International HIV/AIDS Alliance
Together to end AIDS

COMMUNITY ACTION ON HARM REDUCTION

coAct
expertise in drug use and hiv

Альянс
International HIV/AIDS Alliance in Ukraine

aidsalliance.org

Good practice guide for employing people who use drugs

Photos © Slava Kushakov

About the International HIV/AIDS Alliance

We are an innovative alliance of nationally based, independent, civil society organisations united by our vision of a world without AIDS.

We are committed to joint action, working with communities through local, national and global action on HIV, health and human rights.

Our actions are guided by our values: the lives of all human beings are of equal value, and everyone has the right to access the HIV information and services they need for a healthy life.

About Community Action on Harm Reduction

Community Action on Harm Reduction (CAHR) is a four years multi-country project expanding harm reduction services to more than 180,000 people who inject drugs (PWID), their partners and children in China, India, Indonesia, Kenya, Malaysia and Myanmar.

The programme has involved people who use drugs (PWUD) in the design and delivery of services, and advocates for the human rights of PWUD. There is a strong focus on building the local capacity of community-based organisations and sharing knowledge about what works.

CAHR contributes substantially to country HIV responses among PWUD in terms of methods, services and techniques.

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Contents

Foreword

Alvaro Bermejo
Executive Director
International
HIV/AIDS Alliance

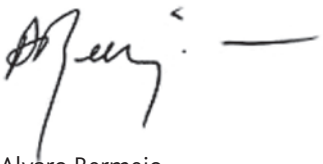
Participation is a widely held value in the Alliance. Alliance Linking Organisations across the world have a long and proud history of working with, alongside and as part of the communities we serve, the communities hardest hit by HIV and AIDS and by human rights violations related to HIV status, gender, sexuality, sex work or drug use.

Participation takes many forms. At its most modest it can be tokenistic, for example plucking individuals from their communities to serve on a committee or advisory group. But at its best it can be truly transformative, both for our organisations, and for ourselves as advocates, managers, programme officers, people.

One of the most powerful ways that we can demonstrate our commitment to participation is to ensure that the communities we serve are amongst us, in our organisations and part of our daily working lives. That's where learning happens, and where good ideas and novel approaches unfold. It's where we learn most directly about HIV vulnerability and risk, and where we plan and deliver programmes that will bring an end to HIV vulnerability, HIV risk, and ultimately, AIDS.

Employing people who use drugs in our organisations is part of that effort. Because of the illegal nature of drug use, this can be complicated. Our practice as employers needs to adapt and be open to challenge. We need to find the balance between rights and responsibilities, and to create working cultures that are both supportive as well as demanding of our staff. Because together, we are in the business of ending AIDS.

So this guide is full of practical tools and suggestions to make our organisations truly participatory and truly harm reduction in orientation. The tools and tips come from the things that we are doing or have tried, along with the tools and tips from our allies and friends in other harm reduction organisations. We hope you find it useful. We like feedback, so get in touch if you want to help us improve our work to ensure that our organisations continue to reflect and empower the communities we serve.



Alvaro Bermejo
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Alliance Linking Organisations (LOs) Kenya AIDS NGOs Consortium (KANCO), India HIV/AIDS Alliance (Alliance India) and Alliance Ukraine identified the need for guidance on employing PWUD in the HIV and harm reduction services and programmes that we implement.

Mat Southwell from Coact researched and wrote the guide, based on interviews with representatives of organisations implementing harm reduction programmes in China, Kenya, Kyrgyzstan, India, Indonesia, Malaysia, Russia and Ukraine. Interviews were conducted by Olexandra Lakhina, Myroslava Andruschenko and Maryna Braga from Alliance Ukraine. Lesya Tonkonog (Regional Technical Support Hub for Eastern Europe and Central Asia) provided assistance with decoding and transcribing the interviews, and translation into English.

The guide was piloted at the workshop "Employing people who use drugs in harm reduction", which took place in April 2014 in Bangkok, Thailand. The workshop was facilitated by Mat Southwell (Coact), Charanjit Sharma (Alliance India) and Maryna Braga (Alliance Ukraine). Workshop participants included Basheeib Taib Abdulrehman (Reachout Centre Trust, Kenya), Sylvia Awuor Ayon (KANCO), Shi Shao Bo (AIDS Care China), Anton Mulyana Djajaprawira, Raditya (Rumah Cemara, Indonesia), Han Qing Feng (AIDS Care China), Lin Hai (Zeyi Psychological Support Team, China), Amran Bin Ismail (Komunity Cakna Terengganu, Malaysia), Vyacheslav Kushakov (Alliance Ukraine), Judy Mungai (Kenyan Network of People who Use Drugs), Mazlimi Bin Ramthan (Malaysian AIDS Council), Malini Sivapragasam (Malaysian AIDS Council), and Ardhany Suryadarma and Suhendro Sugiharto (Indonesian Network of People who Use Drugs). These participants helped to refine and develop an earlier draft of the guide.

Pascal Tanguay provided advice on standard operating procedures (SOPs) and links to SOPs from the CHAMPION-IDU project, led by Population Services International (PSI) Thailand, in addition to providing feedback on a draft.
Nicky Bath and Teresa Jankowska, formerly managers of the Healthy Options Team, provided comments. Nicky was also able to reflect on her experience of employing PWUD during her time as executive director of the New South Wales Users and AIDS Association (NUAA).

Tam Miller and Buff Cameron from Coact provided early reflections and comments. Professor Pat O'Hare contributed editorial skills.

Olga Beliayeva from the Association of Substitution Treatment Advocates of Ukraine provided advice on employing people on opioid substitution therapy (OST).
The document was also shared for consultation with the International Network of People who Use Drugs (INPUD), regional networks of PWUD, and Alliance Linking Organisations that are part of the CAHR project. Comments were provided by Mick Webb from INPUD.

Maryna Braga (Alliance Ukraine) managed this project, Susie McLean, Jayne Grier and Gemma Taylor (Alliance secretariat), Tanya Deshko and Slava Kushakov (Alliance Ukraine) reviewed and guided the project. Kathryn Perry edited the publication. Design was made by Tough Slate Design.

In 2010, the Open Society Foundations published *Harm reduction at work*[1]*:* a guide for organizations employing people who use drugs , by Raffi Balian and Cheryl White.

This resource sets out important issues relating to the employment of PWUD in harm reduction services and drug user organisations. It continues to be a source of inspiration for many organisations who are delivering harm reduction programmes, and has greatly informed this guide. Raffi Balian provided comments on the guide and contributed the Counterfit case study.

The guide was developed in line with the Alliance's *Good Practice Guide. HIV and drug use*[2]*:* community responses to injecting drug use , available at: www.aidsalliance.org. It forms part of a series of guides and programming standards that bring together evidence and expertise from the Alliance's global community-level HIV programming to guide good practice in a range of technical areas.

[1] Balian, R and White, C (2010), Harm reduction at work: a guide for organizations employing people who use drugs, Open Society Foundations. Available at: www.opensocietyfoundations.org/reports/harm-reduction-work.

[2] International HIV/AIDS Alliance (2010), Good Practice Guide. HIV and drug use: community responses to injecting drug use and HIV. Available at: www.aidsalliance.org/assets/000/000/383/454-Good-practice-guide-HIV-and-drug-use_original.pdf?1405520726

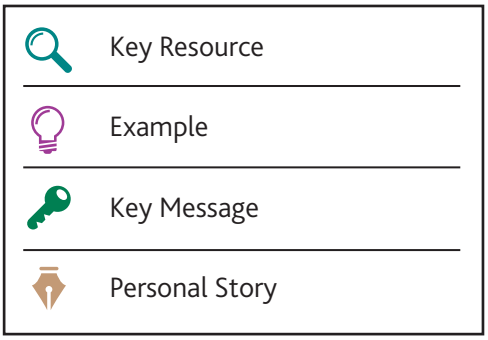
Abbreviations and definitions

Active drug users	People who choose to use mind-altering substances.
BBV	Blood-borne viruses
CAHR	Community Action on Harm Reduction project
Drug dependence	Drug dependance means that a person needs a drug to function normally. Dependence can be both physical and psychological.
Ex-drug users	Ex-drug users are people who have chosen to no longer take drugs. This choice may have resulted from a desire to end problem drug use or it may have been influenced by wider life changes, health issues (such as HIV, HCV) or personal choices.
KANCO	Kenya AIDS NGOs Consortium
Gross misconduct	Gross misconduct is a legal term meaning wrongful, improper, or unlawful conduct that staff undertake with forward planning or deliberately, or without concern for the consequences of the action. When gross misconduct is proven this will normally result in immediate dismissal.
Harm reduction	Harm reduction is a set of practical strategies and ideas aimed at reducing the negative consequences associated with drug use. Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of PWUD.
HIV	Human immunodeficiency virus
HCV	Viral hepatitis C
INPUD	International Network of People who Use Drugs
LGBT	Lesbian, gay, bisexual and transgender people
LO	Linking Organisation, the name for Alliance national civil society partner organisations
Low-threshold services	Low-threshold services are services that respond to the lifestyle of people they are seeking to serve. Low-threshold services are easy to access as they are provided at a convenient place and time, and at an affordable price or free of charge. They are also confidential and do not impose many rules on clients.
Meeting note	Meeting note is a summary of a meeting to review a concern, not an informal or formal warning. It is outside of disciplinary proceedings.
Methadone Anonymous	Methadone Anonymous is a 12-step group for clients of methadone programmes and supports people who want to follow a recovery model while on OST.
Mindfulness	Mindfulness is a meditation practice that emphasises awareness of the present moment, while calmly acknowledging and accepting feelings, thoughts and bodily sensations.
NA	Narcotics Anonymous
NSP	Needle and syringe programme
OST (opioid substitution therapy)	OST (opioid substitution therapy) describes the medical procedure of replacing an illegal opioid drug, such as heroin, with a longer-acting but less euphoric opioid, usually methadone or buprenorphine, that is taken under medical supervision.

Abbreviations and definitions

Peer-education	Peer-education programmes are designed with and delivered by PWUD to promote health and rights.
Peer volunteers	Peer volunteers are peers or clients of a service working on a voluntary basis.
Peer outreach worker	Peer outreach worker is a person who uses drugs who has been trained in peer education, HIV prevention and harm reduction, and provides counselling and advice to their peers in the places where they live or gather.
PEP	PEP (post-exposure prophylaxis) is the medical response to prevent transmission of HIV after potential exposure to the virus. Medical assistance can include risk assessment to exposure, first aid, counselling, HIV testing, the prescription of a 28-day course of antiretroviral drugs, support and follow-up.*
Problem drug or alcohol use	Problem drug or alcohol use refers in this guide to drug or alcohol use that impacts negatively on the performance of staff in the workplace or during working hours.
PWID	People who inject drugs
PWUD	People who use drugs
Recovery	Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life.
SOP	Standard operating procedure
TB	Tuberculosis
TOR	Terms of reference

Key to icons used in this guide



* AVERT. Accessed on 28 August 2015. Available at: www.avert.org/post-exposure-prophylaxis-pep.htm

Section 1: Why we employ people who use drugs in harm reduction

Key Message

PWUDs have the right to participate in decisions that influence their lives.

PWUD have insights and expertise that can help inform the planning, delivery and review of harm reduction and HIV services. When we involve PWUD in the design and delivery of services, our work becomes more relevant, targeted and accessible.

Working in partnership with PWUD helps our services to reach and connect with other PWUD more effectively, and to understand and meet their needs. A really powerful way of involving PWUD is to employ them as staff.

Employing PWUD sends out a clear message that they are valued partners and are welcome at all levels of service delivery. It also has a very practical set of benefits, helping services to better understand the needs and lived experience of PWUD.

PWUD have the right to be employed. Policies that routinely exclude PWUD from the workplace are discriminatory.

The Alliance's journey to promote the participation of PWUD is a long one. In 2003 we published *Developing HIV/AIDS work with drug users: a guide to participatory assessment and response*[3]. In 2008 we published *Nothing about us without us: greater, meaningful involvement of people who use illegal drugs*[4] in partnership with Canadian HIV/AIDS Legal Network, the Open Society Institute and the International Network of People who Use Drugs (INPUD). In 2013, we published our *Alliance Accreditation System*[5], where we set out our approach to community mobilisation and participatory approaches. And then in 2013, we published R*eaching drug users: a toolkit for outreach services*[6], which describes peer education and peer outreach processes.

This guidance follows the principles set out in the Alliance's *Good practice HIV programming standards*[7] and *Good Practice Guide: HIV and drug use: community responses to injecting drug use and HIV*[8]; along with *Harm reduction at work: a guide for organizations employing people who use drugs*[9], published by Open Society Foundations.

More information about the participatory approach used to develop this guide is included in Appendix 1.

PWUD can face many barriers to entering the workforce, but our organisations can respond creatively to help to overcome these. Examples of efforts to make workplaces more accessible and supportive of staff who use drugs are described in Section 3.

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[3] International HIV/AIDS Alliance (2003), *Developing HIV/AIDS work with drug users: a guide to participatory assessment and response.* Available at: www.aidsalliance.org/resources/311-developing-hivaids-work-with-drug-users

[4] Canadian HIV/AIDS Legal Network, International HIV/AIDS Alliance, Open Society Institute (2008), *"Nothing about us without us". Greater, meaningful involvement of people who use illegal drugs: a public health, ethical, and human rights imperative.* Available at: www.aidsalliance.org/assets/000/000/376/310-1.-Nothing-about-us-without-us-Report-(English)_original.pdf?1405520211

[5] See note 2.

[6] International HIV/AIDS Alliance (2013), *Reaching drug users: a toolkit for outreach services.* Available at: www.aidsalliance.org/resources/314-reaching-drug-users-a-toolkit-for-outreach-workers

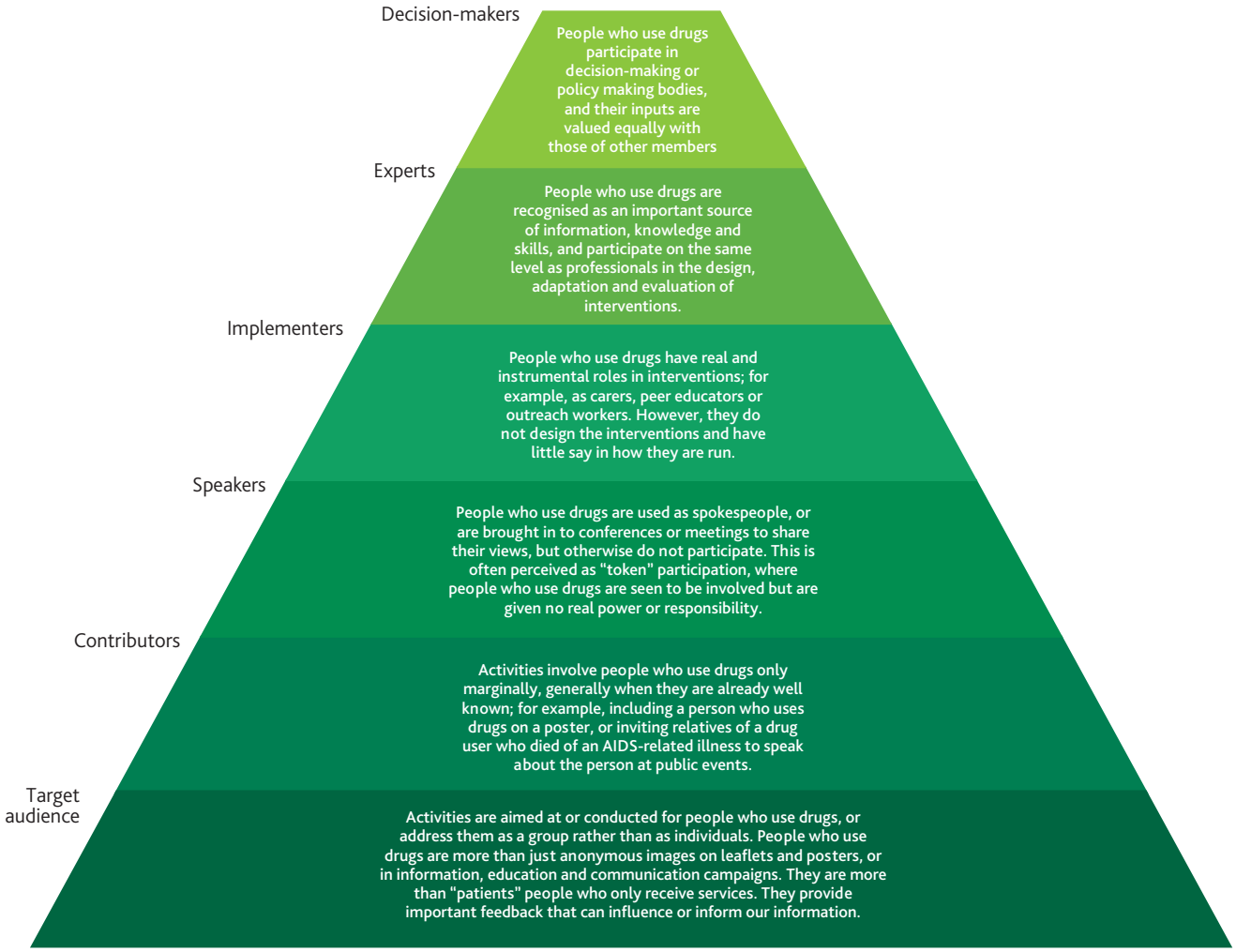
[7] International HIV/AIDS Alliance (2013), *Alliance accreditation system.* Available at: www.aidsalliance.org/resources/336-alliance-accreditation-system

[8] See note 2.

[9] See note 1.

A pyramid of involvement*

This pyramid models increasing levels of drug user involvement, with the highest level representing complete application of the greater involvement principle.



Personal Story

"During the time when I was a client of a harm reduction programme, I was arrested for minor misconduct and risked going to prison. But the organisation Virtus bailed me out and I got a conditional sentence. After that I started changing my behaviour. I joined a substitution therapy programme and started working as a peer educator. Later on I became a project coordinator. Now seven years have passed and I realize that I'm free and my life has become better thanks to my organisation. At present I do my best to grow together with the organisation."

Elena, Virtus, Ukraine

* See note 2.

Section 2: Employing people who use drugs in our organisations

Key Resource

International HIV/AIDS Alliance (2010), Good Practice Guide. HIV and drug use: community responses to injecting drug use and HIV. Available at: www.aidsalliance.org/assets/000/000/383/454-Good-practice-guide-HIV-and-drug-use_original.pdf?1405520726

Key Resource

"**Support. Don't Punish.** is a global advocacy campaign to raise awareness of the harms caused by the criminalisation of PWUD. The campaign aims to change laws and policies that impede access to harm reduction interventions, and to promote respect for the human rights of PWUD."[12]

www.supportdontpunish.org

2.1. Introduction

Employing staff who use drugs adds to the richness, capacity and connections of harm reduction services. It helps to connect our organisations to the local drug scene, and brings specialist knowledge and lived experience about drug use into our work.

Peer-driven interventions have been shown to be highly effective HIV prevention strategies[10], demonstrating increased responsiveness and reach. The Strategic Investment Framework identifies community mobilisation as one of the core elements of the HIV response with PWID[11].

2.2. When drug use is a problem (and when it is not)

Drug use is complex, and debate on the rights and wrongs of it can become easily polarised. In this context, the medical (disease) model of drug use tends to dominate. This emphasises the problems of dependence as an inevitable consequence of using heroin and other drugs. As a result, the response to drug use is often described as a treatment or cure for a medical illness. The medical model also dominates many 12-step programmes, such as Narcotics Anonymous (NA). It also influences the way many health professionals, academics, politicians and members of the public understand drug use. They share a belief that PWUD quickly lose the ability to control their drug use, and make conscious, autonomous or rational decisions about it.

However, the United Nations Office on Drugs and Crime (UNODC) acknowledged in the *World drug report 2014* that only 10% of PWUD will experience problems arising from their drug use[13]. This implies that many people's experience of drug use can be non-problematic and often pleasurable. Similarly, some of our staff will have experiences with drugs that are non-problematic and recreational.

Although in the alcohol field the concept of controlled drinking is now widely accepted[14], for many years the possibility of non-dependent and controlled heroin use has been largely ignored, despite evidence that such patterns exist[15]. This research demonstrates that some people are able to use heroin in a non-dependent or controlled manner. Studies of people using cocaine have also shown well-established patterns and strategies for self-control. These studies highlight the importance of the social context in which drugs are used and its impact on an individual's experience of drugs and their effects[16–25]. We learn from these studies about the importance of context when trying to understand drug use patterns, and question the value of framing drug use as an individual failing or illness.

[10] Centre for Health, Intervention and Prevention. Peer driven intervention [online]. Available at: www.chip.uconn.edu/research/intervention-resources/peer-driven-intervention/ [Accessed 23 April]
[11] Schwartländer, B et al. (2011), 'Towards an improved investment approach for an effective response to HIV/AIDS', Lancet 377(9782):2031–41. Available at: www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)60702-2/abstract
[12] Support. Don't Punish. [online] Available at: www.supportdontpunish.org

Example

Examples of peer-led interventions

- Delivering needle and syringe programmes (NSPs).
- Promoting safer injecting and health awareness for PWID.
- Promoting voluntary HIV counselling and testing.
- Promoting treatment adherence for people on antiretrovirals (ARVs), and on hepatitis C (HCV) and tuberculosis (TB) treatment.
- Supporting access to and engagement with harm reduction services, including OST.
- Following up on PWUD who drop out of services.
- Saving the lives of opiate users with naloxone programmes.
- Promoting harm reduction with stimulant users.
- Reaching hidden networks of women, and lesbian, gay, bisexual and transgender (LGBT) PWUD.
- Providing knowledge of and responses to new drug trends and emerging risk behaviour.
- Reaching settings where professional outreach workers cannot or tend not to go with harm reduction advice and materials.
- Providing peer feedback to service providers, donors and planners on the quality, impact and reputation of services among PWUD.
- Advocating for greater investment in harm reduction, and challenging barriers in the legal environment to harm reduction and peer participation.
- Delivering peer research into drug-taking patterns, trends and prevalence.
- Providing mutual aid to support controlled drug use or abstinence.
- Building and supporting networks of PWUD.
- Providing information to people resistant to be engaged with services.

[13] UNODC (2014), World drug report 2014. Available at: www.unodc.org/documents/wdr2014/World_Drug_Report_2014_web.pdf
[14] Cox, WM, Rosenberg, H, Hodgins, CH, Macartney, JI, Maurer, KA (2004), 'United Kingdom and United States healthcare providers' recommendations of abstinence versus controlled drinking', Alcohol and Alcoholism 39(2):130–4.
[15] Robins, LN, Davis, DH, Goodwin, DW (1974), 'Drug use by U.S. Army enlisted men in Vietnam: a follow-up on their return home', American Journal of Epidemiology 99:235–49.
[16] Robins, LN, Helzer, JE, Hesselbrock, M, Wish, E (1979), 'Vietnam veterans three years after Vietnam', in L Brill and C Winick (eds) The yearbook of substance use and abuse, New York: Human Sciences Press.
[17] Zinberg, NE and Harding, WM (1982), Control over intoxicant use: pharmacological, psychological and social considerations, New York: Human Sciences Press.
[18] Blackwell, JS (1983), 'Drifting, controlling and overcoming: opiate users who avoid becoming chronically dependent', Journal of Drug Issues 13(2):219–35.
[19] Zinberg, NE (1984), Drug, set and setting: the basis for controlled intoxicant use, New Haven, CT/London: Yale University Press.
[20] Shewan, D et al. (1998), 'Patterns of heroin use among a non-treatment sample in Glasgow (Scotland)', Addiction Research 6(3):215–34.
[21] Shewan, D and Dalgarno, P (2005), 'Evidence for controlled heroin use? Low levels of negative health and social outcomes among non-treatment heroin users in Glasgow (Scotland)', British Journal of Health Psychology 10(1):33–48.
[22] Warburton H, Turnbull PJ, Hough M (2005), Occasional and controlled heroin use: not a problem? Joseph Rowntree Foundation.
[23] Cohen, P and Sas, A (1993), Ten years of cocaine: a follow-up study of 64 cocaine users in Amsterdam, Amsterdam: Instituut voor Sociale Geografie.
[24] Cohen, P and Sas, A (1995), Cocaine use in Amsterdam II: initiation and patterns of use after 1986, Amsterdam: Instituut voor Sociale Geografie.
[25] Ditton, J and Hammersley, RH (1994), 'The typical cocaine user', Druglink 9:11–12.

For those who do experience problems with drugs, there are often other social or psychological factors that contribute to the problems. These include homelessness, poverty, isolation and social exclusion, unemployment, family breakdown, histories of sexual abuse and other forms of trauma, mental health issues, incarceration, and exposure to criminalisation.

The social factors influencing heavy or dependent drug use are sometimes hard to change, and so this kind of drug use can be difficult to stop.
Drug use is a complex and diverse phenomenon, and there are many different ways of understanding and responding to drug-taking, problem drug use and risk exposure. In this guide, we suggest some strategies and ideas that others are working with to ensure that PWUD become part of our organisations; that our work is shaped by harm reduction and human rights principles; and that we manage risks successfully– risks to staff, including staff who use drugs, and risks to our organisations.

Managing complexity is part of the process and challenge of bringing together people with different experiences and perspectives in harm reduction organisations.

Alongside stressing the value of employing PWUD, it is important to understand that our organisations are at the same time asking PWUD themselves to take risks. This is particularly so for peer outreach workers and others working in active drug scenes. These risks may be to their health, psychological well-being and professional credibility, and can include police harassment, criminalisation and incarceration.

Managers of organisations that employ PWUD also take risks. Since drug use is criminalised in most countries, employers need to ensure that no drug use takes place on the premises of, or as part of the activities of, our organisations. Many people or institutions will not understand why we employ PWUD, and managers will be required to justify their decision to do so. Managers will often need to take extra measures to ensure that staff who use drugs are supported and managed well. Through the development of individualized support strategies managers should empathize but not compromise the effectiveness of services provided by staff.

This section explores some of the specific issues that arise when we employ staff who use drugs. We focus on three different groups of PWUD: ex-drug users, clients of OST programmes, and people actively using drugs. These categories help us to consider the variety of needs of PWUD who are in different places with their drug use.

Each staff member is an individual, with their own needs and support systems. It is also important to that their actual life experience may not be so clear-cut as the definitions used in this section. While some people will remain fixed in their choices around drug use, others will move through a number of different choices in their lives, sometimes frequently. This may be informed by a whole series of factors, including choice.

2.3. Rights and responsibilities

Everyone working in services targeting PWUD has a responsibility to attend work in a state where they are able to perform their job and represent the organisation in an effective manner. This includes staff who use drugs. Equally, organisations have a responsibility to create a welcoming environment that provides equality of access and opportunity for PWUD.

A range of different factors impact on work performance for everybody, including:

- TRAINING AND EDUCATION
- SLEEP PATTERNS
- STRESS
- LIFESTYLE (having a good balance between work and personal life)
- EXERCISE AND DIET
- FRIENDS AND FAMILY
- WORKING HOURS AND WORK PRACTICES
- HOUSING OR HOMELESSNESS
- STAFF WORKING RELATIONSHIPS
- RELATIONSHIPS WITH CLIENTS (particularly after the arrest or death of a client)
- DRUG AND ALCOHOL USE

An effective organisation should offer all staff and volunteers support systems and strategies for participation in order to create a healthy and productive workforce. Providing these exclusively to staff who use drugs could prove divisive. Strategies to support staff who use drugs are best considered as part of a wider process of support for all staff who have a range of needs, lifestyles and practices.

Some PWUD will have chronic health conditions. This may also be true for other staff who do not use drugs. It is important to have consistent policies for all staff with chronic health conditions, rather than focus exclusively on HIV, HTC and TB.

Some PWUD will be using harm reduction services, such as OST or drug treatment services, and recovery support activities. The level of flexibility required for staff to use these services will vary, but this may impact on traditional working hours.

The Alliance respects staff's right to privacy and understands that in a climate of stigma, discrimination and criminalisation, some staff may choose either to keep their drug use private or may not wish to have it made public outside of the staff team or workplace.

2.4. Employing ex-drug users and people in recovery

Ex-drug users understand how drug scenes operate. They have technical knowledge of different drugs and drug-taking practices, and personal experience of accessing healthcare services. However, their experience and knowledge will become less relevant over time, as drug scenes evolve and change. Then they can use their connections with active drug users to remain in touch with changing trends.

Personal Story

"I have made a decision not to take drugs anymore and have found the 12-step model helpful. However, I am still a member of the drug-using community and I stand with my peers who are still using. Part of my contribution is being a worker with Alliance India where I can make a practical difference by supporting harm reduction. However, I am also a member of the Indian Drug User Forum because I believe in the rights of drug users. Therefore my aim is to advocate towards enabling access to health and human rights of my fellows to reduce stigma and discrimination in some form or other."

Francis Joseph, Alliance India

People currently not using drugs are a sub-group of ex-drug users who may have a strong investment in a particular model of change that requires and provides ongoing engagement in self-help activities. There are many staff who successfully use drug use recovery models while continuing to support harm reduction approaches, and respect their clients' right to self-determination.
When staff who are currently not using drugs are able to match services to the needs and choices of individual clients, their personal values and beliefs do not impact negatively on the service. They can point to recovery-based services for clients who want them, but not push them or make participation in recovery-based services a requirement. Recovery-based services work for some people but not everyone.

In services that promote the medical/disease model of addiction, the choice to employ staff who are in recovery may be part of sustaining a workforce that is able to represent the organisation's beliefs and culture, as well as deliver its services. The challenge with this approach is that it can create a narrow and self-validating service model, where peer participation is only open to those who embrace and sustain a recovery approach. This can push away people who are actively using drugs. Our services are for all PWUD who have HIV and other needs, not just those who are in recovery.

For those fearful of employing staff who actively use drugs, employing ex-drug users or people in recovery can seem like a logical first step. It can appear to offer a way to explore the idea without the apparent risks or complexity of employing active drug users or those on OST. However, this is a false assumption. Drug use is rarely a fixed state: people in recovery can relapse and people who are not using may choose to start using again.

2.4.1. Employing people who are engaged in OST and drug treatment

OST clients bring an additional set of skills, connections and understanding to an organisation. They can help the organisation to understand the range of different models and medicines that can be used in the treatment of opioid dependency.

Sometimes people on OST work in or alongside OST services as advocates, supporting people to manage their treatment and their relationships with prescribing doctors. They can also encourage an "expert patient" approach to service provision.

Some people on OST can work as drug treatment workers in OST services or alongside doctors delivering services.

Others can use OST to provide the stability that enables them to continue to work, helping them to manage or avoid illicit opiate use. These staff may work in a variety of roles throughout the organisation, including managing services, and their use of OST may or may not be disclosed to the organisation.
Some people on OST use substitution therapy as a way of stopping illicit opioid use for all or most of the time. For some, this extends to embracing a recovery model, reflected in groups such as Methadone Anonymous, who see abstinence from illicit drug use and exclusive use of OST as a recovery strategy. Others use OST as a mean of stabilising their illicit opiate use without completely stopping.

The quality of OST programmes can vary substantially. They can offer flexible and client-centred approaches, or they may be more inflexible, presenting clients with rigid rules about when and how to use OST. This means that working practices have to take account of the requirements of local OST programmes, particularly their model for dispensing OST. When dispensing happens on a daily or frequent basis from a fixed site, restrictions can be placed on staff's time and availability. This can be addressed with flexible working hours, which need to be negotiated as part of the terms of employment.

Example

"Rumah Cemara is a harm reduction service that was formed by people in recovery to help our actively using peers. However, different staff at times have relapsed into active drug use. Some were able to recover abstinence but we've also had to pragmatically learn how to manage with staff who are active drug users or on OST. This has been part of our journey of learning as a team."

Ardhany Suryadarma, National Policy Manager, Rumah Cemara, Indonesia

Personal Story

"I am employed by the International HIV/AIDS Alliance in Ukraine as a senior officer and I have been working my way up to achieving this for three years. My background is in economics, and thanks to an opioid substitution therapy programme I worked as a director of a small business. When I heard about the work the Alliance Ukraine is doing, I hastened to join it. I studied all the vacancies, but there was a requirement to have at least three years of work experience in HIV prevention.
When I got familiar with the vacancies, it seemed to me that my skills and abilities were not sufficient for applying. To get this job I started working for a local non-governmental organisation as a peer counsellor, providing advice and support to people on OST, and facilitated trainings and workshops. I also became an official representative of the Association of Substitution Treatment Advocates of Ukraine in the Public Council of the State Service of Ukraine on Drugs Control.

Personal Story (cont'd from previous page)

When I became confident enough and had received the required work experience, which was reflected in my resume, I applied for a vacancy announced by Alliance Ukraine, went through three stages of interviewing and I got this job.

I like the activities and work I'm involved in for this organisation. I think the Alliance serves as a good model in Ukraine. Staff here understand what they are doing. I feel comfortable here. The organisation cares for its employees and their comfort at work. I have not got any privileges due to that fact that I am new at this position, although I feel their support and understanding as I am on substitution therapy and live with HIV and hepatitis C."

Anton Basenko, Senior Officer, Alliance Ukraine

In other settings where OST services are more flexible, staff who use OST may benefit from take-home doses and less frequent dispensing arrangements. This means that their attendance at work is usually uninterrupted. However, even in these cases, staff may need time off or flexible working arrangements to attend occasional appointments at their OST service. Flexible arrangements such as take-home doses and flexible dosing policies are better for PWUD who work anywhere, including in our organisations.

Inflexible or insufficient dosing of methadone or buprenorphine can also impact on the performance of staff on OST. If they are prescribed less OST than they need, it makes it harder for them to achieve and maintain stability.
A particular challenge for staff on OST is work-related travel. Many OST doctors require advance notice from clients before they travel, and some clinics limit the number of times that clients can request take-home doses for travel within a given period.

Sometimes arrangements can be made between different prescribing centres that allow staff on OST to receive their dose of OST while working away from home. Such arrangements normally require the client on OST to see their doctor and for letters to be exchanged between the prescribing doctors. Sometimes organisations that are hosting meetings for PWUD from out of town can arrange for a supply of methadone or buprenorphine for the duration of the meeting.

In settings with no or limited OST services, active drug use may be a practical reality for dependent opiate users.

2.4.2. Employing people who are active drug users

Staff who are themselves active drug users have the strongest connection with active drug users in the community. So creating employment opportunities for active drugs users, particularly those from the local drug scene, can help to enhance the profile and reach of a service. Active drug users have a live engagement in an evolving drug scene, so they will be able to quickly identify and report on changing trends and pressures for local drug users.

Active drug users are most commonly employed as peer outreach workers to help engage new clients, particularly those who are not using harm reduction services. Peer outreach workers are able to reach into hidden parts of illicit drug scenes and create a network of connections that, over time, becomes a powerful resource for our harm reduction organisations.

However, fears about employing people from a criminalised population have caused many managers and organisations to "play safe" and avoid hiring people who actively use drugs. This guide seeks to share best practice from organisations that do employ active drug users, both within the Alliance and beyond. By sharing good practice and practical tips, we hope that more organisations will decide to benefit from the unique skills and expertise of PWUD.

Key Resource

Balian, R and White, C (2010), *Harm reduction at work: a guide for organizations employing people who use drugs,* Open Society Foundation.

Available at: www.opensocietyfoundations.org/reports/harm-reduction-work

2.4.3. Employing people who are active stimulant users

Employing people who are actively using stimulant drugs is an area where there is even more limited experience.

Many stimulant users have recreational or controlled patterns of use that may not be visible to organisations, and will have no impact on their performance. However, for others, use of stimulants can involve a "peak-and-crash" pattern of behaviour, and this will pose challenges for organisations that need to sustain services.

Personal Story

"As a senior manager, I have to deliver important activities and meet key targets so this means I need to be responsible and effective in my work. This means I have to keep my engagement with drugs in balance. When I had problems at one point with my drug use, this did lead to problems with timekeeping and my presentation in the office. Alliance India did give me time off to address my problems and to recover my balance.

There remains a challenge for managers to understand that all drug use is not problematic and that being in balance can be supported by OST and can also include occasional active use."

Charanjit Sharma, Technical Advisor:
Drug Use & Harm Reduction, India HIV/AIDS Alliance

2.5. The value of staff who use drugs

Salary equity is good practice for all organisations, and applies to all staff –those who use drugs and those who do not.

Peer outreach workers who are actively using drugs are often employed on lower salaries than outreach workers from other backgrounds. This is discriminatory. Lower salaries are only justifiable where the role being performed is different and requires fewer skills and experience than those of a more highly paid worker. Knowledge and experience of drug use scenes and practices is a valuable asset for our harm reduction programming.

Staff performing the same role should receive the same salary, regardless of their use of drugs. Salary levels should be based on the duties and responsibilities required of each role, and applied to all staff, whether or not they use drugs.

Example

Counterfit in Toronto, Canada

Counterfit was founded in 1998 following peer-based research on the needs of PWID in Toronto. A rapid rise in HIV transmission had occurred among PWID in the early 1990s, and HIV rates rose to 50% amongst PWID in Ottawa, Vancouver and Montreal. The research highlighted two key issues: the risks of an overly centralised model of delivering needles and syringes, and the need for peer-driven interventions; and also the risks of limiting supplies of injecting equipment for people using stimulant drugs.

Learning from these findings, Toronto health authorities opened eight NSP services across a number of different settings. One of these services was Counterfit, which opened in 1998. It was attached to a local community health centre, with one full-time worker and four part-time workers.

Counterfit continues its harm reduction programming today. A community advisory group oversees its work, and half of its members are PWID.

The combination of roles – full-time staff, part-time harm reduction workers and volunteer peer educators – creates opportunities for PWUD to progress through the organisation. The threshold between volunteering and part-time work is low, and there is an active commitment to the professional development of staff with experience of drug use. All but one of Counterfit's current team of 23 staff are PWUD.

There are challenges for the part-time harm reduction workers, as the part-time hours limit their incomes. Counterfit is responding by attracting new funding and developing initiatives such as focused work with women who use drugs. These new developments allow for the participation of a more diverse range of harm reduction workers. Part-time harm reduction workers' hours have now increased to between 10 and 15 hours per week.

Importantly, staff who use drugs are paid to come together once a month to talk as a group of peers before meeting and training with full-time staff. Food is provided to support these monthly capacity-building sessions.

From its fixed-site NSP, Counterfit also operates community-based satellite services (also known as secondary needle exchanges) in the homes of those who sell drugs or make their homes available for people to inject drugs. The people running these community sites receive a fixed monthly fee and a free mobile phone.

"The unique level of respect and involvement afforded drug users within the programme has allowed them to be active participants in providing services to others and has resulted in true community development in the best sense."

Counterfit Independent Audit 2003

Section 3: Strategies to support people who use drugs at work

3.1. Introduction

PWUD can face many barriers to entering the workforce, and we need to respond creatively to help to overcome these. We can make our organisations healthy workplaces for all staff, including PWUD. Support strategies for PWUD should sit within a wider set of staff welfare and human resources policies that are designed to support all staff.

The support strategies described in this section represent a menu of options that have been used successfully by a number of organisations. Since the needs of organisations can vary considerably, we should choose the strategy, or mix of strategies, that might offer the right fit for our organisation. Through trial and error, organisations will learn to identify the mix of support strategies that will enable individual staff members and teams to function effectively without being too demanding.

Providing positive support strategies shows an organisation's commitment to creating a healthy workplace. It also demonstrates adherence to the following Alliance human rights-based standard: "Our programmes are designed to build the capacity of both rights holders and duty bearers to claim their rights and to promote, protect and respect the rights of others"[26].

While an organisation is responsible to its workforce, there is also a parallel responsibility among staff to look after themselves and to strive to achieve a healthy work–life balance. All staff, including PWUD, have their own ways of getting support, including from family and friends, sport and recreation, activism or volunteering, and engaging in community, self-help or faith-based organisations. The strategies and tips we suggest here are to complement the support systems that people ordinarily use.

[26] International HIV/AIDS Alliance (2014), Good Practice Guide: HIV and human rights. Available at: www.aidsalliance.org/resources/400-good-practice-guide-hiv-and-human-rights

Example

The Healthy Options Team

The Healthy Options Team (HOT) was a community harm reduction agency founded in 1990 in east London, UK. HOT was a pioneering agency known for its innovative responses to HIV and drugs that was built on a dynamic partnership with PWUD. HOT operated for 16 years and over this time had four different team leaders.

HOT pioneered community mobilisation techniques and harm reduction. The employment of PWUD was a deliberate and effective part of a wider strategy of community mobilisation with the active drug-using community of east London. Employing PWUD alongside national health service (NHS) professionals gave HOT the capacity to work with highly complex clients and fast-changing patterns of drug use and risk behaviour.

In addition, HOT employed community mobilisation techniques and peer education to promote harm reduction and to respond to changing drug trends and patterns of risk behaviour. This included peer education programmes run by peers working on a voluntary basis or for small one-off payments. HOT also supported and worked in partnership with six different local drug-user groups.

HOT had a comprehensive community student programme that gave clients the chance to engage in a formal training and peer apprenticeship programme. As Nicky Bath, HOT's manager from 1997 to 2000, commented: *"The Community Student Program at HOT was revolutionary as it provided an opportunity for community members to share and reinforce their expertise while at the same time learning new skills. Everyone's journey was unique as students designed their own pathway and this ensured that the program remained relevant and dynamic."*

HOT's volunteer and peer education programmes were meaningful because peer volunteers knew that with the right training and experience they could eventually apply to work paid shifts and apply for paid positions.

Since HOT was part of the UK's NHS, this pioneering work was well supported by the hospital's human resources policies and advisors. Over time, HOT managers developed a specialist body of knowledge on human resources strategies relating to the employment of PWUD, but this was always based on standard human resource management principles and procedures that were used across the wider health sector.

HOT's example shows that staff who use drugs can work effectively alongside health service professionals. As Teresa Jankowska, HOT's manager from 1995 to 1997 noted: *"The most powerful memory I keep with me from the unique experience which was HOT, is how our NHS staff welcomed the opportunity to work alongside staff who use drugs. There was a great synergy of knowledge, skills and experience and the eagerness to share and learn from each other was truly inspirational!"*

HOT demonstrated that with the right policy environment and support systems, staff who use drugs can work at all levels of an organisation. Problems will occur but these can be managed. HOT's pioneering work was worthwhile because staff who use drugs added to the range of skills and experience within the team. They were also key to the organisation's reputation with local PWUD, who described HOT as "being like a family".

Australian radio show about HOT users: *Doing it for themselves*, available at www.abc.net.au/radio-national/programs/healthreport/users-doing-it-for-themselves/3563196

3.2. Code of conduct, alcohol and other drug policies

A code of conduct is a set of rules that defines the principles, values, standards and expected behaviour of staff and other stakeholders in an organisation. It is designed to contribute to the welfare, safety and rights of all those working in and affected by the organisation.

The process of developing an organisation's code of conduct is important, as involving people in its development helps to ensure understanding and shared agreement.

Although a code of conduct should have a broader focus than just drug and alcohol use, this is a good place to set clear standards around drug use, drug supply and intoxication at work.

Reviewing and renewing the code of conduct from time to time can ensure that it remains up to date and in fresh in people's minds.

Alcohol and other drug policies should be underpinned by the principle of "fitness to work", where the issue is about job performance rather than drug use. By focusing on staff's fitness to work rather than their consumption of drugs, the organisation can demonstrate a commitment to the health and human rights of PWUD in the workplace. Dismissing workers purely on the grounds of drug use is not recommended, nor does it reflect harm reduction principles.

Example

"Our rules of conduct have been developed by people who use drugs themselves. We made it in a form of group discussion on the topic 'Our rights'."

Nataliya Kitsenko, Head of HIV Prevention Department, Way Home, Ukraine

3.3. Induction

Induction training offers an early opportunity to establish organisational values and introduce new staff to their workplace. At a basic level, it familiarises them with the fundamentals of the organisation, and can help to establish clear expectations in terms of ethics, integrity and workplace standards, as described in the code of conduct.

Induction provides an important opportunity to ensure that all new staff properly understand that they are working in an organisation that employs PWUD and values their meaningful participation. This can help new staff who use drugs to feel validated in their decision to work for the organisation and help all staff to understand that PWUD do not have second-class status in the organisation. *(see Appendix 2).*

Induction for all staff, including staff who use drugs, should address first aid training and managing overdose for field workers, access to first aid kits, fire extinguishers, universal precautions, safety and security protocols, safe disposal boxes for used injecting equipment, evacuation and emergency protocols, and serious incident reporting.

[26] International HIV/AIDS Alliance (2014), Good Practice Guide: HIV and human rights. Available at: www.aidsalliance.org/resources/400-good-practice-guide-hiv-and-human-rights

3.4. Health checks and immunisation

Frontline harm reduction workers may risk exposure to blood-borne viruses (BBV) in their work, and staff who inject drugs may also face this risk in their personal lives. It is important that all staff have access to voluntary HIV (and other BBV) testing and treatment services.

In settings where immunisation against hepatitis A and B is available and affordable, employers should consider prioritising peer workers for immunisation as a health protection measure. In addition, peer workers should have access to TB prevention advice and post-exposure prophylaxis (PEP).

Example

Practical tips for involving people on opioid substitution therapy in training and events

When organising events and trainings, it is important to ensure access to OST for participants. This can be arranged in the following way:

When announcing the event, inform potential participants that they will have access to OST. This lets people on OST know that they are welcome to apply.

The prescribing doctor should send a request to the doctor of an OST centre in the area where the event is being organised.

This request should be sent in advance of the event, and should contain personal information about the client, the amount of medicine the person receives, and the number of days of treatment they need.

OST clients should take the original request letter, the doctor's recommendations, and an original and a copy of their passport when they go to get treatment.

Organisers of the event need to know when the OST dispensing site opens and how far away it is from the accommodation or training centre. The event may need to start later in the morning to allow for dispensing.

Providing transport to and from the dispensing site ensures that everyone goes and returns from the clinic efficiently and in company.

"Harm reduction programme staff need constant learning and capacity-building. When OST was introduced in Ukraine, we had problems with people on OST attending training courses. Staff and volunteers of harm reduction programmes had challenges attending educational activities that took place in cities that were far away from where they were dispensed OST. Now it takes a couple of hours to organize the process of receiving the OST in another site, which makes it easy for employees receiving OST to attend trainings, seminars and conferences."

Olga Beliayeva, Head of the Board, The Association of Substitution Treatment Advocates of Ukraine

3.5. Practical arrangements for staff on opioid substitution therapy

Staff on OST will need flexible working arrangements to comply with the dispensing arrangements of their OST service. It is important to understand the requirements of the OST clinic in terms of medical appointments, and this should be discussed between managers and staff as part of their induction.

3.6. Managing chronic health conditions

Proper consideration needs to be given to staff living with chronic health conditions within the organisation. PWUD may be living with HIV, viral hepatitis or TB, and they may also have other health conditions that are not specific to drug use. Staff who use drugs should be offered flexible working hours to allow them to benefit from HIV treatment, OST and related healthcare services.

Understanding the impact of different treatments is a prerequisite for a practical conversation with staff about the likely effect of these on their work performance, so that management and communication strategies can be agreed. Positioning a response to the staff who use drugs within a wider context of human resources policies for people with chronic health conditions will help to avoid the perception of special treatment for PWUD.

Example

"When I need to undergo medical check-ups I phone my coordinator and say directly that I will be an hour late for work. Thank God there is no need to invent something. People in our office understand everything."

Social worker, Virtus, Ukraine

3.7. Staff training and professional development

Staff who are recruited from volunteer-based peer education programmes, particularly those employed as part time peer outreach workers, may have been unemployed for some time and have limited professional experience. Such posts are designed to be accessible to those still engaged in active drug scenes. While these people bring strong engagement and peer understanding, they may also require training and guidance on working in an office setting, using administrative and communication systems, working as part of a multi-disciplinary team, and line management arrangements. We need to remember that when anyone begins new employment, whether or not they use drugs, it takes time for them to become familiar with new working practices and policies.

In organisations that use community mobilisation strategies with PWUD and also employ PWUD, it is important all staff enough time to explore and learn about drug use and drug-using scenes through training and group discussion. This can help to build understanding and cohesion among a mixed staff team.

Key Resource

International HIV/AIDS Alliance in Ukraine.

Harm reduction lessons [online course]. Available in Russian, Ukrainian and English at: www.aidslessons.org.ua

Example

Training allowance

India HIV/AIDS Alliance works with local organisations to implement the Hridaya (CAHR) project www.allianceindia.org/our-work/hridaya/ in the states of Bihar, Haryana, Uttarakhand, Jammu, and Manipur. They are supporting the professional development of peer educators. They allocate funds for the development and support of peer educators which can be used either for training at school or for getting a professional education. Training allowance covers half of the costs and the other half has to be paid by the peer educators themselves or their families. This fund demonstrates to peer educators that their professional development is important.

3.8. Peer risk assessment

Example

"Coact supports drug user activists in some highly challenging and risky environments. We need to help staff who use drugs to operate as safely as possible in places where the risk of police and state violence, interacting with drug suppliers, corruption, vigilantism and volatile using environments are all part of daily reality. Risk assessment, scenario planning and developing standard operating protocols are all key strategies."

Buff Cameron, Coact consultant and personal security expert

PWUD live and work in societies where they face stigma, discrimination and criminalisation. Once they become employed as a peer outreach worker, this can raise their profile in the local community and require them to manage public knowledge of their drug use with family and friends. At times, this can bring unwanted attention from the police, media and, sometimes, vigilante or anti-drugs groups.

A peer risk assessment allows staff to think about how they manage the interface between work and an illicit drugs scene. This can be facilitated by a simple exercise called a "Risk assessment circle" (see Appendix 3). A peer worker can use this as a tool for self-reflection, but is most helpful when it is used as part of peer mentoring or other support systems.

The exercise helps a staff member with lived experience of drug use to identify and rate the potential risks in their work or personal life. The exercise is then followed up with risk prevention planning and risk management strategies. These plans are deliberately personal, and will normally be kept confidential between the peer worker and the peer mentor or manager who guides them through the self-assessment process.

Making these support tools widely available within the organisation, and creating a culture of support and personal risk management, can also help other staff who have not disclosed their drug use.

3.9. Managing relapse and preventing burnout

Key Resource

Moore, S and Birgin, R (2012), *Standard operating procedure to reduce and manage relapse and burnout, PSI*

Available at: www.cahr-project.org/resource/standard-operating-procedures-to-reduce-and-manage-relapse-and-burnout/

Preventing burnout

What is burnout? Burnout occurs when workers feel overloaded by the problems of others, and unable or helpless to change the situation. It is a common response to the chronic emotional strain of working intensely with other people, especially those who are having serious problems or illnesses.

What causes burnout? Staff who use drugs may experience a range of personal pressures related to living and working in a criminalised context. They may also feel burdened by caring for clients with complex and multiple needs, particularly in environments with limited resources, high levels of stigma and discrimination, and high levels of demand. Heavy workloads can result in staff having limited time to reflect on and process these experiences.

Signs and symptoms of burnout

Physical symptoms can include low energy, chronic fatigue, weakness, gastrointestinal disorders and hypertension. Backache, headaches, muscle tension and weight loss are also common.

Behavioural symptoms can include memory loss; attention deficit; inability to concentrate; increased conflict with or withdrawal from work colleagues and family; absenteeism; decreased productivity; increased use of alcohol and other drugs, as well as relapse; and insomnia or disturbed sleep. Negative attitudes towards work, clients and other staff are also common

Psychological symptoms can include frustration; anger; loss of self-esteem or interest in work; feelings of hopelessness, helplessness or not being appreciated by the organisation; disillusionment, depression and anxiety.

Individual strategies

- Take time out
- Have realistic expectations of yourself, your organisation and clients
- Eat well and regularly
- Avoid or control drug and/or alcohol use
- Stay healthy, get some exercise and practice mindfulness meditation techniques
- Be aware of your "normal" versus "abnormal" responses to circumstances
- Identify support networks to discuss work and other issues

Organisational strategies

- Burnout prevention training for staff includes: managing stress and stigma | time management and goal setting | developing internal coping skills | using social support mechanisms, such as peer support groups
- Promoting communication between staff members improves morale, and encourages staff to feel part of the team
- Observing and responding to changes in the team's stress levels
- Encouraging a healthy work–life balance among staff
- Setting concrete and realistic goals for each week helps staff to stay focused and feel a sense of accomplishment

Managing relapse

What is relapse?

Relapse is the renewal of regular drug use by a formerly dependent person after a period of abstinence, often in response to drug-related cues or stress.

Understanding relapse

Relapse occurs due a range of physical, psychological and social factors. When people have to adapt to lifestyle changes relating to their health, personal relationships, finance, housing, employment or legal problems, these can become factors that contribute to the risk of relapse.

Because drug use is stigmatised, and PWUD may be ostracised from employment or social life, relapse can be intensified by feelings of isolation. For many PWUD, established friendships are mainly with other PWUD. For some people, social stigma and discrimination, or distrust and suspicion from family members, friends and colleagues, may increase the possibility of relapse.

Managing relapse

There are three aims underlying relapse management:

/ 1 **Managing cravings.** Cravings are marked by a strong desire to use drugs. They can be very powerful and may lead to lapses. Help colleagues identify personal strategies that both prevent and control cravings. These might include strategies such as focusing attention elsewhere, talking to a support person, walking, listening to music or using mindfulness meditation techniques.

/ 2 **Behavioural interventions to manage high-risk situations.** If a person does not manage their cravings, drug-seeking is likely to follow. If this occurs, it's important to acknowledge that a single occasion of relapse does not mean that a return to dependency is inevitable. It is important that all relapse management programmes reinforce that "a lapse is not collapse".

Strategies to reduce the likelihood of relapse include structuring time to avoid boredom or isolation, managing feelings of anger or frustration, coping with depression or grief, and managing or avoiding situations that may trigger the desire to use drugs.

The ability to refuse offers of drugs, or to resist social pressures when offered drugs, are important in reducing the risk of relapse.

/ 3 **Address ongoing social, medical or economic factors that may contribute to relapse.** To manage relapse or heavy drug use in the long term, an individual may require help with finances, legal problems, domestic violence, accommodation, health concerns, childcare and employment. Coping skills, management of emotional well-being, problem-solving and skills training are all important types of psychosocial support that provide long-term support to manage relapse.

3.10. Peer support

Peer support groups are designed to help peer workers reflect on workplace pressures and challenges, and to gain advice and support from their peers. They may form spontaneously among staff or can be set up as part of the support structures for staff from drug-using backgrounds.

Peer support groups should not be confused with 12-step groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). A blurring or combining of approaches could make the group unattractive to active drug users or people on OST.

Peer support groups can provide a point of consultation for managers, although some groups may choose to focus on their support function and not interact formally with management.

Key Resource

International HIV/AIDS Alliance (2012), *Reaching drug users: a toolkit for outreach services.*

Available at: www.aidsalliance.org/resources/314-reaching-drug-users-a-toolkit-for-outreach-workers Information on capacity-building for peer outreach workers.

3.11. Peer mentoring

More experienced staff can mentor new staff who use drugs, helping them to engage su ccessfully with their workplace and get tailored support in their professional roles. Mentoring can be structured or informal. It may take the form of meeting for coffee to check in on progress, or it could involve being on the end of a phone or participating on social media platforms when particular questions or challenges arise. Including peer mentoring in the induction process can be particularly useful as a PWUD transitions from being a volunteer to a more professional role.

Peer mentors can also provide support on managing drug use and cravings in the workplace, offering advice to peer workers who are experiencing problems. In this situation, the staff member who uses drugs continues to be responsible for both their drug use and compliance with workplace policies on drug use.

However, the peer mentor can provide additional "low threshold" support that is recognised by the organisation but outside the line management structure. Privacy and confidentiality are important in peer mentoring. Peer mentors should only disclose their conversation with a peer worker if their actions or plans constitute gross misconduct or if the staff member's or someone else's life is in danger.

Example

Petty cash for coffee and a chat

The New South Wales Users and AIDS Association has a petty cash float that enables staff to go out for coffee to provide informal peer support.

3.12. Peer retreats

Peer retreats provide a chance for peers from across an organisation to come together and support each other. They can be a time for relaxing and socialising together, as well as an opportunity for personal and professional development and capacity building. Peer retreats can be useful forums for auditing an organisation's employment of PWUD and its community mobilisation programmes more widely.

3.13. Psychological/professional support

Example

Clinical counsellor

PSI Thailand hired a clinical counsellor to provide emotional, psychological and professional support to peer outreach workers.

Staff who use drugs can face difficulties and emotional challenges in their work that are not experienced by other staff. This can be particularly true for peer outreach workers, who may face challenges such as:

- WORKING IN HIGH-RISK SETTINGS
- MANAGING PERSONAL DRUG USE WHILE WORKING IN SETTINGS WHERE THE SUPPLY AND USE OF DRUGS IS TAKING PLACE
- LOW PAY OR PART-TIME SALARIES
- PRESSURES OF CARING FOR CLIENTS
- MANAGING BOUNDARIES WITH PEERS WHILE WORKING FOR A HARM REDUCTION ORGANISATION
- GRIEF AND LOSS
- STIGMA AND DISCRIMINATION
- THE PRESSURES OF CRIMINALISATION

When these factors combine, they can lead to accumulating pressures that, if left unchecked, can cause emotional distress and negatively impact on performance. In turn, this can trigger relapse or destabilise drug use.
This is why it is important to invest in psychological and professional support for peers, not least to reduce a potentially high turnover of staff and associated costs of training new employees.

The role of psychological/professional support is to provide peers with non-threatening help to improve their work performance and motivation while managing their personal issues. Psychological/professional support can include coaching or counselling, and focuses on work-related issues. This should not be confused with therapy. The main focus should be to provide staff who use drugs with the chance to reflect on their experiences, to manage their well-being, and to develop and strengthen their work performance.

Psychological/professional support can also be used to help staff reflect on taking on new roles or complex situations, and to mediate when problems arise between staff members. It can be particularly valuable when staff who use drugs are struggling to adapt to new roles or are experiencing problems managing drug use in the workplace.

Managers need to understand and consent to psychological/professional support. The remit of psychological/professional support can be set out either in terms of reference (TOR) or three-way contracts (see Appendix 4).

Those providing psychological/professional support are only expected to disclose their discussions with peer workers in instances of actual or planned gross misconduct, or when someone's life or the staff member's own life may be in danger.

3.14. Performance review

Many managers and organisations agree performance management plans for the year. Performance management establishes an organisation's expectations of its staff, helps identify staff development needs, and supports accountability. Specific issues relating to peer work or to staff who use drugs can be added to a performance management plan to foster a culture of support and development.

These might include a learning objective on a specialist aspect of peer work such as peer research, or an agreement to train as a peer mentor and provide support to new staff who use drugs.

Performance review sessions can be good moments to assess whether a staff member who uses drugs would benefit from some of the specialist or additional support described in this section.

Example

"As in many organisations, some conflicts happen at our organisation as well. In order to deal with these conflicts, we have chosen a mediator. The mediator is normally an unofficial leader chosen by staff using a voting system. The mediator performs the role of a judge in resolving conflict situations. As a rule all participants in the conflict are gathered in one room together with a mediator and start discussing the situation. This helps to resolve conflicts quickly and effectively, and this procedure is clear to all employees."

Mikhail Karelin, Head of Our Help, Ukraine

3.15. Sensitisation training for staff who do not use drugs

Sensitisation training has been widely used with other marginalised groups to help bring about a change in attitudes and practices in workplaces. It can help to develop skills and understanding, and it can work well when people are ambivalent to change and/or don't have deeply held personal views that are linked to core values.

It can also be successful when it provides a space for staff to reflect together on identities, social stereotypes, power relationships and empathic practice. It is less effective when it becomes blaming or when it seeks to impose values on others.

Creating opportunities for staff who use drugs, peer volunteers and non-drug using staff to interact and socialise together can be a helpful way to address the stigma and discrimination associated with drug use. Setting up events or occasions or platforms where peer volunteers, clients and members of local drug user groups can be involved helps deepen the understanding of staff who do not use drugs .

Using peer trainers to deliver skills training can be useful too, as it normalises the role of PWUD as a group of experts that engages actively with the service. During trainings it is helpful to discuss cases which may happen in real life (Appendix 10).

Example

"In HOT we used psychological/professional support widely for all staff. We were asking people to stand strong in the face of an HIV epidemic that for some was taking away their friends and peers, and we were doing the home and terminal care work. Staff needed a space to process and understand what was happening so they could go back to being strong and could sustain healthy working relationships with colleagues, clients and peers. It wasn't perfect but coaches helped us manage the imperfections."

Mat Southwell, HOT Manager, 1990 to 1995

3.16. Positive recruitment

Example

Clinical counsellor

PSI Thailand hired a clinical counsellor to provide emotional, psychological and professional support to peer outreach workers.

It is important that peer volunteers have the opportunity to secure paid positions, and for peer workers to have fair opportunities to progress through the organisation. When this does not happen, it can be seen as an indication of the second-class status of peers. This can undermine the recruitment of peer volunteers and foster resentment between peer volunteers and paid staff.

Programmes that invest in developing peer volunteers also want to see the best of them progress through into paid positions. This sends out a clear message about the values and commitment of the organisation.

However, peers may face a number of structural barriers in the recruitment process:

PEERS MAY HAVE GAPS IN THE TIMELINE OF THEIR CVs

PEERS MAY HAVE CRIMINAL RECORDS

EXPERIENTIAL EXPERTISE CAN BE DIFFICULT TO DESCRIBE ON A CV OR IN AN INTERVIEW

PEERS MAY NOT HAVE EXPERIENCE OF FORMAL WORK INTERVIEWS

SHORTLISTING IS NORMALLY UNDERTAKEN AGAINST A LIST OF ESSENTIAL AND DESIRABLE CRITERIA. FAILURE TO MEET ONE OR MORE OF THE ESSENTIAL CRITERIA NORMALLY LEADS TO THE CANDIDATE BEING EXCLUDED

There are a number of strategies that have been used successfully to improve the chances of peers securing employment when vacancies arise.

Preparation for employment training for peer volunteers

Peer education programmes should provide employment training or coaching to those who have contributed to the programme for a year or more. This should address the features common to all preparation for employment training, but with a particular sensitivity to the needs and challenges faced by PWUD.

Documenting personal learning in peer education programmes

It is important to give peer volunteers the opportunity to document their learning and keep a record of their progress to support later applications for jobs in the harm reduction or related sectors. Gathering evidence should not be compulsory, but rather an activity that can be made available to those committed to pursuing a career in the drugs field.

Stepping-stone posts

Training posts can be created to help people bridge the gap between volunteering and employment. Training positions can be created from vacancies, and sometimes it is possible to create two part-time training positions from a single, higher-paid, full-time vacancy. The advantage of this approach is that there may be an opportunity for the two trainees to apply for the more substantial full-time position when it is reinstated at the end of the training.

Training posts

Another approach is to create a training post from a vacant position. A lower-grade training post can be created for six months to a year, with clear development targets. The salary savings are invested in the trainee, whose training is achieved within the budget originally allocated for the post. At the end of the fixed term, the post reverts to its normal grade. The trainee then would be in a strong position to compete for the job, or the post could be interviewed internally to maximise the chances of the internal candidate.

Internal interviews

When an organisation has a strong body of peer volunteers, it may wish to give this group the chance to compete against each other for a vacant position. This would give the organisation the best chance of employing someone from its peer education programme – something that is important for the status and credibility of the volunteer programme. However, a clear condition of this approach must be that the successful candidate has to meet the specified threshold for employment. If no candidate meets the essential requirements, then the job should go out for open advertisement.

The advantage of this approach is that peer volunteers have to meet the threshold of competence to be appointed as peer workers but do not need to compete with someone from a professional background who would not necessarily have the same community capital and networks of the peer volunteers.

Managers can select different recruitment models when looking at the overall balance of the team. Internal recruitment provides one effective way of prioritising people from the peer education programme in the recruitment process.

Explicit calls for applications

When jobs are advertised, it is important that calls for applications clearly state that PWUD are able to apply (see Appendix 5). Employing PWUD is still not common practice and therefore a willingness to consider applications from PWUD needs to be clearly stated. If there are any restrictions on who can be employed, then this also needs to be stated clearly.

Peer participation in the recruitment process

When PWUD are included in the employment process, this sends out a clear message about the values of the organisation and how meaningful participation has been mainstreamed.

PWUD can be included in the recruitment process in a number of ways:

- Someone from a peer background can be included as a full member of the interview panel. This person might be drawn from a peer education programme or local drug user group. Some initial capacity-building may be needed. One strategy is for a peer panel member to focus on issues of meaningful participation and community mobilisation as a technical area (see Appendix 6).

Example

Internal recruitment

Counterfit in Toronto, Canada, employs harm reduction workers who work on a part-time basis. Staff are recruited exclusively from Counterfit's peer volunteer team. Internal recruitment rewards those who have worked as volunteers and reflects the

Example

Group of peer interviewers

A drug agency in London, UK, recruited a group of peers who were trained to take part in staff interviews. Peer interviewers have since been involved in interviewing for drug workers and a senior medical practitioner, and are now included routinely on recruitment panels. Both peer recruiters and managers describe the contribution as real, useful and a good message to incoming staff about the organisation's values.

/ 2 A panel of peers can undertake a pre-interview with the candidates. The peer panel can agree on methods for testing the candidates, either by interview or through an exercise. The peer panel would then feedback their assessment of the candidates to the interview panel, who would make the final selection.

/ 3 One or more peers can be used to show candidates around the service. Impressions can be fed back to one or more members of the interview panel, who would decide on the appointment.

Example

Hridaya, the Alliance India CAHR programme

Hridaya, managed by Alliance India as part of the CAHR programme, is establishing harm reduction in five Indian states that do not have a strong history of harm reduction and where there is very poor access to services for PWID (Bihar, Haryana, Jammu, Uttarakhand, Manipur and Delhi). These states and their local organisations had limited experience of working with PWUD as partners, which is why Alliance India decided to design a programme based on community mobilisation that would focus specifically on promoting drug user participation. Hridaya now has 36 harm reduction projects across the five states, and supports the employment and capacity development of 72 PWUD as peer counsellors. In addition, expert PWUD consultants develop and review the project. In 2014, the Hridaya programme reached 132,000 PWUD.

Alliance India's goal is to create employment and development opportunities for PWUD alongside developing harm reduction services. This means that PWUD are employed as part of a funded and supported programme. Both mainstream NGOs and service providers experience the benefits of employing PWUD to deliver their HIV services and of meaningful participation. Alliance India also created new paid positions called "peer counsellors". These jobs are designed for PWUD who are interested in community mobilisation, and help to create a dedicated entry path into employment. Peer counsellors engage PWUD, and provide safer injecting, and other health and practical, advice.

The peer counsellors need a level of stability in order to perform their work, and OST can be helpful in achieving this. Peer counsellors also play an important role in staff development and learning for staff who do not use drugs, educating other staff teams about harm reduction, drug use and HIV risk, and challenging stereotypes and stigma.

Hridaya has a peer progression budget, which is a fund to help peer counsellors to develop their core skills, including completing schooling, computer skills, counselling skills, or other training that supports their personal and professional development. This development strategy is intended to give peer counsellors every opportunity to progress in their career within the Alliance.

The commitment of the organisation to employing PWUD is also reflected in the composition of the team coordinating this programme at a national level. All three staff members – project manager, project officer and advocacy officer – have lived experience of using drugs. In addition, two of the three regional coordinators employed to support the project are also PWUD. This shows how PWUD can be involved from entry-level employment through to management of the project. In addition, they can also be involved in capacity-building and high-level advocacy for harm reduction and peer participation.

The project has helped to initiate new drug-user networks in three of the five states (in Manipur, a state drug-user network existed before the start of this project). This shows the positive impact of creating capacity through employing PWUD on wider community mobilisation and networking among other PWUD.

Section 4:
Managing problems and challenges

4.1. Introduction

Organisations that are part of the Alliance 'family' of organisations are committed to being fair employers to all their staff, and to providing all staff with a safe and supportive workplace. Staff management practices are shaped by organisational policies and national employment laws, and by recognition that staff in our organisations are one of our key assets.

Staff who use drugs have the same rights as others to be valued and treated equally. Moreover, good managers recognise that staff who use drugs, and particularly peer outreach workers, face additional risks and pressures because they are PWUD and therefore have to manage stigma, discrimination and criminalisation.

The previous section highlighted a range of support strategies that organisations can adopt to create a safe and supportive environment for all staff, particularly staff who use drugs. In this section, a range of challenges particular to employing PWUD are addressed. The goal for this section is to offer good ideas and strategies for managing challenges from organisations that have successfully employed staff who use drugs. As organisations learn about and adopt and adapt what other organisations do, it's important to stress that an organisation's response to problems and challenges should always remain consistent with national employment law.

Strategies for managing problems and challenges with staff who use drugs should be set within the context of the organisation's human resources policies. These should include policies for performance management and staff development, grievance and disciplinary procedures, procedures for managing absence and/or sick leave, and codes of conduct.

Issues or concerns are best explored in a face-to-face meeting between a staff member and their manager. A standard model for review meetings is described in Appendix 7.

4.2. Problem drug use and work

When drug use has a negative impact on staff performance, time-keeping or attendance it becomes a problem. Staff may be too intoxicated, stimulated or sedated to perform their work roles, or alternatively drug use outside of work time may impact on performance or reliability at work.

Problems with drug use can include a person visibly using drugs during work hours, being visibly intoxicated during work hours, being incapacitated by drug use, lateness or a failure to attend work. When problem drug use becomes visible, it can impact on a staff member's credibility with colleagues and clients, and it can affect the public reputation of the organisation.

It is important not to read all signs of drug-taking, such as paleness, pinned or dilated eyes, or sweating, as a problem. These symptoms can legitimately exist for someone who is on OST and appropriately medicated.

Organisations that employ PWUD need to recognise that from time to time some staff may struggle to contain or manage their drug use to the point where this becomes an issue in the workplace. The primary objective of intervening is to support the staff member to recover control or achieve abstinence (whatever their preference), or otherwise manage their drug use in a way that does not impact negatively on their performance at work.

In order to resolve problems with drug use, managers should meet with the person to review their drug use and its impact on their work performance. This allows for a discussion about patterns of problem drug use in the workplace and the impact on colleagues, clients and the organisation as a whole. Are changes in work roles, client issues, personal or social stress factors, changes in drug use or adherence to treatment contributing to the problem? The goal here is to understand the issues and support change, not blame and attack. However, restating the organisation's standards or code of conduct is important too. These meetings are also an opportunity to discuss staff responsibilities and the impact of drug and alcohol use during working hours. We need to make sure that staff fully understand their obligations and responsibility towards their organisation and its clients.

The reasons why staff may experience problems with drug use at work could include personal or work issues, or a combination of both. These are best explored in a non-threatening and supportive management environment. This will allow staff to discuss issues openly, helping them reflect on how they can manage their drug use and improve their performance.

Solutions are likely to be tailored to meet the individual needs of staff, and the agreed strategy for change might include workplace support and a commitment from staff to seek further outside support.

A peer mentor can provide self-control coaching (see Appendix 8). They could support a colleague to make the best use of OST or address problems with their OST service, or support with recovering abstinence. This strategy relocates support away from formal management systems but ensures that staff who use drugs have access to additional support that is recognised by managers.
If patterns of problem drug use continue, and particularly if staff fail to engage in support measures or take personal action to address their drug use and its affects at work, then the problem should be addressed through the organisation's disciplinary policies. The focus here should be the poor performance arising from the unresolved problem drug use, and any resulting damage to the organisation's reputation.

Employer-led mandatory urine testing to identify PWUD is not recommended. It confuses identifying drug use with identifying problem drug use. Problem drug use is much better identified through self-disclosure, and this requires a supportive and respectful workplace. Employer-led mandatory urine testing undermines working relationships and the trust between management and staff who use drugs.

However, providing voluntary access to urine test kits for peers to self-test before undertaking outreach can be a useful tool to reduce the risk of arrest or problems with law enforcement in settings where drug testing is used as an enforcement measure.

See Appendix 9 for a checklist for managing staff with problem drug use at work.

4.3. Imposing personal models and philosophies of drug use

There are many different ways of describing or understanding drug use. People have strongly held views on and experiences of why people use drugs, what the problems associated with drugs are, and what the best methods or goals are in managing problem drug use. Staff who use drugs can be deeply invested in a particular framework for understanding drug use that might have been significant in their own lives. It might be a political framework such as human rights framework, a self-help model such as 12-step programmes or the approach used by a service provider, such as a medical or therapeutic community model.

Ideally, staff will be able to distinguish between the personal values of a particular model or framework in their own life and the importance of the service user's right to choose their own model or framework for understanding their drug use and managing problem drug use. This distinction is an important principle in a rights-based approach that seeks to empower PWUD. However, sometimes staff can push the model or framework they personally favour at a client or colleague who may be at a different stage in their process of change or prefer a different approach.

When staff promote their favoured model or framework without allowing for different views, the effect is often that people with different views will disengage from the service.

A key principle in harm reduction is the right to self-determination. An harm reduction approach is pragmatic and recommends interventions that match both the service user's readiness for change and their expressed need. Staff in our organisations need to respect self-determination.

At an individual level, trying to persuade or argue in favour of a preferred approach or outcome with a client can unintentionally provoke resistance from the client[27]. For this reason, even if it is part of a well-designed strategy, this kind of persuasion is usually ineffective.

Certain language about active drug use or drug users may be experienced as judgemental and discriminatory. For example, using words like "clean" to describe being drug free can give the impression that active drug use and drug users are dirty or unclean. This kind of language can cause offence and undermine self-esteem and trust. When this happens, language becomes a barrier to promoting harm reduction strategies and engagement in harm reduction services.

[27] Miller, WR and Rollnick, S (2002), *Motivational interviewing* (2nd edition), Guilford Press.

Staff who are active drug users need to take care when discussing drug use or situations involving drug use in front of staff or clients who are working to achieve or sustain abstinence. This is an expression of respect for those working to achieve or sustain change rather than a negative view of active drug use.

The issue of imposing personal models of drug use can be addressed in the organisation's code of conduct and discussed as part of induction, staff training and professional development. Managers can set up a reflective discussion with staff that helps them to understand how they can remain personally committed to their own models or philosophies of drug use while respecting the client's right to choose and the Alliance's commitment to harm reduction.

Interventions to manage these problems amongst staff could include:

A COACHING MEETING BETWEEN A MANAGER AND THE STAFF MEMBER

A MEDIATION MEETING BETWEEN THE STAFF MEMBER AND COLLEAGUES OR CLIENTS

TEAM TRAINING OR A DISCUSSION ABOUT MANAGING PERSONAL MODELS OR PHILOSOPHIES OF DRUG USE, AND CLIENTS/COLLEAGUES' RIGHT TO CHOOSE

4.4. Criminal exposure

Staff members may be arrested while undertaking outreach and carrying harm reduction materials, such as injecting equipment. They may also get caught up in a police action against an open drug scene or drug-using environment.

At a personal level, people who use illicit drugs are inevitably involved in illegal activities, whether this is purchasing drugs or carrying drug-related paraphernalia. The severity of laws in different settings, and the operational priorities and approach of the police, will determine the level of exposure to problems with police faced by staff who use drugs, and particularly peer outreach workers.

Some PWUD at times engage in criminal activity to fund their drug use. This may lead to them being arrested for a crime that may come to the attention of their employer. Staff who commit a crime to fund their drug use may steal equipment, money or personal possessions from their employer, or may become involved in corruption or employee fraud.

Staff who use drugs may also supplement their income by engaging in sex work. In settings where sex work is criminalised, this can lead to arrest and exposure for both the individual and the organisation.

Because drug use is illegal, PWUD are criminalised and socially excluded. Corrupt police officers can target visible PWUD because they believe that these people will not report them to the authorities because they risk being exposed as a drug user. The police may not distinguish between peer outreach workers and active drug users, or they may struggle to recognise that a peer outreach worker has a formal reason for engaging in the active drug scene. Women who use drugs are particularly vulnerable to being targeted by the police, particularly if they are also engaging in sex work.

Drug use is criminalised in every country in the world, and staff who use drugs may be subject to police attention or criminal action, particularly if they are a peer outreach worker. However, it is the role of the legal system to prosecute staff who use drugs and criminally sanction them, not the employing organisation.

Sometimes a manager may need to consider whether the organisation's reputation has been damaged by a staff member's engagement in criminal activity. The question would be not just whether the incident took place but whether it had brought the organisation into disrepute. Managing PWUD does involve risk, which is usually offset by the potential value of employing staff who use drugs. However, if a staff member has acted recklessly in a way that has endangered the organisation, or in a manner that has shown little regard for the organisation's reputation, this should be reviewed and assessed within the disciplinary policies of the organisation.

It is important to understand local laws and the likely response of the police to outreach work, including transporting and exchanging injecting equipment, and outreach or peer workers becoming caught up in raids on drug supply or drug-using venues. Understanding local laws and policing practices helps to:

- ESTABLISH POLICIES THAT DEFINE HOW PEER WORKERS SHOULD BEHAVE ON OUTREACH, AND WHAT THEY SHOULD DO IF ARRESTED OR FACE UNWANTED POLICE ATTENTION
- LIAISE WITH THE POLICE ABOUT THE WORK OF OUTREACH AND PEER WORKERS, AND SIGN OFFICIAL AGREEMENTS OR RECEIVE LETTERS OF SUPPORT
- PROVIDE TRAINING TO POLICE OFFICERS TO EXPLAIN THE ROLE OF OUTREACH AND PEER WORK
- ESTABLISH LINKS WITH LAWYERS OR LEGAL SERVICES THAT CAN BE CALLED ON IF STAFF FACE LEGAL PROBLEMS WHILE PERFORMING THEIR DUTIES

If a staff member is arrested while on outreach or while delivering services, the organisation has a duty of care towards them. People are innocent until proven guilty, and the first step is to ensure that they have access to a lawyer and are released from police custody as quickly as possible.

It is important to keep a schedule of the shifts that staff are working and their planned time of return. Outreach policies can define at what point and under what circumstances a worker should be considered to be missing.

If staff are arrested in their own time for drug use or possession, or drug-related activities unconnected to work, managers need to distinguish between private lives and professional responsibilities. Drug possession-related offences outside of work should not routinely be a disciplinary matter, as reflected in our commitment to 'Support. Don't Punish' principles, and the Alliance policy on decriminalisation[28].

Key Resource

Birgin, R and Moore, S (2012), *Operating procedures to improve community-level collaboration with law enforcement,* PSI.

Available at: www.cahrproject.org/resource/psi-standard-operating-procedures-to-improve-community-level-collaboration-with-law-enforcement/

[28] International HIV/AIDS Alliance (2015), *Policy position on Decriminalisation and HIV*. Available at: http://www.aidsalliance.org/resources/613-policy-position-on-decriminalisation-and-hiv

Example

Strategies for working with the police

Provide information on harm reduction and the purpose and benefits of NSPs.

Use materials to identify outreach workers so that police understand who they are. For example jackets, hats, bags and other accessories can be used to identify outreach workers rather than PWUD.

Always remain calm and polite.

Try to initiate negotiation with higher-ranking officers.

Avoid checkpoints.

Women staff may politely remind officers of regulations stipulating that they should be searched by women officers.

Calmly ask for a phone call to help organise the bail fee.

Memorise badge numbers or vehicle license plates.

When police activity is intense, deliver needles and syringes to agreed hiding places.

Carry a card with the name and contact number of the local project manager.

Source: Birgin, R and Moore, S (2012), *Operating procedures to improve community-level collaboration with law enforcement,* PSI. Available at: www.cahrproject.org/resource/psi-standard-operating-procedures-to-improve-community-level-collaboration-with-law-enforcement/

Sometimes staff may be victims of police corruption or face criminal sanctions for undertaking their job. It is important that managers act to protect staff, and staff deserve full support if they have complied with organisational policy. Such cases may require documenting a human rights violation and acting accordingly if police action against a staff member has included violence, abuse or corruption. However, documenting and acting on human rights abuses by law enforcement can be dangerous in many parts of the world, and staff and service users should never be coerced into this process without fully understanding and consenting to it.

If a crime, such as theft or corruption, has been committed by a staff member against their organisation, this may be considered misconduct or, in more severe cases, gross misconduct. Depending on the role and seniority of the staff member, theft or corruption could be dealt with by means of restorative justice. Restorative justice is a theory of justice that emphasizes repairing the harm caused by crime. This is achieved through cooperation between all stakeholders when victims, offenders and community members meet to decide what to do.[29]

[29] Restorative justice online. Accessed on 28 August, 2015. Available at: www.rjonline.org

Employee fraud undertaken by someone with financial or managerial responsibility is a serious matter that can meet the threshold for gross misconduct and requires immediate investigation and action.

4.5. Moving from being a peer to working in a harm reduction organisation

Field guidelines to support peer outreach workers' engagement with the police

CARRY PICTURE IDENTIFICATION AT ALL TIMES.

MAKE SURE THAT THE PROJECT MANAGER ESTABLISHES A RELATIONSHIP WITH THE LOCAL POLICE FOR RAPID AND APPROPRIATE RESPONSES

CONDUCT OUTREACH WORK IN PAIRS

MAKE CONTINGENCY PLANS FOR WORST-CASE SCENARIOS THAT ARE SHARED WITH PARTNERS AND AGREED ON BY TEAMS

OUTREACH WORKERS ARE ADVISED TO NOT CARRY VALUABLES IN THE FIELD.

DO NOT GIVE CLIENTS ANY IDENTIFYING INFORMATION ABOUT YOURSELF (E.G. SURNAME, HOME ADDRESS, HOME TELEPHONE NUMBER)

Source: Birgin, R and Moore, S (2012), *Operating procedures to improve community-level collaboration with law enforcement*, PSI. Available at: www.cahrproject.org/resource/psi-standard-operating-procedures-to-improve-community-level-collaboration-with-law-enforcement/

PWUD are often employed in harm reduction services precisely because they have a strong engagement with the local drug-using network. However, becoming an employee of those services can sometimes result in a negative impact on their relationships with their peers, who remain service users, or clients of the service. The new relationship can provoke jealousy, which in turn may create bad feeling and hostility.

Staff who use drugs can find themselves in conflict with their former peers in these changed circumstances. When they attempt to assert professional boundaries with a former peer or friend, this may cause unintended offence and be experienced as the staff member relegating their peer to a second-class status as client. In a worst-case scenario, conflicts with clients can place staff who use drugs at risk when they are working among active drug scenes.

The process of developing and appointing peer volunteers, peer outreach workers and other staff needs to be transparent and fair. When new staff who use drugs are appointed following a rigorous recruitment process that is in line with organisational policy, these new staff have greater credibility with their peers. It is important that advertisements for new positions and development opportu-

nities are widely promoted within local peer volunteer programmes and among the clients of the harm reduction service. Looking for opportunities to build collective pride among those who are offering something back to the service and drug-using community can also be helpful.

Mediation can sometimes provide a way for a staff member and client to understand each other's intentions and views. This approach should only be considered when both parties are willing to engage in it.

If a client continues to raise unreasonable concerns about a staff member and undermines them within the wider group of service users, manager can meet with the client. This can provide a space for grievances to be expressed to help assess if there are any grounds for concern. If there are not, the organisation's support for the staff member should be clearly expressed.

If it turns out that the peer worker has been misusing their change in status and a legitimate area of concern has been identified, this should be addressed through the organisation's performance management or disciplinary procedures. Psychological/professional support or peer mentoring could be used to help staff under pressure from clients while other strategies are being employed to resolve the situation.

4.6. Inappropriate relationships with clients

Professional boundaries are important in harm reduction services because staff are working with clients who can be vulnerable. In these circumstances, staff have a responsibility to their clients to work to the best of their abilities and to ensure that their help and support does not damage or disenfranchise clients. As this kind of work can be stressful and draining, maintaining professional boundaries will also help staff to manage themselves and their emotions.

These professional or therapeutic boundaries are widely taught to health and social care professionals. They offer clear and defined rules and limits to relationships with clients of healthcare and harm reduction services.

Within this framework, close personal or sexual relationships between staff and clients are widely regarded as a breach of professional boundaries, and contravene expected standards for an empathic and/or therapeutic relationship.

It is important to understand the power dynamics at the heart of most inappropriate relationships. Whenever someone is in a relationship involving unequal power – practitioner–client, team leader–peer outreach worker, manager–intern – caution should be exercised before progressing into a closer personal or sexual relationship. Advice should be sought from peer mentors, colleagues, a coach or managers before stepping across traditional boundaries.

Staff who use drugs, particularly peer outreach workers, may face added complexities in this context. They may already have longstanding relationships with clients, and they may even be part of mutual friendship groups. This can raise different issues around relationships with clients/peers, and may become a point of conflict between staff who use drugs and those from other professional backgrounds.

It is inappropriate for staff who use drugs and their clients either to use or buy drugs together during work hours. Similarly, a close personal or sexual relationship with a client is inappropriate in particular if the client is vulnerable and the staff member has an empathic or therapeutic relationship with them.

A staff member who uses drugs may decide they want to develop a close personal or sexual relationship with a client. Ideally this would be raised with a peer mentor, colleague, coach, or manager in order to test concerns, before stepping across traditional boundaries.

When a relationship between a staff member who uses drugs and a client is approved and accepted within the organisation, this may provoke discomfort or confusion for staff used to more traditional boundaries. Space needs to be made for these concerns to be discussed and explored.

Managing abuses of power within professional relationships is a key issue of concern for organisations. The first step is to ensure that the organisation has a policy defining the standards expected in professional relationships. This should specify who staff should speak to in the organisation if they are uncertain about developing a friendship or sexual relationship with a client.
Induction programmes that include peer mentoring and dedicated training for staff who use drugs provide an opportunity to inform and engage new staff in organisational policy on this sensitive issue.

Undertaking a peer risk assessment (see Section 3) will normally include a review of relationships with former peers and other clients of the harm reduction service. This is intended to help staff who use drugs to think in advance about issues or risks that might arise. The risk assessment circle (see Appendix 3) is another useful risk assessment tool that can be used to identify and address risks associated with inappropriate relationships between staff and clients..

A healthy working environment will allow staff to talk early on and openly about problems that may arise. Psychological/professional support and peer support groups can also provide a useful safety net where staff who use drugs can test out their thinking and explore strategies for managing difficult situations, such as multiple relationships with clients.

Where a manager feels that a relationship is a cause for concern, they should meet with the staff member to explore the nature of the relationship. They should consider:

- DOES A THERAPEUTIC OR PROFESSIONAL RELATIONSHIP EXIST?
- DOES A POWER RELATIONSHIP EXIST?
- HAS THE STAFF MEMBER HAS BEEN TRANSPARENT AND SOUGHT ADVICE?
- DID THE RELATIONSHIP EXIST BEFORE THE STAFF MEMBER WAS EMPLOYED?
- ARE ALL PARTIES CONSENTING TO THE RELATIONSHIP IN AN INFORMED MANNER?

Key Message

"Borrowing and lending money can blur boundaries between staff and service users. The service user is usually the one who suffers most when one of the parties is unable to pay. If the service user borrows money, he may avoid accessing the program's services until the debt is paid. Likewise, an outreach worker who owes money to a service user might avoid providing services to that user."

Balian, R and White, C (2010), *Harm reduction at work: a guide for organizations employing people who use drugs,* Open Society Foundations. Available at: http://www.opensocietyfoundations.org/reports/harm-reduction-work

4.7. Supplying, or soliciting the supply of, illicit drugs

The sale of drugs during office hours is a serious offence that requires immediate investigation and action. However, selling drugs outside the workplace is less clearly bound by disciplinary policy. Nevertheless, it is possible to consider it as a problem because it can impact on an organisation's reputation, particularly the practice is revealed as part of a high-profile arrest or coupled with media exposure.

If a staff member is caught selling drugs, they may face time in prison or a substantial fine. Then the organisation will need to consider whether the threshold for disciplinary action has been met. This will require an investigation within the framework of normal disciplinary procedures.

The organisation also has a responsibility to ensure that the suspended staff member is properly supported. The individual remains innocent until proven guilty and an employee until the investigation is completed. Support needs to be provided in a manner that is not seen to influence the investigation. Those involved in providing support should have no involvement in the formal investigation, and those involved in the formal investigation should not provide support.

Induction provides an important opportunity for the organisation to clarify its expectations around the sale or supply of drugs.

Undertaking a peer risk assessment (see Section 3) should address the issue of selling or supplying drugs to others in order to help staff think in advance about managing these risks. The risk assessment circle (see Appendix 3) is another useful risk assessment tool that is normally undertaken with a peer mentor or as an exercise in self-reflection.
Drug use between staff during work time or soliciting drugs from a client would reach the threshold of misconduct. Normal disciplinary procedures should be followed in both cases.

Supply of drugs by a staff member during work hours or on work premises normally warrants immediate disciplinary action according to organisational policies and procedures.

4.8. When peer support groups become unhealthy

Sometimes structures established to support peer workers can create dynamics that are unhealthy for the organisation. The peer support group can become a team within a team, or a space for fostering dissent against management or organisational policy or strategy.

Although a peer support group is intended to provide a space for peer workers to manage the challenges of their work, this can be incorrectly perceived as a secretive space or as offering special privileges that are not available to all. Peer support groups should be available to all staff, and managers should not restrict this option only for staff who use drugs or peer workers.

Mediation is often a good first point of engagement. It is important that different stakeholders in the team have the right and space to express and explore their views and experiences. When people become fixed in their views it is much harder to bring about change.

Managers can also meet with the peer support group, or its representatives, to review the terms of reference for the group. This can be a helpful way of restating boundaries and expectations. It can also help to uncover differences of understanding or interpretation.

If a peer support group is considered to be operating outside the agreed terms of reference and continues to refuse to conform, or appears unable to change after mediation and disciplinary action have been deployed, the group can be suspended for a fixed period of time to allow for a resetting of the group after a break.

4.9. Managing staff with health conditions that impact on performance

HIV, viral hepatitis and TB are all chronic health conditions that affect PWUD in particular. As we have discussed, PWUD bring expertise and credibility to services like NSPs and harm reduction organisations. And people living with HIV, viral hepatitis, TB and other chronic conditions can similarly offer other skills and experience in managing treatments, interacting with health care providers, and dealing with stigma and discrimination. However, alongside these benefits also come some practical realities that include complying with a treatment regimen and attending hospital appointments. Occasionally, there may also be periods of ill health that can result in a person being unable to continue working.

Staff who do not use drugs can also have periods of ill health, chronic health conditions or live with a disability that requires regular use of health care services. Therefore, a positive approach towards staff who use drugs will also help to ensure a supportive workplace for all staff.

The following health-related challenges may influence a team's work:

STAFF MAY NEED TO BRING MEDICATION TO THE WORKPLACE AND TAKE MEDICINES DURING WORK HOURS
APPOINTMENTS WITH MEDICAL SERVICES MAY TAKE PLACE DURING WORK HOURS
STAFF PERFORMANCE CAN BE AFFECTED BY A PARTICULAR DRUG TREATMENT REGIMEN; FOR EXAMPLE, FOR HCV, AND METHADONE
STAFF MAY FACE UNEXPECTED PERIODS OF ILL HEALTH OR HOSPITALISATION
STAFF MAY BECOME PARTICULARLY FATIGUED AFTER WORKING FOR LONG OR INTENSE PERIODS
STAFF MAY BECOME INCAPABLE OF PERFORMING TO THEIR FULL POTENTIAL BECAUSE OF SUSTAINED POOR HEALTH
PRESSURE ON OTHER STAFF MAY INCREASE OR THE COST OF ADDITIONAL STAFF MAY INCREASE TO COVER THE TIME LOST THROUGH ILL HEALTH

Managers or human resources staff should ask staff when they start about how they may need to use health services. It's important that this is an open and confidential conversation that will help managers to understand their requirements and negotiate a balanced response.

Organisations can offer support through:

- FLEXIBLE WORKING POLICIES, INCLUDING WORKING FROM HOME OR FLEXIBLE HOURS
- AGREEING TO ALLOW FOR ALL OR SOME OF THE HEALTH CARE APPOINTMENTS TO BE COVERED DURING PAID HOURS
- PROVIDE HEALTH INSURANCE FOR STAFF
- REVIEW SICK LEAVE LEVELS BY LINE MANAGERS, AS PART OF DISCUSSING PERFORMANCE AND SUPPORT NEEDS

In particular, staff with chronic health conditions may need extended support to accommodate long-term disability.

If a staff member starts to use an excessive amount of sick leave, options to manage this can include:

- DISCUSS WITH HUMAN RESOURCES STAFF ABOUT THEIR NEEDS AND HOW THE ORGANISATION CAN SUPPORT THEM
- OFFER REDUCED WORKING HOURS AND THE POSSIBILITY OF WORKING FROM HOME
- OFFER A PERIOD OF LEAVE THAT COULD BE PAID, PARTIALLY PAID OR UNPAID, DEPENDING ON INDIVIDUAL CIRCUMSTANCES AND ORGANISATIONAL POLICY
- ENSURING THAT THE HEALTH NEEDS OF STAFF WHO USE DRUGS ARE REFLECTED IN HUMAN RESOURCE POLICY ALONGSIDE, FOR EXAMPLE, MANAGING HIV IN THE WORKPLACE

Thanks to ARVs and improving HCV treatment, the impact of chronic ill health has significantly reduced from the early days of the HIV epidemic. However, access to these treatments still varies depending on the context, as does individual experiences of treatment. The need to manage and support PWUD who are receiving treatment for dependency (for example OST), HIV, TB or HCV, belongs alongside wider needs to manage and support other staff with chronic or long term health issues.

If a staff member's health worsens to the point where they cannot sustain full-time work, it may be necessary to negotiate reduced hours for a while or indefinitely.

4.10. Managing a death in the workforce or among the client group

Staff with chronic health conditions can die, people who use opiate drugs can overdose, and expected or unexpected deaths can happen among all staff and volunteers.

All of us grieve when we experience a death, and if we experience that grief in a healthy way, we can see it as a natural and inevitable part of life. However, if grief becomes a problem because of our personal histories, or because we have too many deaths to cope with, we may become unable to manage and then a more complex grief reaction can occur (see Appendix 11).

When staff are grieving, the organisation can provide access to psychological/-professional support and create a space to mourn during work hours. It is also good practice to encourage informal activities, such as a funeral or memorial service for mutual support. Keeping a memorial book, or photos for those who have died among staff, volunteers and clients/peers can support healthy mourning and remembrance.

In addition, an organisation may consider a one-off bereavement payment for the family of the deceased staff member, or arrange a collection among staff and partners for the family.

Drug user activists mark 21 July as International Drug User Remembrance Day. This can be a helpful time in the year to come together and acknowledge those who have died among staff, peer volunteers and the client/peer group.

Running grief awareness training sessions for staff and volunteers to help people understand patterns of healthy grief and complex grief reactions can also help staff to deal with the impact of grief and look out for each other if grief reactions become problematic. (Appendix 11)

Example

East London memorial service and tree

In 1996, HOT planted a tree in a local park in memory of PWUD who had died during the HIV epidemic and from overdose. Once a year, staff and clients would gather for a multi-faith/humanist memorial service, which would conclude with a visit to the memorial tree. Staff would also visit the tree at other times for quiet reflection, and sometimes find piles of fresh ashes there, as the tree became a place of memorial and connection for the local drug using community.

Appendices

Key Message

"In April 2014 we gathered CAHR partners for a three-day workshop to pilot the guide and discuss some practical issues related to the employment of PWID. It turned out to be very a hot topic for everybody – managers, peer workers and community representatives alike. Besides discussing the guide, participants had a chance to develop some practical skills on dealing with the difficult situations that can arise when managing harm reduction programmes. The mutual conclusion was that it's not only about managing people who have experience of drug use. It's also about effective management of entire harm reduction teams that consist of people with different background, skills and experience."

Maryna Braga, Senior Manager: International Technical Support, Alliance Ukraine

Appendix 1: How we developed this guide

In 2013, the Alliance undertook an audit of its employment practices with PWUD. Staff from the Alliance Ukraine interviewed representatives of organisations implementing harm reduction programmes in China, Kenya, Kyrgyzstan, India, Indonesia, Malaysia, Russia and Ukraine. The audit showed the current level of employment of peer workers and identified ongoing challenges. It also revealed that the Alliance had more experience of and confidence in employing ex-drug users than of employing people on OST programmes, and very little experience employing active drug users.

The Open Society Foundations resource "Harm reduction at work" had successfully stimulated an interest in employing PWUD among LOs. This interest was reinforced during a training event in Bangkok (see below), where Alliance participants expressed their commitment to the principle of employing staff who use drugs, but felt they did not have the policy guidance to manage this specialist area of employment practice.

The Alliance invited Coact to provide technical advice on the results of the internal audit, which stimulated discussion about how the Alliance family could be encouraged to go further in employing PWUD. There was a particular interest in increasing the employment of active drug users.

Coact also held a virtual consultation with representatives from Alliance Ukraine and the Regional Technical Support Hub for Eastern Europe and Central Asia, Alliance India and the Alliance secretariat. This helped to develop shared understanding and gave further insights into the Alliance's development journey. It also identified examples of best practice, and led to the first draft of the guide.

Alliance pilot programme

This resource was tested at a training event run with participants from the Alliance CAHR programmes in Kenya, Malaysia, Indonesia and China. Three trainers with different but complementary skills and experience delivered the training at an event held in Bangkok, Thailand, in April 2014. The three trainers each brought with them a distinctive body of knowledge that was used as a reference point in the training:

AUDIT OF ALLIANCE PRACTICES – MARYNA BRAGA, ALLIANCE UKRAINE

HOT CASE STUDY – MAT SOUTHWELL, COACT

PRACTICAL EXAMPLE OF THE ALLIANCE EMPLOYING PWUD – CHARANJIT SHARMA, ALLIANCE INDIA.

The participants were a further source of knowledge given their experience of using peer volunteers and employing PWUD. They also reviewed the guide, which was tested through case studies, role plays, scenario planning and virtual feedback.

Importantly, partners from country drug user groups were also present, consistent with the advice provided in this guide. This added the perspectives of groups that work in partnership with harm reduction services and also have their own experience of employing PWUD.

Key Message

"It feels like we are finally being fully welcomed into services as real equal partners."

Suhendro "Ebbe" Sugiharto, PKNI Indonesian Drug User Network

Appendix 2: Specialist induction checklist

The following key points about employing PWUD and meaningful participation could be usefully added to the induction checklist:

- Organisational values around meaningful participation and employing PWUD.
- Policy on drug use in the workplace.
- Rights in the workplace and support systems.
- Staying healthy in a stressful work environment.
- The importance of operation policy and Standard Operating Procedures in guiding working practices.
- A commitment from the organisation to learning through reflection.

Appendix 3: Risk assessment circle

Written by Southwell M, Cameron B and Wright for the guide

HOW TO MAKE YOUR RISK ASSESSMENT CIRCLE

Making a risk assessment wheel is very easy. It is something that can help you think about the risks that you face in your life related to your work or wider life as a person who uses drugs. Importantly, it helps you to identify areas of risk and then to identify risk prevention and risk management strategies.

/ 1 Get two pieces of plain A4 paper. On the first, list the risk areas that you face in your life as a staff member who use drugs and in your wider life as a person who uses drugs.

This might be any number of areas (not usually less than four or more than ten). The diagram shows this list in the black text box.

/ 2 On the second piece of paper draw a largish circle and divide it into a number of parts, one for each main area of risk.

/ 3 Label each part with the name of one of the risk areas (from the list in Step 1).

/ 4 Decide on a scale of 1to 10 how much risk you are exposed to within each area,

1 being very low risk and 10 being very high risk. Mark the segment to show this. When deciding on the level of risk, you need to think about the potential consequences of a risk area and the likelihood of it happening.

/ 5 When you have done this for each area, take a look at the risk assessment circle. Note the areas where risk is high and explore the reasons for these high scores with your peer coach. You should prioritise these areas of higher risk for discussion.

/ 6 Draw another two concentric circles outside the original circle (they will be bigger than the first).

/ 7 The first circle you've added is where you will note strategies that you have for preventing risk in this area. Take the chance to review these strategies. Can any be improved or added to? Use this peer coaching conversation to be clear about risk prevention strategies. The coach may offer strategies used by other peers for your consideration.

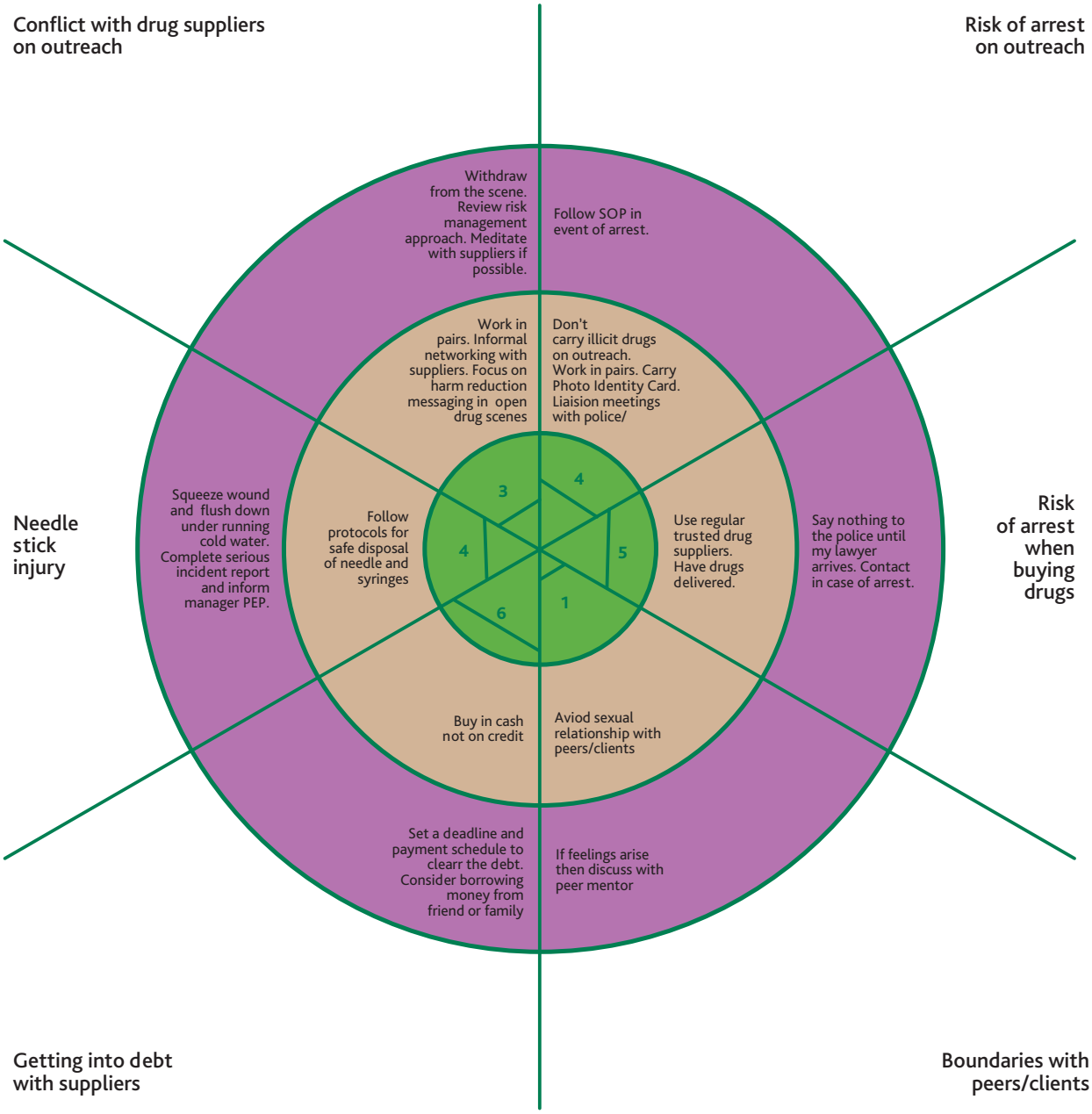
/ 8 The second circle is where you think about how you would manage the risk. Imagine that despite your best efforts or due to an error, you find yourself exposed to risk. How will you respond? Talk through the scenario with your peer coach and identify how you would respond on the second circle.

/ 9 Now review your overall risk assessment plan. Rehearse your risk avoidance and risk management strategies to help them to remain fresh and at the forefront of your thinking.

/ 10 It is best to keep your risk assessment plan private. In work areas, the requirement will be to operate to standard operating procedures and strategies will be employed at a team level. However, other areas of risk are more personal and can involve discussion of the purchase of drugs. As such, this tool is designed for self-reflection or to support a peer mentoring session.

/ 11 It is good to review and refresh your risk assessment circle from time to time, either when your situation changes significantly or once a year, to help you to remain focused on the risks you may encounter and to respond to changes in your risk profile.

Risk assessment circle



Risk Areas

RISK OF ARREST ON OUTREACH	GETTING INTO DEBT WITH SUPPLIERS
RISK OF ARREST WHEN BYING DRUGS	NEEDLE STICK INJURIES
PERSONAL/PROFESSIONAL BOUNDARIES WITH PEERS/CLIENTS	CONFLICT WOTH DRUG SUPPLIERS IN BUY ING/USING VENUE ON OUTREACH

Appendix 4: Terms of reference

Support group model terms of reference

<Harm reduction service> agrees to allow the support group for staff who use drugs to meet on its premises at <agreed frequency>.

The support group will meet in staff's own time / during work hours / during the lunch break.

The support group is designed to enable staff to reflect on personal challenges and issues arising from working as staff and being PWUD across different aspects of the group members' lives. The group can choose to share this learning with the wider staff group or management to support a whole team dialogue about these issues.

The support group needs to avoid becoming a team within a team. It should operate as a support structure not an alternative staff or management structure.

If concerns exist about this arrangement, management will contact the support group in the following way _____.

If concerns arise among the support group, these should be addressed to _____.

This TOR will be reviewed on <date>

Psychological/professional support model terms of reference

<Harm reduction service> agrees with <name coach/supervisor> to provide non-managerial supervision to <name staff member>.

The agreement is to support <number of sessions>/monthly for one hour/one-off supervision session with <name staff member>.

The non-managerial supervision should be undertaken in support of the operating policies of <harm reduction service>

If the coach/supervisor has concerns about the practices of management or the operating policies, these should be raised in the following way: _____.

The aim of the coach/supervisor is to support the staff member to engage effectively in the organisation, including supporting the organisation to reflect and develop.

Coach/supervisor sessions are confidential and disclosure with management is not required, with the exception of gross misconduct or where someone's life is in danger.

The coach/supervisor is obligated to report plans by the staff member to commit gross misconduct or to report if they admit to gross misconduct. This should be reported in the following way_____. All staff should be made aware of this obligation at the start of their first session.

This TOR will be reviewed on <date>.

Appendix 5: Examples of job advertisements for staff who use drugs and peer outreach workers

<Harm reduction service> welcomes applications from people with personal experience of drug use, HIV, sex work and engagement in harm reduction services.

This peer workers post is open to people with personal experience of drug use. Candidates should be able to operate as an outreach and harm reduction worker on active drug scenes.

Appendix 6: Model questions for peer interviewers

/ ? What do you understand by the term "meaningful participation" of PWUD?

/ ? Can you give an example of supporting the meaningful participation of PWUD or involvement in a drug-user group?

/ ? Can you describe some of the barriers to accessing harm reduction services and use examples from your own or others' experience?

/ ? Can you describe an example of operating in an active drug scene that promoted the health of PWUD?

Appendix 7: Conducting a review meeting

Review meetings provide a chance to explore a particular issue or concern. They may take place as part of a standard management supervision meeting, or the manager may call a review meeting to address a particular issue.

Explain the purpose of the meeting and give the staff member the opportunity to ask any questions.
Advise the staff member about the issue under discussion and highlight any relevant standards or policies that relate to the issue.
Highlight the staff member' seniority and the expected level of performance for their position or grade.
Give the staff member the opportunity to explain their understanding of the issue and how it relates to their performance. Encourage them to raise any concerns they may have about their job.
Discuss, identify and agree any appropriate support (see Section 3), training or development that could be provided to address the issues and facilitate improvement, if needed.
Agree a summary of the meeting in a meeting note, and agree if and when you will meet again to review progress.

Appendix 8: Developing a self-control programme

Making a commitment

List the benefits of achieving self-control. Tell others about your intentions, and post written reminders around your home. Put time and energy into designing your self-control programme, and plan ways to deal with obstacles before they occur.

Identifying the problem

Identify the behaviour that you want to change (known as the "target behaviour"). Keep detailed records of when the behaviour occurs over a period of one to two weeks. Make a note of what happens before the behaviour (antecedents) and what comes after (consequences). The antecedents and consequences are factors that influence the occurrence of the behaviour. Sometimes, just the process of keeping a record will alter the target behaviour by increasing your awareness of what you are doing.

Setting a goal

Once the target behaviour has been defined, decide how the behaviour should be changed. The goal should be specific so that progress can be measured. It should also be realistic. It is better to set a small goal and progress to bigger goals than to set a big goal and quickly become discouraged. Indicate a time frame in which the goal can be realistically achieved.

Applying self-control strategies

The self-control strategies are known as "controlling behaviours". Your choice of strategies will depend on your target behaviour (see below).

Self-monitoring

While using the self-control strategies, continue to keep written records about any reoccurrence of the target behaviour. Keeping records is essential for determining if the strategies are effective. If you are gradually meeting your goal, your strategies are effective. If you can see little progress towards your goal, either the strategies are being used incorrectly or they are ineffective and should be changed. Self-monitoring should enable you to gather the necessary information, but should not become too lengthy or complex. You will lose motivation to continue monitoring if the procedures are time-consuming or inconvenient.

Making revisions

Based on the information gathered during self-monitoring, decide if any changes to the plan are needed. One advantage of self-control programmes is that you can choose the strategies that will work best for you. This increases the likelihood that you will adhere to the programme. Therefore, make sure your self-control programme remains flexible and adaptable.

Types of self-control strategies

Self-control strategies can be grouped into three broad categories:

Environmental strategies:
changing the group of people you socialise with
avoiding situations or settings where an undesirable behaviour is more likely to occur
changing the time of day for participating in a desirable behaviour to a time when you will be more productive or successful.

Environmental strategies involve changing the times, places, or situations where you are likely to experience problematic behaviour.

Behavioural strategies:
increasing social support by asking others to work towards the same or a similar goal
placing visual cues or reminders about your goal in your daily environment
developing rewards for engaging in desirable behaviours or punishments for engaging in undesirable behaviours
eliminating anything that habitually reinforces an undesirable behaviour
engaging in alternative, positive behaviours when you are inclined to engage in an undesirable behaviour
creating ways to make a desirable behaviour more enjoyable or convenient
scheduling a specific time to engage in a desirable behaviour
writing a behavioural contract

Behavioural strategies involve changing the experiences or consequences of a behaviour.

Cognitive strategies:
using self-instructions to cue yourself about what to do and how to do it
using self-praise to commend yourself for engaging in a desirable behaviour
thinking about the benefits of reaching your goal
imagining yourself successfully achieving your goal, or using imagery to distract yourself from engaging in an undesirable behaviour
substituting positive self-statements for unproductive, negative self-statements.

Cognitive strategies involve changing your thoughts or beliefs about a particular behaviour.

Appendix 9: Checklist for managing staff with problem drug use at work

- / ? What are the indications that there is a problem and what supporting evidence is available?
- / ? Is there a second party (staff member, client, partner, etc.) involved in raising the concern or formal complaint? Does this require the organisation's complaints or grievance procedures to be followed?
- / ? How is the staff member who uses drugs or peer outreach worker performing in other areas? Is this visible drug use occurring in isolation or is it linked to a more general drop in performance?
- / ? Has the issue been addressed in supervision? Has this been documented? Has this led to any changes in performance and visible drug use?
- / ? In a meeting with the staff member, highlight expected practice and feedback on their visible drug use and any related performance issues. Explore these issues and the staff member's awareness of the problem.
- / ? If the problem is acknowledged, explore options for greater workforce support within the organisation (see Section 3) and/or agreed self-referral to OST, harm reduction or psychosocial services.
- / ? Set targets for improved performance, with agreed review dates and objective sources of feedback, and include self-reflection, whether or not the problem is acknowledged. Confirm these in a meeting note.
- / ? If the behaviour does not change with support, more formal disciplinary action should be considered.

Appendix 10: Training exercises from the Bangkok workshop

Case study 1

Masha is a staff member who does not use drugs. She complains to you, the team manager, about a peer worker called Alexey. She is angry that he is showing visible signs of drug use at work. Masha complains that Alexey's eyes are pinned, he gets sweaty, particularly when the weather is warm or the room is hot, and he has a pale complexion. When you ask her, Masha acknowledges that Alexey hasn't been falling asleep or "nodding off".

Masha accepts that Alexey works hard and is liked by the clients, but she also doesn't think it is the job of workers to be liked.

Alexey is on a methadone maintenance programme.

Tasks: *What are your concerns?*
What action would you take as the line manager?

Case study 2

Rajan has been on buprenorphine for two years and has been a stable and productive member of the management team. However, he has been visibly stoned at work during the last month, and this has been noticed both by you (his line manager) and his colleagues.

His performance has been affected and he has not been delivering work on time. This has been particularly remarked upon, as Rajun has been known up until now for his strong project management skills. During office hours, he is also noticeably making regular trips to the bank that take an hour or more rather than the usual half hour.

Tasks: *What are you are your concerns?*
What action would you take as the line manager?

Case study 3

Victoria is a peer worker who is on methadone. She has to pick up her dose from her clinic on a daily basis. Her clinic is a 30-minute bus ride away from the agency. The clinic doesn't start dispensing methadone until 10am, and this means that Victoria starts work later than all the other staff. This is a particular problem on Wednesdays, as this is the day when the team meeting takes place. When Victoria misses the beginning of the meeting, she loses the chance to participate in team discussions and to influence key decisions.

This has started to make Victoria feel frustrated at work and she has begun to find excuses to leave the office early. This is causing other staff to complain that Victoria is working part time while being paid a full-time salary.

Tasks: *What are you are your concerns?*
What action would you take as the line manager?

Case study 5

Michael has been recruited from his local drug-using community. He is a very well-known and trusted peer. Operating with standard worker–client boundaries are impossible for Michael because his roots in the community run so deep. However, it is Michael's connection to his community that makes him such an attractive peer worker. He has been talking to you in supervision about the problems of clients visiting him at home and asking for financial help.

Michael knows that his peers respect him and that they appreciate his work. However, he feels guilty about having a job and a salary when many of his peers are struggling. This leads him to lend money to clients, which creates bad feeling among his peers and is against agency rules. However, he finds it difficult to say no when they talk about their shared history as peers and their changed circumstances.

Tasks: *What are you are your concerns?*
What action would you take as the line manager?

Case study 6

Andrew is a peer outreach worker who regularly undertakes outreach into a drug-dealing house. The drug supplier runs a secondary peer needle exchange. Andrew takes new stocks of injecting equipment to the supplier's house, and the supplier hands them out for free to his injecting customers.

You are Andrew's manager. You get a call from the local police station informing you that Andrew has been caught up in a police raid on this address. Andrew has been arrested, along with five customers and the supplier. The police have seized a quantity of heroin and they have announced the successful raid to the press.

Tasks: *What would you do for Andrew?*
What else would you do?

Case study 7

Rahul is a project-based peer worker. His role is to undertake outreach and to run the needle and syringe exchange. This involves substantial contact with the active drug users using your service. He has worked for your organisation for the last 12 months and has been an effective worker.

A client called Geeta comes to see you, as Rahul's line manager. She informs you that Rahul has been helping her to buy drugs and has been charging a commission for this service. She tells you that at first she was happy with this arrangement because Rahul gets good-quality drugs at a fair price and she doesn't have to take the risk of finding drugs on the street.

However, Geeta is now unhappy because she has been cutting back her using and now wants to use the drop-in centre at your agency. However, every time she comes in she sees Rahul and this triggers her desire to buy more heroin. She asks if she can be allocated to a new worker. She doesn't want to get Rahul into trouble.

Tasks: *How would you respond to Geeta and her concerns?*
What would be your next steps with Rahul?

Case study 8

Written by Reachout and KANCO

Zuhura is 24 years old and the mother of a two-year-old son, who lives in Mombasa county in Kenya. Like other PWUD, she has regularly experienced violence and discrimination, including human rights violations, harassment and false charges by law enforcers. "Our life as active injecting drug users have been a hell on earth," she says.

Zahura is employed as a peer worker by Reachout Centre Trust, an organisation that provides harm reduction services to PWUD in Mombasa. She has been trained by Reachout on harm reduction and safer injecting practices.

As a peer outreach worker, she provides health services in her "den", where most of her peers respect her. At weekends, especially at night, she distributes clean needles and syringes to her peers. Sometimes she becomes caught up in a police raid.

As her project manager, you have received information that she will be appearing in court charged with possession of narcotic paraphernalia. She risks spending between 5 and 20 years in prison.

Tasks: *What would you do for Zuhura?*
What part will you play as a project manager in this situation?

Case study 9

Written by Rumah Cemara

Noni is a 30 year-old ex-drug user. She is divorced, with two children under five years old. She is used to taking the children to the office and leaving them there while she works. Noni is a senior field staff member, who regularly reaches targets, and her experience is valuable to her organisation. She often asks for permission to leave the office to take care of her children at home, and comes in late in the morning.

As staff turnover in the organisation is high, senior field staff invariably become role models for new field staff. Senior management is worried that new staff members may follow Noni's example and that her attitude will impact negatively on the behavior of others in the workplace. In addition, the organisation does not have space to look after children.

Tasks: *What should the manager do in this situation?*
How can the manager help Noni to face up to her issues?

Case study 10

Written by Rumah Cemara

Many people distinguish between drug users in recovery, former drug users and active drug users. However, there is a thin line between an active and inactive drug user (or drug user in recovery), and it can be easy to start using drugs again. Udin, a manager with a drug-using backgound, knows that some of his staff with experience of drug use are also living with HIV. This is why he becomes particularly challenged when any of these staff members go back to using drugs. Then they can start having problems with the law, jeopardise their health, and risk overdosing, conflicts may also happen between employees. Involving PWUD meaningfully in harm reduction and HIV prevention programmes is important. But at the same time an organisation must protect itself from violation of the law that can happen when employees use and purchase drugs.

Tasks: *What must you do as a manager to support the involvement of PWUD in your organisation?*

What must you do to create a comfortable working environment for everyone?

Appendix 11: Normal and complex grief reactions

After the loss of a loved one, it is usual to experience a normal grief reaction. This reaction occurs with other losses too, such as losing a body part or after a miscarriage or abortion. A normal grief reaction must be distinguished from a more complex grief reaction

Normal grief reactions	Complex grief reactions
Minor weight loss	Significant weight loss (above 5% of body weight)
Minor sleep disturbance	Significant sleep disturbance Intense feelings of guilt and worthlessness
Mild feelings of guilt Illusions (mistakenly taking one stimulus (visual or audio) for a different one)	Hallucinations or delusions (thinking you have seen someone or something which is not there)
Attempts to return to work and social activities	Resumes few if any work or social activities
Cries and expresses sadness Severe symptoms resolve within two months	Considers or attempts suicide Severe symptoms persist for more than two months
Moderate symptoms subside in a year	Moderate symptoms persist for more than a year
Management:	**Management:**
Grief peer support groups	Grief counsellor
Co-counselling	Assessment by community doctor and onward referral to specialist services
Visit to community doctor	Antidepressant medications and, where needed, antipsychotics

Source: Fadem, B (2012), *Behavioural science in medicine* (2nd edition), Lippincott, Williams & Wilkins and Walters Kluwer.

Notes

Good practice guide for employing people who use drugs

"It feels like we are finally being fully welcomed into services as real equal partners."

Suhendro "Ebbe" Sugiharto, PKNI Indonesian Drug User Network

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