How to Support Peer Workers in the AOD Space

JUNHAO (Jason) YANG, Christabel Louise May, Shaneece Hanley

UniSA Community Outreach Center

The Institute, 611 Magill Road, Magill, South Australia 5072

Table of Contents

Table of Contents 1

Acknowledgements 2

Executive Summary 4

Recommendations 4

Glossary 8

Aims and objectives 10

Background 11

Barriers in the provision of services 14

Comparison between other states frameworks 17

Defining lived experience and living experience workers 19

Medical Model vs Human Rights Model 20

Interview with AOD peer workers 22

Conclusion 26

References (APA 7th) 27

Appendix A — NATIONAL QUALITY FRAMEWORK FOR DRUG AND ALCOHOL TREATMENT SERVICES 32

Appendix B — LANGUAGE GUIDELINE IN DRUG AND ALCOHOL SERVICE (THE POWER OF WORDS) 33

Appendix-C Interview Questions with Family Drug Support (FDS) 37

Appendix-D Interview Questions with Hepatitis SA 38

Acronyms 39

Acknowledgements

Acknowledgement of Country

The research team at the University of South Australia Community Outreach Centre acknowledges the Karuna people as the traditional owners of the land and waters of the Greater Adelaide Regions on which we studied, conducted our research and completed our project. We acknowledge that the land we meet today is the traditional land of the Kaurna people and that we respect their spiritual relationship with their country.

Acknowledgement of the South Australian Network of Drug and Alcohol Services (SANDAS)

The South Australian Network of Drug and Alcohol Services (SANDAS) was established in 2004 to enhance community well-being and reduce the harms associated with alcohol and drug use. SANDAS is a not-for-profit association funded by membership contributions, the Commonwealth Department of Health, the SA Department for Health and Wellbeing and a range of other organisations on a project basis. Initially, SANDAS aims to reduce harm associated with alcohol and drug use while emphasising health, social justice, equity, reconciliation, cultural safety, and inclusion. SANDAS promotes evidence-based interventions provided by qualified workers and values the lived experiences of clients, families, peer workers, and communities.

Acknowledgement of the University of South Australia Community Outreach Centre (UniSA COC)

The Magill Community Outreach Centre (COC) within UniSA Justice and Society offers placement opportunities for social work and human services students. It provides diverse experiences, including project and research work, collaborative project design, grant writing, and community engagement activities. Projects stem from partnerships with community organisations, offering valuable real-world experience. Students participate in peer supervision and professional development sessions, learning from guest speakers and each other. The placements involve mixed activities, fostering an understanding of societal issues and practical skills. COC placements enable students to significantly impact communities, enhancing their professional development and setting them apart.

Acknowledgement of team

We want to express our appreciation to the South Australian Network of Drug and Alcohol Services (SANDAS) and the Magill Community Outreach Centre (COC). With a four-month timeframe, each of us studies a different degree: Master of Social Work, Junhao (Jason) Yang, Bachelor of Social Work, Christabel May, and Bachelor of Social Science and Psychology Shaneece Hanley. The dedication and collaboration of each team member and the fundamentals of our degrees have been implemented into this report, as each team member has a unique skill set.

We have received unwavering support from Mr. Michael White, Executive Officer of SANDAS, who shared his knowledge at all the report stages. Lastly, Ms. Rita Rao and Ms. Binita Gautum Joshi, thank you for your constant support and supervision of us as students and for overseeing the project.

We want to extend our gratitude to Hepatitis SA, OARS, and FDS and their peer workers from these organisations who have shared their experiences, insights, and time. We value your input; it gave us an in-depth view of the quality of our research.

Executive Summary

This paper is an overview of the current climate and critical considerations related to peer workers/lived experience workers in the AOD space. This document explores the challenges, strategies, and recommendations to address substance use disorders and promote effective recovery-oriented outcomes in South Australia.

Key Findings:

- **Role and Contribution:** Peer workers and lived experience workers have a particular skill set when working in the AOD space, which shows empathy and different perspectives towards AOD and social support services, which is based on personal experiences of the challenges surrounding substance use disorders.

  Client Engagement: Lived experience and peer support roles enable rapport, trust, and confidence with clients, which leads to further engagement in recovery interventions and better overall outcomes for AOD use.

- **Integration:** Even though peer workers/lived experience workers potentially have barriers, such as the lack of professional acknowledgment, lack of training, and barriers to funding for support programs.
- **Recommendation**: Based on the research and interviews conducted , this proposal has made various recommendations for the individual, organisation, and the legislative bodies regarding advocacy, confidentiality, community development, self-care, and enhanced interconnectedness between the AOD services.

Recommendations

This research identified seven key recommendations:

Advocacy

Organisations should support peers to advocate for appropriate services. Advocacy is crucial in the AOD space, which will improve positive outcomes for people, their loved ones, and communities who are affected by substance use. Organisations play an essential part in advocacy, which should be aimed at promoting harm reduction and educating on reducing the stigma associated with AOD.

Organisational Supports

Organisations can offer comprehensive training programs to improve outcomes for peer workers, provide mental health support, and establish supervision/feedback with their supervisors. Organisations can enhance their peer-led involvement, leading to less burnout, less turnover of staff and more successful outcomes for their employees and clients who use their services.

Confidentiality and consent while implementing peer support

In the AOD space, confidentiality and informed consent must be an ethical responsibility that should be upheld to gain success in peer support interventions. Privacy ensures that personal information is not shared with others, and identities are protected, which creates an environment where service users feel safe to disclose potentially sensitive details of their AOD use. Peer support interventions must comply with privacy laws, and disclosures made only when permission is given.

Importance of implementing community development principles in drug and alcohol services

Implementing community development principles in AOD services is essential for making a sustainable and inclusive support system for people who may be struggling with substance use disorders. The underlying principles of community development focus on the local community's empowerment and involvement. Services can use local knowledge, resources, and networks, leading to more positive outcomes and culturally appropriate resolutions in AOD ensuring services can be tailored to a community's unique needs making interventions more effective (Bess et al., 2020)

The benefits of using community development principles in AOD include enhancing the accessibility of AOD services and treatment programs, encouragement, and the acceptance

of those services. Services that are developed with a community's contribution are more likely to be used and trusted. Collaborative approaches are argued to reduce the stigma that can be associated with AOD, ensuring community members feel safe and supported and empowering them to advocate for the services they have designed and implemented. Community-driven initiatives can also be explored to develop peer-support groups and networks that have been proven to help with recovery. Peer-support has been argued to reduce the feelings of isolation and offers practical advice on living with the AOD issues.

Consultation with regional community leaders and First Nation elders before implementing the peer support project to ensure localisation and adaptation based on the community's preferences, autonomy and goals is essential.

Targeting and preventing potential burnout among staff

Organisations should monitor peers for burnout to prevent high turnover rates by regularly checking in on their employees and gathering data while maintaining privacy. Peer workers should feel comfortable in their workplace and be empowered to speak up about addressing concerns or worries about their well-being.

Fostering a workplace culture that promotes professional well-being and client care should be considered of highest importance at the organisation level as it aims to improve the work environment and balances the high job demands of peer workers. Organisations should evenly distribute workloads throughout the team and facilitate collaboration, teamwork, and professionalism through relevant training and programs that support the psychological safety of their peer workers to better support their clients with AOD use.

Self-care strategies for peer workers & organisational care

Organisation should support appropriate self care strategies. Self-care is critical for peer workers to maintain their mental well-being while working in a demanding job. Self-care is about taking care of yourself, getting enough sleep, eating nutritious meals, and regular exercise. This can help with managing ongoing stressors since it provides care for the body's spiritual, physical, emotional, and mental well-being.

Some activities of self-care include: taking care of physical and psychological health, managing and reducing stressors, honouring emotional and spiritual needs, fostering and sustaining healthy relationships with others, and achieving an equilibrium across one's personal environment and work lives.

Promote the enhanced inter-connectedness between the AOD services

Professionals who work in the AOD space can create a seamless continuum of care by fostering solid connections and collaboration among various AOD service providers, including healthcare professionals, social workers, community organisations, and peer support groups, and by promoting inter-connectedness between AOD services and programs. Interconnected systems guarantee that people who seek AOD support will receive a consistent and holistic approach to their recovery journey. Addressing the physical, psychological, social, and environmental influences allows information sharing and better resource allocation in the AOD space, leading to better outcomes in people's recovery.

By having interconnected systems, services may improve and better respond to the co-occurring problems that people face with substance use disorders. Examples include people who have an AOD disorder, who could also experience other challenges such as mental health or the justice system. Integrated services that can address multiple circumstances that people face at once (Wutzke et al., 2021). This approach reduces fragmented care where there is a possibility that people may fall through the cracks of healthcare systems. By being collaborative, the service providers can advance access to a range of further services that could be crucial in the recovery of the entire person. Services that may be beneficial include housing support, education programs, employment assistance, mental health, and financial assistance which is argued to help with continuing recovery.

Glossary

Advocacy	Describes the efforts that aim to influence policymakers and stakeholders to support or change guidelines and measures that aim to reduce harm for people with AOD disorders. It can involve improving access to treatment and support services for people and their families seeking support. They advocate seeking funding, treatment programs, support groups, or rehabilitation centres to reduce the harm.
Cultural competence	The ability to participate ethically and respectfully in professional and personal intercultural settings and explore the diversity it brings within society.
Dependence	Dependence is the term used to describe the use of drugs, alcohol, or tobacco that continues even when significant problems related to their use have developed and affected the person's mental and physical health. The person relies on a type of substance to feel 'normal' or cope with everyday routine.
DSM-5	The *Diagnostic and Statistical Manual of Mental Disorders 5th Edition* (DSM-5) is the handbook used by healthcare professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders. *DSM-5* contains descriptions, symptoms and other criteria for diagnosing mental disorders. It provides a common language for clinicians to communicate about their patients and establishes consistent and reliable diagnoses that can be used in research on mental disorders. It also provides a common language for researchers to study the criteria for potential future revisions and to aid in the development of medications and other interventions.
Empowerment	Has a focus on the achievement of the clients goals by what strengths, resources and resilience the client has, this empowers the person to gain motivation, control of their lives and self-confidence.
Human Rights	Human rights are universal rights that are integral to everyone, regardless of sex, nationality, ethnic origin, colour, language, religion, or any other position. These human rights include the fundamental rights to a whole and healthy life, such as education, food, housing, health, and freedom.

ICD-10	The 10th revision of the International statistical classification of diseases and related health problems (ICD-10) contains guidelines for recording and coding, together with much new material on practical aspects of the classification's use, as well as an outline of the historical background to the classification. The ICD-10 provides a basic description of the ICD, together with practical instructions for mortality and morbidity coders, and guidelines for the presentation and interpretation of data. It is not intended to provide detailed training in the use of the ICD.
Lived or Living Experience	The term 'lived or living experience' in these situations is defined as the individual's personal experience with alcohol and other drug use, as well as involvement in recovery, treatment, and harm-reduction services. It could also pertain to assisting a loved one who is affected by AOD use or dependence.
Resilience	Resilience defines the ability to cope with unexpected changes and challenges in one's life. Resilience also defines the action to strengthen one's capacity to deal with these challenges even if it is not always practicable to prevent stressful or adverse situations. In drug and alcohol services, resilience is the individual's ability to cope with tough times by applying their inner strength and engaging support networks. Thus, resilience aims to establish one's ability to face difficult situations and maintain functioning mental health
Recovery-Oriented Approach	Is a framework that supports the recovery of individuals that empathises the clients right to self-determination, hope, goal setting and self-management.
Social Justice	Commitment to creating fairness and equity in resources, rights, institutions, and systems, and the treatment of marginalised individuals and groups of people who do not share equal power in society.
Trauma-Informed Care	Trauma-Informed Care acknowledges that healthcare organisations and care teams need to have a complete picture of a patient's life situation - past and present - in order to provide effective health care services with a healing orientation. Adopting Trauma-Informed Care can potentially improve patient engagement, treatment adherence, and health outcomes, as well as provider and staff wellness. It can also help reduce avoidable care and excess costs for both the health care and social service sectors.

Aims and objectives

Aim

The overall aim of this study is to critically examine the necessity and methods to improve the support for peer workers who have lived experiences of drug and alcohol. This project also aims to demonstrate a series of evaluations, literature review, and recommendations to establish an unbiased, ethical, responsible, and culturally competent peer support network that can be applied to the AOD service network.

Objectives

- To conduct a comprehensive analysis that enhances the importance and urgency in establishing a support program for the peer workers with a lived experience of drug and alcohol use.
- To investigate possible barriers in providing peer support service within the drug and alcohol service network in South Australia while exploring the possible actions to support advocacy and raise social awareness.
- Drawing on the previous peer-reviewed journals, ethical review, and research to facilitate the resilience of peer workers with a lived experience of drug and alcohol use.
- To critically examine and analyse the contemporary policy and guidelines regarding drug and alcohol while demonstrating critical comparison between South Australia, other jurisdictions, and national practice standards.

Background

The role of peer workers and what they do

Peer workers are people who have successfully maintained their personal rehabilitation from AOD dependence and who offer non-clinical help to others in similar circumstances (Scannell, 2022). According to Boniface and Hodges, (2022), workers with lived experience utilise their personal journeys of mental or alcohol and other drug use struggles, utilising services, and finding healing, as well as supporting others through similar experiences, to form connections grounded in shared understanding, empowerment, and hope. Therefore, peer support is a crucial strategy that develops rapport by utilising the common lived experience of AOD use and recovery (Scannell, 2022).Peer workers can offer the distinct perspective of having gone from being a client to a peer worker, which can encourage those seeking their own resolution and give them hope that AOD dependence recovery is achievable (Scannell, 2022).

Core Roles of lived experience workers can take the form of direct roles, such as peer support, or indirect roles, like lived experience academic or leadership work (Boniface & Hodges, 2022). A peer worker's responsibilities include helping to establish and grow harm reduction peer advisory groups, incorporating personal experience with drug use into the program's design, implementation, and evaluation techniques, and providing one-on-one or group peer support to AOD dependent individuals, their carers, and family members within defined models of care (Eddie et al., 2019). Some requirements peer workers need involve holding a social work, psychology, or social science diploma, having completed the cost-free online NDIS Workers Initial module certification, or having a fundamental knowledge of a range of supplementary frameworks of practice that assist individuals with their mental health, dependence on alcohol, and other drugs (NADA, n.d.).

Other roles include advocates who empower individuals or groups with mental health problems to advocate for their rights and needs in different settings. These peer educators offer education based on their own experiences for fellow peers, mental health professionals, or members of the community and peer consultants who collaborate with mental health service providers to offer consumer or carer viewpoints in all stages of planning, execution, and assessment, as well as offer input to service users (McMahon, 2019).

Peer work/peer support is a major part of the alcohol and other drug and wider community services and health workforce, as peer work is becoming more known, and is being incorporated in many fields. It involves aiding others in healing and recovery (Boniface & Hodges, 2022). According to Boniface and Hodges (2022), peer support is structured around fundamental principles such as respect, shared responsibility, and agreement on what is helpful to facilitate the support exchange between individuals. Peer support does not adhere to psychiatric models or diagnostic criteria. It involves empathetically comprehending someone else's circumstances by relating to emotional and psychological suffering together. Discovering a sense of belonging with others with similar characteristics can create a strong connection. This link, or bond, is based on a profound, comprehension rooted in shared experiences where individuals can coexist without the limitations of conventional (expert/patient) connections (Boniface & Hodges, 2022).

Workers with personal experience play a significant role in AOD treatment and harm reduction services, now earning increased acknowledgment for the valuable role they play in assisting clients in their recovery journey (Kostadinov, Skinner & Duraisingam, 2023). Peer workers who have first-hand experience with AOD issues make a significant contribution to the workforce in alcohol, tobacco, and other drug treatment. The quality of services can be improved by incorporating peer workers into the workforce, as they offer unique insights, empathy, and understanding to clients from their own shared experiences (Australian Government, 2019). This point of view can potentially improve empathy, comprehension, and rapport with consumers, resulting in more efficient assistance and attention (Queensland Health, 2023). Furthermore, peer workers aid individuals, families, and caregivers by helping them navigate the healthcare system, advocating for their interests, and encouraging self-advocacy.

Ethical issues and considerations

Ethical matters have been emerging at a national level, which can lead to ongoing challenges that can be hard to navigate in the AOD space. (Hölscher et al., 2023). The reason for the importance of ethics in AOD settings, particularly for peer workers, is the increasing knowledge base of occupations that relate to aspects of human life, and what people do and how they have a lack of control that could potentially affect their physical, psychological, cultural, and spiritual needs (Hölscher et al., 2023). These capacities carry with them considerable social power to act in ways that either promote or act against the wellbeing and interests of individuals. According to the Association of Social Workers (AASW, 2020), Many

social theories underpin human rights and social justice frameworks, which aim to engage people, the community, and larger structures to address AOD challenges. Therole of social workers and human service workers is to strive to support people's work in partnership with community and government organisations. (AASW, 2020).

Peer workers have a unique skill set from their lived experience. Peer workers offer a listening ear, a fundamental understanding of the issues of AOD, and demonstrate empathy for clients. However, peer workers must be able to navigate their personal experiences and those of their clients while upholding their professional practice and integrity. Peer workers need to have a good sense of their self-care. People working with a lived experience must be aware of the potential workplace hazards and triggers that could conflict with their mental health and the health and safety of their clients, creating dilemmas in the service delivery for already such a vulnerable group. According to the Office for Victims of Crime (n.d.), vicarious trauma can have significant effects on individuals working in the field of victim services. Peer workers are at more risk of vicarious trauma (VT), which may interfere with their recovery journey.

Peer workers can utilise this table below as a quick checklist to identify signs of vicarious trauma.

Some common indications a peer worker may be suffering from vicarious trauma may include but are not limited to:
• ***Decreased participation in activities that used to be pleasing***
• ***Being distracted, which can increase the risk of incidents***
• ***Difficulty managing emotions and feeling 'emotionally numb' or 'shut down'***
• ***Potential relationship issues (e.g. withdrawing from friends and family, increased interpersonal conflicts, avoiding intimacy)***
• ***Unhelping coping or dependence behaviours (e.g. over/under eating, substance dependence, gambling, taking undue risk)***
• ***Avoiding work and interactions with clients or constituents***
• ***Feeling vulnerable or excessively worrying***

Barriers in the provision of services

The number of people who reach out and receive help relating to their AOD issues is low compared to the hypothesised need. It is hypothesised that this is due to the perceived level of discrimination or stigma they experience when seeking treatment. The World Health Organisation (WHO) empathises the importance of people being able to seek and support and care when and where they seek it, by integrating mental health services along with training to address stigma, (WHO) aims at creating a more inclusive environment for people with substance use disorder.

Structural stigma may be a significant reason why people do not reach out for treatment services. Structural stigma refers to institutional and societal beliefs and attitudes that create harmful biases towards individuals who suffer from AOD. That can lead to further prejudice and discrimination (Roche et al., 2021). Structural stigma can be found in health care systems, private and public bodies, police, services, correctional institutions, education, and

legislative bodies. Structural stigma can be linked to lower levels of funding for AOD services despite the high demand for AOD treatment in Australia. There is a need for further investment in multidisciplinary team skills, mentoring/supervision, counselling, and essential leadership (Skinner et al., 2021). It is crucial to note that the AOD workforce should receive adequate support. Some workers have unique skills and needs that require additional or specific support to provide the highest quality service and maintain a healthy well-being. Moreover, the organisations and the legislative bodies should conduct more comprehensive research into the peer workers' and the clients' lived or living experiences of structural stigma to demonstrate adequate support and structural reforms accordingly.

Compulsory or coerced referrals are when people are referred to organisations in the AOD space, by law enforcement, courts, child protection or other health care. It has been found that compulsory treatment programs deliver poorer outcomes due to stigma than voluntary programs (Beem, 2020). This is thought to be because there is a perception that people who are engaging in mandated programs are "criminals" or "addicts" as opposed to someone who seeks support on their own. This is based on the acknowledgment of risk reductions linked to the utilisation of voluntary programs as it appears normalised as a rational decision and takes responsibility for AOD use, which creates further discrimination and marginalisation.

People who use AOD can do so for many reasons: for enjoyment, to cope, to escape reality, to give them energy, to help them sleep, or to forget. People on the outside and how they view the service recipient are critical because it will help determine the narratives in which people who AOD may see themselves and how others see them. This affects their response to wanting to reach out for support, creating a sense of fear in the person that prevents them from seeking treatment due to being judged. Neoliberalism has been argued to make those inequalities worse as governments limit spending on social issues significantly affecting lower-income people, and creating barriers to receiving services. Therefore, there is a significant demand for the organisations, funding bodies, and governments at all levels to be open to the public's feedback and complaints. Only by doing so, the government and the organisations can thus transfer their role from the 'oppressor' to the active 'supporter' in protecting the client's dignity, agency, and human rights.

Workplace Discrimination: Peer workers more likely to have experienced organisational issues regarding stigma and discrimination, pay discrepancies, and power imbalances and boundaries that surround the job role. Employees who have

personal experience were much more prone to reporting instances of discrimination at their place of work and have reported workplace harassment more often than non-lived experienced workers (Chapman et al., 2020). It is crucial to note that many of the AOD workforce with lived experience do not disclose their personal experience in the workplace, according to Skinner et al., (2021).

Furthermore, it is important to note that stigma is the root cause of discrimination and adoption of stereotypes about people who use substances and by extension peer workers who have lived or living experiences of using substances. According to Greer et al. (2019), people who use substances are a population that is frequently the target of prejudices and presumptions that overlap with other issues, such as homelessness and poverty. Peer workers might face prejudice and discrimination because of their personal history of substance use or treatment. This negative perception may result from coworkers, customers, or the wider society, affecting their confidence and work connections (Meumann & Allan, 2019). Peer workers may find it challenging to uphold proper boundaries in their interactions with clients. As they may find it difficult to maintain professional boundaries while providing both empathy and support (Meumann & Allan, 2019).

Role Confusion: Peer workers may experience confusion regarding their position in the organisation and the distinctions between their roles and traditional staff roles (Meumann & Allan, 2019). Defining expectations, responsibilities, and limits can aid in resolving problems associated with unclear roles. Therefore, peer workers would require better-targeted training and supervision in supporting their enhanced performance and capability. Specifically, continual professional development, mentorship, and supervision customised to peer workers' specific needs are essential for their development and success in their positions (Meumann & Allan, 2019). Similarly, peer workers within the organisation may encounter restricted chances for career progression or growth in their professional development. Establishing opportunities for progress, acknowledgment, and honing skills can effectively tackle matters revolving around career development (Meumann & Allan, 2019). The AOD sector then faces constraints in terms of resources and funding for peer support initiatives, training, and professional growth opportunities. Peer workers may encounter difficulties when trying to access the essential support and resources needed to effectively perform their roles (Queensland Health, 2023).

Risk Related Barriers: Peer workers in the AOD field may be at risk of experiencing a relapse because of the nature of their job and exposure to triggers related to

substance use (Queensland Health, 2023). Continuously being mindful and taking care of oneself is necessary when trying to balance one's healing process while also helping others with theirs (Queensland Health, 2023). Helping individuals who have gone through trauma or are battling with substance abuse can be unsettling for peer workers with their history of trauma. It is essential to manage triggers and uphold emotional health while assisting others through challenging situations (Queensland Health, 2023). In addition, peer workers face a risk of burnout because of the emotional requirements of their position and the possible stressors related to working in the AOD field. Peer workers need to make self-care a priority, reach out for help when necessary, and have the necessary resources to manage stress and emotional difficulties (Lancaster, Ritter & Stafford, 2013; Meumann & Allan, 2019). Moreover, the government and the organisations should provide more funding to research projects that target peer workers' experiences and potential exposure to a relapse. In doing so, the government and the organisations could thus design more comprehensive support programmes or services to better support peer workers' functionality while raising social awareness regarding the challenges that peer workers have been facing.

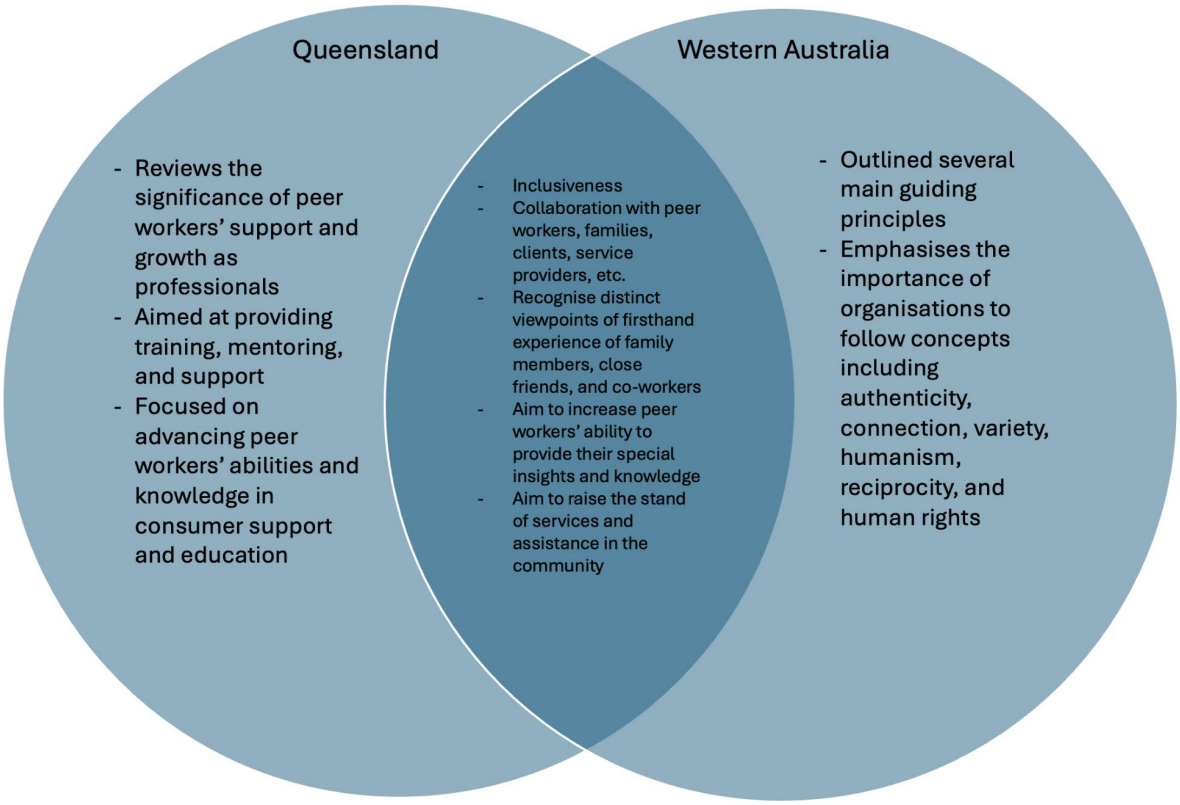
Comparison between other states frameworks

This project aims to raise awareness regarding the noticeable absence of a peer workforce (lived/living experience) framework for South Australia. There exists a *Western Australia lived experience (peer) workforce framework* and a *Queensland peer workforce framework*. Both frameworks seek to enhance the awareness of peer workers and support peer workers in their journey and career by emphasising inclusiveness, unification,

professional growth and guiding principles that assist organisations to better understand peer work and to work with peer workers.

The WA and Queensland frameworks share similar key components, with one of the major key components being inclusiveness and collaboration. These key components highlight the significance of including peer workers in providing services (Queensland Health, 2023). Additionally, it recognises the distinct viewpoints and input of those with firsthand experience, as well as those of family members, close friends, and coworkers (WA Peer Supporters' Network, 2018). Collaboration is another important element that is included in the frameworks. The two frameworks discuss the importance of collaboration, with peer workers, families, clients, service providers etc, this is to increase their ability to assist their clients and pinpoint services that could be improved (WA Peer Supporters' Network, 2018 & Queensland Health, 2023). Furthermore, collaboration allows peers to provide their special insights and knowledge to raise the standard of services and assistance that people in the community can receive (WA Peer Supporters' Network, 2018).

However, the two frameworks also have different components, which may be based on demographic and location reasons. One of the main differences is that the WA framework discusses the importance of some main guiding principles. The guiding principle element of the WA framework emphasises the importance of organisations following some guiding concepts, including authenticity, connection, variety, humanism, reciprocity, and human rights (WA Peer Supporters' Network, 2018).In contrast, the Queensland framework reviews the significance of peer workers' support and growth as professionals. The support and growth as a professional component highlights the significance of providing training, mentoring, and support to advance other peer workers' abilities and knowledge in consumer support and education (Queensland Health, 2023).



Finally, a gap in the knowledge base and service systems of South Australia has been identified. It is recommended that further studies be done to create a model specific to South Australia. To do this, further study and interaction with current peer workers will be needed to incorporate their expertise into creating a model for local peer support workers. A South Australian framework for peer workers should be adopted or developed, as it benefits not only the peer workers but also the wider community and organisations that assist those struggling with drug and alcohol dependence. The education, early intervention and prevention, treatment and support, and harm reduction programmes run by AOD professionals may all greatly benefit from the involvement of peer workers. Client results will be enhanced as a result. Furthermore, it might lessen the load on the legal, health, and community systems.

Defining Lived experience and Living Experience Workers

Peer workers ***would normally*** use their own diverse and unique experiences to manoeuvre through systems and seek to use their rehabilitation to assist others (Byrne et al., 2022). Peer workers who have been employed for specific roles and have a lived or living experience of alcohol and/or drug use incorporate that experience into their professional work (Insight Queensland, 2022; Kostadinov, Skinner & Duraisingam, 2023). There are different types of peer workers, such as peer workers with a living experience of drug and alcohol use (many work in harm reduction programs such as needle and syringe programs or the emerging pill testing programs), peer workers with a lived experience of drug and alcohol use (who are in recovery and either choose abstinence or managed use) and peer workers with a lived/living experience of relatives/family members who use substances (who may work at organisations that support families in the AOD sector).

The difference between lived and experienced AOD workers is important as they bring different perspectives to their work. Living experience workers refer to the first-hand "living" knowledge of the people who are using AOD. Some people in this group may identify as people who are dependent but manage their use to minimise harms. ”Lived” experience refers to people who historically used AOD but have now ceased use. This is often referred to as being in recovery and may refer to total abstinence.These unique groups of individuals can use their experiences to support their clients who may be accessing treatment and support services. Peer workers can use their lived experience to help bridge the gap between AOD services and clients who access those services.

The peer (lived/living) experience can be a dynamic, moving process rather than focusing on the past unresolved experience. This can be an ongoing process for people's experience who may be currently actively using AOD. There could be daily challenges for peers such as managing cravings, stigma, and social or legal issues which are associated with the living experience of AOD. Living experience is present-oriented, dealing with ongoing substance use and its immediate impacts, providing a real-time, dynamic perspective. Lived experience is often utilised in peer support, advocacy, and education to inspire and guide others, while living experience informs immediate interventions, harm reduction, and support strategies to address current needs.

Medical Model vs Human Rights Model

There is a tension between the medical model and a human rights based model. This project presents a critical analysis of the discourses of the medical model while emphasising the need to implement a human rights model in peer support programmes simultaneously.

Medical model

The medical model has predominantly legitimised the disease model and the authoritative power of medicine (Rogers & Pilgrim, 2021). Its main features include a biological emphasis, an illness framework, diagnosis, prognosis, aetiology, and treatment processes (Rogers & Pilgrim, 2021). This modelviews conditions as illnesses that may have a precise diagnosis, the reason for prognoses, and their causes. This model focuses on objective and scientific evidence. This can be at the expense of the diversity of other holistic approaches.

The DSM-5 which can be considered the centrepiece of the medical model, codifies and presents objective scientific evidence (Rogers & Pilgrim, 2021). However, Rogers & Pilgrim (2021) argue that despite some eclecticism, the medical model has demonstrated a strong bias towards medical treatments. The medical model has also created stigmatisation and stereotypes for individuals while focusing on the containment of risk over recovery (Rogers & Pilgrim, 2021). The medical model risks undervaluing peer work as it focuses on risk containment and disease. In contrast peer work focuses on the biases of the medical model, showing empathy, recovery, and shared experience. Peer work challenges the medical model's viewpoint as peer support is a more expansive approach to the ongoing treatment and recovery of AOD.

Recovery-Oriented Approach

Generally, the Recovery-Oriented Approachhas emerged from the first-person accounts of the consumer empowerment movement, and argues that whilst recovery is challenging it is probable. Specifically, while working in an AOD space of recovery, the Recovery-Oriented Approach moved away from a deficit-based approach, focusing on dignity, strength,

exploring further supports, and using the language of recovery. When working with people with a lived experience, the Recovery-Oriented Approach Emphasises shifting the person's identity through confronting the stigmatisation, labelling, and oppressive power hierarchies to reject the power of AOD use as a central and defining identity (Bland et al., 2015). Consequently, the Recovery-Oriented Approachencourages significant others, including family and practitioners, to become 'hope carriers' to support individuals when hope is of the essence (Bland et al., 2015). Therefore, AOD workers should acknowledge the expertise of the person's lived experiences and shift from 'doing for' to 'doing with' the client.

Trauma-Informed Care

Trauma-informed care argues that the recovery process should focus on strengthening the client's capabilities using elements of empowerment and safety t. (Levenson, 2020). Initially, the Trauma-Informed practice aims to support recovery by enabling the client to acquire distress-management strategies for more efficient daily functioning (Levenson, 2020).AOD clients' traumatic experiences may pose destabilising and counterproductive long-term effects if not appropriately dealt with. Hence, trauma-informed care concentrates on active listening and open-ended questions, and listening with curiosity and compassion to ensure the client feels respected, valued, which is essential in their journey to recovery.

Applying TIC in regards of cultural competency

Trauma-Informed Care (TIC) in the peer support program should also focus on actively supporting Aboriginal and Torres Strait Islander clients and their communities. Menzies (2019) has argued that the current approaches to addressing Alcohol and Other Drugs (AOD) use within Australian First Nation communities will have limited impact unless accompanied by a significant focus on understanding and addressing the high level of trauma within these communities. This requires recognising the historical and intergenerational trauma resulting from colonisation, systemic discrimination, and social marginalisation that many Aboriginal and Torres Strait Islander and communities experience.

Services that areTrauma informed are more likely to be culturally acceptable, building on the diversity of recovery strategies identified as effective for First Nations people, enhancing self-determination in regard to the unique healing practices that are suitable to their needs. Peer workers should have training in cultural competency, which involves a deep

understanding of Aboriginal and Torres Strait Islander cultural norms, values, traditions, and social structures in society.

Interviews with AOD peer workers

Background

The Second component of this project is focused on interviews with peer workers from the AOD field. In order to gain insight into the first-hand experiences of peer workers along with their perspectives, three semi-structured interviews were carried out.

In general, this project has adopted the qualitative research methodology to collect information or 'data' as part of the research programme (Carey, 2012). Through conducting semi-structured interviews, The project aims to understand the lived experiences of peer workers while demonstrating the process of knowledge production (Cohen, Manion & Morrison, 2007). The interview questions are designed to critically draw on the impressions generated from the peer workers' experiences, words, actions, behaviours, and observations (Bryant, 2015)

This project aimed to collect data in an empowering and participatory way, which emphasises the significance of 'Listen and Understand' (Buchanan & Wendt, 2018). In doing so, this project aims to promote the peer workers' active participation in the interview process to generate qualitative data and collect first-hand evidence. This project aims to adopt in-depth face to face interviews with the aims of using the lived or living experiences of the peer workers to generate strength and advocacy for the entire AOD peer worker workforce. Moreover, the interviews have adopted active listening to understand the peer workers' lived experiences that can generate a collective strength to overcome adversity (Buchanan & Wendt, 2018). Lastly, the data collection process also adopts the practice of

confidentiality and anonymity. The finalised interview transcript will use the words such as 'peer worker' and 'interview participant' rather than addressing the peer workers' name directly.

Thus, this project has transcribed the interviews with Family Drug Support, Hepatitis SA and Offenders Aid & Rehabilitation Services (OARS) into case studies to better present the voice of the peer workers and advocate for their needs.

Case study: Family Drug Support

An Interview was conducted with two Family Drug Support SA peer workers who have the lived or living experiences of family members that use alcohol and other drugs. The peer workers role is to run the support groups, support family members who are supporting the AOD users, bring community members together, and share stories and strategies.

Initially, the interview participants introduced their experiences of working as peer workers that have lived or living experiences of families or loved ones who use drugs and alcohol. The interview participants have pointed out that the role of peer workers is to facilitate understanding, address the biases and prejudice in the community, while creating a safe space for the clients to share their experience and seek support while not worrying about encountering discrimination or stigmatisation. Moreover, the peer workers' role also involves educating each other, service users, and community members on drug and alcohol use to minimise the harm driven by AOD use and support the person's physical wellbeing.

Simultaneously, the interview participants also revealed the interconnectedness between AOD and mental health while demonstrating peer work in the agency. The interview participants acknowledged that the lived experiences of supporting a family member as an ongoing process, while the impact on the peer workers' mental health can be persistent and need to be addressed regularly.

Moreover, the interview participants also raised the topic of self-care. The self-care forms that were mentioned were to maintain social activities and friendships, ensure work-life balance, and take breaks and holidays when needed. Regular debriefing with colleagues and supervisors, and personal self-care routines like yoga, gym, and massages. It is important to note that each person's self-care looks different to others.

Finally, the interview participants provided insights into the structural reforms and changes for the peer workers that they would like to see. They recommend that all Family Drug Support peer workers have the opportunity to complete a Certificate IVin AOD, and attend training provided by Family Drug Support. Whilst these are some of the requirements to be a peer worker at Family Drug Support Family peer workers are still classified as support workers rather than professional workers. (Winter. C & Tolley. A personal communication, May 15, 2024).

Case study: Hepatitis SA

During the interview with Hepatitis SA, the peer worker mentioned several emerging key themes, one of which was valuing lived experience. It was emphasised that recognising and valuing peer workers' expertise in the sector is crucial as they bring a unique skill set that is valuable in service delivery in AOD programs. Next, the conversation swiftly moved to self-care and funding allocation. It was noted that better self-care management and programs dedicated to peer workers must be better equipped to accomplish job satisfaction and maintain their well-being successfully.

As noted by the participant, team building exercises were mentioned and believed to be suitable for peer workers as she believed that these provide opportunities for peer workers to support each other, share ideas, and reflect. Activities such as these can create a more supportive environment, collaboration, and mutual respect amongst the team, developing a healthy and supportive working environment.

The interviewee noted that there is an ongoing need and demand for professional development for peer workers that is specifically tailored towards lived experience workers. Many peer workers may not feel comfortable in academic settings. It was mentioned that peer workers need to learn everything: how to dress, use the phone, and send appropriate emails, so professional development programs should be considered to enhance the skill set of experienced workers.

Recruiting people who are familiar with drug language, how to safely inject, street issues, and the current drug scene can be complex. It was mentioned that peer workers may lack office experience, phone manners, and professional etiquette, making the recruitment process challenging.

The main points taken away were self-care and the need for training and support for lived experience workers. TAFE courses, short courses on professional behaviour, computer skills, email and phone etiquette, and other aspects of professional behaviour. This ongoing support may help future peer workers be able to smoothly transition into their AOD roles and navigate the ongoing demands of the sector.

Case study: Offenders Aid & Rehabilitation Services (OARS)

This interview did not follow a semi structured format but was more of a general conversation. This gave great insights into the AOD space. The Peer worker interviewed noted they work part time due funding constraints. They noted that they were the first point of contact before treatment programs were tailored. The peer worker helps facilitate group work sessions alongside a qualified counsellor as well as one-on-one counselling sessions, some of which are mandated by police (Police Drug Diversion) or the drug diversion court. There are drug awareness sessions and SMART Recovery groups, which are a self-referral process. Services are for people who use drugs and are not open to family members; however, OARS has employed a family support worker who can help assist friends and family in the process of supporting their loved ones as a more tailored role was suitable.

The peer worker mentioned that sometimes, a relevant amount of self-disclosure is essential for building client rapport. They have a background in the criminal justice system in another state which. The worker identified the period of engagement with the justice system as a low point in their life and that experience prompted them to change, improving their life outcomes. The work identifies as a peer worker with lived experience of substance use and the rehabilitation system. They also studied for a community services certificate, and have worked for ten years as a peer worker. The work highlighted the importance of peer workers

and the training and development of peer workers in the sector. This highlighted better client outcomes, connections, and ongoing support for the recovery journey.

There was a discussion about the potential for discrimination that could be based upon a peer worker's criminal history and the nature of their crimes, which could cause difficulties when finding suitable employment. However, organisations such as OARS in the AOD space have been noted to be supportive. The worker has had positive experiences of not being discriminated against for their past, which has provided them with a safe space to further build confidence in the sector. They discussed struggling with self-doubt because they were the only peer worker and had fewer formal qualifications compared to other colleagues. However, over time and with support, training opportunities, supervision with supervisors, and debriefing, their confidence increased and they became more comfortable navigating the role. It was mentioned that further personal development training and government funding would be highly beneficial starting points in addressing mental well-being for peer workers in the AOD space.

Conclusion

This report has examined the lived and living experiences of peer workers that work in the AOD setting. Moreover, the critical analysis of the theoretical frameworks that underlines AOD service has revealed the urgent need to initiate support programs and legislative reform to provide comprehensive support for peer workers in South Australia. Specifically, peer workers' experiences of stigmatisation and discrimination remains a dominant cause of negative work experiences in the AOD setting. This has consequently diminished peer workers' capacity capability to provide sufficient support for the service users while, in some instances, severely impacting peer workers' mental wellness. This has the effect of prolonging the long-lasting stigmas towards the individuals who live with substance use, deepening the impact of structural discrimination.

The research sought to identify if there is a need for demonstrable organisational reform and the construction of a legislative framework led by the South Australia government that would support the further development and support of a peer workforce.. To achieve these aims and support the objectives, a literature review, scoping of other jurisdictional

frameworks and two semi-structured interviews and one unstructured interview were conducted. The research found clear documentary support for further work to be undertaken. Peer workers from three different agencies provided critical insights into numerous issues that indicate that reforms are much needed. Initially, the peer workers have requested the systemic recognition and valuation of their lived and living experiences. They indicated that peer workers should be acknowledged and recognised by legislative and commissioning bodies for their unique insights that provide expertise in shaping quality AOD services. Furthermore, the peer workers urged the need for better self-care management and more resources dedicated to peer workers. Similarly, team-building activities should be initiated by AOD agencies since they are identified by the research as essential for peer workers to share ideas and foster collaboration and mutual support among peer workers. Agencies and education providers also need to work together to develop professional development opportunities explicitly tailored for peer workers since some peer workers have experienced uncomfort and lack of confidence for working in academic professional development settings. Specifically, peer workers have identified the need for AOD agencies to provide training to support new peer workers to adapt to industry norms, professional behaviour, to develop appropriate conduct and boundaries, and understand best practice.

Therefore, on behalf of the South Australian Network of Drug and Alcohol Services (SANDAS), we present this paper to the relevant bodies and urge immediate support and action on all levels to support peer workers that work in the AOD setting.

References (APA 7th)

Álvarez, A. S., Pagani, M., & Meucci, P. (2012). The Clinical Application of the Biopsychosocial Model in Mental Health. *American Journal of Physical Medicine & Rehabilitation*, *91*(13), S173–S180. https://doi.org/10.1097/phm.0b013e31823d54be

Australian Government. (2019). National framework for alcohol, tobacco and other drug treatment 2019–29. Australian Government: Department of Health and Aged Care. https://www.health.gov.au/sites/default/files/documents/2020/08/national-framework-for-alcohol-tobacco-and-other-drug-treatment-2019-29.pdf

Beem, A. (2020). Governing cannabis highs and harms: Australia's neoliberal harm minimisation illicit drugs framework (Doctoral dissertation). Queensland University of Technology. https://eprints.qut.edu.au/203745/1/Amanda_Beem_Thesis.pdf

Bess, K. D., Fisher, A. T., Sonn, C. C., & Bishop, B. J. (2002). Psychological sense of community: Theory, research, and application. In A. T. Fisher, C. C. Sonn, & B. J. Bishop (Eds.), *Sense of community research, applications, and implications* (pp. 3-24). Springer.

Bland, R., Renouf, N., & Tullgren, A. (2016). Social work practice in mental health: An introduction [Review of the book *Social work practice in mental health: An introduction*, by R. Bland, N. Renouf, & A. Tullgren]. *Aotearoa New Zealand Social Work, 28*(3), 94-. https://doi.org/10.11157/anzswj-vol28iss3id253

Boniface, S., & Hodges, E. (2022). A guide for understanding lived experience perspective, expertise and related concepts. SA Lived Experience Leadership & Advocacy Network (LELAN), Adelaide. Retrieved April 9, 2024, from https://www.lelan.org.au/wp-content/uploads/2023/01/Resource_Lived-Experience-Glossary_2022.pdf

Bourassa, D. B. (2009). Compassion fatigue and the adult protective services social worker. *Journal of Gerontological Social Work, 52*(3), 215–229. https://doi.org/10.1080/01634370802609296

Bryant, L. (2015). Introduction: Taking up the call for critical and creative methods in social work research. In L. Bryant (Ed.), *Critical and creative research methodologies in social work* (pp. 15–38). Routledge.

Buchanan, F., & Wendt, S. (2018). Opening doors: Women's participation in feminist studies about domestic violence. *Qualitative Social Work*.

Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L., Castles, C., Craze, L., & Saunders, M. (2021). National lived experience development guidelines: Lived experience roles. National Mental Health Commission. https://www.mentalhealthcommission.gov.au/getmedia/0b13e22c-bfe3-4c0d-b348-25a0edb1a723/NMHC_Lived-Experience-Workforce-Development-Guidelines_Roles

Carey, M. (2012). *Qualitative research skills for social work*. Ashgate Publishing Ltd.

Chapman, J., Roche, A. M., Kostadinov, V., Duraisingam, V., & Hodge, S. (2020). Lived experience: Characteristics of workers in alcohol and other drug nongovernment organisations. *Contemporary Drug Problems, 47*(1), 63–77. https://doi.org/10.1177/0091450919894341

Childs, B. (2021). Mind's peer work framework. Mind Australia. https://www.mindaustralia.org.au/sites/default/files/2023-04/Mind_peer_work_framework.pdf

Cohen, L., Manion, L., & Morrison, K. (2007). *Research methods in education* (6th ed.). Routledge.

Eddie, D., Hoffman, L., Vilsaint, C., Abry, A., Bergman, B., Hoeppner, B., Weinstein, C., & Kelly, J. F. (2019). Lived experience in new models of care for substance use disorder: A systematic review of peer recovery support services and recovery coaching. *Frontiers in Psychology, 10*, 1052. https://doi.org/10.3389/fpsyg.2019.01052

Grebely, J., Gilliver, R., McNaughton, T., Conway, A., Cunningham, E., Henderson, C., Hadlow, B., Molloy, K., Doab, A., Tillakeratne, S., Pepolim, L., Harrod, M. E., Dore, G. J., & Read, P. (2023). Single-visit hepatitis C point-of-care testing, linkage to nursing care, and peer-supported treatment among people with recent injecting drug use at a peer-led needle and syringe program: The TEMPO Pilot Study. *The International Journal of Drug Policy, 114*, 103982. https://doi.org/10.1016/j.drugpo.2023.103982

Hölscher, D., Hugman, R., & McAuliffe, D. (2023). Part V: Ethical issues and challenges in social work. In *Social work theory and ethics*. Springer.

Insight Queensland. (2022, September 12). Victoria Kostadinov and Jack Nagle-Harnessing the power of the lived experience voice [Video]. YouTube. https://www.youtube.com/watch?v=sX--M0KXCWM

Introduction to self-care. (n.d.). Social Work Buffalo. https://socialwork.buffalo.edu/resources/self-care-starter-kit/introduction-to-self-care.html#title_3

Kashwan, P., MacLean, L. M., & García-López, G. A. (2019). Rethinking power and institutions in the shadows of neoliberalism. *World Development, 120*, 133–146. https://doi.org/10.1016/j.worlddev.2018.05.026

Knight, C. (2015). Trauma-informed social work practice: Practice considerations and challenges. *Clinical Social Work Journal, 43*(1), 25–37. https://doi.org/10.1007/s10615-014-0481-6

Kostadinov, V., Skinner, N., & Duraisingam, V. (2023). Workers with lived and living experience: Characteristics and wellbeing in the Australian AOD sector. *Contemporary Drug Problems, 50*(4), 527–540. https://doi.org/10.1177/00914509231210928

Lancaster, K., Ritter, A., & Stafford, J. (2013). Public opinion and drug policy in Australia: Engaging the "affected community." *Drug and Alcohol Review, 32*(1), 60–66. https://doi.org/10.1111/j.1465-3362.2012.00497.x

Levenson, J. (2020). Translating trauma-informed principles into social work practice. *Social Work (New York), 65*(3), 288–298. https://doi.org/10.1093/sw/swaa020

McMahon, J. (2019). Community of Peers Project Final Report: A project to undertake a feasibility study into the establishment of a member-based organisation for the peer workforce in Australia. Private Mental Health Consumer Carer Network Australia. Retrieved April 10, 2024, from https://www.livedexperienceaustralia.com.au/_files/ugd/907260_03122e9e815d46c987265442f7f6676c.pdf

Menzies, K. (2019). Understanding the Australian Aboriginal experience of collective, historical and intergenerational trauma. *International Social Work, 62*(6), 1522–1534. https://doi.org/10.1177/0020872819870585

Meumann, N., & Allan, J. (2019). Peer workforce models in alcohol and other drug treatment. Lives Lived Well. Coordinate: An Australian Government Initiative. https://www.coordinare.org.au/assets/298704c8ac/Literature-Review_AOD-peer-support-models.pdf

NADA Network of Alcohol and Other Drugs Agencies. (n.d.). Working in the AOD sector. Retrieved April 9, 2024, from https://nada.org.au/jobs/working-in-the-aod-sector/

Office for Victims of Crime. (2020). The vicarious trauma toolkit: What is vicarious trauma? Office for Victims of Crime. https://ovc.ojp.gov/program/vtt/what-is-vicarious-trauma

Queensland Health. (2023). Queensland Health lived experience (peer) workforce framework. Queensland Government. https://www.health.qld.gov.au/__data/assets/pdf_file/0039/929667/peer-workforce-support-framework.pdf

Roche, A. M., & Skinner, N. (2021). The non-government alcohol and other drug workforce in Australia: Findings from a national survey. *Drug and Alcohol Review*. https://doi.org/10.1111/dar.13278

Rogers, A., & Pilgrim, D. (2021). *A sociology of mental health and illness* (6th ed.). McGraw-Hill Education.

Skinner, N., Kostadinov, V., Duraisingam, V., McEntee, A., Nicholas, R., & Bowden, J. (2021). Review and revision of the national alcohol and other drug (AOD) workforce development (WFD) strategy: Discussion paper. National Centre for Education and Training on Addiction (NCETA), Flinders Health and Medical and Research Institute (FHMRI), Flinders University, Adelaide, Australia. https://nceta.flinders.edu.au/application/files/7016/3969/7235/AOD_WFD_Strategy_Discussion_Paper_-_FINAL_.pdf

Skinner, N., McEntee, A., & Roche, A. (2020). Australia's alcohol and other drug workforce: National survey results 2019-2020. National Centre for Education and Training on Addiction (NCETA), Flinders University.

WA Peer Supporters' Network. (2018). The peer workforce report: Mental health and alcohol and other drug services. http://www.comhwa.org.au/wapsn

Wutzke, S. E., Shiell, A., Gomel, M. K., & Conigrave, K. M. (2001). Cost effectiveness of brief interventions for reducing alcohol consumption. *Social Science & Medicine, 52*(6), 863-870. https://doi.org/10.1016/S0277-9536(00)00187-2

Appendix A – NATIONAL QUALITY FRAMEWORK FOR DRUG AND ALCOHOL TREATMENT SERVICES

Guiding Principles

The National Quality Framework has nine nationally agreed Guiding Principles:

The Guiding Principles include statements of commitment that articulate key aspects required to improve quality in AOD treatment services. Accreditation standards ability to meet the minimum level of quality for the delivery of AOD treatment services, as stated in the Guiding Principles, will be assessed. The Acceptable Accreditation list will communicate the accreditation standards that meet the minimum level of quality.

Appendix B – LANGUAGE GUIDELINE IN DRUG AND ALCOHOL SERVICE (THE POWER OF WORDS)

> ***"Stigma is judgment, labeling, stereotyping, it is dehumanising, fear shame, it is ignorance, it is insidious."***

Avoiding stigmatising language when referring to people who use drugs

Stigmatising terms | Stigmatising in certain contexts | Preferred neutral terms

Stigmatising terms	Stigmatising in certain contexts	Preferred neutral terms	Reason to use preferred terms	Additional guidance
Junkie, druggie, drug user, drug abuser	Addict, alcoholic/alkie, IDU/injecting drug user, intravenous drug user	Person who uses or has used alcohol or other drugs	The order of the words we use, as well as the actual words , affects the images generated about the person or group being described. Using person-first language recognises that the most important label is that of 'person' – that a person be understood as a human being before they are anything else.	A person working in communications may include these guidelines to inform how their organisation could talk about people who use alcohol and other drugs. This may include both legal and illegal drugs.
Drug habit	Alcoholic, addict, person with a substance use disorder	Person with a dependence on drugs, person with a dependence on alcohol	People who use alcohol and/or other drugs should not be assumed to have a substance use disorder. 'Substance Use Disorder' is a clinically accurate term to describe the 'constellation of impairments caused by repeated use of a substance'. Using stigmatising terms can negatively affect judgments made about a person who uses alcohol and/or other drugs, including attitudes towards if they should receive punishment or medical care.	Not making assumptions about how and when someone uses drugs maintains trust while working positively to support the person, their family, or the wider community.
Suffering from addiction (currently or previously)	Addicted	Person experiencing addiction	The term 'suffering' implies that the person has a poor quality of life, and no control over their actions. Someone who is experiencing addiction may not be currently using alcohol and/or other drugs. 'Addiction' is a medical term used to describe a condition where someone continues to engage in a behaviour despite experiencing negative consequences.	When speaking with someone with lived experience of alcohol or drug dependence, asking what their preferred terms are can be a positive strategy to avoid using terms that a person might find stigmatising.
Abuse, misuse, problem use, non-compliant use	Alcohol abuse, pharmaceutical misuse	Substance use, non-prescribed use, non-medical use	The term 'abuse' can imply a moral failure and is often not necessary to describe a health condition. Sometimes there may be a scientific justification, such as referring to someone who meets the Diagnostic and Statistical Manual of Mental Disorders criteria for 'alcohol abuse', but in general, abuse be avoided. The term 'pharmaceutical misuse' may be used to describe the use of a prescribed medication when not following prescription directions.	A person may use more of a prescribed medication than they have been prescribed, such as benzodiazepines or opioid analgesics. Using the preferred terms allows you to focus on supporting the person's wellbeing.

"Stigma ignores the whole complexity of people's story"

Stigmatising terms	Stigmatising in certain contexts	Preferred neutral terms	Reason to use preferred terms	Additional guidance
Using again, fallen off the wagon, failing treatment	Had a setback, relapse	Currently using drugs/alcohol (after a period of not using)	These phrases can imply failure and can make people feel shame, which takes away from the focus that the person may have for the future. Using the preferred term considers that people may use drugs at different times in their life and doesn't take away their sense of control as they make different choices over time.	In treatment and clinical settings, it may be necessary for information about a client to be conveyed by a practitioner to other colleagues. It's important that people remain mindful of language to avoid implying failure or perpetuating stigma in their practice. Sharing these guidelines amongst peers can be a positive strategy to avoid stigma in these situations.
Clean/dirty needle, dirties	Freshies	Sterile/unsterile, used/unused, new/old	Using terms like 'clean' and 'dirty' suggest a value judgment that links these concepts with the person. The preferred terms are descriptive clinical terms that name the object, rather than attributing judgment to the objects and the people that use them.	
Dirty/clean urine/blood, tainted blood		Positive/negative urine/blood drug screen, specific description of clinical condition, blood containing hepatitis C	Describing urine or blood as dirty/ clean implies a value judgment that people who test positive are dirty and that associates alcohol and/or drug use with being unclean. Preferred terms focus on the clinical findings regarding a fluid sample and so avoid a value judgment implication that may be stigmatising.	
Complex / challenging people		People with complex/ challenging needs, people with co-occurring needs	Focusing on a person's actions, behaviours, or circumstances as being complex or challenging separates the behaviour from the person. This avoids making a negative judgment about them as a human being by identifying the behaviour or circumstances as the issue.	When working in a multidisciplinary team, whether in a policy or clinical context, use person first/ centred language when speaking or writing about people with complex needs.
Doctor shopper		Person with multiple prescribers	Using the stigmatising term implies blame and can isolate the person as the problem. Using the preferred term focuses on the medical care and other support that person may require.	In Victoria, SafeScript is a public health system to help prescribers and pharmacists keep track of prescriptions of high-risk medications. This will help with preventing the harms associated with people having multiple scripts for risky medications.

"Stigma prevented me from getting help"

Avoiding stigmatising language when referring to or talking with people who no longer use alcohol and/or other drugs

Stigmatising terms | Stigmatising in certain contexts | Preferred neutral terms

Stigmatising terms	Stigmatising in certain contexts	Preferred neutral terms	Reason to use preferred terms	Additional guidance
Clean, ex-addict, former addict, used to be a ['junkie', 'druggie', 'drug user', 'drug abuser'], stayed clean, hit rock bottom	Person who is recovering from drug use/ dependence, sober	Person who is no longer using, person who has stopped using alcohol/drugs, person with lived experience of drug use/ dependence	Use language that highlights a process of self-determined change. You can also use it to refer to people stopping or reducing their use. Using stigmatising terms can imply a character judgement.	

Avoiding stigmatising language when referring to treatment

Stigmatising terms	Stigmatising in certain contexts	Preferred neutral terms	Reason to use preferred terms	Additional guidance
Replacing one drug/ addiction for another; liquid handcuffs		Pharmacotherapy treatment, Medication-Assisted Treatment of dependence (MATOD)/ Medication, Opioid Substitution/ Replacement Therapy/ Treatment (ORT/ OST), Opioid Pharmacotherapy Program (OPP)	Pharmacotherapy is medicine. It is an evidence-based treatment for drug dependence for specific drugs, typically opioids (both illegal and prescribed).	People who are on methadone programs regularly report experiencing stigma and discrimination. Using terms such as pharmacotherapy or medication helps to reinforce that it is a medical treatment.
Non-compliant, lacks insight, in denial, resistant, unmotivated	Not engaged, hard to reach, hard to engage	Treatment has not been effective, chooses not/ disagrees to treatment	These terms characterise the individual as cooperative or uncooperative and regard the person as a passive and submissive recipient of care. Some people who use drugs may be seeking health care for something other than their drug use and may have other health priorities that they need addressed.	
Drug seeking, manipulative, splitting, attention seeking		Person's needs are not being met	People who use alcohol or other drugs need appropriate health care. Without it, they may not be able to reduce or stop their use of a drug(s) on their own. If their needs are not being met, they do what they can to manage. These terms are unnecessarily judgemental and may not take into account the complexity of substance use and a person's circumstance.	

"Stigma makes you start believing in the stereotypes about yourself"

Avoiding stigmatising terms when referring to people living with blood borne viruses

Stigmatising terms Preferred neutral terms

People who inject drugs are at risk of acquiring blood borne viruses, such as hepatitis C and HIV. People who live with these conditions also experience stigma. This can result in compounding stigma, which is the combination of stigma surrounding the use of drugs and stigma surrounding the blood borne viruses.

Stigmatising Term	Preferred Term	Reason to use preferred term
Victim, sufferer, carrier, infected, diseased, contaminated	Person who has/is living with hepatitis C or HIV, survivor	These terms are disempowering and may imply that people have no control over their lives.
Catch it, became infected/reinfected with	Contract/acquire/ has been exposed to/diagnosed with hepatitis C or HIV	These terms suggest something that is contagious and should be avoided or feared. It is not always relevant to ask how a person acquired viral hepatitis. Always provide harm reduction information, to avoid having to guess or make judgements about current drug use.
Spread, give/gave	Transmit/transmission	Transmission is the correct term when referring to the virus passing from one person to another.

More information

If you would like to know more about the work that was completed to develop these guidelines, how to apply them, or a summary of the project, you can download more information here: adf.org.au/powerofwords.

- Would you please explain the Family Support Programme you are running.
- How do you recruit people who have lived or lived experiences of drug and alcohol use?
- Have you attended any training to improve your skills?
- Can you discuss your experiences of working with peer workers who have lived or lived experiences of families or loved ones who use drugs and alcohol?
- Do you have any experience supporting peer workers while undergoing mental health conditions? If so, how have you provided drug and alcohol support to them while addressing their mental health conditions?
- Have you experienced or engaged with a peer worker who has relapsed? What strategies did you use to support them in maintaining their recovery goals?
- Have you collaborated with other agencies or professionals? If so, what were they?
- How do you address confidentiality and privacy concerns when supporting peer
- Are there any agency recommendations to assist with self-care? Or do you have a self-care routine? If so, what is it?
- Based on your experience of peer support so far, are there any recommendations you would like to make for future peer support programs?

Appendix-D Interview Questions with Hepatitis SA

- What range of services does Hepatitis SA offer to individuals dealing with hepatitis in Adelaide? And are there out-reach services in the smaller communities? (regional and outback)
- Are there any support groups or counselling services available for individuals with hepatitis?
- Can you explain the referral process for services and support?
- How would you define what a peer worker is? (lived experience/living experience of AOD).
- What criteria are needed to become a peer worker?
- How are peer workers trained and supported to ensure they can successfully help others?
- Can you describe some of the roles peer workers partake in?
- What roles do peer workers play in supporting individuals affected by hepatitis? (responsibilities)
- How does Hepatitis SA incorporate peer workers with lived experience into their programs and services?
- Have you noticed any barriers or issues peer workers are facing, whether in the organisation or in general? If so, could you talk about them?
- What peer worker support services do you provide in your organisation, and can you tell us more about the support services available to peer workers?
- Are there any upcoming events or workshops that community members can participate in to learn more about hepatitis and its management?
- Based on your experience of peer support so far, are there any recommendations you would like to make for future peer support programs?

Acronyms

AOD	Alcohol and Other Drugs
AASW	Australian Association of Social Workers
DOA Workers	Drug and Alcohol Workers
FDS	Family Drug Support
OARS	Offenders Aid & Rehabilitation Services
ROA	Recovery-Oriented Approach
TIC	Trauma-Informed Care
VT	Vicarious Trauma