting fentanyl, it's 20 cents a hit and they're charging 10 bucks a hit, they can be like fuck that I want heroin, like if its fentanyl fine fentanyl prices.

Everyone: Fuck it's cold, let's go.

Photo: Edinburgh's phenomenal mazes of alleyways



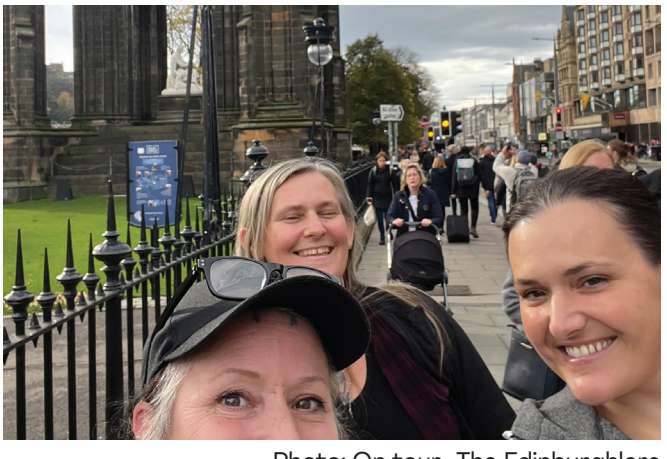


Photo: On tour -The Edinburghlers

LIAM
PEER WORKER
MELBOURNE

Q1

To be a peer worker is to be connected to your community in both a professional and non-professional capacity. It is to have a shared understanding and connection to the culture, joy, pleasure, passion, pain and fear with people you love, trust or can relate to. It is taking your valuable experience and connection and holding it front-and-centre through the bullshit, the bureaucracy, the frustration, the barriers, the stigma, the lack of understanding and advocating for your community's importance, experience, health and rights.

Q2

Peers challenge the moralistic narrative of drug use that was popularised by the war on drugs and persists through many aspects of mainstream health services today. It takes lived experience to truly appreciate and understand the complexity and duality of using drugs. So often are people demonized, stigmatised and humiliated by health workers who believe they know best, yet they become another barrier to accessing the services that people may need. In a health system built by a society that criminalizes PWUD, peer workers are the empathy, the compassion, the understanding and the safety.

Q3

No. I am currently the only living experience peer harm reduction worker at my organization. The supervision and connection I have access to is provided by an external network of peers employed in adjacent roles throughout Melbourne.

Q4

The tide is turning for peer workers in Australia, and living experience is getting the recognition is deserves as a vital part of any health system which includes mental health or AOD. However, there are still serious issues facing the peer workforce in Australia. It is important to continue emphasising the value of differences between groups of peer workers, so as to prevent the homogenisation of peer workers across AOD treatment, harm reduction, mental health and sex work within new 'lived and living experience workforces. Whilst it is important to recognise the similarities between these communities, it is essential to identify the differences in their experiences so as to properly ensure our protection within mainstream health services.

Q5

It is almost ironic to see the similarities between drug law reform and the uptake of peer work happening alongside each other. Both drugs and the people who use them are criminalized, yet similarly have something valuable which those that criminalize want to use. For peer workers, it is their living experience to help improve a broken system... For drugs like MDMA and psilocybin, it is their therapeutic value. For true change to happen, there must be a shift to acknowledge that the absolute majority of harms relating to drug use are due to prohibition and its enforcement throughout every aspect of our society.

For the peer workforce to be protected within mainstream health services, we cannot continue to be criminalised.

For the peer workforce to feel valued for our experience, we cannot continue to be criminalised.

For any long-term and meaningful change, we cannot continue to be criminalised.

LYNN
PEER LEADER IRELAND/EuroNPUD

Interviewed By Matt (Fuse Initiatives)

M: So you were saying you are a peer?

L: I feel like it's a heavy question, a loaded question and one we get a lot in the network [EuroNPUD], and that I have thought a lot about in my life, and because I'm someone who uses drugs and has used drugs in the past, and so when we talk about who is a peer, we have to think about the privileges we've experienced in our life, so just because I've smoked heroin and injected coke and smoked crack and done all these things, I haven't necessarily had the same experience as someone who's done all these things but has for example experiencing homelessness or housing insecurity, so in that regard I feel like I've had a different experience to other folks, you know?

M: So yeah I don't wanna

pre-empt your own definition of peer, so I guess a lot of these questions have been developed with our definition of peer in mind… particularly Nadia my boss and the program we are running Fuse initiatives is doing a lot of work for peer workers around conditions and the orgs that employ them and so on, so we've kind of had to lay out what is a peer worker in this context, a harm reduction peer worker, but I don't wanna be prescriptive about anything, but…

L: Well I think a lot of the times we, because peer work is kind of a new thing for a lot of orgs, and in a lot of people's minds, there's a tend to make it a binary thing, like profess and mgmt., like your questions even like management leadership, and then peer workers… people can occupy both spaces. So I'm in a management position, I've also worked as a peer. I'm also someone who identifies as a drug user, and I've also worked in services who are developing peer work and services and that kind of thing, so I feel like I can speak to what I can speak to you know?

M: Right, so we think that ideally orgs that are going to employ peer workers should have peers at all levels?

L: for sure. Like labour is important, like getting equal pay. Like just because someone is a peer worker doesn't mean they should get like 20 bucks an hour less. I think some organisations see it as a way to get a cheap workforce.

M: Why do you think it's so important to have Lived or Living Experience peers – current peers – in management. and leadership roles?

L: I think having peers in management and leadership roles is so important for a number of different reasons, like first of all if you're talking about management or leadership of a team of peer workers that is supporting people who are on OAT. Do you guys call it OAT where you're from?

M: Consumers call it OST. MATOD-is the latest bureaucratic name. What's the "A" in OAT?

L: Agonist. Yeah, we call it OST here in Ireland too, but OAT in [the rest of] Europe. So I think it's important because there's only so much you can learn from a manual or a course – rather than what you learn from experience, there's so much more that you learn from living your life, so someone who's been on OAT for 40 years, and is supporting a team of peer workers who are supporting people who are on OAT, Is going to have a lot more perspective on what's going on for their workers, but also for the people that they're trying to support, and also for the programs that they're creating. So I think that's the biggest reason, that there's this level of understanding that you just can't replace with academic learning or book learning or whatever.

M: Does your org provide adequate and appropriate discipline-specific support?

L: Well the way we work is there's two permanent staff, myself as ops manager and Matt [Southwell] as CEO. The rest of us are all set up as consultants, like project managers, and they all get a daily rate. We match up roles with living experience, like the person heading up our OAT support project is someone who is on OAT, the project manager doing our harm reduction program is someone with living exp, and so on. So Mat & I provide supervision and check-ins to our team. So we have 8 project managers and we split that, and they come to us for check-ins and serial support, so in that way we provide support to them – but we're all about self-determination, so it's all about fitting them in where they are most capable based on their personal experience.

M: Are you 'out' within your org as a PWUD?

L: I am yeah, but just within my organisation; like I was in another org previously in a peer role, and again I was out within my org as someone who uses drugs, but not within the wider sector if that makes sense. So recently I applied for a relief job, because I needed more money, and I got the job they were like great, need the experience, and so

I went for my second shift there, and they were like oh we were going through our records and it showed that you accessed the needle exchange here, for pipes, last year. And they asked is that for personal use? And I said yeah, and they were like oh sorry we can't have you working here. I actually got fired for outing myself as a drug user.

M: So, just for having used the needle exchange the year prior?

L: Yeah. I know- it's fucked. And it's not even a written rule, there's this 2-year rule, not even written down it's just an assumed thing, that if you're working in a service you have to be abstinent for 2 years from drugs, although loads of professionals working in those spaces who do use drugs, but just didn't need to use the services or whatever, they don't get fired. Even if they do coke or whatever on the weekends after work, because there's like this drug exceptionalism or whatever.

M: Well that's fucked up. I'm sorry you...

L: Yeah, so after that happened I was just like well, cat's out of the bag so I might as well just roll with it. It is a bit weird, I'm not out to certain members of my family and so on, so it is a bit weird to live this line of being professional and so on.

M: What is the climate for peer workers in Ireland in particular and Europe in general?

L: In Ireland it's starting to become more of a thing in my role with EuroNPUD, I've talked to orgs here in Ireland about wanting to support them to develop peer policies – I think some orgs here are still under this idea that people who are currently using drugs are too chaotic to employ, too chaotic to have in these spaces, where I'm like, no, it's that your policies aren't there to support these structures y'know. There's still the climate in Ireland isn't great but the conversations are starting to happen which is good. In Europe it's kind of different all over, but in Spain and Portugal it's really good, there's loads of peer work opportunities and orgs that do that, the UK.... I think is still very recovery-based, so they have peer workers but all their peer workers like, 'love recovery'. So yeah, it has a ways to go but there's just, the important thing is there's countries we can learn from you know. Like me, coming from Canada I just like have all those policies available so it's good.

M: How long have you been in Ireland, when did you leave Canada?

L: I moved in 2016, until late 2017, then I went back to Canada for family stuff but then came back in 2019 and have been here since.

M: Did you do any peer work in Canada?

L: No, in Canada I was like doing relief work at a shelter, and then I was doing admin for the same org, but like while I was doing the admin work they were developing a peer services dept, so I kinda got to see that process happen in terms of people getting paid fairly and having flexible policies like paying people in cash, having that conversation, peer workers that would show up on shift but that org it was like the same thing, we had peers who were using drugs all the time but they just weren't open, they weren't identifying themselves as drug users – I think that's a big thing, people who are professionals who are PWUD need to identify themselves as such as a solidarity thing... without co-opting it, taking it over.

M: Yeah I mean you probably read the final question, it's certainly a part of it right... so what can you do as an individual or what needs to be done to flip the paradigm when it comes to the need for drug law reform, and when it comes to the fact that most peer workers are forced to work in unsafe workplaces? That's certainly a good start what you said before.

L: Yeah I think it just needs to be more of a normalisation of like, everybody uses drugs, y'know 99% of people are gonna use a drug or use drugs constantly in their lifetime and we need to acknowledge that but also in like a structural workforce way acknowledge it, but someone I know I can't remember what they're doing, some kind of tech job, but they get drug

tested randomly. And I'm like why are you getting drug tested for weed? You like sit at a computer and type stuff all day, it doesn't make any sense. So like as I think people need to get more involved with the drug law reform thing in terms of personal activism. Even within their communities, if people are talking about stigmatising PWUD, saying well I use drugs, to make it more commonplace, because it is. Even people popping Solpadine and stuff, that's an opiate you know.

M: Well I guess that's it – is there anything you think we should've asked but didn't?

L: I like the last question because it's important, because we always need to change things and make things better and not just talk about the current landscape or whatever. I suppose like yeah cuz within these questions it's all about work and labour, so I guess like work conditions, like what do people need to be supported in a workplace as people who are out as being DU or people who don't have a choice to be out because they're accessing that drug service.

M: Yeah that's an interesting one too right, cuz there's people who are hired for their Living experience and are so 'outed', so some choose to call themselves LIVED experience instead, so it doesn't out them to everybody right, but there's also people who have been service users. Like your story right, that's absurd, them pulling up a record of you going there previously to get a pipe...

L: From like a year ago! In retrospect I should've gone across the street to the smoke shop and bought a pipe. But I did it I was also doing it as a point I have a right to access these services, if I need to get a straight pipe I should be able to do that without being stigmatised, so y'know. That needs to be taken into consideration in terms of workforce and labour, is that some people don't have a choice to be outed or whatever, to be labelled as someone who uses drugs, and some people do. So those people with the choice need to think how they can use that choice to lift other people up y'know.

M: How do you think they do that?

L: Kind of what I said before, like if they're someone who uses drugs, acknowledging that they do use drugs... but not taking those spaces away, like if you smoke weed you can't speak for someone who uses heroin, and just cuz you did coke in college [proper (Australian) English: Uni] doesn't mean you can speak for someone who smokes crack on the regular, so like acknowledging that there's drug exceptionalism, but doing it in a way that makes sure it doesn't make things worse for other people.

"I went for my second shift there, and they were like oh we were going through our records and it showed that you accessed the needle exchange here, for pipes, last year. And they asked is that for personal use? And I said yeah, and they were like oh sorry we can't have you working here."

TRACEY
PEER ACTIVIST
EUROPE/SPAIN

Q1

I'm an activist; I work in this role because it brings together many things – first and foremost, promoting and advocating for human rights and laws and policies to advance them, and the opportunity to work with, and learn from amazing people.

Q2

A person who is not a peer can have the best intentions, but there is no substitute for lived experience. Peer workers are a signal of respect for people who use drugs. Peers can help to build trust, which is really important, given the stigma and discrimination people who use drug usually face in healthcare and other settings. Peer workers also know how programmes, policies and services can be shaped to better meet people's needs; they contribute a lot of valuable information.

"A person who is not a peer can have the best intentions, but there is no substitute for lived experience."

Q3

I'm a freelancer, so this question does not apply.

Q4

I lived in the US (New York and Massachusetts). In the best cases, peers were valued, respected and included in decision- and policy- making, but often they were tokenized and exploited, not paid enough -or at all – or offered opportunities to grow in their roles.

Q5

As an activist, I use evidence to argue for policy change. For years, my work focused on access to hepatitis C treatment, especially after oral drugs became available. It astounded me that people who use drugs were excluded from clinical trials of new hepatitis C drugs, despite being the most affected population. This led many doctors not to treat people who use drugs, because of the lack of information from trials (among other reasons). Working with other activists, many who were people who use drugs, and a handful of great researchers, eventually this vicious circle was disrupted: hepatitis C treatment trials were done for people who use drugs, demonstrating that they were as likely to be cured as people who were not using drugs. Policies and guidelines began to change – although they have not fixed everything yet. The real problem lies with the limits of using a disease to advance human rights and social justice– if drug use, and people who use drugs remain criminalized, all the research in the world is not going to fix the underlying problem. If what you are doing is illegal, how can you find a safe place?

The laws must change.

BRIT
PEER WORKER
VICTORIA, AUS.

" I work in this role because I love it. I can be myself; I've never felt more like my true, genuine self in a workplace before. "

Q1

Being a peer worker to me means that I can connect with people who use drugs who are accessing services in ways that non-peer workers just aren't able to. Everyone who uses drugs is obviously gonna have wildly varying experiences of drug use and the highs and lows that go with it (pun intended). But we also share at least one common thing – having a stigmatised identity that leads to us consistently being discriminated against and treated differently by people living outside that identity, and how this manifests when accessing services. Also, I do a lot of workforce trainings, so it means that I can facilitate discussions with people who work with people who use drugs in ways that brings it out of the theoretical and into the real world – it makes the trainings more genuine.

I work in this role because I love it. I can be myself; I've never felt more like my true, genuine self in a workplace before. And because I'm good at it – my education and background gives me the skills and confidence to be able to bridge some of that

gap between “workers” and “drug user community”, to demystify the world of illicit drug use for people whose knowledge about drugs comes mostly from mainstream media and other stigmatizing sources. And I do it because I have the ability to use my social privilege for the benefit of others – my whiteness and middle class background (among other things) give me more of a buffer against the consequences of being an “out” injecting drug user, so I think I have a responsibility to try and use that to advocate for others who can’t be as out and proud as myself.

Q2

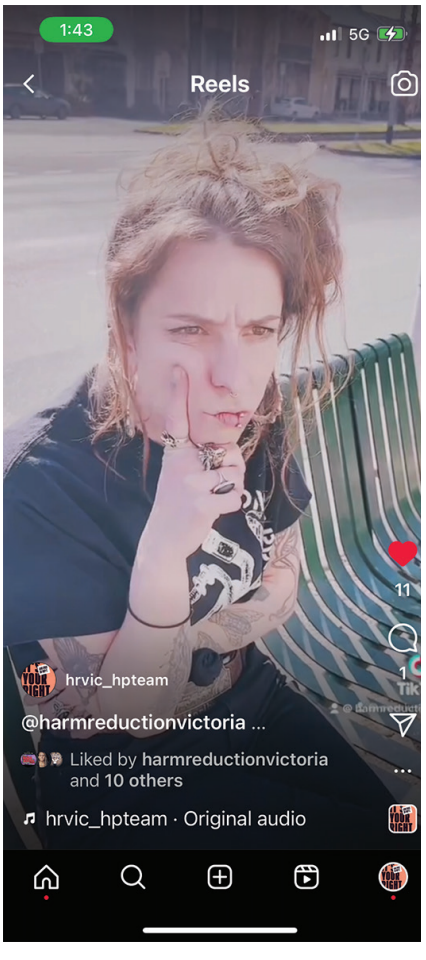
Unfortunately, there’s a massive gap between healthcare, community care and self-care knowledge sources and communities of people who use drugs. There’s also a massive gap in service provider’s knowledge about illicit drug use and communities of people who use drugs and associated behaviours and cultural practices. Peer workers are so so so important because of the way that we can carry knowledge back and forth between these worlds. And because we come from the communities who are marginalised, we are (hopefully) sharing that knowledge in ways that centre the human rights of people who use drugs – sharing knowledge and information that empowers people who use drugs, and working with the community services sector and service providers so that they can improve the way they work with us.

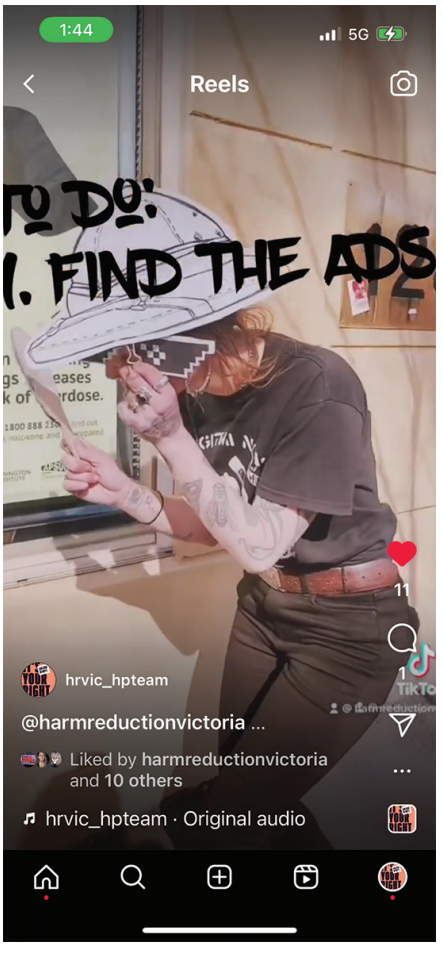
Q3

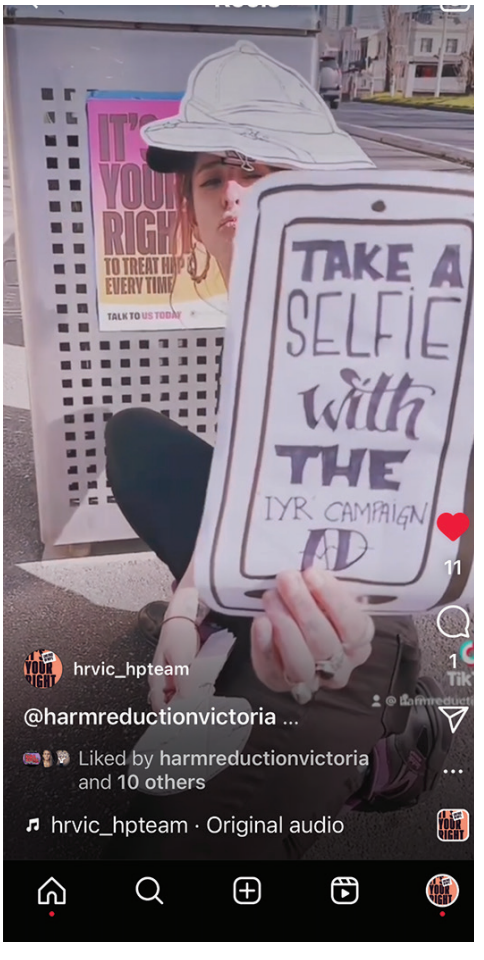
I am extremely lucky to be working with my local drug user organisation at the moment, and pretty much everyone here uses drugs, or has done. My workplace is extremely supportive and understanding.

Q 4

It really seems to vary a lot between organisations. I am part of a support network for peer workers, many of whom have shared their experiences of hardship working as the only designated peer in the org, or in orgs that don’t allow them to disclose their lived or living experience of drug use. While it seems to be improving, there is definitely a long way to go in victoria, and in so-called australia. There are still a lot







of organisations that see the hiring of a peer worker as a good opportunity to appear like they are progressive and receive some extra government funding, without genuinely valuing the knowledge and expertise that the peer brings into the workplace, and without providing adequate (or any!) support. Too often there are stories of peer workers being treated differently, their behaviour being monitored more heavily that other workers, having to work harder than others for the same recognition, and being expected to do the same work as non-peer workers but at a pay rate much less than their co-workers. Too often peer-workers are the only one in their organisation, and feel their presence is just to tick a box and their presence is being exploited for the benefit or the org and at the cost of their health and well-being.

Q5

As an individual in a position where I am going in to other workplaces and training non-peers about drugs and the people who take them, I can continue to challenge the dominant narrative about drugs and drug use. I get invited to talk to services about drug related harm, so it's really important that I use these opportunities to highlight the fact that the overwhelming majority of drug-related harm comes from the criminalisation drug use and the war on people who use drugs and associated policies. And when there is a focus on harmful or problematic/chaotic drug use on an individual level, point out that this is a symptom of a very sick society and that drugs often serve as a coping mechanism and survival tactic for people and communities that are fighting for their lives under white-supremacist capitalist patriarchy.

But obviously there is only so much you can do as an individual, only so much power you have. To flip the current paradigm, to switch the dominant narrative, we need to continue to build resistance from a grass-roots level in ways that centre and empower community. We need to shift the way society thinks about drugs and the people who use them, but this is going to take time. How do we undo over one hundred years of the drug war? It's not gonna happen overnight. But things are changing slowly, so I think we have to dig our heels in and keep fighting for safety at work and an end to stigma and discrimination in all forms, not just in the realm of drugs. The struggle for drug user rights is part of the larger struggle against domination and oppression, and I think we need to consider how we can work with other communities and other human rights movements, like the prison abolition movement, to share resources and act as true allies to support each other to fight our common enemies.

SECRET SERENITY SEEKER
PEER WORKER
AUSTRALIA

Q1 For me, being a peer worker, at it's core, has always been about honesty and real human connection. It is about sharing and the demonstration of community and it's unmatched ability to support and heal. I see the human need to recognise the self in others and to feel as though they belong, and so peer work is about this compassionate extension of lived and living experience. I think that I work in this role because my values are reflected in the modus operandi of peer work and it feels pretty natural to me to operate intentionally in life. I have always needed things to be meaningful (this does not always lead to a healthy place).

Q2 Aside from the fact that peers offer particular insight into what implicates the health of the people that we serve, peer workers are so important because people who use drugs are still widely rejected and punished by systems and society, ultimately marginalizing and creating vulnerabilities for people based on stigmatic beliefs. With the recognition and valuing of people with living and lived experience we can perform the dismantling of archaic and punitive responses to drug use as a moral deficit or a weakness of character, and build systems that incorporate the voices of the people that it exists for.

Q3 Unfortunately, not even close. I am needing to remain anonymous in these responses, and in any other peer networking that I am involved in. Peers are not recognized on a personal or structural level within the org, are not included in service planning, development of practice frameworks, nor in policy and procedures. There is nothing to protect the rights of peers, nothing to support the specific needs of peers, and what feels like an outright denial of the relevance and skills of peers, which creates an environment that alludes that living and lived experience of drug use is unwelcome at the least, and risky and untrustworthy at the most.

Q4 I think the climate for peers where I work is not necessarily representative of the climate for peer work as a whole, currently. I know this because I have worked in another organization that freely and proudly operated with great acceptance to include peer workers. They hired people into designated peer positions, made sure that job descriptions and work requirements were inclusive and intentional, celebrated peers for their diversity and skills. I could even be honest about needing to pick up my pharmacotherapy on a Monday morning and we worked the roster to include that and I never once felt judged or ashamed about myself. Because this is the thing right, whether I chose it or not, I have experience with drug dependence. And any action (or non-action) that denies, rejects, or shames that experience ultimately encourages the discrimination against people who use drugs. So, the climate is fraught, imbalanced, and very much a dynamic space. There are a lot of powerful voices and bodies out there and brilliant advocates and allies of people who use drugs. But stigma is a complex beast and embedded in culture and politics and so the reality is that for a lot of people, the fact that they have lived and living experience of drug use impacts their very sense of safety and security in very real ways.

Q5 Through trying and terribly hurtful experiences of direct discrimination within the workplace, I have learned that denial of the relevant parts of myself only further harms and disempowers my ability to be an intentional and considered worker. And so as an individual I have learned to seek and identify safe spaces to collaborate and share my experience. We need to continue to seek partnership with others of similar values, and to advocate for the rights of people who use drugs as not dissimilar to the human rights of anyone else. That is to have a safe place to work, for it to not be lawful to discriminate against a person just merely for the fact that they use drugs, to have equal opportunity to contribute to and influence community, and to have the right to privacy and ownership over theirs.

Right: ARTWORK BY SECRET SERENITY SEEKER


KILLER
DO YOUR PAINTINGS EVER COME BACK TO LIFE
YOU DO, JUST TO DIE AGAIN


DE VOTE