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HARM REDUCTION **LIVING & LIVED EXPERIENCE** WORKFORCE DISCIPLINE FRAMEWORK

ACKNOWLEDGEMENT

Wominjeka.

Harm Reduction Victoria acknowledges the Traditional Custodians of these beautiful, unceded lands and waters that nourish and inspire us - where we live and work.
We pay our respects to the Culture and to Elders - past and present.

Always was. Always will be Aboriginal land.


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initiatives
network • development • training


HARM
REDUCTION
VICTORIA


VICTORIA
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GLOSSARY

Alcohol and Other Drugs (AOD) Sector: A collective term for all AOD services funded by the Victorian Department of Health and covered by the AOD Program Guidelines, including prevention, early intervention, harm reduction, treatment and ongoing support programs. This includes AOD services available to all Victorians, targeted services such as Aboriginal and youth services and AOD services provided to people in the community as part of a court order.

Blood-Borne Viruses (BBVs): an infection that can be transmitted from one person (the donor) to another through direct contact of bodily fluids, especially blood. This can be from a used needle, a bite injury to the skin, or transmission of bodily fluids including sexual intercourse.

Harm Reduction Peer Workers (HRPWs): also known as Living Experience Peer Workers, HRPWs are people with a lived or living experience of drug use and risk of overdose who are employed in harm reduction work. HRPWs promote the health and well-being of people who use drugs.

Lived and Living Experience Workforces (LLEW): A collective term for individuals who draw on and contextualise their personal lived and living experience with lived experience principles, frameworks, and discipline practice to inform their work. These roles are designated positions in which LLE is the key expertise criterion.

Needle and Syringe Program (NSP): a strategy for increasing needle and syringe availability to injecting drug users and minimising the transmission of blood-borne viruses such as HIV and hepatitis B and hepatitis C.

People who use drugs (PWUD): People who use and or inject drugs.

Sexually Transmitted Infections (STIs): are spread predominantly by unprotected sexual contact. Some STIs can also be transmitted during pregnancy, childbirth and breastfeeding and through infected blood or blood products.

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CREATED BY HARM REDUCTION VICTORIA, IN COLLABORATION WITH THE VICTORIAN DEPARTMENT OF HEALTH AND THE ORGANISATIONS OF THE LIVED AND LIVING EXPERIENCE WORKFORCE DEVELOPMENT PROJECT.

INTRODUCTION

Harm Reduction Peer Workers (HRPWs), also known as Living Experience Peer Workers,[1] are people with a lived or living experience of drug use and risk of overdose who are employed in harm reduction work. This document is intended to serve as a foundation for the development of the peer workforce across a variety of organisations that work with the community of people who use drugs (PWUD).

HRPWs promote the health and well-being of people who use drugs.[2]

This document is intended to serve as a framework for the development of the peer workforce across a variety of organisations that work with the community of people who use drugs.

This Framework seeks to inform peer workers, their employers, funders, other stakeholders, and the wider Victorian community about HRPWs. This includes the values and principles of harm reduction, as well as the skills, experience, and knowledge of HRPWs that are necessary to perform their roles. The document outlines the scope of practice for HRPWs; several appendices on the types of organisations likely to employ HRPWs; and a list of potential roles in which they may be employed.

The Royal Commission into Victoria's Mental Health System was established in 2019. In February 2021, three reports were published that included 65 recommendations to bring about reform of the Mental Health and Wellbeing sectors, including the Alcohol and Other Drugs (AOD) sector. The AOD sector includes harm reduction.

Established in 2022-24, the Lived and Living Experience Workforces (LLEW) development program supported existing or developing new projects to realise authorised, supported and sustainable LLEWs in public mental health and AOD services.

The program was informed by and seeks to build on the many decades of activism and advocacy by the mental health consumer workforce, AOD consumer workforce, mental health family/carer workforce, and AOD family/carer workforce, people with lived and living experience of trauma, mental health challenges, suicide, substance use, and their families, carers, and supporters, advocates, and allies. The program also recognises the unique needs and perspectives within individual LLEW disciplines as well as between them.

The implication of this is that while some agendas are shared/common among LLEWs, this diversity needs to be acknowledged and supported through the program.

Ultimately, this work has validated the work that the drug using community had already been doing for over more than four decades.


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WHAT IS HARM REDUCTION?

Harm reduction is a philosophy born out of communities of people who use drugs (PWUD) creating models of care that prioritise evidence based practices, and are grounded in public health and justice.[3]

Harm reduction was founded in the context of widespread frustration with poor outcomes from more traditional models of alcohol and other drug (AOD) treatment, which mandated abstinence and permitted little flexibility to adapt to individuals' circumstances and needs.

It grew out of the community response to the HIV/AIDS crisis in the early 1980s, where people who use drugs began organising their communities through grassroots organisations, such as Harm Reduction Victoria (then VIVAIDS). These organisations are some of the earliest examples of peer work in Australia.[4]

"Harm Reduction refers to policies, programmes and practices that aim to minimise the negative health, social and legal impacts associated with drug use, drug policies and drug laws. It is grounded in justice and human rights. It focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that people stop using drugs as a precondition of support."[5]

Peer-led Harm Reduction organisations recognise that zero-tolerance drug policies and abstinence-only treatment approaches do not stop entire populations from using drugs, and they often make the conditions in which people use drugs more dangerous.6 In contrast, Harm Reduction organisations seek to neither condemn nor condone drug use, but work to lessen any negative health and social effects associated with the use of illicit drugs by meeting people where they are currently, and taking direction from them on where they would like to go – rather than just where society might like them to be (often abstinent).[7] It recognises that not all drug use is harmful: only around 1

NOT ALL DRUG USE IS HARMFUL;

ONLY 1 IN 8 PEOPLE WHO USE DRUGS WILL EVER NEED TO SEEK TREATMENT.

in 8 people who use drugs will ever need to seek treatment.[8] Even then, most harms surrounding drug use are rooted in drug criminalisation and stigmatisation, rather than drug use as an act.[9]

Many people who use drugs do so with informed intent and feel no need to stop. Others whose drug of choice can result in dependence might experience negative effects or risks, but still make a rational choice to continue using due to its positive impacts.

Some may use drugs and seek to stop, and harm reduction embraces this experience as well.

Harm reduction does not prescribe goals to people who use drugs or moralise their decisions but empowers people who use drugs to determine what would be best for them, considers their individual needs and circumstances holistically, and offers resources to support them in their personalised journeys.[10]

LIVED & LIVING EXPERIENCE IN HARM REDUCTION

The community of people who use drugs, like many criminalised and/or marginalised communities, have long experienced criminalisation and stigmatisation, often resulting in poor social and health outcomes.

In fact, the Alcohol and Drug Foundation has reported that people who use drugs are amongst the most stigmatised and discriminated-against members of society.[11] These power imbalances are often imposed on people who use drugs by politicians, police officers, media representatives, as well as healthcare and social service providers.[12] This stigmatisation in healthcare is compounded by how, historically, abstinence-only treatment has been regarded as the blanket solution to every problem people who use drugs may face. Additionally, drug education borne out of the 'War on Drugs' often features demonisation and scare tactics about drugs and the people who use them. The most consequential effect of these experiences is to impress upon people who use drugs that society deems them unworthy of the same standard of care to which people who do not use drugs are entitled. If they seek advice or treatment from healthcare services, they will often be disbelieved, lied to, discriminated against, ultimately coerced into an abstinence-based recovery that they likely did not want or need.[13]

In the absence of trust in traditional healthcare providers, people who use drugs almost invariably turn to their own community, sharing skills and knowledge earned through their own experience to educate and help each other to address the harms associated with drugs and with the impacts of unjust drug laws.[14] These activities are at the core of Harm Reduction peer work – which has been practiced as a matter of survival by the community for decades – before its relatively recent acknowledgment by healthcare institutions, government, and wider society.
Since it has begun to be understood and valued more broadly, Harm Reduction peer work has been found to be both incredibly cost-effective and vital in effectively improving health and social outcomes for a marginalised community.[15]

This acknowledgement and funding of the Harm Reduction Peer Workforce by government has resulted in more meaningful involvement of the drug-using community in harm reduction programming. It is aligned with the concept of "Nothing About Us,

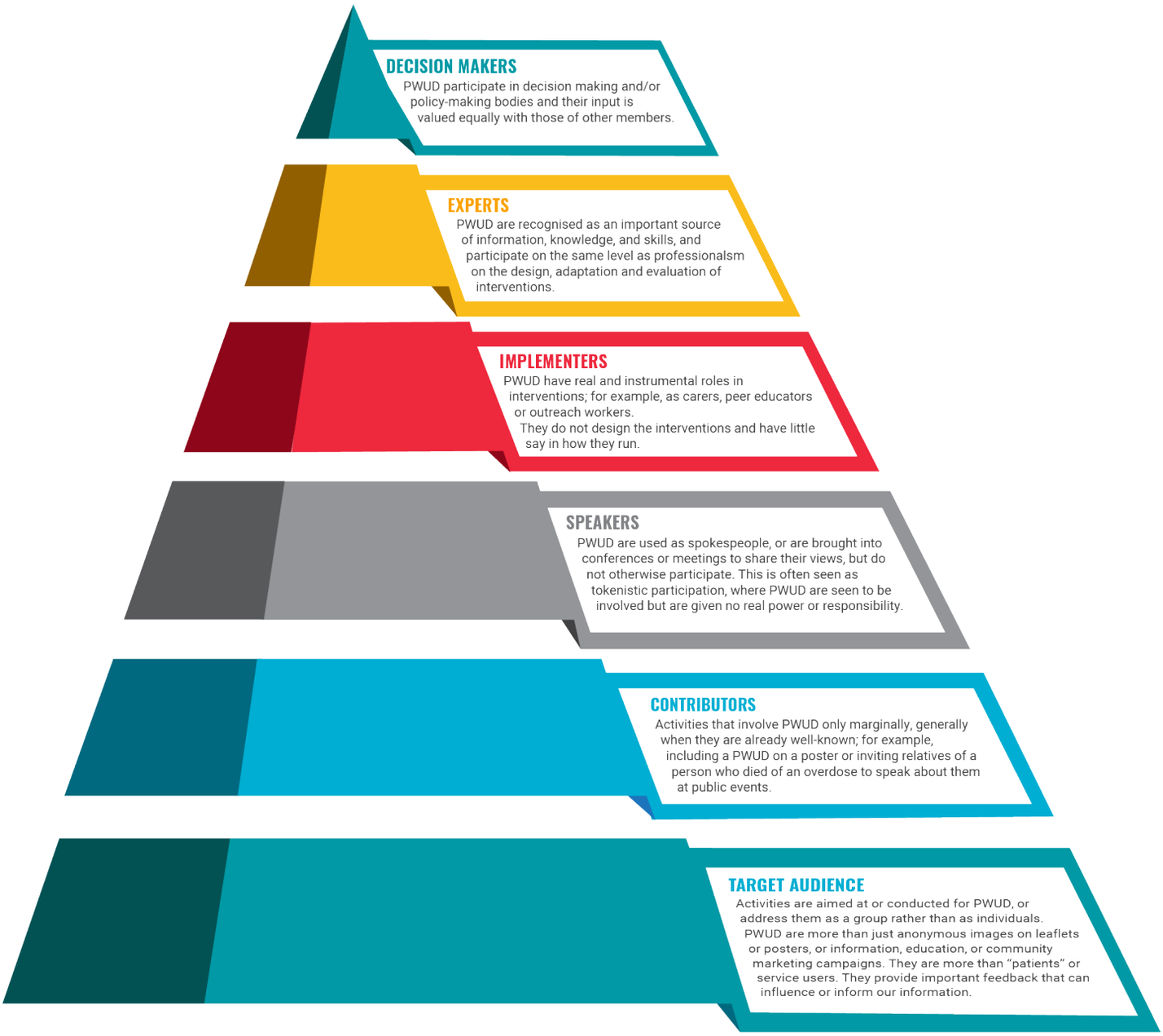


Figure 1: Adapted from: International HIV/AIDS Alliance (2015). Good practice guide for employing people who use drugs.

Without Us" and is reflected in the pyramid of involvement. The pyramid of involvement demonstrates increasing levels of people who use drugs involvement, with the highest level representing complete application of the greater involvement principles.

HRPWs help cultivate environments where people who use drugs often feel welcomed, embraced, and understood using an organisation's services.[16] HRPWs contribute their expertise from their living experience of illicit drug use, which often allows them to develop meaningful relationships with service clients and foster a sense of community within the organisation.

They help break down walls of stigmatisation in organisations and combat alienation that people who use drugs have historically experienced in service-providing settings.[17] Because of their living experience, HRPWs communicate non-judgmentally and in language specific to communities of people who use drugs, acting as bridges to healthcare.[18] In this way, HRPWs are assets to their employing organisations and their communities of people who use drugs.

OUR VALUES

VALUES

Harm Reduction peer work has a shared set of values and principles. Guiding values include a commitment to harm reduction, belief in platforming living experience in decision-making ('Nothing About Us, Without Us'), dedication to improving the health and human rights of people who use drugs, recognition that living experience is valid and important expertise, and acknowledgement of ongoing grassroots activism in communities of people who use drugs .[19]

Harm Reduction peer work values shared experiences, learning from and respecting differences, working with empathy and compassion, building mutually empowering relationships, and empowering people who use drugs to make their own decisions without judgement or discrimination.[20]

PRINCIPLES

HRPW's principles emphasise that HRPWs voices deserve to be valued as essential to harm reduction programs. HRPWs represent a stigmatised and criminalised community, and they connect with their community and are accepted by them as peers.
Because they have diverse experiences and perspectives, they often understand that individuals' relationships with substance use is not fixed and can have wide-ranging use-values.[21]

Harm Reduction peer workers are dedicated to creating equitable access to services across genders and races, engaging 'hidden communities' that usually experience barriers to accessing services, and contributing to dismantling barriers to healthcare that people who use drugs disproportionately face.

OUR PRINCIPLES

SCOPE OF PRACTICE

HRPWs may be employed in a wide range of roles and organisations, reflecting the diversity of people who use drugs and their experiences.

HRPWs may work in health promotion settings (focusing on bloodborne virus prevention, testing, and treatment), as well as overdose education and response. HRPWs may share information about safer injecting practices and vein care while distributing sterile injecting equipment and naloxone in their communities, often through a Needle and Syringe Program (NSP).

They may also practice health-related skillsets, like phlebotomy, and can help connect people who use drugs to pharmacotherapy options. HRPWs may work in research settings that impact people who use drugs (often about bloodborne viruses or stigma), and they may work in settings where psychedelics and other similar 'party drugs' are more prevalent, like in nightlife and festival settings. The examples above are by no means exhaustive. HRPWs can hold any position (including medical, academic, executive, and policy positions), depending on their professional, educational, and personal backgrounds. No matter what role they may occupy, HRPWs' unique experiences and perspectives act as bridges between their workplaces and communities that foster mutual understanding and improvement.

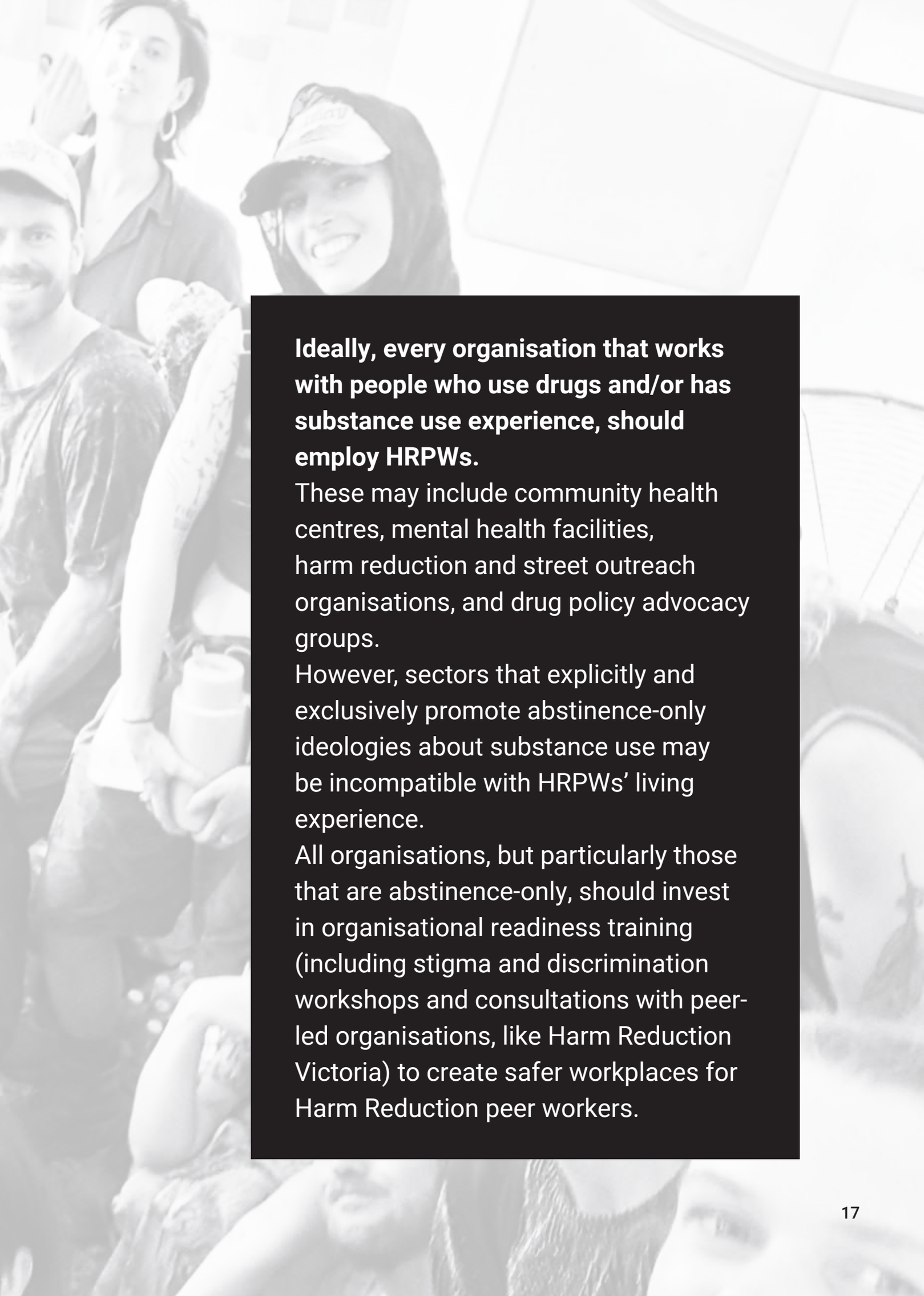
HRPWs may have workplace boundaries with their clients that vary from non-peer staff members. HRPWs' connections with their community mean that they may relate more informally with their clients: this ability to relate is one of HRPWs' strengths.

Organisations employing HRPWs should be empower them to create boundaries that best fit their individual needs and support them in adapting and maintaining them. Organisations should also be aware of unique challenges HRPWs may face outside of working hours, given that issues they counter in their employment may also affect their personal lives. HRPWs can collaborate with supervisors and other peer workers to navigate these dynamics and how it affects them.

To ensure HRPWs can perform to the best of their abilities, it is imperative that they are provided with practice supports such as opportunities to network with the wider HRPW community, capacity to attend external discipline-specific supervision, and culturally appropriate training and career development opportunities.

Furthermore, employing organisations should invest in assessing their organisational readiness to ensure they are culturally and strategically prepared to employ HRPWs in a safe and supportive environment.

ORGANISATIONS EMPLOYING HARM REDUCTION PEER WORKERS



Ideally, every organisation that works with people who use drugs and/or has substance use experience, should employ HRPWs.

These may include community health centres, mental health facilities, harm reduction and street outreach organisations, and drug policy advocacy groups.

However, sectors that explicitly and exclusively promote abstinence-only ideologies about substance use may be incompatible with HRPWs' living experience.

All organisations, but particularly those that are abstinence-only, should invest in organisational readiness training (including stigma and discrimination workshops and consultations with peer-led organisations, like Harm Reduction Victoria) to create safer workplaces for Harm Reduction peer workers.

THEORIES AND KNOWLEDGE

Harm Reduction peer work did not begin with designated HRPW roles in organisations. Harm Reduction peer work has existed for as long as communities have used drugs, with people who use drugs sharing information, support, and care with their peers.

While HRPWs in mainstream organisations are relatively new positions, the skills and duties they practice are not.

Harm Reduction peer work started becoming formally recognised during Australia's HIV crisis in the 1980s, when the government and public health officials realised that the most effective responses would be led by the most impacted communities (gay men, sex workers, and people who use drugs).[22]

Since then, HRPWs have been integrated into strategies that address health issues that people who use drugs experience, however, Harm Reduction peer work is still vibrant in spontaneous and informal spaces. Formalised Harm Reduction peer work must remain grounded in this ongoing grassroots work and activism occurring in communities of people who use drugs.

Harm Reduction peer work has been integrated into health responses because it has a wealth of evidence and theory proving its effectiveness. Most notably, people who inject drugs in Australia have an HIV rate of 2.5 per cent, compared to the United States' 6.7 per cent.[23,24]

There are three particularly salient theories, each operating at a different level, that underpin Harm Reduction peer work: the health belief model, social learning theory, and theory of participatory education/empowerment.

HEALTH BELIEF MODEL

The health belief model influences individual behaviour, as it posits that if an individual wants to avoid a certain health condition (i.e. HIV) and believes that an action would prevent it (i.e. using sterile injecting equipment), then they will do that action.[26] This is complemented by the social learning theory, which has a more interpersonal scope than the individualised health belief model. It explains how people learn by observing others with whom they identify, and that training in the skills/behaviour they observe contribute to their confidence in practicing the skills/behaviour in the future.[27]

SOCIAL LEARNING THEORY

Situating the social learning theory in terms of Harm Reduction peer work, people who use drugs are more likely to learn harm reduction strategies from peers and then use their training knowledge to further diffuse spread the information in to their networks.[28]

THEORY OF PARTICIPATORY EDUCATION/EMPOWERMENT

The theory of participatory education/ empowerment operates at a structural level, holding that a population's empowerment (or lack thereof) and economic and social conditions shape their health.

If a population is disempowered with poor economic and social conditions, they are more likely to have substandard health.[29]

Harm Reduction peer work empowers people who use drugs to influence their community's health through horizontal learning processes; this theory also prompts societal change to address the economic and social conditions of people who use drugs.

TRAINING & SKILLS DEVELOPMENT

DISCIPLINE-SPECIFIC TRAINING AND SKILLS DEVELOPMENT

It is important to recognise that having a lived or living experience of drug use is an essential element of the expertise required to be a Harm Reduction peer worker.
However, this experiential expertise should be complemented by discipline-specific training to ensure that the HRPW has the necessary skills to implement the use of their lived or living experience.

As such, a discipline-specific induction package and a comprehensive training curriculum is required. Both training packages will be regularly evaluated and consultations with the workforce will ensure that the training is responsive to the needs and wants of the workforce.
This will ensure that as the workforce expands and diversifies, the training will remain relevant and responsive to the needs of the community and the workforce.

DISCIPLINE-SPECIFIC INDUCTION

The discipline-specific induction package aims to provide HRPWs an introduction to the work to ensure that they have the necessary entry-level skills and knowledge to commence their new role.

The induction package is comprised of the following modules:

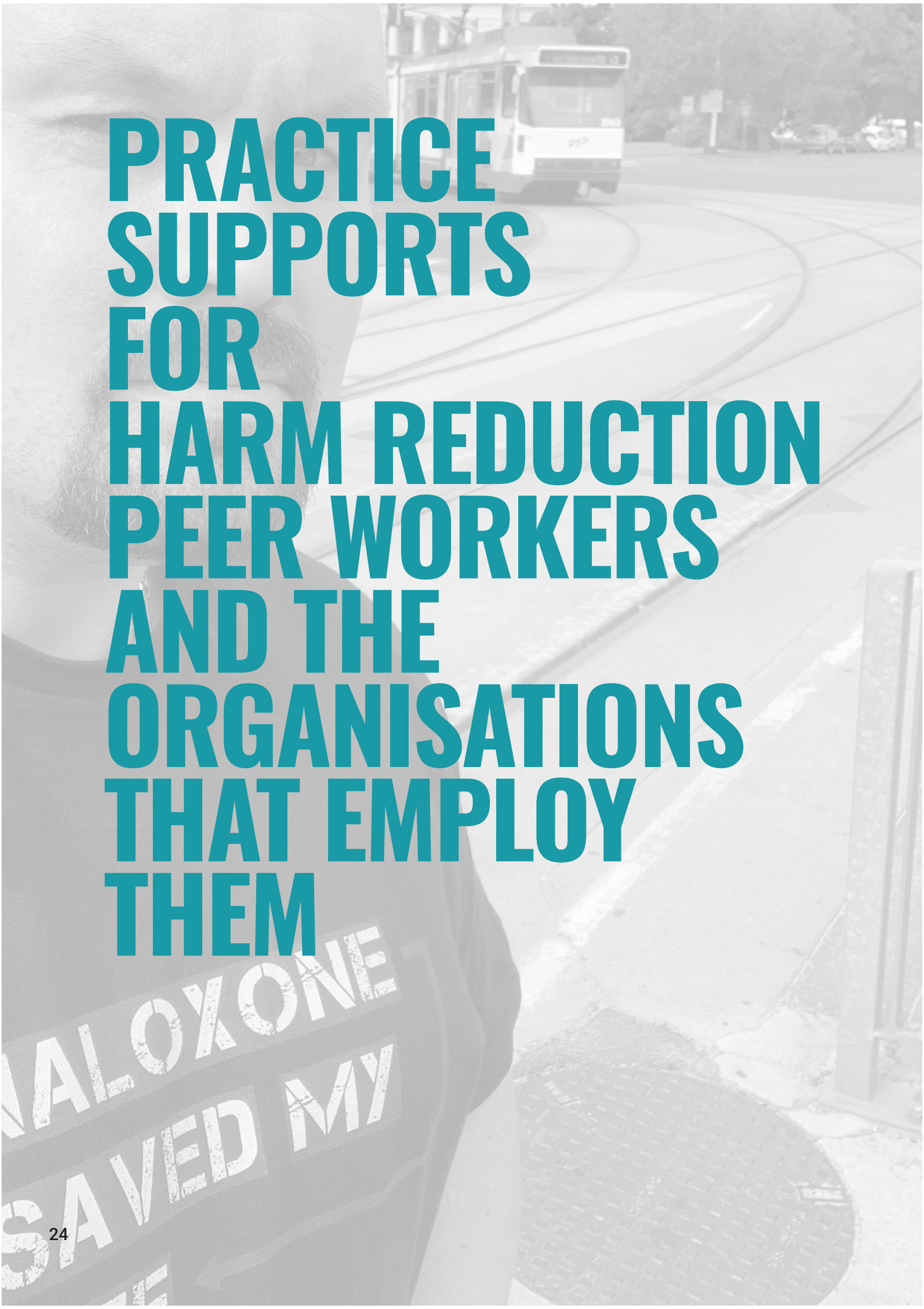
MODULE	TRAINING TOPICS
INTRODUCTION TO HARM REDUCTION PEER WORK	• History of the drug user movement and peer work • Harm Reduction 101 • Qualities of a Harm Reduction Peer Worker • Peer education • Communication, diplomacy, de-escalation and conflict resolution • Purposeful disclosure • Confidentiality
SCOPE OF PRACTICE	• Scope of practice • Role clarity • Navigating boundaries • Managing dual relationships • Use of technology and data collection • Balancing professionalism and passion • Working alongside non-peer colleagues
PEER WORKER EMPOWERMENT	• Learning from experienced Harm Reduction Peer Workers in different contexts • Self-care, vicarious trauma and prevention of burnout • Combating stigma and discrimination • How to get the most out of discipline-specific supervision • Peer survival guide and workplace safety
DISCIPLINE-SPECIFIC LEARNING	• Substance specific education • Overdose recognition and response (including administration of Naloxone) • Blood-Borne Viruses (BBVs) • SexualitySexually Transmitted Infections (STIs) • Needle and Syringe Program (NSP) • Ethics and legal practices- understanding what legislation applies to people who use drugs and the impact they have on our community • Mental health first-aid • Managing aggression

COMPREHENSIVE, ONGOING TRAINING CURRICULUM

The comprehensive ongoing training curriculum provides HRPWs with the necessary skills and knowledge to enhance their practice.
It further affords an opportunity to learn and acquire more specialised harm reduction knowledge as well as leadership skills.

This curriculum is comprised of the following modules:

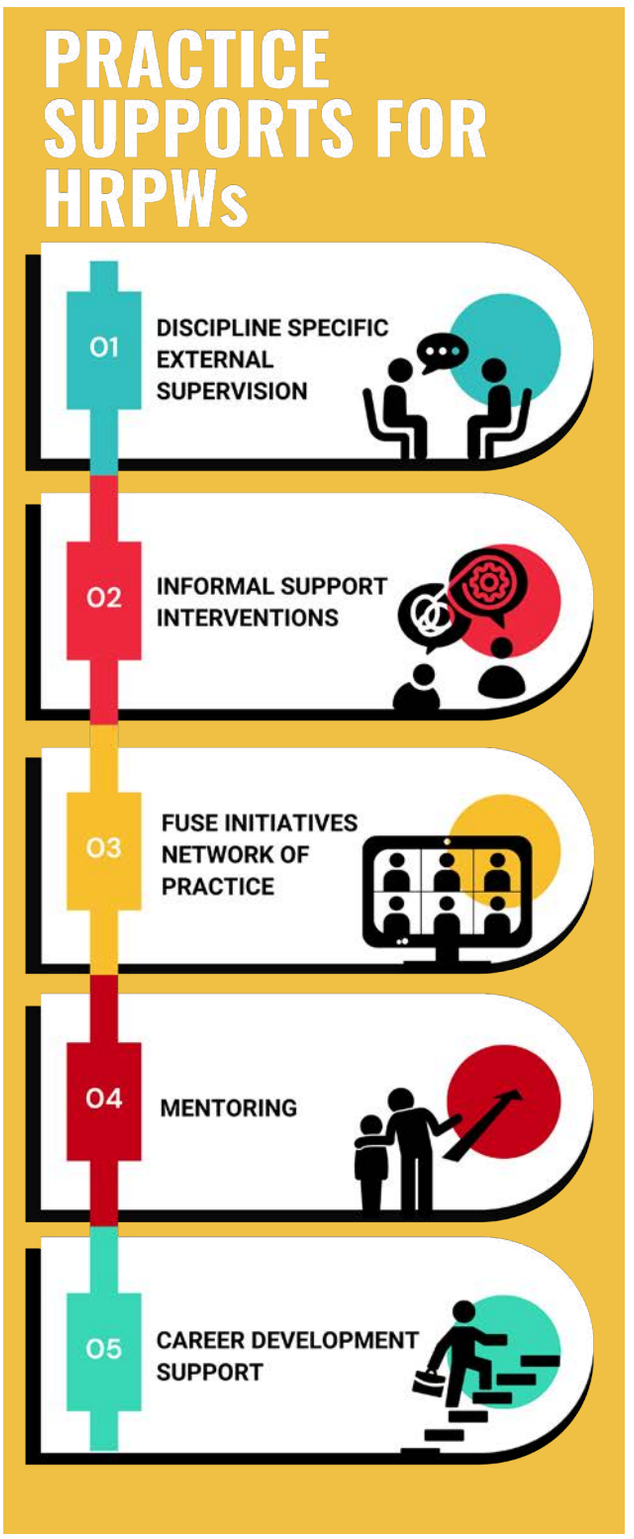
MODULE	TRAINING TOPICS
DISCIPLINE SPECIFIC TRAINING	• Substance specific education • Overdose recognition and response (*including administration of Naloxone*) • Blood-Borne Viruses (BBVs) • Sexuality Transmitted Infections (STIs) • Needle and Syringe Program (NSP) (*including distribution of Naloxone*) • Legal issues • Mental health first-aid • Managing aggression • Advocacy for individuals • Occupational health and safety for peer workers • Presentation skills • Intersectionality- working with other peer work disciplines and other allied communities
LEADERSHIP	• Qualities of a leader • Project management • The power of data • Grant and proposal writing • Mentoring others • Managing risk • Managing budgets • Organisational and systemic advocacy • Engaging with research

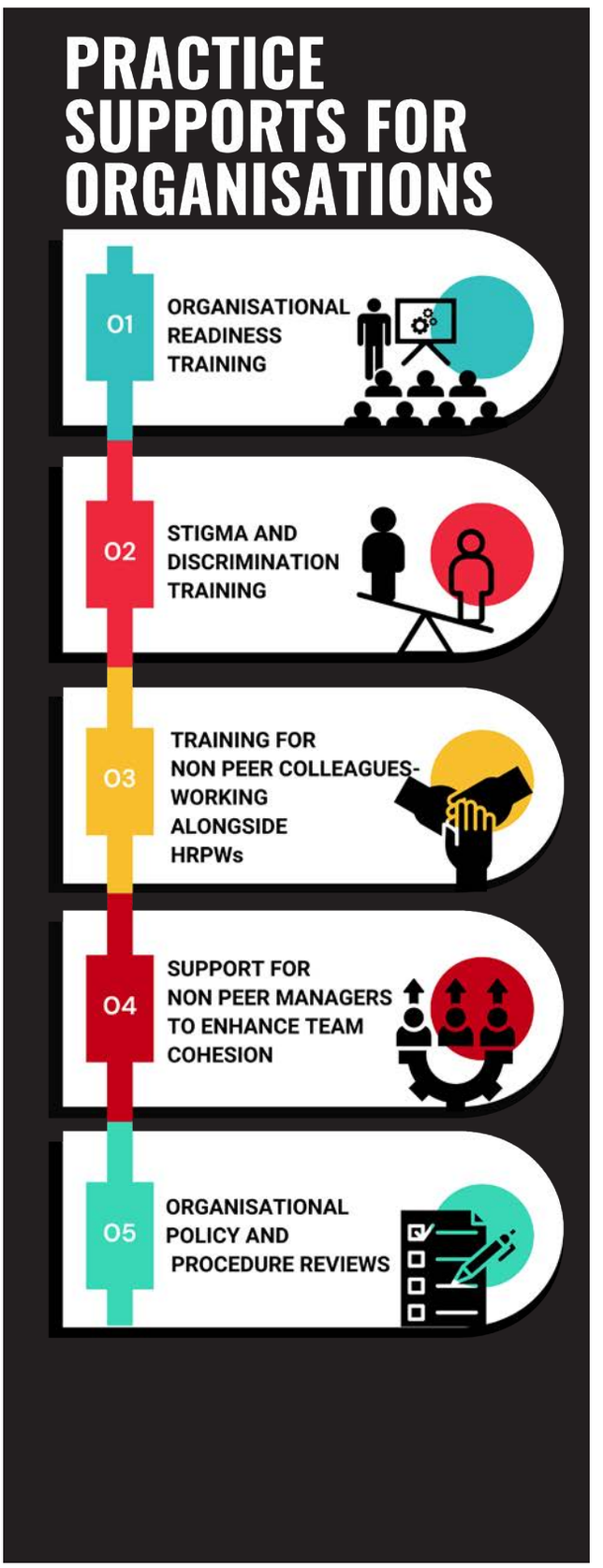


PRACTICE SUPPORTS FOR HARM REDUCTION PEER WORKERS AND THE ORGANISATIONS THAT EMPLOY THEM

IN ADDITION TO TRAINING FOR HRPWS, ADDITIONAL PRACTICE SUPPORTS ARE REQUIRED FOR BOTH HRPWS AND THE ORGANISATIONS THAT EMPLOY THEM.

THE FOLLOWING PRACTICE SUPPORTS ARE AVAILABLE:



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CONCLUSION

As a discipline, Harm Reduction peer work has long been established as best practice for working with people who use drugs.

It has grown from an unfunded, grassroots, community-led model to being the valued, respected and funded discipline it is today.

However, despite this important recognition, it is imperative to keep the momentum up to ensure that HRPWs and the organisations that employ them are appropriately supported to provide culturally safe workplaces and sustainable workforces.

This framework provides a roadmap to success and sustainability for the Harm Reduction Peer Workforce moving forward.

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