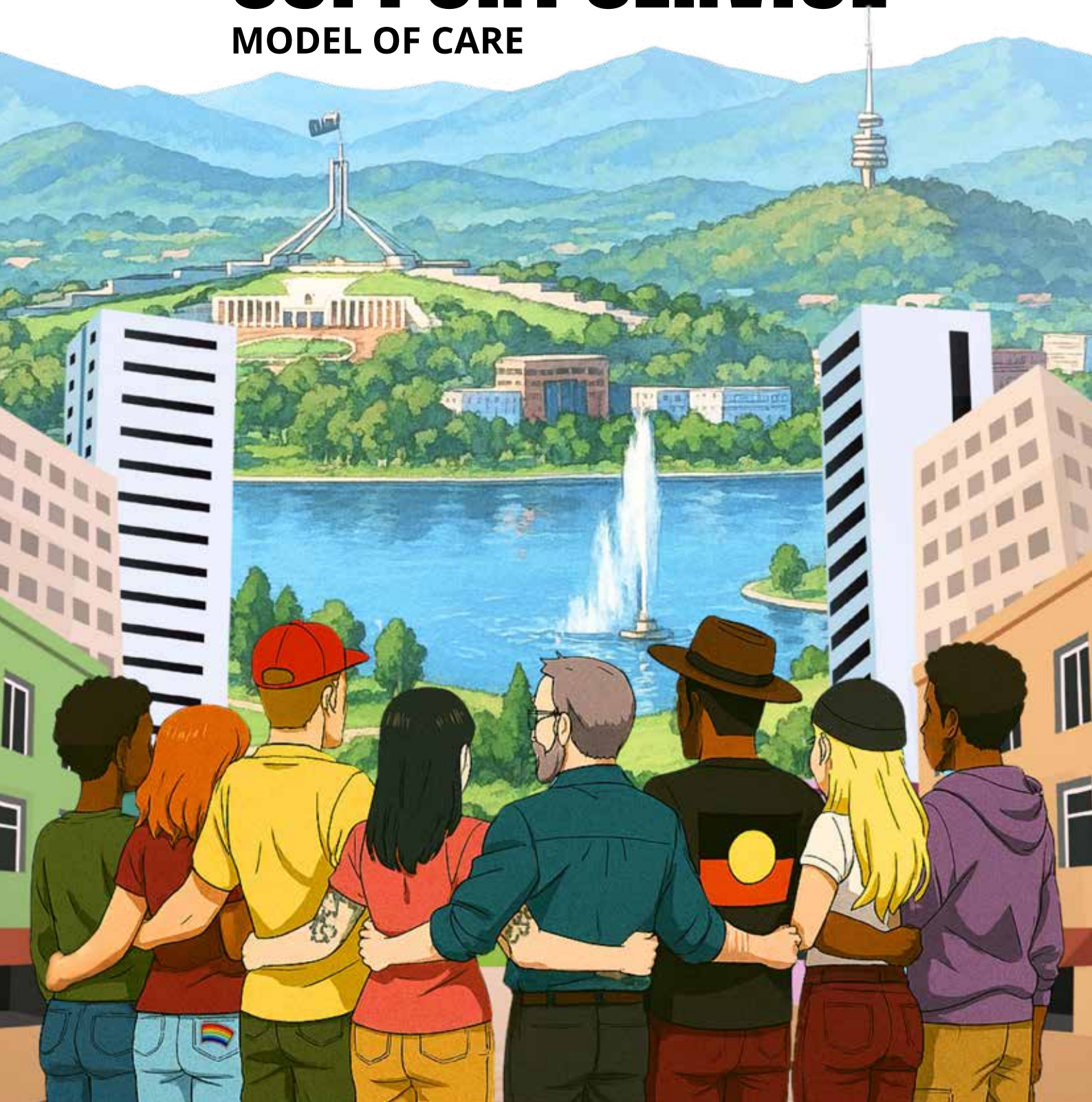


PEER TREATMENT SUPPORT SERVICE

MODEL OF CARE



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The Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) have prepared the new Peer Treatment Support Service Model of Care to guide our practice. The model has been developed across several years integrating staff feedback, consumer and community feedback, internal documents and good practice within ATOD peer workforce research.

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MODEL OF CARE

Acknowledgement of Country

We acknowledge the traditional owners and custodians of the land on which we live and work and on which land this paper was written, the Ngunnawal and Ngambri People. We acknowledge that no Australian land was ever ceded and that the colonisation of Australia resulted in a genocide of Aboriginal and Torres Strait Islander peoples. Colonisation continues to cause serious and ongoing stigma, discrimination and marginalisation for Aboriginal and Torres Strait Islander people as well as increased rates of mortality and over-representation within the criminal justice system. We recognise these ongoing harms and pay respect to Elders past and present and extend that respect to any Aboriginal and Torres Strait Islander people reading this paper.

Acknowledgement of Community

We acknowledge and value the contribution diverse cultures, identities and lifestyles make to our region and the richness of our society. We acknowledge the important contributions of people who use drugs and people who use drug treatment services to the field of harm reduction and drug and alcohol treatment. We acknowledge the significant harms that the criminalisation of drugs has on individuals and society and wish to acknowledge the pioneering work of drug user activists and drug user organisations over the decades. We recognise the devastating toll that overdose continues to have on individuals and our community.



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We acknowledge the CAHMA staff and volunteers and especially the Peer Treatment Support Service (PTSS) workers of CAHMA for their commitment in providing individual care for CAHMA service users and their hard work in ensuring people who use drugs and people who use drug treatment services in the ACT have equal access to health and social care. We thank them for their ongoing contributions to the work that makes up this model of care.

We thank and recognise the service users of CAHMA and in particular the PTSS for their trust, faith and understanding and especially service users who provided their stories for the case studies referred to in this document. CAHMA recognises your strength and resilience and appreciates your ongoing persistence in challenging stigma and discrimination.

Testimonials

Adam

"From the time I have been involved with CAHMA services and support workers I have been shown care, compassion, acceptance and respect with an unwavering amount of support and encouragement and dignity. My situation and my life, as well as my outlook on my future, has changed dramatically for the positive. They have been standing beside me this whole time and I'm a better man because of the help this service has provided and it's ongoing. I'm on the right track now and I have time with my daughters as a result of their involvement and I'm truly grateful for Michelle, Louise, Nina, Natasha, and Darren and all the volunteers there and I hope one day to do for others what CAHMA has done for me so thank you."

Bree

"You have made me feel welcomed and not judged and you have helped me more than any other services and encouraged me to be a better person and parent I find working with you is easy and not over whelming. Your understanding of recovery and relapses and the process of it all has been extremely helpful."

Hayley

"There is a huge difference in my experience of being a client of a mainstream case manager and a client of CAHMA's PTSS. For the PTSS worker it's not just a job, it's more than that. My trust and connection with them is much stronger because they went through the same struggles like myself and they do know exactly what I am going through. With them I don't feel judged and because of it I am able to be completely open and honest which reflects positively on my treatment outcomes."

Tracey

"I've had on-going high-level support for over a decade now. Personal and community support, I value this service immensely and I'm always recommending CAHMA to other people! Many Thanks for all the support"

Trudy

"The best thing about Julia and CAHMA is that you guys are relatable, you don't judge. I like that you guys really care. You call, you message, you follow-up. Where normal people would have given up many times over by now, but you keep wanting to help and trying to help. I think the main thing is you literally understand what it's like, so it's a lot better, you are not judgemental. You also offer different types of help. I think you guys rock! Legendary! And I seriously mean thank you for everything."

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Executive Summary

The Peer Treatment Support Service (PTSS) Model of Care outlined in this document describes the person-centred framework for the provision of individual care at the Canberra Alliance for Harm Minimisation and Advocacy (CAHMA). This model is unusual in its scope, as it works across the whole spectrum of drug and alcohol approaches from harm reduction services and principles all the way through to providing support for people to access abstinence-based services. As such, it seeks to be a model for inclusive practice where the journey of the individual and their goals and aspirations is the central priority of the service. The model of care uses respectful and modern “drug user organisation (DUO) community preferred” language and conceptualisation of alcohol and other drugs, and is firmly anchored in an extensive research and evidence base.

The PTSS has grown organically since 2016, when a concerted strategic decision was taken by CAHMA to provide one-on-one support for individuals, in response to significant gaps that were identified in local Canberra health and social systems. In particular, CAHMA recognised that the complexity of social systems and the effects of stigma and discrimination meant that people were locked out of meaningful engagement with a wide variety of different services and systems that most people take for granted. This resulted in challenges and obstacles in people’s lives becoming greater and issues often snowballing, causing significantly more harm than necessary. The focus of the PTSS is to provide timely (often immediate) and tailored support to people who are marginalised by society and by the criminalisation of drug use and to support them to move past a state of crisis, in order to be able to plan and manage their own health and wellbeing. Hand-in-hand with these skills is the ability to navigate local service systems and to have enough social capital and resilience to thrive. To support the diverse goals and aspirations of service users, the PTSS uses an inclusive and respectful approach that includes a wide range of PTSS worker journeys and identities. These identities are then matched with the goals and aspirations of the service user to ensure a safe and successful experience.

One of the core strengths of the PTSS is that workers are recruited through an organic volunteer engagement process, meaning that most PTSS workers have undergone similar journeys and experiences to the service users with whom they work. Importantly, this includes accessing local drug treatment and harm reduction services, making the PTSS a natural continuation of the health and wellbeing journey for many people as they transition from service user to peer worker. This

livelihood approach, which supports the dynamic personal and professional growth of workers, coupled with the deep understanding of local conditions and local services that comes with this journey is what makes the PTSS special.

Concepts of peer, peer worker and peer treatment support worker are defined in this document to ensure that a unified understanding and conceptualisation of peer work is gained. Lived and living experience (which we call lived experience through-out the text), words that are becoming synonymous with being a peer, are unpacked and discussed as one of the key components that defines a peer. Importantly, we cover the core concept of peer identity, which is often overlooked in practice. The hope is that this will be of benefit both to CAHMA community members and to the broader community who are increasingly interested in understanding how peers define themselves, how they operate and what makes an individual a peer.

In this model of care, the principles and approaches that underpin the PTSS are detailed. The model is built on four underlying principles of peer treatment support:

1. providing accessible services
2. promoting health and wellbeing
3. advocating for human rights
4. challenging stigma and discrimination

The PTSS approach to service delivery is also outlined, including its four key approaches:

1. person centred care
2. timely service provision and broad scope of practice
3. integrated care and partnership
4. low threshold engagement.

Engaging in peer treatment support and the community development approach has many benefits to service users:

1. Enhanced conceptualisation and understanding of available choices in accessing treatment services, harm reduction approaches and therapeutic interventions.
2. Enhanced planning, prioritisation and sequencing of health goals.

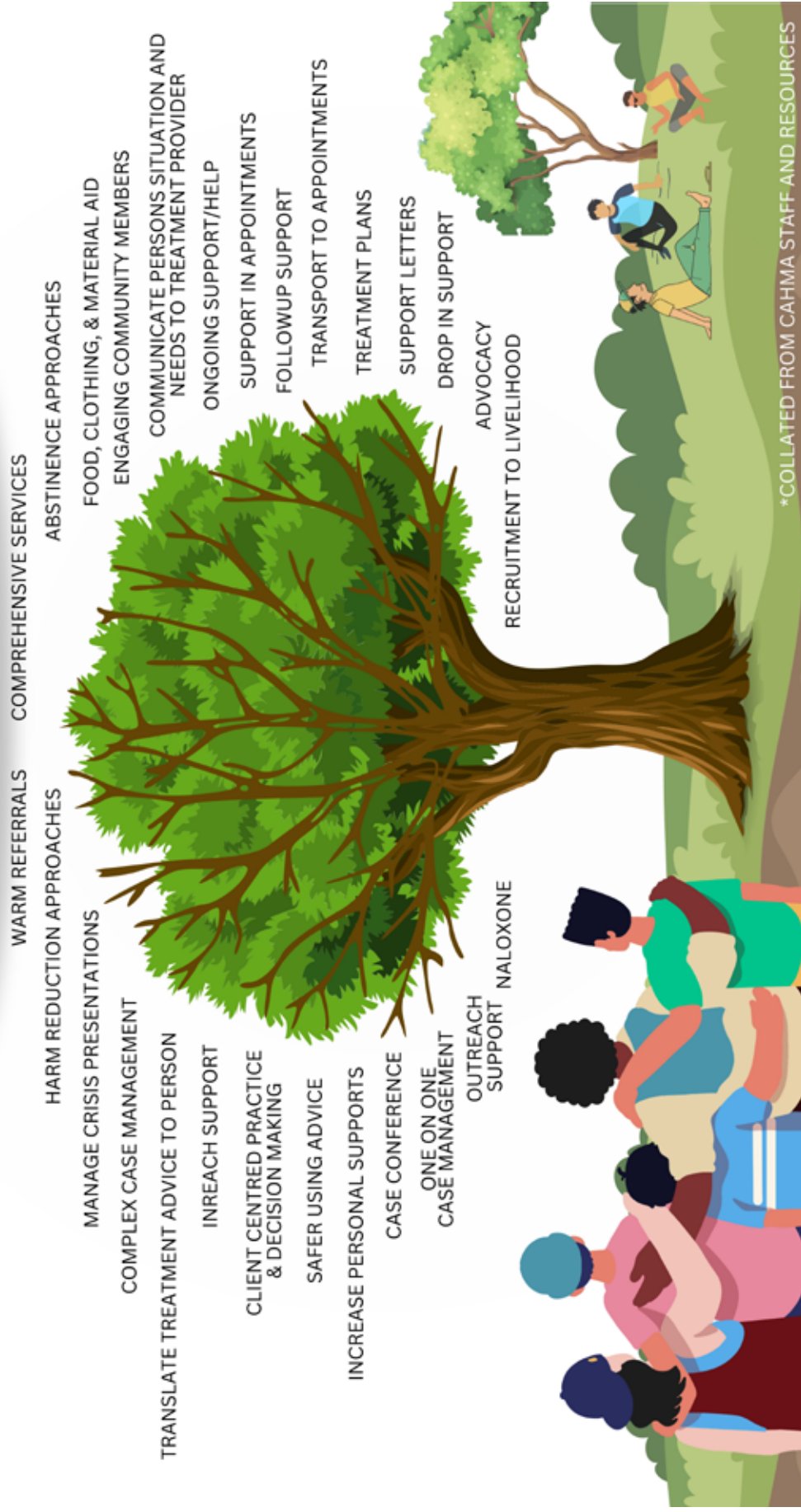
3. More successful engagement with the service system and understanding what treatment will entail.
4. Better understanding of treatment processes and possible outcomes.
5. Enhanced agency and control of health and wellbeing.
6. Well established relationships and networks with health professionals.

There are also benefits for the peer workers themselves, as well as broader social benefits to the ATOD sector and society as a whole, which will also be discussed.

This document also outlines the process of peer treatment support and the different steps involved: from initial engagement; to assessment; goal identification and prioritisation; exploration and treatment plan development; support aimed towards empowerment; and finally empowering independent system navigation. In practice, the process is dynamic and people will dip in and out of the PTSS for years, utilising the service when their health and wellbeing or social circumstances become more complex and disengaging when they attain their health goals. This ongoing engagement over long periods is a key feature of the service and a key strength in avoiding crisis. Hopefully, each time the person returns, they are more confident in navigating the system, have more social capital, a better team of healthcare professionals that they are engaged with, and more knowledge about themselves and the system they live within.

Lastly, the document aims to help other organisations seeking to employ peer treatment support workers to do so in a manner which is safe, ethical and successful. Across Australia the benefits of incorporating peer workers in health and social services is being realised, but there is a lack of clarity about how to integrate peer workers into multidisciplinary teams and organisations that are not peer led and community controlled. Unfortunately, there are no easy solutions, and the successful incorporation of peer worker teams requires a whole of organisation approach. This includes discussions and decisions on implementing changes at different organisational levels; incorporation of peer expertise/leadership; consultation with service users and front-line staff; and changes in culture, recruitment, training and supervision.

WHAT DOES THE PTSS TEAM DO?



*COLLATED FROM CAHMA STAFF AND RESOURCES

Glossary of Terms

AODTS-NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set; data collected by the Australian Government about alcohol, tobacco and other drugs treatment services and their clients.
ATOD	alcohol, tobacco and other drugs. ATOD is the preferred acronym in the ACT sector, however CAHMA acknowledges there are different levels and types of stigma and discrimination between licit and illicit substances. In this document when we refer to “drug use” or “drug treatment” we are including alcohol and tobacco as contextually relevant.
Advocacy	the action of speaking up for and promoting the rights of another person.
AIVL	the Australian Injecting and Illicit Drug Users League; the national peer-led peak organisation representing peer-based harm reduction and drug user organisations.
Carers ACT	the ACT community organisation that provides advice and support to unpaid carers, including those supporting someone who is using alcohol, tobacco and other drugs.
CDP	Community Development Program; CAHMA's volunteer training program.
Chat to PAT Van	Directions Health Service mobile clinic vehicle that provides doctor and nurse services to marginalised Canberrans including people who: use drugs; use drug treatment services; are experiencing mental ill health; are experiencing homelessness; are experiencing significant disadvantage.

Chosen family	the people we choose to be with who provide support and fulfil the social role of family without being related to us; the term reflects the networks of mutuality and belonging that are cultivated beyond the traditional family structure.
Consumer representatives / Consumer reps	a member of a committee or other decision-making body who voices consumer perspectives and takes part in the decision-making process on behalf of consumers.
Cultural awareness	sensitivity to the similarities and differences that exist between two different cultures; often specific to the differences between First Nations Australians and others, with emphasis on the history of colonisation and trauma.
Discrimination	unfair treatment of a person because of their attributes, characteristics or background.
CYF	Children, Youth and Families; the ACT child protection services.
DUO	a drug user organisation; a peer-led organisation with a focus on support and advocacy for the drug using community.
FDS	Family Drug Support; a support service for families and friends who are supporting someone using drugs and/or alcohol.
FOH	front of house; the first point of contact at CAHMA.
Harm reduction	policies, programmes and practices that aim to lessen the negative health, social and legal impacts associated with drug use, drug policies and drug laws; one of the three pillars of harm minimisation.
Health promotion	the process of enabling people to increase control over, and thereby to improve, their health.

Lateral violence	harmful behaviours directed by members of a marginalised group towards each other, rather than outwards towards the source of its marginalisation.
Lived experience	knowledge based on someone’s first-hand practical experience, personal history, and observations which influence an individual’s perspective and insight. In this context lived experience has particular reference to past or continuing ATOD use and/or ATOD treatment as well as marginalisation associated with stigma, discrimination and criminalisation. Living experience of drug use is also included in this definition of lived experience to remove any arbitrary distinctions and hierarchical implications between people with past and people with ongoing experience.
Media training	learning how to handle TV, radio and phone interviews and how to share personal stories of drug use and/or drug treatment.
Naloxone	an opioid antagonist that can be used to reverse or reduce the effects of opioids in the case of overdose.
NSP	needle and syringe program; service that provides sterile needles and syringes along with health advice for people who inject drugs.
OMT	opioid maintenance treatment; ongoing treatment of opioid dependency with regular dosing of methadone, buprenorphine or buprenorphine/naloxone. Also called opioid dependence treatment, opioid agonist treatment, medication assisted treatment of opioid dependence, pharmacotherapy and other names. CAHMA uses opioid maintenance treatment as this is the term currently used in the ACT, not for any ideological preference.

Peer mentoring	the act of a more established peer worker providing guidance and support to another (usually newer) peer worker.
Peer supervision	the act of a trained and experienced peer worker providing guidance and workplace oversight to other peer workers.
People who use drugs	a person who identifies as using drugs including alcohol and tobacco. This definition seeks to include alcohol and tobacco where contextually appropriate but also recognise the significant differences in stigma and discrimination between different drugs as well as the negative effects of criminalisation on people who use illicit drugs.
People who use drug treatment services	This term recognises that some people no longer wish to identify as a person who uses drugs but rather as a person who uses drug treatment services. This is common where a person is maintaining or seeking abstinence as one of their health goals.
Person centred care	an approach that treats each person respectfully as an individual human being, and not as a condition to be treated. It involves understanding, respecting and working with what is important to the person, rather than expecting them to fit within an existing treatment framework. It prioritises an individual's agency, goals, hopes and aspirations as well as a person's strengths and support networks as a crucial part of health and wellbeing.
Purposeful disclosure	the intentional sharing of aspects of a peer worker's own story with the aim of supporting a person's treatment and/or harm reduction journey. The term has been used across diverse healthcare settings but most often in the context of stigmatised conditions.

RediCASE	a brand of case management software.
Self-stigmatisation	the process of internalising stigma and holding negative views of oneself.
Social capital	the network of people and resources that an individual knows and can draw on in their life to provide support.
Social determinants of health	the complex interplay of non-medical factors that influence health outcomes.
Stigma	the labelling and stereotyping of difference, at an individual and structural-societal level, that leads to negative perceptions and loss of status.
Systemic change	transformation of a system to create lasting change.
Warm referral	also called supported referral. When the worker discusses the services another organisation offers, gains consent to contact the other organisation and makes an appointment for the client. The worker may also take the client to the first (and subsequent) appointments.
WHS	work, health and safety; requirement for a safe workplace.

Introducing CAHMA

The Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) is the alcohol, tobacco and other drugs (ATOD) consumer organisation for the Australian Capital Territory (ACT). CAHMA is recognised as part of the ACT's specialist drug treatment sector,¹ and conducts peer-based drug treatment, harm reduction, treatment support, health and social system navigation and individual and systemic advocacy from its drop-in community centre in Belconnen. CAHMA is a not-for-profit incorporated association.

CAHMA is a member of the Australian Injecting and Illicit Drug User's League (AIVL) and grew out of the Australian Human Immunodeficiency Virus (HIV) response in the 1980s, first gaining funding in 1988 as the ACT IV League (ACTIV).² CAHMA is proud to represent people who use drugs and people who use drug treatment services in the ACT and is an active member of the Australian Drug User Organisation (DUO) National Network co-ordinated by AIVL.

Within the ACT, CAHMA is a unique service which operates on a peer-based, person-centred philosophy. This means that it encourages, supports and facilitates people to act on their own behalf and to participate directly in improving their own lives and advocating for their own needs and the needs of their community.^{3,4}

The team at CAHMA is made up of both paid workers and volunteers, who use their lived experience of alcohol, tobacco and other drug use to build therapeutic relationships and undertake person-centred interventions. These interventions are grounded in active listening, empathy and peer relationships.⁵ CAHMA offers a wide range of services and programs to the community. One of these services is the Peer Treatment Support Service (PTSS).

The PTSS at CAHMA began as the Treatment Support Service, providing support and advocacy for people engaged with the Opioid Maintenance Treatment (OMT) program in the ACT. It was originally known as the Pharmacotherapy Advocacy & Action Team (PHAAT) and was a driving force for systemic change by representing consumer needs. The PTSS also grew out of The Connection, CAHMA's Indigenous program. As part of The Connection, the Aboriginal Peer Worker at CAHMA would often provide transport to a client's important appointments as well as support the person to attend court appearances, appointments with Children, Youth and Families (CYF), medical appointments, and other stressful and difficult social engagements, as an advocate. Usually, this work was in response to crisis and CAHMA began considering early intervention strategies, so that not only could help

be available during acute periods, but support could be provided to prevent crises from occurring, to assist in the achievement of personal goals, and to empower people to take control of their health and wellbeing regardless of where they were in their journey.

As CAHMA began to provide more comprehensive services through its drop-in centre, it became clear that people were looking for help with a wide range of different issues associated with drug use and drug treatment. In addition to crisis support, CAHMA was being asked to help members of the community with navigating the alcohol and other drug treatment sector (especially entry and exit from residential and other rehabilitation services) and support with wider health issues (including mental health) and integrated healthcare (especially advocating within the hospital system). Additionally, CAHMA identified a need for advocacy and support around the social determinants of health (including housing, legal support and navigating the CYF system) and in respect of other issues of concern to the community.^{6,7} The PTSS was developed in response to community need and in recognition of the complex and overlapping issues that can impact people's health and wellbeing, including the experience of stigma and discrimination.⁸

Peers and Peer Workers

The term 'peer' refers to a person with shared qualities, abilities, experiences or social position as others within a group.⁹ Essential to this concept, is that both the person and the members of the group accept and regard one another as "equal in standing, rank or value".¹⁰ Peers, therefore, are individuals who share a set of lived experiences with other individuals in a group and within that group all individuals are regarded as equal and there are no power imbalances. Additionally (and closely related), is the concept of 'peer identity'. The Australian Injecting and Illicit Drug Users League (AIVL) covers this idea in their 2006 peer education framework: "Being accepted as a peer is a social process of identifying, and being identified, as part of a group, network, community or culture. It is not a decision that can be made by others outside the process."¹⁰ In summary, there are several components to being a peer: shared experiences, qualities and abilities which make the group members equal in standing; and personal and group identity. In the context of this model of care, being a peer means identifying as a person who uses or has used drugs. It also includes people who prefer to identify as using or having used alcohol, tobacco and other drugs (ATOD) treatment services.¹¹ Important to being a person who uses drugs or drug treatment services, is the lived experience of drug use, in particular, the "range of shared characteristics and similarities based

largely on experience of using drugs".¹⁰ Goodhew and colleagues elaborate on the notion of lived experience to encompass relevant factors beyond that of drug use, in particular "experiences of accessing health services and experiences of stigma and discrimination".¹² These experiences are critically important to the identity of ATOD peers as it binds the peer group together in a shared understanding of being marginalised, criminalised, undervalued and thought of as 'other' in society.^{13,14} It is this shared experience and understanding of the difficulties involved in health care and social system access which forms trust and rapport between peers and provides a basis for shared understanding between CAHMA peers and individuals who access CAHMA services.¹

Using this definition of an ATOD peer, it is now possible to turn to a discussion of how an ATOD peer can use their expertise by experience to inform their role as a 'peer worker'. CAHMA's definition of a peer worker is an ATOD peer who uses their lived experience and their individual and group identity to inform their work by creating trusting relationships with service users; shaping therapeutic interventions and care provision; giving support and understanding; providing information and education; and progressing individual and systemic advocacy.

A peer worker is someone who identifies and is identified as sharing an experience of alcohol, tobacco and other drug use and who uses their lived experience and their individual and group identity to inform their work by 1) building trust with service users within the context of an equitable relationship; 2) shaping therapeutic interventions and care provision; 3) giving support and understanding; 4) providing information and education; and 5) progressing individual and systemic advocacy.

Historically, peer work approaches have contributed to wider social change.¹⁵ Peer work approaches have been instrumental in Australia's successes in HIV/AIDS prevention.¹⁶ The mobilisation of action by affected communities and the use of peer initiatives that draw on the lived experience of those most impacted, have been central to the effectiveness of Australia's efforts to contain the spread

1 The discussion around defining 'peer' and 'peer worker' is ongoing at CAHMA, as it is in the ATOD sector more broadly. There remains a diversity of views about what defines a peer. In particular, the idea that peer identity is dependent on the acceptance of this identity by the community, bumps up against the broadly accepted notion that a person has a right to determine their identity. Others argue that the word peer itself implies an identity in relation to another person and that therefore mutual recognition is important. CAHMA continues to debate and discuss this issue and seeks to always use the most inclusive and supportive definitions of peer and peer work that we can in our work.

of the HIV and other blood borne viruses.¹⁷ Australia's approach has recognised the need to involve people with lived experience in policy, program development, implementation, monitoring and evaluation.

ATOD peer workers are individuals who have experience using drugs and/or using drug treatment services and can draw on their lived experience to relate to the situation of those they are supporting. This personal understanding of drug use is of immense value as it helps to create a trusting and non-judgemental environment for service users.¹⁸ Additionally, peer workers are able to provide support and guidance that is tailored to the needs of individuals, rather than a one-size-fits-all approach.

Peer workers in the ATOD sector in Australia can be helpful in navigating the complex system of services that are available.¹⁹ They are the go-between, connecting individuals with the right services and support to meet their particular needs.²⁰ Often there is an expectation that peer workers need to be experts in all areas of healthcare and have an encyclopaedic knowledge of social services. This expectation is unhelpful and unrealistic and fails to acknowledge that a peer worker's expertise is actually in network provision and the building of linkages with experts in diverse fields.²¹ At CAHMA, therefore, we are very clear that we don't expect our peer workers to be experts on every field, but rather to concentrate on building networks of supportive experts who are safe for our community to engage with. Peer workers are also valuable in providing mentoring and support to individuals regardless of their current drug use or intentions around future drug use.²² This additional support can be instrumental in helping people make changes that improve overall wellbeing. Lastly, peer workers act as role models for people undergoing similar health and social circumstances and can promote hope and foster resilience.

CAHMA peer workers perform a number of different roles across the varied programs and services that CAHMA operates. Peer work roles at CAHMA include: disseminating harm reduction information and education to ATOD peers in the ACT; training in overdose recognition and response; undertaking interventions for safer using; providing information about blood borne virus prevention, testing and treatment; training and upskilling community members for peer worker roles through the Community Development Program (CDP); peer mentoring; and providing peer supervision to maintain the health and wellbeing of peer workers and to build resilience and safer peer boundaries to minimise vicarious trauma.

At the heart of this model of care is the peer treatment support role and the PTSS. CAHMA defines peer treatment support as a specific type of peer work where a peer supports another peer (usually one-on-one, but group support can also be part of this role) through a variety of methods including case management, care coordination, emotional support and active listening, provision of transportation and material aid, individual advocacy, and support navigating and understanding health and social systems.

Peer treatment support is a specific type of peer work where a peer supports another peer through methods, including, but not limited to: case management; care coordination; emotional support and active listening; provision of transportation and material aid; individual advocacy; and support navigating and understanding health and social systems.

Because the service that CAHMA offers under this model of care is centred around supporting the individual to access the services that they need, the peer workers that are employed under this model of care are called peer treatment support workers.

Guiding Principles of the Peer Treatment Support Service

CAHMA's PTSS is underpinned by a set of principles that collectively guide the way that PTSS workers interact with and respond to the needs of the community. Integral to the PTSS process is the trusting relationship that is cultivated between the PTSS worker and the individual through all stages of the PTSS journey. In the absence of a trusting relationship, the process of peer treatment support will fail to affect the positive change that individuals are seeking through their engagement with the PTSS.²³

CAHMA exists as an accessible service to promote health and wellbeing and to advocate for the human rights of drug-using communities, while recognising that stigma and discrimination have often powerfully shaped the lives of people who use drugs and people who use drug treatment services.²⁴

PTSS GUIDING PRINCIPLES

PROVIDING AN ACCESSIBLE SERVICE	PROMOTING HEALTH AND WELLBEING	ADVOCATING FOR HUMAN RIGHTS	CHALLENGING STIGMA AND DISCRIMINATION
<ul style="list-style-type: none"> Providing accessible, inclusive and non-judgemental services Valuing and respecting diversity Building social capital among the community that CAHMA serves Building mutual respect within the ACT's ATOD sector 	<ul style="list-style-type: none"> Recognising that people who use drugs and people who use ATOD services care about their health and the health of their community Making healthy choices the easy choice Putting ATOD consumers in control of their health outcomes Focussing on promoting positive health and wellbeing outcomes, not only on addressing ill health 	<ul style="list-style-type: none"> Driving initiatives that promote social justice and equity Acting as a voice for the oppressed, marginalised and powerless Promoting empowerment and self-determination for people who use drugs and people who use ATOD services Challenging dehumanising policies and procedures 	<ul style="list-style-type: none"> Recognising the damage caused by stigma and discrimination Challenging public misconceptions in addressing stigma and discrimination Recognising the value of the lived experience of people who use ATOD services Using peer identity to role-model resilience to stigma and discrimination

Providing an accessible service

CAHMA provides accessible, inclusive and non-judgemental services where diversity is valued and respected. The PTSS team is constituted in such a way as to reflect the wide range of experiences, needs, identities and backgrounds of service users. Providing an accessible service is not simply a passive action of removing barriers, but involves CAHMA having an active presence in the community and empowering individuals to actively build *social capital*. Social capital is the network of people and resources that an individual knows and can draw on in their life to provide support and precipitate positive change.²⁵ For this reason, peer identity is critical in building this social capital as it binds people together and allows formation of large networks of people and resources.²⁶

Peer identity is critical in building social capital, in the form of networks that individuals can draw on to provide support and precipitate positive change.

CAHMA seeks to bolster social capital and build mutual respect within the ACT's ATOD and broader community sectors. CAHMA recognises that service users may move in and out of other treatment services and will almost certainly access allied services concurrently with PTSS.²⁷ PTSS workers support community members to access the appropriate services in achieving their health and wellbeing goals.

This necessitates CAHMA building and maintaining relationships with services across the ACT. When a PTSS worker refers an individual to another service they are implicitly 'vouching' that the service is safe, reliable and accessible. In essence, they are creating a network of accessible and supportive services across the system which individuals can access and thereby increase their social capital and improve their health and wellbeing. The act of building networks of supportive services and providing warm/supported referrals to these services is at the very heart of peer treatment support.²⁸

Promoting health and wellbeing

The PTSS is built on the recognition that people who use drugs and people who use drug treatment services care about their health and the health of their community. It is often said that making the healthy choice is difficult in our society and this is particularly so where stigma and discrimination are present. For example, going to hospital can be quite scary and confronting for many people. Stigma and discrimination makes visiting hospital even more challenging and difficult for people who use drugs and people who use drug treatment services. Stigma can lead to denial of pain relief medications; refusal of access to opioid maintenance treatment (OMT); low levels of trust between patients and health providers; and denial of basic human rights and health equity.²⁹ In addition, entering a hospital setting may mean navigating smoke free environments and losing access to substances which the person may be using to self-medicate.^{30,31} Staff within hospital settings have often been trained to be suspicious of people who use drugs and people who use drug treatment services and to seek reasons for their engagement with the hospital system besides the need to improve their health. These reasons include “drug seeking” or theft of medication or medical equipment.³² Often hospital workers have misconceptions about opioid maintenance treatment and its interactions with opioid pain relief. This results in the incorrect assumption that a person who is taking opioid maintenance treatment doesn’t require pain relief or is in some way already equipped to deal with pain.³³ Further issues surround buprenorphine treatment and its interactions with opioid analgesia,³⁴ causing inadequate or in-compatible pain relief to be provided. For these reasons, barriers to accessing health services can be prohibitively high for people who use drugs and people who use drug treatment services.³⁵

PTSS workers understand that supporting a person who is accessing health services almost always involves dealing with issues created by stigma and discrimination and not by health issues per se. Dealing with these type of obstacles requires numerous and diverse strategies on many levels – from educating health service staff and building trust and rapport with them, to creative problem solving and advocacy at both individual and systemic levels.

Case Study 1 – Charlie

Systemic barriers to accessing appropriate healthcare for people with complex needs can be significantly compounded by the stigma and discrimination that arise in the context of drug and alcohol use. CAHMA's PTSS was able to work with Charlie, a 57-year-old man with a longstanding alcohol dependency, to access a range of services in support of his physical and mental health. The PTSS worker to whom Charlie was assigned, identified barriers that were preventing him from accessing and completing withdrawal (detox) and reducing his alcohol intake towards the sustained abstinence that he was aiming for.

When Charlie first came to CAHMA he was drinking to avoid entering into dangerous withdrawal and sought support from CAHMA for admission to a withdrawal unit. On enquiry, the withdrawal unit told him that he could not be admitted until he had first attended hospital to assess whether he was physically able to handle the withdrawal process. However, when Charlie went to the hospital they triaged him as being insufficiently unwell to require any kind of urgent response. They then sent him home. This bureaucratic impasse was repeated on several occasions, delaying Charlie's access to necessary treatment and highlighting systemic gaps in the healthcare system's response to individuals with complex needs.

Because of Charlie's childhood history of institutional abuse, he often found it challenging to remain the full duration of treatment at detox or consider residential rehabilitation programs, as the environment exacerbated his sense of vulnerability and precipitated trauma responses. During attempts to secure Charlie's repeat admissions to detox over a six-month period, instances of apparent bias and reluctance from staff were observed. On one occasion, a staff member expressed frustration upon hearing Charlie's name, indicating preconceived ideas about his situation and capacity to engage in treatment. Moreover, there were instances where the scheduled admission dates for Charlie were repeatedly postponed, raising concerns about the facility's willingness to accommodate him. Concerns about treatment effectiveness or resource allocation, intersect with possible bias against individuals who may require multiple detox admissions and have complex needs. These challenges underscore the importance of advocating for equitable access to treatment and addressing stigma and discrimination within healthcare systems to ensure individuals like Charlie receive the support they need.

Charlie's past encounters with male authority figures – marked by abuse and exploitation – instilled deep-seated distrust and aversion towards seeking support from men. The discomfort with male workers added another layer of complexity to his therapeutic journey. At the same time, Charlie's alcohol-induced psychosis manifested in a way that could be experienced as threatening to female workers. A PTSS worker from CAHMA was able to support Charlie to access an appropriate counsellor who could begin to help Charlie manage complex trauma, as a pre-requisite to addressing his alcohol dependency in any kind of sustained way.

Navigating these intertwined challenges required a comprehensive and person centred approach that addressed Charlie's unique needs, strengths and vulnerabilities. It necessitated creating a supportive and non-threatening therapeutic environment, exploring alternative treatment modalities that could accommodate his trauma responses, and implementing health and wellbeing planning. The PTSS collaborated with Charlie to identify and address these challenges and was pivotal in fostering his resilience and empowering him to reclaim agency over his life.

PTSS workers act as role models to service users, providing positive examples of the effects of health prioritisation and of engagement with health and social systems.¹⁸ This is important, as many of CAHMA's community members have had significant negative encounters with health and social services and these negative experiences may be ongoing. For this reason, it is beneficial for people to see the potential benefits and outcomes of prioritising health and wellbeing, manifested in someone who has undergone the same or similar challenges. This role-modelling provides hope and inspiration to service users and in many cases is the difference between a person disengaging from the system when a negative interaction occurs and courageously persevering with service engagement. As such, the PTSS at CAHMA is focussed on promoting positive health and wellbeing outcomes, not only on addressing ill health. PTSS is fundamentally about putting the community member in control of their health outcomes and ensuring that they are supported to be the lifelong driver and advocate of their own health and wellbeing.

Importantly, promoting positive health outcomes and prioritising individual choice includes understanding the positive aspects of people's drug use as well as the potential negative health consequences.³⁶ This innate knowledge of the rational and emotional reasons why a person is using drugs is fundamentally important to the therapeutic peer relationship and to promoting health and wellbeing.

Advocating for human rights

CAHMA follows the International Network of People Who Use Drugs, Consensus Statement on Drug Use Under Prohibition – Health, Human Rights and the Law.

³⁷ This document states that “Criminalisation and the understandings that justify it, have resulted in the rights of people who use drugs being systematically and endemically violated globally”. Underpinned by worldwide consultation with people who use drugs (including in Australia through consultations at AIVL and CAHMA), the Statement asserts that because of this criminalisation, people who use drugs often “do not have recourse to the same legal infrastructure as other citizens, notably laws protecting rights to be free from violence and discrimination, and the right to health.”³⁷ The Consensus Statement articulates the human rights of people who use drugs and establishes a set of demands to ensure the human rights of people who use drugs around the world are met and are not violated.

The human rights of people who use drugs

Right 1: The right to rights.

Right 2: People who use drugs have the right to non-discrimination.

Right 3: People who use drugs have the right to life and security of person.

Right 4: People who use drugs have the right not to be subjected to torture or to cruel, inhuman, or degrading treatment.

Right 5: People who use drugs have the right to the highest attainable standard of health.

Right 6: People who use drugs have the right to work, to free choice of employment, to just and favourable conditions of work, and to protection against unemployment.

Right 7: People who use drugs have the right not to be subjected to arbitrary arrest or detention.

Right 8: People who use drugs have the right to bodily integrity.

Right 9: People who use drugs have the right to found a family entitled to protection by the law, entitled to privacy, and entitled to be free from arbitrary interference.

Right 10: People who use drugs have the right to assemble, associate, and form organisations.

From CAHMA's perspective, these are all important rights and form the basis of everything that CAHMA does, including in its PTSS. CAHMA also includes people who use drug treatment services in all human rights set out by the INPUD consensus statement. In terms of Right 5 – the right to the highest attainable standard of health – one person from AIVL, consulted for the Consensus Statement, made a highly relevant comment, noting:

*There is a high degree of stigma and discrimination experienced by drug users in Australia and this is often the experience with healthcare professionals. Access is impacted by this as stigma acts as a barrier ... If you can pass as a non-drug user it's okay, till they find out ... General 'suspicion' of the motives of people who use drugs ... often results in misdiagnosis, under-medicating for pain and/or onerous and unnecessary monitoring and surveillance.*³⁷

The World Health Organization has ranked illicit drug dependence as the most stigmatised health condition globally.³⁸ This stigma is prevalent in the media, the broader community and, distressingly, within health services.³⁹ The United Nations Office of the High Commissioner for Human Rights (OHCHR) notes that “treating drug possession for personal use as a crime intensifies discrimination” and can have negative consequences for the health, security, and human rights of individuals and communities worldwide.⁴⁰ CAHMA has built and is driving initiatives that centre and promote social justice and equity for people who use drugs and people who use drug treatment services. This is important because of the criminalisation, stigma and discrimination to which people who use drugs and people who use drug treatment services are subjected. As a community-controlled, peer-led organisation, CAHMA has adopted and is guided by the slogan “nothing about us, without us”.⁴¹ The Peer Treatment Support Service promotes empowerment and self-determination for people who use drugs and people who use drug treatment services. A key role of the PTSS worker is to advocate for community members, against the backdrop of CAHMA's broader role of being a voice for the oppressed, marginalised and powerless. In the PTSS, human rights advocacy happens throughout a person's engagement with the service and can take the form of:

- Individual/patient advocacy – where a PTSS worker supports and advocates with health and community professionals to ensure the person's treatment journey is guided by the ideals of patient choice, empowerment, person-centred and trauma informed care and health equity. An example of patient advocacy is ensuring that access to medication is suitable and follows human rights criteria.

- Systemic advocacy – where a PTSS worker recognises systemic barriers and human rights issues that are affecting a number of individuals and escalates these system issues to the PTSS Manager for broader human rights advocacy.
- Linking individuals into broader human rights systems – where a PTSS worker supports a person accessing the Human Rights Commission, Ombudsman services or other complaints and feedback mechanisms that address human rights.

Challenging stigma and discrimination

Drug use is highly stigmatised in society and discrimination against people who use drugs and people who use drug treatment services is commonplace, notwithstanding recent efforts to acknowledge and address the harms caused by stigma and discrimination.⁴² Much of the harm is generated by the criminalisation of drugs, which sets up a system where even the possession of drugs is a criminal offence.⁴³ It is difficult to meaningfully alleviate stigma and discrimination without fundamental changes in the law including the removal of criminal repercussions for the possession and use of drugs and the regulation of drug markets.⁴⁴ An example of significant success in addressing broad societal stigma and discrimination, in part through legislative change, can be seen in the shift in societal attitudes towards sexual diversity since the mid-1970s. In Australia, overturning the criminalisation of men having sex with men was hard fought over many decades. Indeed, it continued to be a criminal offence in Tasmania until 1997, with this legal injustice only reversed after the Commonwealth *Human Rights (Sexual Conduct) Act 1994* was passed.⁴⁵ The prolonged struggle to achieve decriminalisation of different forms of sexual expression, laid the groundwork for protections to be inserted into the law, making it illegal to discriminate against someone based on their sexuality. Importantly, these legal changes foreshadowed shifts towards greater acceptance of sexual diversity and the embedding of social norms that limit stigma and discrimination towards LGBTIQ+ communities in Australia.

Until illicit drug use is viewed as a culture phenomenon, to be protected by law – as is sexuality and gender – we cannot expect to make any serious headway in addressing stigma and discrimination. The best that we can hope is to remove barriers of stigma and discrimination for those accessing health pathways. Recent legislative changes in the ACT go some way towards achieving this goal, by enhancing and formalising diversion pathways for people caught with small amounts of some drugs, allowing people to pay a \$100 fine or attend a health

assessment as opposed to being charged with a possession offence. Significantly, work has also been progressed embedding the concept of drug use as a health issue in the ACT police force and other areas of government including the health system. It is hoped that this will alleviate stigma and discrimination against people who use drugs and people who use drug treatment services and promote health seeking behaviour. CAHMA played a leadership role in progressing these legal changes, challenging falsehoods that underpin prohibition of drugs and explaining that many of what are understood to be the harms of drug use are in fact harms caused by the criminalisation and associated stigma and discrimination of people who use drugs and people who use drug treatment services.^{42, 44, 46}

Recognising the damage caused by stigma and discrimination and challenging public misconceptions about drug use and about people who use drugs and people who use drug treatment services is an important part of what CAHMA's PTSS workers do. It includes understanding and challenging self-stigma (misconceptions that a person who uses drugs may hold about themselves and others within their community) and lateral violence (harmful behaviours directed by members of a marginalised group towards each other, rather than towards the source of its marginalisation). PTSS reframes the lived experience of drug use as a valuable form of expertise, on par with other forms of knowledge and expertise that may contribute to addressing the needs of service users. This repositions a commonly stigmatised and discriminated attribute as one of core strength, and provides a meaningful pathway for people who have significant experiences in the area to reframe their entire life as something valuable, knowledgeable and positive. This, in itself, can profoundly alter and enhance a person's health and wellbeing, provide meaning, empowerment and self-respect and elevate the person's perceived value in society.

The act of identifying as a peer fights stigma and discrimination by challenging perceptions that people who use drugs and people who use drug treatment services are unreliable, lazy and cannot hold down a job. Having identified PTSS worker roles is so important because the PTSS worker is wearing their identity on their sleeve and forcing people to reassess their misconceptions and prejudices about drug use.¹⁸ Recently, former ACT Population Health Minister Emma Davidson, spoke on this topic in one of her final speeches in the Legislative Assembly, calling peer workers "cape-less heroes" and stating:

*This is not just because peer workers are courageous enough to be persistent champions and compassionate advocates for some of the most marginalised people in our community or because they create one of the rare service environments where people who use drugs and people who use drug treatment services feel accepted and welcome; it is also because they do all of this while bravely and personally carrying the same burden of stigma and discrimination as the people that they work with and support.*⁴⁷

CAHMA attempts to address self-stigmatisation through education and community development initiatives designed to engender a sense of self-worth and of community inclusiveness and integration.


At that same time, CAHMA directly addresses stigma and discrimination in the healthcare system by offering safe and accessible health services through the drop-in service, GP and nurse clinic, needle and syringe program (NSP) and naloxone program, Aboriginal and Torres Strait Islander peer service, and community outreach programs. CAHMA also provides input into research and system development through expert advisory groups and decision-making processes within the healthcare system, and advocates for systemic change in response to advocacy issues brought up through individual experiences reported to the PTSS. Through the PTSS, CAHMA provides support and advocacy to individuals accessing a range of health services and can help people to challenge the stigma and discrimination that impacts their own healthcare, by providing support to access and navigate complaints processes such as the ACT Human Rights Commission or ACT Ombudsman. Importantly, many health professionals do not understand that they are being stigmatising or are discriminating against people who use drugs and people who use drug treatment services.⁴⁸ The issue is further compounded by the fact that people who use drugs and people who use drug treatment services are currently highly criminalised meaning that in the eyes of the law, discrimination is, in some senses, legal.⁴⁹ This doesn't fit in with the idea that drug dependence and problematic drug use are health issues, and sets the stage for stigma and discrimination across the healthcare sector. The PTSS model provides an effective method of de-stigmatisation, treatment, engagement and empowerment.

The Peer Treatment Support Service Approach to Healthcare

The four guiding principles of the PTSS – providing an accessible service; promoting health and wellbeing; advocating for human rights; and challenging stigma and discrimination – must be combined with a service delivery approach that upholds these principles and guides their practical application. The PTSS delivery approach is underpinned by:

- Person-centred care
- Timely, flexible service provision and broad scope of practice
- Integrated care and partnership approach
- Low threshold engagement

PTSS APPROACH TO HEALTHCARE



PERSON CENTRED CARE
Treating every person with dignity and respect as an individual human being, and not as a condition or disease.

TIMELY, FLEXIBLE SERVICE PROVISION AND BROAD SCOPE OF PRACTICE
Healthcare that will prioritise immediate support and is responsive to people’s needs across multiple life domains.

INTEGRATED CARE AND PARTNERSHIP APPROACH
A “one stop shop” approach with all services required by the person under the same roof.

LOW THRESHOLD ENGAGEMENT
Removing barriers, requirements, hurdles or obstacles to engage with PTSS.

Person centred care

Person centred care is the core approach of the PTSS. Person centred care has many definitions,⁵⁰ however, in this model of care, we define person centred care as an approach that treats each person with dignity and respect as an individual human being, and not as a condition or disease to be treated.⁵¹ It involves understanding, respecting and working with what is important to the person, rather than expecting them to fit within an existing treatment framework. It acknowledges an individual's agency, goals, hopes and aspirations as well as their strengths and support networks as a crucial part of their health and wellbeing.⁵² It seeks to reposition power with the individual and ensure that information, education, consent and choice reside with them.⁵³ Its focus is on supporting the person to manage their health and wellbeing, fulfill their goals and utilise their core strengths and social capital to improve their lives.

Timely, flexible service provision and broad scope of practice

Timely service provision is a crucial part of the PTSS approach. Timely service provision means that when a person enters CAHMA seeking support, priority is given to immediate support and timely follow-up. This is a fundamentally different approach to appointment-based service provision where long waiting lists are commonplace. This approach is facilitated by the CAHMA drop-in centre and outreach BBQs as an adjunct to the formal PTSS, with immediate support including the ability for the service user to sit down and have a cup of tea or coffee or a meal and discuss what it is they require to meet their healthcare goals or to simply discuss what is happening for them, how they are feeling or what is worrying them. This person-centred approach begins the process of building trust and rapport as well as communicating that the person's healthcare is important to CAHMA. From this beginning, timely healthcare continues to underpin the PTSS approach. Wherever possible, healthcare is conducted on the timeframe of the individual. The ability of the PTSS to work without a waiting list is important to service users and has required CAHMA to carefully structure our services with this as a priority.

In addition to timely service delivery, the PTSS approaches healthcare with a flexible lens which places the service user's experience, journey and outcomes as the most important consideration. Too often in healthcare, ideas of operational and clinical risk as well as rigid and restrictive policies and procedures hamper an

individual's ability to access services and receive best practice care.^{54, 55} The PTSS and CAHMA's policies and procedures place flexible and timely service delivery and the unique demands of the individual as the priority, while also carefully managing the risks which flow from this approach. This allows the PTSS to tailor care to individuals in a way which meets their needs and keeps the person-centred in their healthcare journey.

One example of this approach is that the PTSS facilitates transport for individuals in ways appropriate to their specific needs. When available, the PTSS has vehicles that can be used to transport service users, however when these vehicles are not available or their use is not appropriate to circumstances, Uber or Taxis are used to transport service users. By allowing several pathways to overcome the same barrier, the PTSS provides greater flexibility. Despite a greater burden of administration, logistical challenges and higher expenses, this flexibility is considered preferable to saying "no" to the service user. Although this is a simple example, it demonstrates the approach of service user prioritisation that is consistent throughout the PTSS. The outcome of this is a workforce that excels in problem solving, a system of policies and procedures that is agile and adaptable, and a satisfied cohort of service users that know that the PTSS is primarily concerned with their health and wellbeing.

An extension of this flexible service approach is the broad scope of practice that the PTSS operates across. One of the most common barriers that service users face when accessing a service is that the scope of practice of the service does not fit with the person's needs.²⁸ For this reason, the PTSS tries to never say "I'm sorry we don't provide that service here" but instead facilitates warm referral to an alternative service where the person's needs can be met. This approach helps service users feel welcomed and supported. For staff, this can be challenging, however the goal is to help navigate and support rather than to suddenly become a subject matter and systems expert. The way PTSS workers achieve this broad scope of practice is to build expertise in system navigation rather than becoming a subject matter expert across the wide scope of practice. The role can include navigating systems "sight unseen" by asking the right questions, doing the right research and supporting the person in the right manner. Once this distinction is made, the task becomes easier and staff can feel comfortable to support the person in navigating the system, without feeling that they need to be experts on every service the person engages with.

Integrated care and partnership approach

Building on the above approaches, the PTSS tries to integrate care and provide a “one stop shop” approach with all services required under the same roof. Where services are unable to be provided by CAHMA at the CAHMA Community Centre, they are provided by trusted service providers often working in partnership either within CAHMA as a form of in-reach, or from their own services with the provision of transport and patient advocacy options provided by the PTSS. The PTSS currently integrates a number of partner services into its service delivery approach with a roster of services working from the CAHMA Community Centre to provide the “one-stop-shop” approach and leverage the community safety and trust developed by peer relationships. Service offerings constantly change depending on community need, service availability and rostering considerations, however currently the PTSS facilitates the following in-reach services in partnership:

- ACT Corrective Services External Reporting Site for Aboriginal and Torres Strait Islander people – First Nations people can report at CAHMA every Friday to fulfill parole obligations.
- Directions Health Services CAHMA Clinic – Primary Health Clinic with a doctor and nurse providing OMT, sexual health checks, mental health plans, GP services, referrals, wound dressing, vaccination currently once per fortnight.
- Street Law Legal Clinic – Legal advice and referral.
- Street to Home – Housing service for people sleeping rough who need emergency accommodation.
- Care Financial – Financial planning service that helps people budget, reduce debt and understand financial matters.
- Centrelink – Access to a range of payments and services, dependent on need and life circumstances.

Low threshold engagement

The PTSS relies on low threshold engagement techniques provided by other CAHMA services (CAHMA’s drop-in centre and outreach BBQs) to help people who may otherwise be experiencing marginalisation to engage with the PTSS. Low threshold services build the trust necessary to sit down one-on-one with someone and let them into your life, share your goals and aspirations and tell them personal details about your health and wellbeing.²⁸ Often people who use drugs and people who

use drug treatment services have had serious negative experiences with healthcare systems in the past, due to stigma, discrimination and the criminalisation of drugs.⁵⁶ Often these experiences have happened many times over, compounding the issue of trust in health services and reinforcing barriers to engagement with health service providers. For this reason, low threshold engagement is a crucial aspect of CAHMA's service delivery and paves the way for engagement with the PTSS. Low threshold engagement means that there are few barriers, requirements, hurdles or obstacles to overcome to engage with a service. Some characteristics of CAHMA's low threshold services are: you don't have to give your name or any personal details; no referral is required; no appointment is required; no data form needs to be filled out; you can attend intoxicated; you don't need to go with the idea of engaging in a program with a specific goal; you can come and go whenever you like.

The PTSS is also a low threshold service, although it is not as low threshold as CAHMA's engagement services. Within the PTSS structure, low threshold service delivery approaches include immediate peer assessment when a person presents to the PTSS for the first time; flexible appointments; provision of transportation; in-reach; and outreach. Further, the PTSS can be considered low threshold because it meets the person where they are and works towards the goals of the individual across a wide scope of practice.

In this way, people's engagement with CAHMA starts out at the very lowest threshold engagement possible and then as trust is built transitions people to a more structured approach as they gain control over their health and wellbeing, and develop system navigations skills, social capital and support networks. This transition helps people engage with the wider health system, some areas of which have very high thresholds for engagement.

Who is the Peer Treatment Support Service for?

CAHMA's PTSS is suitable for any person in the ACT who uses drugs or drug treatment services, and who is in need of support or advocacy. CAHMA recognises that people have diverse identities around the issue of drug use and supports individuals across this diverse spectrum. At one end of this spectrum are people who are proud of their identity as a person who uses drugs and believe that drug use is an inalienable human right, akin to sexual or gender diversity rights. At the other end of the spectrum are those whose relationship with drugs has caused great and profound damage and destruction to their life and to the lives of family members and friends and believe that the only relationship that they can have

with drugs is one of abstinence. This is why CAHMA uses the terms “person who uses drugs” and “person who uses drug treatment services”, to respect the fact that some of our service users are seeking to distance themselves from drug use and take on a different identity post drug use. The PTSS caters for people across this broad spectrum and strictly focuses on ensuring the safety and respectful treatment of all service users, regardless of their treatment goals and identity.

The PTSS seeks to link service users with PTSS staff who have had similar experiences, have accomplished similar goals and have similar beliefs and identities. This linkage is an important part of the PTSS process and in this way, PTSS provides the correct peer expertise appropriate to the individual’s health journey. Linking service users with staff who share a similar journey enhances their mutual understanding, appreciation, knowledge and rapport. Having said this, CAHMA trains all its PTSS staff to be able to provide respectful and compassionate support to all service users, regardless of their experiences and identities.

The PTSS predominantly caters for adult members of the drug-using community; however, CAHMA’s services are accessible to anyone who wants or needs them. Peer treatment support is carried out in accordance with industry standards in a manner that is equitable, appropriate and sensitive.

PTSS workers work closely with community members from a range of different life circumstances and backgrounds. They understand and have personal experience navigating issues such as homelessness, housing stress, isolation, relationship breakdown, incarceration, legal issues, financial difficulty, substance use, mental health, chronic pain and illness.

People accessing the PTSS can anticipate a safe and welcoming environment free from discrimination, where they can address issues that may have arisen, in a manner and language that makes sense to them.

CAHMA recognises that all individuals are different and that their journey through life is dynamic and changing. As an individual’s life changes so do their healthcare and social needs. Recognising this diversity means supporting the individual to meet their current needs as they perceive them, while accommodating their changing goals and aspirations. In this way, CAHMA accepts, supports and empowers the whole person.

Case Study 2 – Alan

Alan first contacted CAHMA while he was in the Alexander Maconochie Centre (AMC). A lack of suitable transitional services willing to support Alan due to the nature of his prior offending, meant that Alan's incarceration had been prolonged. CAHMA had been recommended as a possible way out of the impasse in which he found himself, and as a source of support and connection.

The initial meeting between Alan and his PTSS worker took place within the AMC and under the watchful eye of a uniformed corrections officer – a considerable barrier to establishing trust and rapport. At that intake appointment, it became apparent that Alan was not going to be released without community service support and accommodation.

The PTSS worker's immediate role was to link Alan with appropriate healthcare, initiate communication with an emergency housing service in the ACT and support Alan through the parole process.

On release from the AMC, Alan enrolled in a 'Circle of Security' course being conducted at CAHMA and began the slow process of working through the trauma that had profoundly shaped his life choices. However, addressing trauma is complicated by day-to-day circumstances that place Alan in a situation of survival, without necessarily thriving.

Living in shared accommodation, Alan has found himself relying on homelessness and street services to survive. He struggles to keep his life moving forward in a positive and constructive way at the same time as meeting and mixing with people who are using substances and living on the street. As a result, Alan has had some difficulties meeting the conditions of his parole. Another major difficulty has been getting onto the Priority Needs Request Housing ACT list. The emergency housing that he moved into upon release has recently been re-classified as 'long-term accommodation', making the process more complex for him to achieve.

The CAHMA PTSS has supported Alan to navigate the everyday difficulties and challenges that come with involvement in the justice system, in ways that counter the stigma and discrimination that Alan faces in so many other areas of his life. At the same time, the service remains prepared to support Alan to further address his mental health and substance use challenges in a more sustained way, when he is ready to do so.

CAHMA operates in a community made up of diverse cultures and subcultures, in which drug use may play a particular role. The CAHMA team keeps informed of safe and respectful practices for all community members. CAHMA has an Aboriginal and Torres Strait Islander program called The Connection which is a peer-based service. The Connection promotes improved health for Aboriginal and Torres Strait Islander peoples and seeks to reduce the harms associated with drug use. The Connection worker links in with the PTSS workers at CAHMA to ensure cultural sensitivity is maintained within the PTSS. This includes ensuring that referral options are culturally appropriate for the individual, helping navigate issues around confidentiality and kinship within community controlled Aboriginal services, offering alternative culturally secure mainstream healthcare options if preferred by the individual, and ensuring that the individual feels safe, secure and in control of their healthcare options. Often, Aboriginal and Torres Strait Islander people feel much more comfortable engaging around their health and wellbeing with another member of their culture and community and The Connection facilitates this and ensures that an Aboriginal person is vouching for the PTSS worker (if they are not also Aboriginal).

Staff, volunteers and students participate in training and support to better understand the specific issues related to culture and diversity. This equips them to respond effectively and in a way that is sensitive and responsive to anyone who comes to the service irrespective of:

- Cultural and linguistic background
- Aboriginality
- Sexuality
- Relationship and/or family status
- Gender or gender history
- Age
- Health (including mental health)
- Disability (physical, intellectual, and other)
- Religious and spiritual beliefs
- Experiences of homelessness
- Interaction with the justice system

CAHMA promotes and provides access to information about its services in a manner which is likely to reach potential service users with diverse needs. PTSS workers acknowledge personal, cultural and social issues beyond drug use and responds to these in an informed, inclusive and respectful manner.

Peer treatment support and the supportive network

CAHMA recognises that no two service users come with the same support structures in place. Where possible, CAHMA seeks to work with the supportive community in which a service user is embedded. However, the service user and their particular goals and priorities will always remain foremost for PTSS workers. This means, for example, if there is a conflict between what the service user wants from their engagement with CAHMA and the demands or expectations of family members, the PTSS worker will prioritise and advocate for the needs of the service user.

When conceptualising family, CAHMA employs the concept of chosen family to describe the network which surrounds a person and provides crucial emotional and practical support. The concept of chosen family, popularised in recent years in the LGBTIQ+ community,⁵⁷ is an important one for people who use drugs and people who use drug treatment services, as the unfortunate effects of stigma and discrimination often ruptures biological families and means that individuals form strong family-like connections outside of the traditional family unit. The term family, in this document, therefore, encompasses both traditional and chosen families.

Often, the journey of a family and/or carer providing support to a person who uses drugs is difficult and stressful and requires a great deal of thought, time and frequent re-conceptualisation of what is helpful and ultimately beneficial.⁵⁸ Often it is natural for family to lean towards a proscriptive, abstinence-based approach to supporting the person they care about. Expert support, information and education may be required to help the family and/or carer reposition their views for long term support, which may or may not include the goal of abstinence.⁵⁹ CAHMA relies on expert organisations such as Family Drug Support (FDS) and Carers ACT to provide this. The PTSS has excellent relationships with FDS and Carers ACT and can facilitate family members and carers accessing these services prior to and during engagement in the PTSS process.

The PTSS can provide real benefits to families and carers where informed consent by the service user is provided for their involvement. Through mutual consent, family members and carers can provide meaningful support for the service

user, thereby fostering enhanced health and wellbeing. It is important that family inclusion and carer inclusion in a service user's PTSS journey is ultimately controlled and maintained by the service user and that confidentiality and consent are carefully and respectfully navigated in order to ensure the integrity of the PTSS process.

Peer work can have positive impacts for families and carers by reducing stigma, decreasing feelings of burden and improving family functioning.⁶⁰ Families often experience isolation and may feel blamed or judged for the alcohol or drug use of their family member. A sense of hopelessness may be generated within the context of this isolation. Connecting a person with the PTSS can mean a whole family is embedded within a network of support and can relieve the burden of isolation from families impacted by alcohol or other drug use.

Why a Peer Treatment Support Service?



The PTSS model has a number of distinct benefits in supporting people who use drugs and people who use drug treatment services.

Benefits to service users

Firstly, a person engaging with CAHMA's PTSS receives all of the benefits that are gained from engaging with complex case management. These benefits include greater continuity of support; improved social networks; and a more positive experience with health and other services.⁶¹ However, for the PTSS user, there are additional benefits. For many, having someone implicitly understand what they are going through is profoundly important. Further, having that same person guide them through the process of engaging with the system to get the best outcome is enlightening. It can be an experience which can be used to inform future engagements with the healthcare system and provide opportunities to role model system navigation.

A major benefit of PTSS is that people have a worker who acts as a guide to available services and supports service navigation. Additionally, the worker helps service users manage expectations about what can and cannot be realistically accomplished in the system. This is often particularly important at the beginning of a person's PTSS journey, where they are trying to determine which goals to progress and the sequencing of those goals. PTSS workers can actively listen and reflect priorities and then explain the prerequisite work or goals which must be completed to make those original goals possible. An example is getting a child back who has been placed into care. This is often the single most important goal a person has, however there are several pre-requisites before this is possible, for example achieving stable housing or improving individual health.

One of the key roles for peer workers is breaking down the stigma and discrimination around drugs and drug use.⁶² As peers with lived experience of ATOD use, PTSS workers are familiar with the effects of stigma and discrimination. The PTSS offers a model of non-judgemental service provision and can help to address stigma within an individual's personal networks and in the wider community. At the same time the PTSS worker plays a part in diminishing self-stigmatisation.

Self-stigmatisation often emerges from feelings of discrimination and can be a serious problem for many people seeking to engage with health and social systems. In particular, self-stigma and previous negative experiences colour a person's perception of treatment and often manifests in feelings of discrimination.⁶³ Given the negative attitudes towards people who use drugs and people who use drug treatment services amongst both the general public and healthcare professionals, actual experiences of stigma and discrimination are common.⁶⁴

Additionally, the overlay of personal histories and self-stigmatisation can lead to people feeling perceptions of discrimination. A benefit of PTSS is therefore to act as a reflection point or sounding board to help people understand the distinction between these two experiences of discrimination. Additionally, the PTSS worker can provide information about the way that the system works and what expectations a person should have when engaging with the system. This, for example, might allow a person to recognise if an extended wait in emergency is a result of discrimination around their drug use or a consequence of normal triaging processes and to determine if, and when, to advocate for themselves. Discrimination is disempowering and can profoundly affect a person's mental health and engagement with healthcare and other services. If it appears that the person is facing discrimination, the PTSS worker can suggest different pathways to deal with the discrimination, including psychosocial support and support contacting the Human Rights Commission, the Health Care Complaints Commission or utilising other complaint mechanisms. The PTSS worker can also pass the issue up to senior management within CAHMA to progress systemic advocacy on a broader level. This helps empower the person as they now know that their concerns are real and are being acted on. Without support, navigating complaints processes, discrimination will often go unchallenged. Making a healthcare complaint is incredibly difficult and burdensome for most people, however when the overlay of stigma and discrimination is added it becomes almost impossible.⁶⁵ People who use drugs and people who use drug treatment services often feel highly vulnerable to being exited from healthcare systems, being further discriminated against or stigmatised, or simply that they are not worthy of putting in a healthcare complaint. Most commonly, people feel that nothing will happen and fear that by standing up for themselves they will be viewed as being problematic and their healthcare standard will actually decrease further. Navigating complaints processes can involve long-term engagement with the process. Additionally, keywords and pathways within complaints processes are often not clear to individuals and having someone to guide them through the process, manage their expectations and inform their choices about what options are available and what the likely outcomes are, is pivotal in supporting individuals to engage with complaints processes.

Benefits to peer workers

Peer workers enjoy a number of benefits associated with the role.⁶⁶ These benefits include the experience of belonging and having a shared identity; the development of increased self-esteem and confidence along with greater self-awareness; the accruing of new skills and the opportunity to share existing skills with others; an improved knowledge of mental health; opportunities for ongoing employment and/or volunteering which can result in an improved financial situation; the expansion of aspirations; and greater support of health and wellbeing.⁶⁷ Additionally, the ability to transform a period of time in your life which you may look on as being a negative experience in a positive light can be very empowering and can provide purpose, direction and hope.

Case Study 3 – Anne

Anne's first steps on the journey towards becoming a leader in the PTSS were taken when she heard about volunteer opportunities at CAHMA's drop-in centre. At the time, Anne was engaged in residential rehabilitation, in an effort to stabilise her health and wellbeing, with the motivation of re-gaining care of her youngest child, following involvement with Children, Youth and Families (CYF).

Anne faced barriers, in terms of the largely inflexible structures of the residential rehabilitation service's transitional accommodation. While she was completing volunteer training, CAHMA worked intensively with Anne to find a suitable housing solution for her and her son and engaged with the residential rehabilitation service to provide support as Anne transitioned out of the service.

During Anne's volunteer training, she demonstrated significant interest and capacity in working with charity organisations to provide material aid to others in need and in supporting other parents who were engaging with CYF around child custody issues. CAHMA worked with Anne to encourage her to build relationships and networks that would further develop her interests. At the same time, Anne was supported in obtaining work skills and documentation, such as a Working With Vulnerable People (WWVP) registration, as well as training in case management, peer support and SMART Recovery. With the support of CAHMA and the Alcohol, Tobacco and Other Drug Association ACT (ATODA), Anne was able to complete her Certificate IV in Alcohol and Other Drugs, allowing her to gain the formal qualifications required of an alcohol,

tobacco and other drugs (ATOD) worker. In the meantime, Anne stabilised her health and wellbeing and regained care of her child.

In her role on the PTSS team, Anne identified a gap for many CAHMA service users who had involvement with CYF. While CYF focuses on the child's welfare, there are insufficient services to support the parent and the parent's health and wellbeing journey, even when this would be in the best interests of the child. What was needed was a peer worker in this space who could demonstrate positive outcomes with CYF and model a pathway to successful reunification with their child or children. Anne understood that such stories of hope were crucial in parents persevering with a CYF process that can be difficult, intimidating, confusing and disempowering. Through peer support and role modelling, Anne worked with parents who had formerly not engaged well with CYF.

Anne's courage inspired other parents to tell their own stories of success and some of them joined the volunteer program at CAHMA and went on to become PTSS workers themselves. Through this community development process an important service gap was filled and a number of CAHMA service users achieved better outcomes in their interactions with CYF, their engagement with treatment services and their involvement with the justice system. Significantly, Anne's activities resulted in CYF engaging with CAHMA in a new and meaningful way, ultimately coming to recognise the value of peer work in this space. CYF then began referring their service users to CAHMA where they felt it was appropriate, inviting CAHMA to present on peer work and moving towards greater acceptance of a harm reduction approach.

In addition to general peer work benefits, the specialised PTSS role has additional benefits for the peer worker. At CAHMA, a strength-based approach is used to identify people who would like to become PTSS workers once they have finished their volunteer and peer worker training. In this sense PTSS work is a specialisation of peer work and is suited for peers who enjoy conducting one-on-one client work and are proficient at system navigation and case management. As a specialisation, peer workers benefit from learning the discipline of PTSS and find a great deal of emotional benefit from helping individuals enhance their health and wellbeing. PTSS workers are given training in case management, case noting, advocacy and support, senior first aid, de-escalation, mental health first aid, trauma informed care and dealing with vicarious trauma. An additional benefit is that PTSS workers are also developing skills which can be transferrable to other ATOD roles such

as case management and other non-peer professions. This increases their employment options and enhances their career development. PTSS workers build large and far-reaching professional networks as well as having the opportunity to be involved in research projects, conferences, symposiums and other academic pursuits.

Benefits to services and the service system

Peer work undoubtedly has positive outcomes for services and service systems. The presence of peer workers in services can lead to more effective and better-quality services.⁶⁸ Peer workers are able to facilitate better understanding between people providing services and people using services and can support people to engage with services.⁶⁹ Moreover, peer workers can be a “social movement for change” by providing visible exemplars, thereby supporting and inspiring personal hope and cultural change. There is some evidence that larger systems of care in society can change when service organisations become more positive in their attitudes to consumers as a result of peer initiatives in areas such as mental health.⁷⁰ Peer workers are able to influence the knowledge and attitudes of other workers, including clinicians, and build meaningful relationships between staff and consumers. Bringing a peer worker’s lived experience into an organisation, can influence organisational policies and procedures and challenge entrenched beliefs and attitudes that undermine effective service delivery.⁷¹

“The benefits of the PTSS to services and systems needs to be independently evaluated, however observations suggest that PTSS workers can identify barriers to service provision and areas of unmet need in service systems.”

Case Study 4 – Holly and Daniel

Holly and Daniel were a young couple who had come to the attention of the ACT’s child protection service Child, Youth and Families (CYF), due to their drug use and associated engagement with the criminal justice system. CAHMA had an established relationship with Holly and was therefore a point of contact for CYF when Holly was five months pregnant with twins and the couple were struggling to navigate health, CYF and criminal justice systems to remain together as a family and ensure that their newborn babies were able to stay in their care.

CAHMA PTSS worker Gail had been working with Holly for around 6 months prior to this point, helping with a number of issues including Holly facing a potential custodial sentence and seeking to enter residential rehabilitation, while still caring for her young teenage daughter. Holly had lost all of her belongings in a house fire and was trying to rebuild and stabilise her life and had come to the PTSS for support. CAHMA PTSS worker Gail had engaged with Holly and CYF and was playing an intermediary role ensuring Holly was supported to engage with CYF, providing emotional support to Holly, and providing material aid including new kitchen appliances, children's clothing and food vouchers. Support also included setting up a support network of ATOD organisations including organising referral and access to an ATOD day program, a counselling service and a women specific support organisation.

As the birth of Holly's twins grew closer, Gail played a role of supporting Holly to attend perinatal health checks and hospital visits for different ailments. Additional support was supplied in co-ordinating CYF visits to ensure Holly had the support of her immediate family and understood and was complying with both bail and urinalysis requirements. Gail also supported Holly by liaising with several residential rehabilitation services to find one that would agree to take Holly in the event that this was an option that the court saw as viable in the place of a custodial sentence.

One of the most important roles Gail played during this complicated and stressful period of time for Holly, was one of role modelling. Gail had experience of the CYF system and of having her children taken out of her care and understood innately the frustration, fear and anxiety which Holly was experiencing. Importantly, Gail also had experience of fighting for her children and regaining custody of her son, which provided hope and strength for Holly at such a critical and difficult period of time.

At this time, Daniel was incarcerated but wanted to reconnect with Holly and his children on release. His court date was approaching and as such, he organised to have a CAHMA PTSS worker put on his phone list while he was on remand and began taking the required steps to prove that he was serious about being reunited with his family.

John, the CAHMA PTSS worker who connected with Daniel, was himself a father who had experience engaging with CYF. John and his partner had been using drugs when their child was born and had experienced CYF remove their child. John had the experience of completing rehabilitation and regaining

custody of his child and was therefore able to function as a role-model for Daniel and offer hope of a possible path towards achieving his goals.

At this stage, Holly and Daniel were being told by services that once their twins were born, they would need to go into residential rehabilitation in order to have custody of the children. Holly and Daniel favoured going to residential rehabilitation together with the twins, in order to provide each other support and so that they could grow as a family. Unfortunately, involved services were unsure that this was a workable option and had concerns regarding how this could be managed successfully. CAHMA PTSS workers backed the couple, providing a viable plan for them to stay together as a family unit while in residential rehabilitation. This plan addressed the concerns of engaged services and mitigated involved risks. This gave new hope and courage to Holly and Daniel as well as powerful motivation to stick to the treatment plan.

As Holly drew near term, she began to experience medical complications and was admitted to hospital several times including into the intensive care ward. While this was happening, John supported Daniel at court and provided written documentation of his past and present engagement with CAHMA including CAHMA's ongoing willingness to support him. As a result, Daniel was able to receive a community service order, and was released from custody.

Holly gave birth to two beautiful babies and Daniel was able to be present at the birth of his children. Daniel continued to provide support for Holly during a period of hospitalisation for the twins due to low birthweight. While this was happening, CAHMA PTSS workers were able to organise places for Holly and Daniel at a residential rehabilitation service for when they were released from hospital. Holly and Daniel were able to transition from hospital into residential rehabilitation as a family, with CYF engaged and supportive of the couple's treatment. With the admission of Holly and Daniel into residential rehabilitation, the future looked bright and the CAHMA PTSS was able to close the case file, until the family finished their treatment at rehabilitation and were ready to engage on the next step of their journey.

This case study showcases the capacity of the PTSS to support the kind of complex transition journeys that are often required in health and social systems for our more marginalised community members. For this couple it would have been too demanding and confusing to navigate these complex systems alone and the combination of role modelling and peer support was crucial in allowing the couple to see the finish-line of their engagement and not lose hope. Additionally,

this case demonstrates the power of the personal story in re-centring the focus of care provision towards the service user's needs and journey. Without this peer intervention, it is likely that the couple would have been separated, and the family unit fragmented. In going the extra mile to ensure person centred care, a drastically better outcome was achieved which will have far reaching implications for the health and wellbeing of a whole family.

This approach also has benefits for involved services. By getting rid of the "us" and "them" dichotomy, which is so common in health service systems and changing the narrative to be more inclusive and person focused, CAHMA was able to bridge the gap between service provider and service user.

Another area of benefits for the system is seen in care coordination with other service providers. This is due to one of the core strengths of PTSS workers – communication. Acting as the clearing house for a person's healthcare needs requires excellent care coordination. PTSS workers often host care coordination meetings, especially when the service user identifies the PTSS space as a safe and respectful place for engagement with health professionals. Increasingly, CAHMA is seen as a safe place that other services can utilise to enhance their therapeutic engagement with joint service users. This also has a system wide affect where CAHMA and the PTSS are hosting in-reach for a large number of diverse services, becoming an integrated harm reduction site.⁷² The provision of in-reach services within CAHMA enhances service access and can provide better experiences for both service users and services engaged in in-reach. It allows in-reach services to gain a better understanding of the needs of individuals and the community, potential barriers that exist to accessing their services and how to engage with marginalised service users in a dignified and supportive manner. Lastly, PTSS workers can positively influence the success of service users as they transition from one service to another, or one care regime to another. Transitioning from one service to another is often associated with people disengaging from the service system.⁷³ Keeping service users engaged inter-services is a core strength of the PTSS.

A positive influence for wider social change

The Peer Treatment Support process sometimes uncovers systemic issues within healthcare (see Case Study 1 – Charlie) and social services. Ongoing engagement with community members will highlight patterns, gaps, needs and barriers to be addressed to the benefit of a broader cohort. Issues for potential advocacy may be identified by the PTSS worker individually or in conversation with others in the PTSS. After identification, barriers and needs can then be passed on to those in systemic advocacy roles who can advocate for system wide change based on experiences gained from peer treatment support of individuals.

Advocating systemically for the needs of the community of people who use drugs and people who use drug treatment services is a key part of CAHMA's work. Because of their lived experience and their peer work training, PTSS workers may be particularly attuned to identifying systemic issues. With appropriate training and support, PTSS workers may also have an opportunity to share their own lived experience in the media, to policymakers or in other spaces where they may be influential in informing change.

CAHMA sits on committees including the Opiate Treatment Advisory Committee and the NSP Advisory Committee. It is a member of ATODA and regularly contributes to peak body activities by representing people who use drugs and people who use drug treatment services. In addition, CAHMA supports Consumer Representatives to sit on committee's and collaborates with the Health Care Consumers Association (HCCA) to provide training for consumer representatives. CAHMA uses these and other forums as appropriate.

The Peer Treatment Support Process

The PTSS process consists of five basic phases of activity. These phases are defined below separately for the purposes of explaining the process. However, in practice, these phases can be dynamic, can overlap and can merge together as required, depending on the service user's needs.

Assessment: This is the process of gaining an understanding of a person's circumstances, needs, strengths, challenges, and their existing and available support networks. Assessment occurs through informal conversations, active listening and peer-based interventions that prioritise shared lived experience. The

PTSS worker carefully and tactfully uses elements of personal experience in order to make the person feel comfortable, accepted and not judged. This process of purposeful disclosure encourages and allows the service user to be honest and open without fear of discrimination, allowing the worker to gather information necessary to assess the person's needs and begin formation of a treatment plan.

Goal identification and prioritisation: After identifying and exploring a person's needs through assessment, the PTSS worker begins to prioritise these needs in collaboration with the service user, in terms of importance and urgency. Treatment goals are established and, if necessary, a stepped or staged approach developed. That is, in order to achieve a desired goal, the person may need to identify steps or stages that must be progressed.

Exploration and treatment plan development: The PTSS worker explores treatment options available to meet the person's needs and in consultation with the service user, considers what factors may shape decisions around development of a treatment plan.

Support aiming towards empowerment: The PTSS worker provides practical and emotional support to facilitate actions that progress the person towards their goal, and addresses barriers that may intervene in that progress.

Empowering independent system navigation: As support progresses and a person achieves treatment goals, they are empowered to rely less on the worker and equipped to navigate health and social systems independently, reaching out to the worker only when necessary.

THE PEER TREATMENT SUPPORT PROCESS

ASSESSMENT

Gain an understanding of a person's circumstances, needs, strengths, challenges, and support networks.



EMPOWERING INDEPENDENT SYSTEM NAVIGATION

Empowering the person to navigate health and social systems independently



GOAL IDENTIFICATION AND PRIORITISATION

Establishing and prioritising treatment and goals collaboratively with the person



SUPPORT AIMING TOWARD EMPOWERMENT

Providing practical and emotional support to facilitate actions and address barriers



EXPLORATION AND TREATMENT PLAN DEVELOPMENT

Explore, consider and agree upon options to meet the person's needs and develop a treatment plan

Assessment

Service users can engage with the PTSS through a number of different pathways including the drop-in centre, community BBQs, and phone and website engagement. Regardless of where the person enters the system, a peer worker will be the first point of contact, and it is at this stage that assessment begins. The point of contact will gather information to determine which level of support (immediate, ongoing, intensive) the person needs and what kind of support they need i.e. engaging with drug treatment, housing, CYF, Centrelink. An important part of this preliminary assessment is identifying the correct staff member to work with the service user. CAHMA staff have a wide range of lived experience and expertise and therefore matching a service user with a peer worker who has that same shared experience is very important, in particular to provide role-modelling, hope and expert consumer insight. For example, someone seeking to regain custody of their children will benefit most from a worker who has successfully completed the process of engagement with CYF and had their children returned to their care. Another person, who is looking to begin OMT but is not sure which medication, prescriber or services are suitable, will benefit the most from a person who has undertaken that journey.

CAHMA prioritises the person having to tell their story as few times as possible. For this reason, it is important that the internal referral is 'warm'. Where possible, this is undertaken face-to-face and involves the point of contact handing the person over to the PTSS staff member and verbally summarising the information received in the presence of the person. This ensures that the person doesn't need to retell the story and ensures that all parties have a shared understanding of the situation and the person's preliminary needs. It also gives the person the ability to refine, correct or add to the information received.

Once a preliminary assessment has been conducted by the point of contact and the person has been referred to the PTSS staff member for support, the PTSS worker will initiate a client registration form (see Appendix One) and a consent to share information form (see Appendix Two). This will be done as part of CAHMA's PTSS assessment and intake process.

The assessment and intake process is informal and dynamic and seeks to capture the person's alcohol, tobacco and other drug needs; along with their health and wellbeing needs. High importance is placed on the quality of this intake process to ensure that the person's experience is positive and empowering. People accessing the PTSS are invited to provide basic demographic information, in order to create a file on an internal system where their information can be stored securely. To record

the length and type of engagement with the PTSS, our team collects information about the person as part of the AODTS-NMDS. This information is de-identified and collected annually by the ACT Health Directorate, who then progress a validation process with the data, before it is sent to the Australian Institute of Health and Welfare (AIHW), who use the information to inform their reports and provide a snapshot of ATOD treatment services nationally. Any information collected is stored securely and de-identified in reporting to assure anonymity.

CAHMA does not use standardised formal assessment to screen clients for eligibility into programs outside of the necessary client registration form which collects data for reporting through the AODTS-NMDS. We believe that in a peer setting, collecting personal data through standardised intake forms is unhelpful and creates barriers to meaningful engagement. Instead, PTSS team members use peer-based interventions such as active listening, purposeful disclosure and discussion to gather information surrounding the person's health and wellbeing, along with any areas where they need support. This may take place over one or many encounters while a trusting relationship is being developed.

During assessment and intake and then later during other interactions including PTSS appointments, information is recorded in CAHMA's rediCASE database. The database is specifically designed to report through a number of systems including the AODTS-NMDS dataset. Information gathered is entered into rediCASE within 48 hours of collection to avoid a backlog of information and to ensure accurate information is recorded. Firstly, the person's client registration information is used to create a unique client file within the database. This happens the first time a person engages with a CAHMA program or service that reports through the AODTS-NMDS, such as the Naloxone Program, The Connection and the PTSS. Once a client file has been created, the PTSS worker will open a PTSS program within the client file. Information regarding the person's PTSS engagement will be noted within the program. Case noting is captured using guidelines set out in CAHMA's Case Management Procedure. Case notes are made for every service contact the person has with the PTSS in a chronological order, ensuring that information is recorded in a manner which is brief, objective, non-judgemental. This gives an accurate description of the nature and content of the interaction, and any actions that have been completed or are planned to happen.

Service users are informed that their client file is confidential and is held on a secure cloud-based database overseen by RediCASE. Service users are also informed that CAHMA may be compelled by law to disclose confidential information about the person, including when CAHMA is subpoenaed by a court and when the

ACT child protection services, CYF, requests information via legal processes. Service users are informed of their right to obtain a copy of their service user file if they wish, unless CAHMA holds reasonable belief that information contained within the file may be harmful to themselves or others.

As the PTSS worker builds familiarity with the needs and wellbeing of the person, they engage in meaningful conversations and promote and discuss support options. Importantly, they skilfully share relevant parts of their own life experience, as needed, to assist with this process. This process of purposeful disclosure, active listening and trust building is the basis of how CAHMA supports people to identify goals and help prioritise their needs.

Goal identification and prioritisation

During the first and subsequent engagements with the PTSS, a shared understanding of goals and priorities in the person's life are identified. This involves a back-and-forth conversation about their goals or desirable outcomes which are then prioritised in terms of urgency, importance, practicality and achievability. This process of agreeing on a set of achievable goals is a two-way process between the person and the worker and is a very important part of PTSS. Often, people have numerous complex concerns, issues and situations in their life and part of this process is about the person gaining an understanding of what is achievable in the health systems available to them and in which order the issues need to be addressed for them to successfully achieve their goals.

Case Study 5 – Louisa

Louisa originally came from Indonesia and first sought CAHMA's help due to a situation of domestic violence. Over a subsequent ten-month period, Louisa maintained intermittent contact with CAHMA, often attending drop-in sessions accompanied by her partner. During these visits, CAHMA staff witnessed evidence of coercive control and physical abuse and found ways to enable safer communication towards Louisa's independence.

Louisa's desire to cease methamphetamine use was thwarted by her partner's efforts to stop her engaging with services which, along with poor English and mental health challenges, may have contributed to her inconsistency in attending appointments and frequent loss of phones, factors that led to some services discontinuing support.

The PTSS worker that supported Louisa was able to recognise the importance of persistence in maintaining contact with someone who was facing multiple barriers to service engagement. Eventually, Louisa made the decision to leave her partner and, with the PTSS worker's support, a safety plan was enacted, which included placement in secure, temporary accommodation. Over time with continued advocacy, Louisa was transitioned into ACT Housing, providing her with greater long-term stability.

Louisa has received extensive support to address both her immediate safety and long-term needs. CAHMA worked closely with Domestic Violence Crisis Service (DVCS) to support Louisa to leave her abusive relationship and to secure temporary housing. A protective order was obtained, and police intervention was necessary due to ongoing threats and violence from her ex-partner. To further support her safety and stability, the PTSS worker collaborated with ACT Housing and advocated on Louisa's behalf by writing support letters and acting as her primary contact, as she did not have her own phone. Through this partnership, Louisa was able to successfully transfer to more secure long-term housing within the ACT system.

Louisa has shown incredible resilience in the face of ongoing adversity. Her willingness to seek help and engage with services demonstrates her strength and determination. She has actively participated in safety planning, legal interventions, and discussions about her future, even as she grapples with the emotional and psychological toll of her experiences.

This case study illustrates the PTSS process of person centred care. The PTSS ability to provide flexible service delivery where attendance at appointments is inconsistent and the provision of understanding about why that inconsistency was the case, was key to supporting the service user to remain engaged and enhance their safety in order to build a new chapter in their life.

Managing expectations, providing insight from lived experience and explaining the systems that are involved, are key in order for the person and the PTSS worker to agree on a set of goals for the person to achieve. Important in this conversation is identifying services which must be engaged with to achieve desired results. Again, lived experience is very useful in this discussion, as the PTSS worker is essentially vouching that the service to be engaged with is safe and reliable.

Exploration and treatment plan development

Once goals have been identified and prioritised, a mutually agreed set of up to three goals will be formalised in a treatment plan. This treatment plan includes any necessary tasks and steps needed to achieve the goals, a risk and challenge assessment of potential harms and treatment obstacles to the service user, and strategies to mitigate challenges identified.

Important aspects of treatment planning at the PTSS involve ensuring that the service user is aware of all options and is given the power to choose their preferred pathway and treatment options. Another important aspect is that the treatment plan is flexible and is a living document. This means it may change depending on changing circumstances for the service user and in response to the outcomes of the treatment journey. This is important, as sometimes expectations of treatment outcomes prove incorrect for the person and are not suitable. For this reason, rather than judging a person's treatment experience as a failure, the PTSS worker will support the person to engage in alternative treatments or create alternative goals. This process of review, discussion and change is a crucial part of the PTSS process and helps service users understand the system and builds empowerment and agency to take control of their health and wellbeing, with the often-limited choices and options available to them.

Aiming towards empowerment

Once treatment planning has been completed, regular appointments are scheduled to help facilitate progress toward the person's goals. Catchups/appointments may be daily, weekly, fortnightly or monthly as required. Throughout this process, the team facilitates access to a range of supports, such as information, referral, transport, advocacy and material aid. At times, a variety of inhouse supports that meet the person's needs may be provided. We may and often do coordinate support from other services to assist in specialised areas. At other times, we may operate in a parallel treatment model with other services. Reviews of goals occur every few months in partnership with the person.

If a person has complex needs, it is often necessary to coordinate support from crisis services to assist in specialised areas. The objective of this coordination is to build a trusted support team around the service user, in order to provide a diverse range of specialised interventions in a safe manner.

The PTSS worker works with the service user and the service user's support networks to engage the person in health and social services. The PTSS approach prioritises partnerships with safe service providers to provide wrap around support for the service user. This is achieved through a combination of multiple elements including: individual advocacy; emotional support and understanding; active listening; purposeful disclosure; provision of material aid; role modelling and mentoring; and education and information-sharing.

A key feature of PTSS involves supported referral and appointments. This involves transportation to appointments, planning important questions to be asked at appointments, patient advocacy and active follow-up. This process increases the likelihood that people will attend appointments as transportation barriers are eliminated. Once in the appointment, the PTSS worker acts as a patient advocate, ensuring that the person receives the best possible treatment matching and is able to understand and engage with the information they are receiving. It enhances patient comfort within appointments, helps to level out power imbalances, reduces anxiety and gives a better chance that the person will feel comfortable enough to ask meaningful questions. The patient advocate role also allows the healthcare professional to gain a better understanding of the needs of the service user, as the PTSS worker explains the person's particular circumstances and health needs. A further benefit of this patient advocacy and transport is that post-appointment the PTSS worker knows how the appointment went and what follow-up may be required. In systems where patient advocacy and transportation elements are not available, post-appointment follow-up is often difficult, and people may disengage with the service if they feel that the appointment has not gone well or if the appointment was missed.

Another aspect of support aimed at empowerment is to provide individual advocacy for service users who are having difficulty navigating treatment and community services. Team members can act as intermediaries to ensure information is accurately and respectfully communicated between the person and their treatment provider. With the person's consent, team members can sit in on appointments or liaise with the treatment providers on their behalf.

Advocacy within the PTSS includes helping people to access opioid maintenance treatment (OMT, also called opioid dependence treatment). This entails helping people on OMT transfer in and out of the ACT, helping people access take-away doses, helping people find suitable prescribers and dosing points, helping people transfer to different levels of the three-tier OMT system and providing mediation and support when disputes occur.

An important function of the PTSS is provision of material aid, usually through co-operation with a large network of charity organisations. Material aid is often crucial in allowing someone to gain control of their health and wellbeing. CAHMA has considerable charity networks and actively works across those networks to provide a range of aid for the person including clothing, food, white-goods, linen, other household items, vouchers for stores, crisis accommodation, tents and swags. Material aid is an unfunded portion of PTSS and therefore CAHMA's ability to provide goods relies on what is currently obtainable through our charity partners. CAHMA's PTSS workers ensure that this is understood by people accessing the service, in order to manage expectations.

Empowering independent system navigation

An aspiration of the PTSS is building capacity within the individual and their support network to meet their needs and overcome barriers in an effective and sustainable way. As a service user's health and wellbeing improves and they begin to have success in achieving their goals, the PTSS worker ensures that more emphasis is placed on the service user becoming confident in navigating the service system independently. This may include ensuring that the service user has credit on their phone in order to communicate independently with engaged services, that a person has an email account that they can access and understand, and that engaged professionals are actively seeking to communicate with the service user in the first instance.

The process of empowering independent service navigation includes PTSS workers employing mentoring, role modelling, skill development, and feedback and support techniques. When progress is being made, the PTSS worker may discuss reducing the frequency of contact to weekly or fortnightly.

One of the signs that a service user is becoming independent from the PTSS is that their health and wellbeing has improved, their support network has expanded, and they no longer experience the same feelings of powerlessness, despair, social isolation and loneliness. This often manifests in new inspiration and interest to help others and to progress from working on their health and wellbeing to working on their livelihood. CAHMA has realised that this is a perfect opportunity for community development and has therefore set up a livelihood pathway in the form of our volunteer program and peer worker training package. This pathway has been so successful that CAHMA no longer recruits externally but rather recruits from our volunteer pool.

BECOMING A PEER TREATMENT SUPPORT WORKER



LEVEL 5 FURTHER EMPLOYMENT / EDUCATION

Level Five formalises expertise in Peer Treatment Support, equipping participants with advanced case management skills and preparing them for specialised service user facing roles.

Further
Education

LEVEL 4 PROJECT WORK

Level Four supports volunteers in identifying career pathways—such as advocacy, research, or peer support—through targeted training, project involvement and strength based approaches.

Area Speciality

LEVEL 3 WORK PLACEMENT

Level Three expands into sector partnerships and outreach, with opportunities for employment and external certifications/training.

Module 5

LEVEL 2 VOLUNTEERING

Level Two deepens engagement with harm reduction and CAHMA's structure, fostering autonomy and team integration.

Modules 3 & 4

LEVEL 1 TRAINING

Level One introduces organisational policies and prepares trainees for front-of-house duties.

Modules 1 & 2

BOUNDARIES SKILLS EXPERIENCE NETWORKING REFEREES PROFESSIONALISM SELF CONFIDENCE

Becoming a Peer Treatment Support Service Worker

The vast majority of CAHMA workers are recruited from CAHMA's Community Development Program (CDP) which provides professional development opportunities to interested and motivated CAHMA community members. This professional development happens through a process of volunteering, upskilling, work experience and further education and training. Accordingly, most CAHMA PTSS workers stem from CAHMA's pool of volunteers who demonstrate exceptional passion for individual work with service users. Usually, the key motivational component in this process is the person's experience of marginalisation in society. Often people who are interested in becoming a PTSS worker have a number of different sources of stigmatisation and marginalisation including: co-occurring mental health, ATOD and other health concerns; Child, Youth and Family (CYF) services involvement; criminal justice system involvement; intersecting social or identity factors such as disability, class, race, ethnicity, culture, nationality, gender, sexuality, issues relating to education or economic security. Diverse combinations of experience, background and identity are highly valuable in providing understanding and support for service users.

The transition from service user to volunteer and on to peer worker is a well-trodden path at CAHMA and one that speaks to the success and sustainability of the PTSS model. Often, when people are exiting the PTSS or other ATOD treatment services, they feel empowered to continue to improve their lives, and may look to developing their career and livelihood as the next step in improving their quality of life. The experience of becoming empowered from a powerless position is often transformative and people wish to give that same gift to others. This highly motivated group forms a major part of CAHMA's recruitment process for the PTSS. Another group of motivated people whom CAHMA recruits PTSS workers from are students who are doing placements. CAHMA has a good relationship with TAFE and other education providers and has formed a pathway for students with lived experience to gain work experience. While lived experience is fundamental to peer work there are some qualities that help the team operate effectively, protect their own wellbeing and protect community members. The qualities that CAHMA's management look for in volunteers and casual staff, relate to the person's substance use, co-occurring issues, support needs, expertise, reliability, teamwork and autonomy, and capacity to maintain professional standards.

When they start, volunteers participate in a comprehensive induction that involves training, mentoring, and opportunities to engage in different areas of the service. Throughout the induction and training process, volunteers work with team members to identify relevant knowledge, skills and experience that may assist them to engage with community and undertake outreach work. Volunteers may have particular interests, insight or connections that they bring, and all volunteers are encouraged to work with the CAHMA team to identify opportunities to respond to emerging or identified community needs.

For some volunteers who wish to develop their skillset, experience and confidence supporting the community further, there is a potential paid career pathway available to them, ranging from casual, part-time to full-time work in different areas of the service, including within the PTSS team. As people transition into these paid roles, and pursue longer term careers supporting the community, they are able to undertake a range of training that better equips them to function in their role.

JOURNEY TO PEER WORKER



SERVICE USER

May currently use substances or have in the past. Substance use may or may not be stable.

May experience a range of co-occurring issues. May or may not be currently engaging with support services.

Support focused on health and wellbeing. Support is provided or coordinated by CAHMA.

Has knowledge, expertise and insight into current life circumstances that is valued by organisation. No expectation to share with peers.



VOLUNTEER

May currently use substances or have in the past. Substance use is stable and avoids interference with ability to volunteer.

May experience a range of co-occurring issues that are managed. May be engaging with support services or have in the past.

Support transitioning from health and wellbeing towards professional development. Support provided both internally by CAHMA and by external providers.

Looking for opportunities to share knowledge, expertise and insight into current or past life circumstances. Able to share strategically to support community members.



PEER WORKER

May currently use substances or have in the past. Substance use is stable and does not interfere with ability to work. Supports others whose goal is to stabilise their problematic drug use.

May experience a range of co-occurring issues that are managed. May be engaging with support services or have in the past. Supports others with co-occurring issues.

Support focused on professional development. Support provided both internally by CAHMA and by external providers.

Has knowledge, expertise and insight into current or past life circumstances. Has developed core skills to work with marginalised people. Able to skillfully disclose to support community members and systemic change.

Able to consistently demonstrate punctuality, reliability and trustworthiness. Able to represent the organisational values and principles. Able to work as individual or as part of a team.

Able to work effectively as an individual or as part of a team. Consistently contributes to a positive workplace culture.

Is able to adhere to professional standards, policy, and legislative requirements



Training Structure for Peer Treatment Support Service Workers

The training for PTSS workers is part of CAHMA's CDP that comprises volunteering and workforce development at CAHMA. This training was developed by CAHMA organically and progressed simultaneously with the gradual growth of CAHMA services, projects and community. Its content and teaching methodology has been shaped by real-life situations and influenced by gaps and needs CAHMA identified with each new trainee, as well as by the feedback and evaluation provided by trainees after completion of the training.

There are five levels of CAHMA's training for PTSS workers (see Appendix Three). Each level contains theoretical and practical elements, and uses a variety of activities and learning methodologies (e.g. readings, videos, research, simulations, observation, practical tasks, game-based learning, shadowing/placement, data collection and analysis, self-reflection etc.)

The training is designed to be adjustable to different life circumstances that trainees may have, different levels of literacy and academic skills, and different work experiences and educational backgrounds. It is also highly flexible, in order to adapt to the pace that trainees need or want.

Each PTSS worker starts with induction into volunteering, which is covered by the first three levels of the training. The induction comprises five modules, covering different relevant aspects of CAHMA's work. Each module contains a list of learning materials, activities and assignments that need to be completed by the trainee in order to progress to the next module or level. In addition, each module covers basic topics, terms and concepts for discussion.

Level one

Level one consists of the first two modules of CAHMA volunteer induction training.

Module one

This module covers the basic policies and procedures at CAHMA, including the code of conduct; privacy; confidentiality; work, health and safety (WHS); feedback and complaints. In this initial phase of the training, the trainee familiarises themselves with different CAHMA policies and procedures and signs agreements that will promote professional and respectful behaviour within the organisation.

In module one discussion topics include:

- boundaries and conflicts of interest;
- peer identity versus lived experience;
- difference between peer workers and workers with lived experience;
- marginalisation, discrimination, stigma and internalised stigma (self-stigma);
- tackling stereotypes about people who use drugs and people who use drug treatment services;
- community development, health promotion, and social determinants of health;
- what is CAHMA (as a peer-based organisation); and
- what is CAHMA's vision and core programs/projects.

Some of the activities and learning methodologies that are used in this phase are reading, discussions, simulations, game-based learning and self-reflection.

Module two

This module prepares the trainee for the practical tasks they will be doing at their first experiential position (placement) – front of house (FOH) in the CAHMA community drop-in centre. In module two the trainee slowly becomes familiar with the CAHMA paperwork and forms (e.g. daily/monthly drop-in centre datasheet, daily tasks form, etc.) and learns about their role as a volunteer through a series of simulations, observations and shadowing of CAHMA drop-in community centre receptionists. Depending on their previous experience and knowledge, trainees spend different amounts of time practicing basic computer skills (logging into the reception account, writing emails, basic Word processing and use of Excel), answering the phone at reception, basic data collection, administration tasks, de-escalation skills, and learning about the operational side of the drop-in centre.

Some of discussion topics for this module are:

- harm reduction language, respectful communication with diverse communities (e.g. respectful use of pronouns for gender diverse community members; respectful language within the mental health and ATOD domains etc.);
- drug use and substance dependency in cultural context; and
- drug use as an issue of health, mental health, identity, politics, class, and human rights.

Some of the activities and teaching methodologies utilised in this module are reading and video materials, discussions, observation and shadowing/placement, simple data collection and analysis, self-reflection and game-based learning.

While at Level one the official position is 'trainee', upon completion, the trainee is ready to have their first independent shift as a volunteer. This involves covering the FOH position independently for a few hours, and performing the majority of tasks related to this role, e.g. taking care of the client area of the drop-in centre, making sure there is enough coffee, tea and sugar in the clients' kitchenette, giving out and heating up meals for drop-in centre visitors, giving out sterile needles and syringes (NSP), and recording all actions in the daily stats sheet.

If the trainee doesn't feel confident to cover the reception on their own, they will be shadowing the receptionist for as long as they need, in order to gain confidence and feel comfortable to do so.

Level two

Once the person achieves the ability to cover the FOH desk independently, the person transitions from the trainee role into the volunteer role. The training time at this level gradually increases, from 1–2 hours per week while at Level one, to spending 4–7 hours per week at CAHMA, of which one hour is usually spent with the CAHMA trainer working through the modules, and 3–6 hours are spent covering FOH volunteering shifts at reception desk two. On top of that, the person spends another 1–2 hours working from home on the reading/watching materials for module discussions and assignments.

Module three

This module is predominantly devoted to learning about harm reduction concepts – history, theoretical frameworks, basic principles, peer education and person-centred care.

To pass this module the volunteer needs to demonstrate a good understanding of the three pillars of harm minimisation and to be able to critically analyse this model, understand the relationships between the three pillars, recognise funding discrepancies and identify inherent contradictions.

Some of the main discussion topics are:

- abstinence versus harm reduction approaches;
- the difference between peer and professional educational models, including benefits and challenges of both; and
- the difference between person-centred and system-centred health services/care.

This module contains the greatest amount of reading and viewing material and is probably the most demanding on participants who don't have good literacy and/or academic skills. For that reason, some teaching methodologies include visual learning aids like matching the words/images to the text, game-based learning and animations. Other activities and teaching methodologies include research, discussion and self-reflection.

There is a compulsory reading list that covers the basics and an additional literature list for those who want to learn more.

Module four

This module is focused on expanding and building on the basic knowledge about CAHMA that participants have gained so far. It talks about CAHMA's history, its vision, mission, organisational structure and model of care. Participants learn in detail about all CAHMA projects, programs, and the different CAHMA teams. This module is more practical, as the trainee has the task of booking a series of individual meetings with different CAHMA project workers in order to discuss the projects they work on. At the end, the participant also has an informal meeting with CAHMA's executive director (they usually go for a coffee) to discuss strategic and governance work, such as relationships with stakeholders, building partnerships, funding, systemic advocacy, media and sector relations. The meeting also opens up a space for the CAHMA executive to discuss any aspects of the training which the trainer feels need to be reinforced, for example peer boundaries.

At the end of this level, the participant is able to confidently cover the FOH desk one, which is busier and has a more complex range of tasks (e.g. filtering phone calls, talking to the drop-in centre visitors and directing the traffic in the drop-in area, multitasking and occasionally utilising risk assessment and de-escalation strategies). At this stage the volunteer is usually motivated to pick up more shifts, able to develop positive and mutually supportive relationships with the workers, and starts to feel confident in discussing ideas, recognising community patterns

(such as emerging gaps and needs). The volunteer will usually feel empowered and included as part of the staff team.

If the volunteer is reliable, punctual and has developed a good sense of professional boundaries over the course of time, that usually means they are ready for the next level of training.

Level three

At this level the volunteer needs to complete the last module – module five, which covers ATOD services in the ACT region and CAHMA’s partnerships within the sector. There is a special focus on CAHMA projects that are run in partnership with other organisations, for example hepatitis C testing (run in partnership with Hepatitis ACT and the Kirby Institute/Flinders University), the CAHMA Clinic (in partnership with Directions Health Services).

Participants at this level are trained to be able to provide naloxone brief interventions to community members through CAHMA’s naloxone train-the-trainer workshops.

At this level the volunteer is preparing to experience work placement on CAHMA outreach programs such as CAHMA community BBQ, health promotion events, Venoscope workshops etc. Additional external training is provided, such as food handling, hand hygiene for health workers and NSP training. Upon completion of these trainings the participant is able to attend outreach sites with the CAHMA outreach BBQ team.

Depending on CAHMA’s requirements and funding capacity, a volunteer at Level three may be offered a casual position. Casual shift availability may vary between one and three shifts per week (sometimes more, depending on how many projects an individual is involved in). Casual workers receive additional training on CAHMA systems (Employment Hero, Swag, SharePoint).

Level four

Once Level four is reached, the participant experiences increased self-confidence, motivation and enthusiasm as they continue to expand their knowledge and understanding of the ATOD sector. They should also be starting to recognise and think about future pathways for their professional growth. They are gradually discovering the main areas of CAHMA’s work that they are interested in and what

cohorts they would be the most interested to work with. It is at this point that participants make a decision about what is the most suitable project/program/domain at CAHMA that they would like to work in, with those who are the most passionate about individual work with service users specialising as PTSS workers. As previously described, this is a process that happens gradually, and during which supervisors utilise a strength-based approach to help the person decide on their peer work pathway, including discussing the participants preferred field of work, offering opportunities as they arise and supporting opportunities initiated or created by the participant. This gives participants experience in their chosen field. At this point participants who are interested in individual advocacy and support will have expressed this to the trainer who will start to organise work with individual clients under the supervision of an established PTSS worker. Usually this will happen organically as they progress through the levels, as many people already know they want to build a career as a PTSS worker. They have already built rapport with many of the drop-in centre visitors over their tenure as a FOH worker and are happy to take on more duties involving individual advocacy and support.

Others may identify different areas they are passionate about, for example consumer representation, systemic advocacy, research, or grant writing. In such cases CAHMA works towards providing additional (external and internal) training which is aligned with the participant's particular field of interest. Examples of training include consumer representative training, first aid training, cultural awareness training, training in grants writing, media training, training on the use of arts in a health setting, etc.

As a result of this training and the self-reflective practices of participants, CAHMA workers and volunteers have participated in a number of ATOD related advisory and consumer representative groups such as the Opioid Treatment Advisory Committee (OTAC); Mental Health, Justice Health, Alcohol & Drug Services (MHJHADS) Governance Committee, ATODA Workers Group, MH-ATOD Alliance, ACTCOSS Justice Reform Group, Service Users' Survey of Outcomes, Satisfaction and Experience (SUSOSE). In addition, CAHMA volunteers and workers are encouraged to identify opportunities and apply for small grants. Staff who have successfully applied for grants will then be involved in their rollout. In this way, participants are provided work opportunities through short-term projects that they are passionate about (e.g. Health Promotion Grants for Peer Connect – a project about harm reduction strategies for people who use drugs during the Covid-19 pandemic; campaigns for Support Don't Punish; Women's Harm Reduction International Network (WHRIN) women's stories and Orange the World Campaign; and ACTEWAGL Bright Start

Essential Home Support Project). This enormously increases the confidence of CAHMA workers and volunteers and their capacity to network within the health and community sector, resulting in real and lasting increases to their employability. As a result of this, many of CAHMA's CDP participants have moved on to jobs across the ATOD and broader sectors or continued with tertiary education.

Level five

This level of training encompasses more specialised areas related to work on particular CAHMA projects – in this case the PTSS. The focus is on expanding and formalising the skills that workers need in order to successfully and professionally provide individual peer treatment support to CAHMA service users. This includes learning relevant PTSS systems such as CAHMA's PTSS database RediCASE. Participants are trained in PTSS basics, with the main training guide being CAHMA's PTSS Model of Care and associated policies and procedures which outline case management, case noting skills, de-escalation and mental health first aid provision.

Topics relevant for discussion at this stage are differences between case management and peer treatment support work, more readings and discussions on the topic of person centred approaches, as well as learning about different types of support groups that can be utilised in PTSS work (self-help, therapeutic, educational, peer support, peer education). This is important at this stage, as some of the workers have high motivation to facilitate specific peer support groups.

The main activities and teaching methods in this phase are placement within the PTSS team shadowing PTSS workers, role play, and eventually doing smaller parts of PTSS work under mentoring and supervision of more experienced workers and managers (e.g. intake, PTSS outreach, patient advocacy, home visits, court support, CYF support, material aid support).

Some examples of external training provided for this group of workers at Level five are: Certificate IV in Alcohol and Other drugs, de-escalation and dealing with difficult behaviours, trauma informed practice, writing case management notes, responding to subpoenas, mental health first aid.

Management and Supervision

Because of the complexity and emotional demands that come with the use of lived experience in peer work, CAHMA provides several layers of support and supervision to the PTSS team.

Individual supervision

The PTSS team is overseen by a PTSS manager. The manager's role is to provide training, mentoring and supervision. They play an integral role in helping individuals on the PTSS team manage the impacts associated with supporting vulnerable members of the community. They delegate work, manage workloads, and help team members to develop professional boundaries and work-life balance. Line supervision includes reviewing the workload, setting the expected standards, monitoring and reviewing performance, identifying learning and development opportunities.

An important adjunct to supervision by a PTSS manager, is supervision by a clinician (e.g. therapist, counsellor or social worker with experience in mental health work and trauma informed care). This clinical supervision may be provided by a dedicated clinical team leader employed by CAHMA or by an external supervisor. Both line supervision and clinical supervision is provided by identified peers, which means they have a nuanced understanding of the peer support worker identity and role. Their firsthand understanding of the complexity and emotional burden of the use of lived experience on the job is crucial to providing adequate supervision to PTSS workers. Both forms of supervision are supportive, flexible, person-centred and have a strong focus on self-care and advocacy.

Depending on the situation and personality of the PTSS worker, the frequency and intensity of supervision may vary. However, because peer staff utilise their lived experience as part of their work duties, supervisors frequently check on how they are managing their wellbeing. In addition, special attention at supervision sessions is paid to topics such as understanding boundaries; confidentiality; conflicts of interest; self-regulation and vicarious trauma; impacts of stress; and the importance of finding an adequate work/life balance.

Group supervision

Once a fortnight, the PTSS team meets for group supervision, which is facilitated by two supervisors. At these meetings PTSS workers are encouraged to discuss and reflect on their work with clients, give each other feedback, brainstorm different ideas related to individual case-studies and debrief. This enables collaborative learning and enhances problem-solving, while also encouraging the team to discuss, as a group, topics covered in individual supervision, allowing new insights and the sharing of constructive responses. Other benefits of this type of supervision include group cohesiveness and teamwork; mutual support; increased collegial respect and appreciation; and inspiring conversations about organisational values, mission and vision.

Additional support for PTSS workers

In addition to supervision CAHMA has systems in place to support PTSS workers, including:

- PTSS Basics—a monthly group for workers who are still learning how to do peer treatment support. Beginners meet monthly in order to familiarise themselves with the basic forms and referral pathways, as well as discussing work accomplished during the month.
- Staff meetings—weekly meetings are held for all staff across CAHMA and staff are required to report results of their weekly work including any statistics, group reports, individual advocacy and systemic advocacy results and ongoing issues.
- Opportunities to become involved in research studies including participation in study recruitment, codesign and conceptualisation, data collection and analysis as well as writeup and publication.
- Opportunities to become involved in research forums and conferences as participants, panellists or presenters.
- Employee Assistance Program (EAP)—CAHMA's EAP program provides flexible access to support from a counsellor or other support professional of the worker's choice.

Case consultation meetings

Each week the PTSS workers consult with a senior worker around caseloads, allocation or reallocation, case plans, and any other considerations regarding a person's support needs.

Depending on the team structure and commitments this process may happen individually or as a team.

The senior worker has oversight of team members' respective caseloads, in order to distribute resources appropriately. The senior worker is integral in providing their expertise, mentoring and encouragement to team members.

File audits

File audits are conducted periodically by senior staff members to ensure files contain all relevant information about the person, statistical data, assessments, consent and referral forms. In addition, case notes are screened for whether they are complete, accurate, timely, and objective. These are placed in the person's file and feedback is provided to the staff member. Areas for improvement may be brought up with the entire team or individually with team members.

Re-allocation

Relationships are central to the PTSS system. As such, all efforts are made to ensure a service user has continuity of care with the same PTSS worker throughout their journey. However, in some circumstances it may be decided that because of needs or complexities, a service user should be re-allocated to another PTSS worker or that a team approach may be necessary. Because the loss of a trusting relationship and the need to re-tell their story can be challenging or even traumatic, it is a process which is used cautiously, carefully and in collaboration with the service user. Re-allocation occurs under the guidance of a senior staff member who can discuss the implications around options, timing, communication, support, boundaries and handover and to ensure that the process remains supportive and transparent for all parties involved.

Closing a PTSS Episode of Care

The PTSS reports closed treatment episodes through the national minimum data set for alcohol and other drugs treatment services. As such, the PTSS endeavours to comply with the criteria for closing a treatment episode while also balancing the needs of the service user. When a conflict occurs, CAHMA prioritises the needs of the service user and the data is recorded as accurately as possible. PTSS workers liaise with the PTSS Manager to ensure that this balance is correct and that cases they are unsure of are sent to management for consideration and later validation within the AIHW data set.

Implementing Peer Treatment Support in Other Services

This section is a synopsis of the types of considerations that CAHMA believes may present to other organisations when implementing a peer service or team that is conducting individual service user support. It is not intended to be prescriptive, but simply a guide to some of the key considerations for non-peer-based organisation in the implementation of a peer treatment support service. Many of the challenges and considerations are common across organisations that are seeking to employ any type of peer role or team and for this reason the discussion below is quite broad and general. While peer-led organisations may find that they already have systems in place to navigate these challenges, non-peer led organisations may be less organisationally prepared. As such, we give a brief history of peer led organisations and their emergence in the Australian healthcare landscape and then go on to focus on providing advice for non-peer organisations. While much of the guidance is generally applicable, the focus is more specifically on the ACT context, with CAHMA as the local community-controlled peer organisation that could provide support and advice to ACT organisations on the implementation process.

A brief history of peer-led organisations in Australia

In Australia, harm reduction peer workers have been traditionally employed in specialist, community controlled/peer-led organisations. This approach originated in the 1980s as a response to HIV, when the federal government decided to fund priority populations as a way of protecting society from AIDS and limiting the spread of HIV. Networks of peer-based organisations were funded to provide

health information, health promotion and services to their communities who were deemed to be most at risk from the virus. These communities were people who inject drugs (through the use and sharing of unsterile injecting equipment), the LGBTIQ+ community and men who have sex with men (through unprotected sex), sex workers (through unprotected sex), and Aboriginal and Torres Strait Islander people (where the risk was exacerbated by racism, marginalisation, and stigma and discrimination). A network of organisations was formed from communities that already existed, to a large extent in an unfunded or self-funded capacity. Examples of these organisations include The Australian Illicit and Injecting Drug User League (AIVL) and its state and territory based member organisations (in the ACT: The ACT IV League, Canberra Injectors Network and subsequently, CAHMA, the Canberra Alliance for Harm Minimisation and Advocacy); the Australian AIDS Councils (in the ACT: the AIDS Action Council and later, Meridian); and the Scarlet Alliance and member organisations (in the ACT: the Sex Worker Outreach Project, SWOP). These organisations are comprised of people who identify as peers, across roles including volunteers, workers, managers, executives and in most cases board of governance members. Most of these organisations are membership based and represent the views of a particular community of people who share common values, experiences and ideals. As such they have intimate knowledge of their community and their policies, procedures and governance frameworks are tailored to provide safe and supportive environments for peer workers.⁷⁴ This expertise has been carefully tailored over decades and represents one of the strong suits in the Australian health landscape.^{75, 76}

The potential for peer workers in non-peer organisations

More recently, non-peer led organisations working in the alcohol, tobacco and other drugs (ATOD) sector as well as related sectors, are looking to employ peer roles and teams as a way of value adding to their workforce and enhancing and broadening their service offering. Other reasons are to leverage the expertise of existing staff that have lived experience; to enhance the emotional safety of the organisation; to provide a more person centred and understanding approach; and in response to the identified growing needs of existing service users as well as the broader community. There are many roles that peer workers can play in one-on-one service user interactions in a non-peer led organisation, for example to help service users navigate an organisations internal systems and other connected health systems, to support transition from one service to another, to provide emotional support to service users throughout their service journey, to advocate

for service users and ensure service users feel understood, valued and respected, as well as other bespoke roles that fill gaps in an organisation's service offering. The wide variety of potential roles peer workers can play is both a strength of employing peer workers, as well as a potential risk and challenge.

In CAHMA's experience of discussing peer worker and team possibilities, often organisations are unsure of how or in what capacity they want to employ peer workers, but they see the possibilities when they look at community-controlled peer organisations and wish to enhance their organisation in similar ways to be more safe, secure and person-centred. This is an admirable goal. However, it is important for non-peer organisations to think carefully and strategically before they undertake the journey of employing peer workers, as it can be fraught with difficulty, can be unsafe for staff and service users if not managed appropriately, and can require significant systemic change within an organisation to be successful.

Accessing peer expertise and leadership

Importantly, organisations need to consider how they will gain access to expertise on building and maintaining peer-based systems and programs or services. One option is reaching out to local peer led organisations to purchase their expertise to support this process, as without an element of peer leadership within the organisation, it is challenging to understand the issues around employing peer workers. This approach has a number of benefits, including enhancing collaboration and partnership, increasing understanding of service user needs, identifying possible roles for peer workers and highlighting potential internal system challenges. Peer based organisations also have access to significant insights into managing risk, creating peer friendly policies and procedures, and overcoming challenges involved in recruitment, supervision and support. The other option is to employ a peer leadership position specifically to roll out the peer worker roles envisioned. This approach involves thinking less about employing individual peer worker positions and more around employing a peer team, with a leader. This has significant benefits and centres the expertise within the organisation. It also fosters career development for peer workers, gives peer workers a stake in the leadership of the organisation and provides internal supervision and line management pathways. In the end, if an organisation wants to do peer work in any meaningful way, investing in peer expertise and peer leadership is critically important.

In practice, in the ACT ATOD sector because of the scarcity of resources, organisations are looking to work with CAHMA to provide expertise and support

to help them recruit, supervise and support individual peer workers within their organisations. An alternative approach which is also being pursued is to put together multidisciplinary teams or hubs of workers which include peer workers employed by CAHMA. These are both practical and realistic options to employ peers in non-peer led environments and have proved a successful first step in inclusion of peer roles within broader teams. This approach has been successful for many reasons, in particular the inclusion of CAHMA as an expert peer led organisation and the acknowledgment and resourcing of CAHMA's expertise in providing recruitment, management and support of peer treatment support workers. We thank those organisations who have realised the expertise of CAHMA in this space and have honoured and supported our intellectual property, knowledge and practice-based expertise in an inclusive and respectful manner.

Questions to consider

This section offers several considerations for an organisation to think carefully about before employing peer workers and teams. These questions should be addressed by an organisation's governance group and operational leadership. Input at both levels should be sought from the peer expertise or leadership that the organisation has decided to access as part of the initial steps of the process of peer treatment support team building.

Governance group questions

The organisation's governance group should think carefully about the strategic plan, current direction and focus of the organisation and discuss how a peer treatment support team will operate within those systems and under the organisation's policy environment:

Why do you want to employ peer workers? What is the aim and objective of employing peers?

When considering this question remember that peer workers thrive in grass roots environments where there is flexibility for them to take initiative, make decisions and prioritise service users as individuals with different healthcare needs. Peer workers require peer colleagues and peer supervisors or leaders, just like other health professionals, to provide guidance and support and to determine direction. Peer workers should be linked in with operational and strategic groups within the organisation and with peer colleagues and mentors within the sector.

Highly clinical, top-down organisations will struggle to meaningfully employ peer workers unless they are willing to make significant policy, procedural, cultural and potentially strategic changes.

What risks are you prepared to take and what priorities are important for you?

Grass root development comes with certain risks, but also benefits in person centred care and stronger connection, involvement and input from the community. Peer workers will typically prioritise individual health outcomes and respond to community need over corporate and clinical risk and this can cause tension if not thought through appropriately. Policy frameworks may need to be reconsidered, and budgets restructured. Governing groups should discuss whether they are prepared to relax their risk profile and change their stance on provision of prescriptive practises built to control risk, in order to embrace person-centred care and individualised treatment.

Examples of differences in risk profile can be found throughout this model of care, with examples being prioritising timely and immediate service provision and running a waitlist free service. Another example is managing risks that surround working with a criminalised community and the risks that arise from working with people who are likely to have a criminal record. CAHMA's policies and procedures are structured in such a way that they state the expectation that staff will have some form of criminal record due to the criminalisation of drug use. This is then balanced with contractual obligations around serious offences and risk management processes to ensure the safety of service users. Many organisations have a "black and white" view of criminal record checks and if drug possession offences, for example, are not taken into account when recruiting peer workers an organisation may be unable to find peer workers to employ. Additionally, any criminal record check process must be implemented in such a way that it does not take the agency and positive importance of a peer worker's lived experience away from them. The same applies in the ACT for working with vulnerable people registration. An organisation that seeks to employ peer workers must be willing to help workers complete the process and be willing to help the person achieve the role by being open to a conditional or restricted working with vulnerable people registration.

Another area of risk to consider is drug use at work and peer workers liaising with service users in their free time. CAHMA has the same rules as any other organisation regarding intoxication at work, however particular diligence is needed to ensure you are creating a safe working environment for people who are using drugs (on their non-work time) and people who are abstinent from drug use. While

doing this, you must also be prepared to be supportive of people who have chosen to continue to use drugs on their own time or risk alienating them and forcing them to lie. This balancing act requires significant nuance, support, trust and compassionate but firm boundaries. If your organisation thinks that this doesn't apply to what you are proposing, then ask yourself what happens if one of your abstinent employees starts using drugs again. How will you respond? Do you have the structures in place to support them? Will your response force them to hide their ongoing drug use? How will this affect their work as a peer? Will your response open the organisation up to potential discrimination liability?

Having friends and getting together with other people who use drugs and people who use drug treatment services is, in part, one of the central parts of what a peer worker is and how they build trust and rapport with other community members. It is what makes peer workers peers. But having friends who are also service users comes with a range of risks, balances and considerations that have to be worked through in order to understand and minimise organisational risk. How will your organisation respond if/when you become aware that a peer worker is friends with a service user outside of work? This is a fundamental risk that needs to be thoroughly explored.

What is the scope of change that your organisation is prepared to undertake to accommodate peer workers?

The above examples of risk considerations should have made clear to governance groups the degree of structural review and strategic change that may be required in order to successfully navigate the journey towards peer inclusion. The governing group can now realistically decide on the level of change that they are comfortable with and that fits within their strategic goals and priorities.

Operational leadership questions

Once the governance group has determined the aim, objective and scope of the peer program/service and determined the level of change required to strategic and policy documents and practices, the operational leadership should determine how to operationalise the intent of the governance group. The questions below may help determine next steps.

What function and role do you want peer workers to play within your organisation?

There are a wide variety of roles that peers can play within an organisation however in this model of care we are describing peer treatment support roles which provide individual one-on-one care. Organisations will therefore have to decide

how this peer role will fit into their broader team and how peer treatment support workers will compliment other roles such as doctors, nurses, counsellors and case managers. When making these decisions around function and role it is important to look at the current gaps and challenges that service users experience when they are engaging with the organisation's services and programs. Insights such as these can be gained by consultation with service users and front-line workers as described below as well as engaging with peer expertise and leadership. Any organisation undertaking this journey should think carefully about staging their process such that the operational leadership group has a good brief from the governance group around scope, a good source of peer expertise and leadership and the results of some consultation work with service users and front-line workers to inform their decision making processes.

It is also important that the function and role of peer workers in the organisation is meaningful, commensurate with their expertise as peers, and offers genuine pathways for career progression.

How will peer involvement be integrated into leadership and governance discussions around strategic direction and what structure should the peer team take?

Pathways for peer workers to be leaders and to input into operational and governance decisions are important considerations when deciding on what peer programming looks like in an organisation. Peer workers can often feel like they are powerless and are right at the bottom of the pecking order, if their ideas are not treated with respect and their projects and plans not seriously considered and integrated into operational and strategic processes. For this reason, integration of peer leadership and fostering pathways for uptake of peer-based ideas and opinions is important to any organisation aiming at having a thriving and dynamic peer workforce.

How will peer workers be supported?

This question should be answered by the operational group in collaboration with clinical or service leadership. Peer workers require supervision and leadership as well as training and support. Peer workers will thrive only if they have proper professional development pathways and are encouraged to progress. Peer workers benefit from external supervision from other peer professionals and appropriate supervision opportunities should be provided. Local peer organisations are a good source of external peer supervisors. These factors will be highly dependent on your organisation's networks, local supervision and training providers, and the professional relationships that your team has. Utilising these grassroots factors

will be important in provision of a bespoke support network that is appropriate for your organisation's peer team.

How are you going to recruit peer workers?

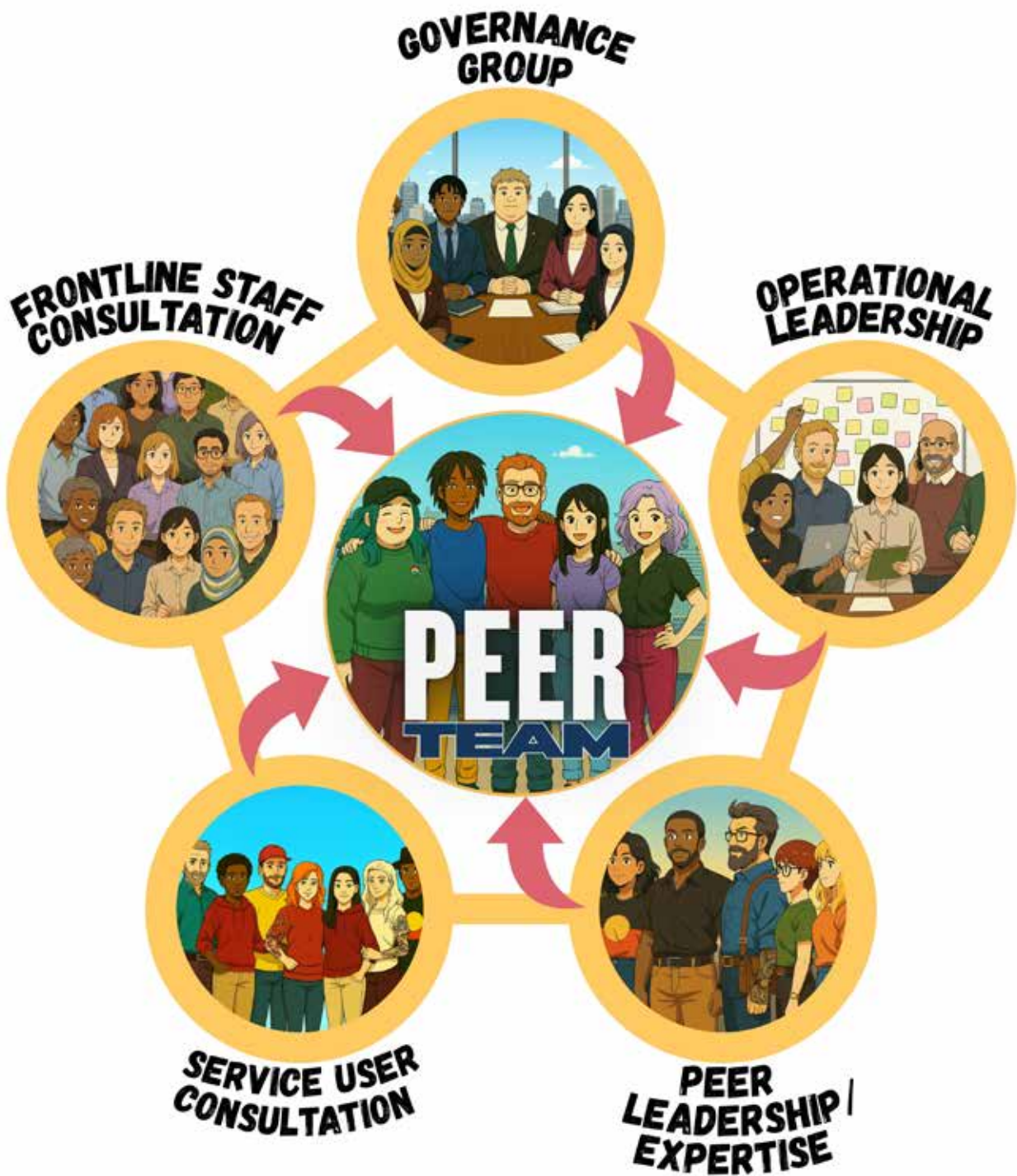
This is a question that should be answered by the operational leadership group in collaboration with the human resources team. It is often impossible to recruit peer workers via traditional mechanisms, as there are few formal qualification frameworks for peer workers. Often, if you recruit peer workers in this way, you will be relying on a pool of peer workers trained by local community-controlled organisations. This is often the most natural way of beginning the peer worker employment journey and strong partnerships with peer led organisations are excellent ways of building peer recruitment strategies. Ultimately, peer recruitment will always be restricted by your capacity to develop your own community of peer workers. Whether to partner with peer led organisations who train peer workers, whether to begin training peer workers as a method of recruitment internally, or whether to rely on traditional recruitment methods is a question for organisations to ask themselves.

How are you going to train peer workers?

Due to the nature of peer work, peers often require many different types of ongoing training to stay abreast of community trends and community need. Developing relationships with peak organisations in your area and embracing training on offer as part of qualification strategies in your local area is important in providing peer workers with their training needs.

Service user and front-line worker consultation

One of the best ways to ensure quality improvement is to have regular consultations with both service users and the front-line staff that work with them. These consultations should be focused on gaining better insight into service user's needs and their expectations, challenges and barriers they face when accessing your different service offerings. Through this process you may learn potential insights that can be applied to informing your development of peer programs and services. The process of the consultation will also provide ownership of the peer program to front-line staff and service users and enhance investment and agency in the results. It also fosters bottom-up grassroots initiative and sets the scene for further changes towards peer based programming. Once again, the process of service user engagement can be informed by your local peer-led organisation.



Final thoughts and barriers

Although not by any means an exhaustive guide, the above suggestions around inclusion of peer expertise and leadership, questions and consultation processes should help non-peer organisations tackle a number of challenges to the ethical employment of peer workers in the ATOD and associated sectors. Challenges and barriers to successful peer employment exist inside and outside of organisations,

including insufficient resourcing; lack of knowledge and understanding of the importance of peer work; stigma and discrimination; and a lack of acceptance of peers by colleagues.⁷⁷

The trend of acknowledging the importance of lived experience and peer work has become noticeable over the last decade, especially within ATOD, mental health, community service and disability sectors. However, in the ATOD sector this positive trend is not accompanied by an understanding of the role, function and support structures that need to accompany employment of peer workers. The lack of the development of adequate operational frameworks, policies and procedures, organisational readiness and workplace culture consensuses, definitions and understanding causes a lot of confusion in the broader sector.

The ATODA Workforce Profile for 2024 showed that 36% of ATOD workers identify as having lived experience in relation to ATOD use on the grounds of having “personal experience of impacts from my own alcohol and/or drug use” and/or “personal experience of engaging with a treatment or harm reduction service for my own alcohol and/or drug use”. This rises to 69% if we include people who identify as having lived experience in relation to ATOD use on the grounds of being “a family member or close friend of someone who has experienced impacts from alcohol and/or drug use” or has “other past or present lived experience of alcohol and/or drug use”. Lived experience in the ATOD sector is therefore very abundance and is one of the reasons for people’s choice to work in this field and is something to be celebrated.⁷⁸

One common misunderstanding is for organisations to conceptualise workers who have lived experience as ‘peer workers’ by virtue of those staff member’s experience. Although this abundance of lived experience in a workforce represents a big pool of potential peer workers, simply having lived experience on its own does not constitute a peer work qualification. Peer work is not simply about employing workers with lived experience but rather requires thorough training, support and placement experience, coupled with strategic and organisational change to meaningfully enact peer programming.

This misunderstanding is further embedded by the increasing trend of specifying “lived experience” roles. This creates confusion, because there are major differences between the role of a peer worker and an employee who has lived experience. In CAHMA’s work, we use the term peer worker, as it includes not only the prerequisite of lived experience, but also the important concepts of individual and group identity and the idea of equality of power.

For CAHMA, having lived experience is an important attribute of a peer worker, but is not a role in itself. A doctor, nurse or case manager can have lived experience which can inform their role as a doctor, nurse or case manager and is very useful and beneficial. But this is significantly different from an identified peer worker position, where the role is to not only utilise one's lived experience but also to identify with a community and to use that identity as the main therapeutic tool in one's work.

A common barrier to successful implementation of identified peer worker positions and teams is how to support peer workers without infantilising them. It is fundamentally important that provision of support, supervision, management style and organisational culture is anchored in a strength based approach and is not arising from a paternalistic, patronizing position where peer workers are considered to need extra support because of perceived innate deficiencies or deficits. This balance can be difficult for organisations and is fundamentally important in ensuring a vibrant, strong and successful peer initiative. Peer expertise can offer considerable help in this area in order to ensure strength based adjustments and provision of necessary support are available, without infantilising peer workers.

It is important that organisations understand that peer worker positions must be funded appropriately as identified peer positions, ensuring that the necessary resources are provided and utilised to enable appropriate remuneration and support for peer workers. Where an organisation tries to tick the box of employing peer roles without the necessary resourcing or support structures, harm often occurs to both the employee and the service users engaging with the organisation. For this reason, CAHMA suggest that organisations seeking to employ peer workers consider the significant support, operational/governance guidance and expertise, and bespoke policies and procedures that are required to create successful peer worker environments.

We hope that this section has been helpful in understanding the challenges and barriers to employing peer treatment support workers in non-peer organisations. Through a combination of accessing relevant expertise on peer programming, asking the right questions at different levels of the organisation and consulting with service users, the broader community and front-line staff, it is possible for non-peer organisations to employ peer teams in a manner which is ethical, safe and productive.

Appendix one



Belconnen Churches Center, 54 Benjamin Way, Belconnen, ACT 2617
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RELEASE & EXCHANGE OF INFORMATION

If there are other people assisting you, it can be useful for us to exchange information to ensure that your care is coordinated. In addition, sometimes you may wish a CAHMA staff member to have contact with specific people (such as partners and other family members). We are only able to release information to people outside of CAHMA when you agree to it and specify the information to be released or where release is authorized under the ACT Health Records (Privacy and Access) Act 1997 or any Other law of the Territory or Commonwealth.

I _____ give permission for information about me to be released/exchanged with the following people:

Name	Relationship/Organisation	Contact Details
*	_____	_____
*	_____	_____
*	_____	_____
*	_____	_____

I give permission for the following information about me to be discussed:

Signature:

Date:

Canberra Alliance for Harm Minimisation and Advocacy is a peer-based organisation promoting the health and human rights of injecting/illicit drug users. CAHMA provides education, support, representation and advocacy for drug user, their families and friends.

Appendix two



CAHMA /CONNECTION CLIENT CONTACT RECORD

<small>(Staff Use Only)</small> Date of contact: Service location:		Staff member name: Source of Referral: or Self Referred	
Name:		D.O.B:	Gender: Female/ Male / Trans Woman/ Trans Man/ Non-binary/ Intersex/ Not Stated/ Other -
Address:			Postcode:
Telephone Contact(s):			<input type="checkbox"/> Consent to Call
Email:			<input type="checkbox"/> Consent to text message
Country of Birth:			<input type="checkbox"/> Consent to email
Country of Birth:		Preferred Language:	

Demographics (circle)

Aboriginal but <u>not</u> Torres Strait Islander	Aboriginal & Torres Strait Islander	Torres Strait Islander but <u>not</u> Aboriginal	<u>Neither</u> Aboriginal or Torres Strait Islander	Non English-Speaking Background	Not Stated
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Accommodation Type (circle)

Gov't housing	Private rental	Privately owned	Hostel/supported accommodation	Detox/ rehab
Psychiatric hospital	Shelter/refuge	Prison	Homeless/couch surfing	Prefer not to answer
Other:				

Living Arrangements (circle)

Alone	Alone w/ children	Spouse/Partner	Spouse / Partner & child(ren)	Friend(s)
Parent(s)	Parent(s) / Friend(s) / Relative(s) & Child(ren)	Other relative(s)	Shared Accommodation	Prefer not to answer
Other:				

Main Drug used by client (circle ONE type only)

Heroin	Opiates	Methadone	Bupe	Benzos	Cannabis
Methamphetamine	Ecstasy	Cocaine	Alcohol	Tobacco	Other:

Method of use for principal drug of concern

Eat/Drink	Smokes	Injects	Inhales	Snorts	Prefer not to answer	Other (please state):
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Secondary or other drugs used by client (circle one or more)

Heroin	Opiates	Methadone	Bupe	Benzos	Cannabis
Methamphetamine	Ecstasy	Cocaine	Alcohol	Tobacco	Other:

Last Injected: (please circle)

0 - 3 months	3 - 12 months	12+ Months	Never Injected	prefer not to answer
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Appendix three

Level	In-house training	Content	Basic concepts	Activities / methodology	Position	Additional training
Level one	CAHMA VOL Module 1 Naloxone basic	Basic policies & procedures: <ul style="list-style-type: none"> code of conduct privacy & confidentiality WHS feedback & complaints 	<ul style="list-style-type: none"> boundaries; conflicts of interest; peer identity vs. Lived experience; difference between peer worker & worker with lived experience; marginalisation, discrimination stigma & internalised stigma; tackling stereotypes about PWUD; community development, health promotion & social determinants of health 	<ul style="list-style-type: none"> reading discussions simulations game-based learning self-reflection 	Trainee	
	CAHMA VOL Module 2	Front of house & practical tasks at CAHMA: <ul style="list-style-type: none"> computer skills emails stats admin reception phone 	<ul style="list-style-type: none"> harm reduction language; drug use/ dependency in cultural context; drug use as: health/ MH/ identity/ political/ class/ human rights issue 	<ul style="list-style-type: none"> reading video material discussions observation and shadowing simple data collection self-reflection 		

Level	In-house training	Content	Basic concepts	Activities / methodology	Position	Additional training
Level two	CAHMA VOL Module 3	Harm reduction: <ul style="list-style-type: none"> • history • theoretical framework • basic principles • peer education • person-centred care 	<ul style="list-style-type: none"> • three pillars of harm minimisation; • relationship between three pillars and funding discrepancies • abstinence vs harm reduction approaches 	<ul style="list-style-type: none"> • front of house • first point of contact with service users • research about CAHMA projects and programs • individual meetings with all CAHMA workers • coffee with the ED 	Volunteer	
	CAHMA VOL Module 4	<ul style="list-style-type: none"> • CAHMA vision & mission • Org. structure Model of care 	<ul style="list-style-type: none"> • CAHMA projects • CAHMA teams & workers 			
Level three	CAHMA VOL Module 5	CAHMA partnerships ATOD services in the ACT	<ul style="list-style-type: none"> • CAHMA systems <ul style="list-style-type: none"> - Employment Hero - Swag - SharePoint • networking 	<ul style="list-style-type: none"> • outreach work • community events • brief interventions • health promotions • community BBQs • community engagement within the harm reduction framework • CAHMA projects promotion • Naloxone • brief interventions • teamwork 	Volunteer/ Casual worker (where available)	<ul style="list-style-type: none"> • NSP certificate • food handling
	Overdose prevention Brief interventions					

Level	In-house training	Content	Basic concepts	Activities / methodology	Position	Additional training
Level 4	The Fix		CAHMA systems	<ul style="list-style-type: none"> research project proposal writing systemic advocacy Grants Campaigns Partnerships Identifying service gaps & community needs 	<p>Project work (as casual / volunteer)</p> <p>Consumer rep</p>	<ul style="list-style-type: none"> consumer rep training Senior First Aid Cultural Awareness training
Level 5	rediCASE PTSS basics Policies and procedures related to individual client work	PTSS model of care	<ul style="list-style-type: none"> case manager vs PTSS worker person-centred approach 	<ul style="list-style-type: none"> shadowing PTSS workers intake and PTSS outreach 	PTSS worker	<ul style="list-style-type: none"> AOD Cert IV, compulsory de-escalation and dealing with difficult behaviours trauma informed practice

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