REDUCING HARMS IN THE WORK ENVIRONMENT

Recommendations for employing and managing peers in harm reduction programmes in South Africa.

Rafaela Rigoni

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ABBREVIATIONS

CDC	Centers for Disease Control and Prevention
FPD	Foundation for Professional Development
GIPA	Greater Involvement of People Living with HIV
HCV	Hepatitis C Virus
INPUD	International Network of People Who Use Drugs
MIPA	Meaningful Involvement of People Living with HIV
OST	Opioid Substitution Therapy
PEP	Post-Exposure Prophylaxis
PWUD	People Who Use Drugs

HARM REDUCTION STARTS AT HOME.

If we want to involve peers in promoting harm reduction in the community, we need to start by promoting harm reduction inside our programmes.

SUMMARY OF RECOMMENDATIONS

1. Pay attention to recruitment.
This applies to recruitment of peers as well as the management staff. It is recommended that both peers and managers are given the opportunity to discuss, in advance, the desired profile and skills of new staff. Peers should be involved in all steps of the recruitment process.

2. Offer diverse work engagement levels.
Not everyone will be ready or willing to work full time or in specific outreach functions. Offering different levels of work engagement creates opportunities for people who use drugs (PWUD) to progress through the organisation while respecting their possibilities and needs at a given moment. Alternative work levels could include part-time or ad hoc activities, or volunteering.

3. Promote a harm reduction approach to drug use among staff.
Develop non-prohibitionist regulations at the workplace and focus on job performance instead of on drug use. What matters is that staff must be fit for work and protect the organisation's image. They must be accountable for their performance, regardless of their eventual drug use.

4. Foster a supportive work environment.
Be appreciative and build trust. Provide good work conditions and support workers' needs and self-care. Be flexible with working hours when staff needs to obtain opioid substitution therapy (OST), or HIV, hepatitis C virus (HCV), or other types of treatment. In addition, be aware that performance may be affected due to side effects of medication.

5. Provide and foster mental health care.
Offer debriefing sessions and other types of psychological and mental health support, both in groups and individually. Contribute to demystify mental health by promoting basic mental health training and incentivizing staff to learn how to deal with stressful situations.

6. Build and sustain boundaries.
This implies being transparent about rules and how they are applied for everyone, but also help to recognise, building, and maintaining boundaries to help protect staff from emotional burden.

7. Invest in team care by promoting diversity and respect.
Invest in team care: excellent communication, team building, and promote an environment of trust among colleagues. Foster the construction of a diverse group and promote respect for this diversity within the team and the organisation.

8. Promote meaningful involvement of staff who uses drugs at all levels, not only on service delivery.
Include staff in planning, evaluating, policy-decision making. This might mean also helping to prepare staff on how to give feedback, as some might have internalised stigma, which might create extra difficulties for sharing ideas.

INTRODUCTION

Meaningful involvement of PWUD

People who use drugs (PWUD) are key actors in harm reduction programmes, playing critical roles, well beyond being a target group. There is growing recognition of the need for meaningful involvement of PWUD in all aspects of relevant policy and programme development. PWUD have the right to participate in decisions that influence their lives and are the real experts when it comes to harm reduction. Substantial evidence confirms the crucial added value peers bring to harm reduction programmes. People with lived experience of drug use help to access and build trust with clients, increase the active engagement of PWUD in care, and are building bridges between the clientele and essential services. Moreover, the meaningful involvement of PWUD in harm reduction programmes brings benefits for users themselves: from learning new skills to improving their own self-care and self-esteem.

Involvement of PWUD in South Africa

The PWUD community has been essential in the development and growth of harm reduction programmes. South Africa is one of few countries that meaningfully included and paid peers at the start of the harm reduction projects. Peers were actively involved in designing, shaping, implementing, and evaluating the existing harm reduction programmes in the country (1). They provided input on local, provincial, and national level policies and plans to improve their health and rights (2). In contrast, many other countries include peers only as volunteers with no financial reimbursement. South African programmes have led the way in recognizing peers financially. Although drug use is still criminalized, South Africa has seen tremendous progress in acknowledging harm reduction (e.g. 3,4), which was achieved by meaningfully involving the PWUD community.

Challenges

Harm reduction work, however, does come with several challenges. Unstable or insufficient funding, non-ideal work conditions, and mental health strain are some of the common problems faced by many harm reduction workers worldwide. Prejudice towards drug use often affects the work of harm reductionists, bringing specific challenges that are sometimes hard to resolve. In the case of peers, such challenges are exacerbated by living conditions, lifestyle and stigma, which may endanger their work, health, and quality of life. Although South Africa has long embraced the involvement of peers, it also faces the challenges arising from such experiences.

Aim of this guide

This guide aims to acknowledge the experiences of South African peers at work in harm reduction programmes and to translate them into practical guidance for service providers. The peer-based recommendations resulting from this activity focuses on good practices and proposals to improve employment conditions for peers. The guide also emphasizes the importance of developing work and management skills that foster a healthy work environment for peers and managers. In turn, a healthier harm reduction work environment

Safe disposal of needles and syringes. Step-Up Outreach team, Cape Town. Image © Mainline

should result in strengthened harm reduction programmes and higher quality services for beneficiaries. The recommendations in this guide build upon an original small-scale study on South African harm reduction programmes, along with previous literature and manuals. It departs from the experiences and good practices of harm reduction workers and makes use of research as support or counterpoint when necessary.

THE GUIDE IS DIVIDED INTO FOUR SECTIONS:

1) **A brief review of the literature on the involvement of PWUD,**
2) **The most common challenges related to peers and harm reduction work in South-Africa,**
3) **Recommendations on how to tackle such problems, and finally,**
4) **A concluding section summarises the recommendations per actor and provides resources for further readings.**

BACKGROUND AND LITERATURE

Meaningful involvement of Key Populations and PWUD

Key populations (KP) have the right to self-determination and involvement in decision-making processes that affect their lives. The Greater Involvement of People living with HIV (GIPA) principle (5) formalized this principle in 1994. Together with the Meaningful Involvement of People Living with HIV (MIPA) (6), these principles advocates for significant participation of people living with HIV at all levels, fostering the development of supportive political, legal and social environments. Similar principles of meaningful involvement have been extended to other KP groups, such as sex workers (7), transgender people (8,9), men who have sex with men, people in prisons and detention (10), and people who use drugs (11). Tools to assess communities' levels of engagement and representation and to identify gaps and steps to strengthen commitment are widely available (12).

In the drug field, the International Network of People Who Use Drugs (INPUD) has been calling for the meaningful involvement of PWUD in all interventions involving the community, based on the motto "nothing about us, without us" (13). There is growing recognition of the need for meaningful involvement of people who use drugs in all aspects of relevant policy and programmes development. Harms can best be reduced, where affected people participate meaningfully in decisions concerning the systems and services that shape their lives (14).

For meaningful involvement to take place, KP individuals and their organisations must be involved in several levels, ranging from policy decision-making to expert evaluation and planning, and implementation of activities. In the harm reduction field, peers have been taken several roles in education, health services delivery, peer support, counselling, research assistance, advocacy and advisory committees (15). Political participation and self-organisation of PWUD are fundamental for more effective and humane drug policies, and must always be encouraged by harm reduction employers (16). Therefore, although service delivery is peers' most recognised role, it represents only one way of involving peers in a programme. Meaningfully engaging peers comprises much more than having peers delivering services (17). It involves providing and supporting the space for peers to be actively involved in all aspects of decision-making processes that affect their lives; this includes service delivery as well as the regulations controlling it, or the public policies influencing the programmes' workings.

Benefits of PWUD involvement in service delivery

Several studies show that hiring peers can improve harm reduction programmes. Peer-delivered interventions have been identified as a critical enabler in the HIV response (18,19). In addition, peer involvement in programmes has also been shown that this is effective in reducing the transmission of viral hepatitis (20) .

Peer support can lead to a more active engagement of people who use drugs and other KPs in care (21–23). Evidence shows that peer education is the most effective way to share new knowledge and skills among PWUD (24). Many PWUD do not trust social or

health workers and may fear stigmatising attitudes in care services (25). When messages come from peers, beneficiaries are more likely to adopt practices that could save their lives. Peers are trusted more quickly because they share experiences, language, and background with the community they assist (26). This makes it easier to convey honest harm reduction education and information (27,28). Peers also act as a bridge (29) between the PWUD community and various care services, an essential component of an integrated model of care. Moreover, peers extend services reach, as they are also available at times and locations not served by more formalised services (30,31).

It is particularly important to involve peers in services that are starting, or that need to reach out to new target groups or groups using new types of substance or combinations (32–34). Community members are authorities in the harms that they experience. They can offer valuable insights on how to understand the factors enabling or hindering care as well as those increasing the chances of behavioural change and risk-reduction for drug use.

Finally, the meaningful involvement of people who use drugs in harm reduction programmes can also have several benefits for peers themselves. Being employed in a job that is recognised as socially relevant contributes to improved self-esteem. Working in a structured environment may allow users to gain essential skills that can facilitate future entrance into other jobs, and it provides peers with an increased feeling of belonging and contributing to a community (35). Increasing self-confidence and self-efficacy helps peers to advocate for human rights and stimulates sustainable change in the drug-using community (36).

Practical challenges and questions

Despite the abundance of evidence advocating for the benefits of peer work, practical recommendations on how to involve peers in harm reduction programmes are meagre. PWUD can face many barriers to entering and remaining in the workforce. A few reports provide excellent guidance:

- **Open Society Foundation** provides a hands-on guide for organisations employing people who use drugs (35). The guide offers clear recommendations on workplace policies and strategies on recruitment, training, supervision, support, evaluation, conflict resolution, and boundary maintenance. It also describes good practices of two user-driven and user-centred organisations.

- **International HIV/AIDS Alliance** provides a guide on good practices for employing and supporting people who use drugs at work (37). The guide builds on multi-country experiences and considers potential differences between ex- and active users as well as those who are engaged in OST.

- Finally, **INPUD** offers practical guidance on implementing HIV and hepatitis C programmes with people who inject drugs (the IDUIT guide) (38). The manual describes good practices from around the world, focusing on community empowerment, legal reform, human rights, stigma and discrimination, health and support services, service delivery approaches and programme management.

Yet, there still is a great need for a better understanding of the lived experiences of PWUD who work in harm reduction to make concrete recommendations for service providers. How can South African harm reduction organisations support and guide peers, thereby improving the effectiveness and efficiency of peer-led programmes in the country?

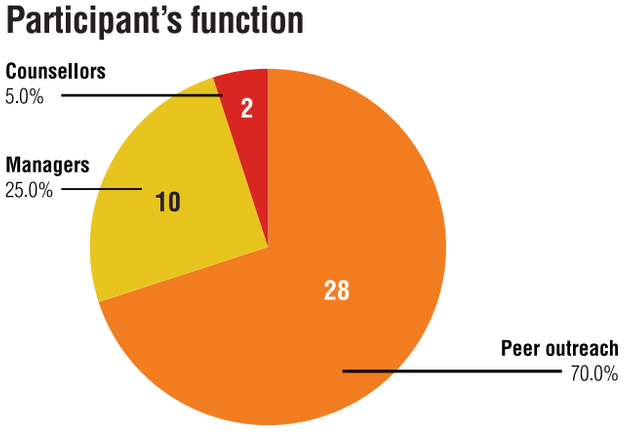
This guide

To answer this question, the present guide builds upon previous knowledge. It is focused on the street-level challenges and experiences of peers and management staff working in harm reduction programmes in South Africa. In doing so, it brings new themes to light and offers practical and situated peer-led recommendations. The guide provides:

- An understanding of the challenges and needs of service providers and PWUD working as peers in South Africa;
- Recommendations to help design a work environment in which peers feel respected and engaged; and
- Guidance to create an enabling work environment for peers and other harm reduction workers, while also respecting programmatic and organisational needs.

How the guide was developed

The challenges and recommendations described in this guide were drawn from the experiences and insights of peer outreach workers, counsellors, and managers working in South African harm reduction programmes. An **assessment** was carried out by an independent consultant in March 2020[1]. Forty workers from harm reduction programmes participated in the assessment, with 20 participants from Cape Town and 20 from Pretoria. The chart below shows the number and proportion of participants according to their functions in the programmes.



[1] The consultant (Rafaela Rigoni) was hired by Mainline Foundation. The project was funded by the FPD - Mainline's partner - with the support of CDC/PEPFAR

The methods used for the assessment were in-depth interviews, participant observations, and insight group sessions. These include:

a) **Two insight sessions** with groups of eight peer outreach workers each
b) **Twenty hours of participant observations** with six peer outreach workers: two days accompanying the team's outreach work, and one day accompanying a "sweeping" project (peers collect used syringes from public areas in exchange for a small stipend)
c) **Eighteen in-depth interviews:**
    - Six with peer outreach workers with a minimum of one-year experience in a South-African based harm reduction programme,
    - Two with peer counsellors with a minimum of three years' experience in a South-African based harm reduction programme, and
    - Ten with staff members from low and medium management level (field coordinators, programme coordinators, programme managers), with or without lived experience.

There were no incentives provided in exchange for participating in the assessment. A **brief literature review** was conducted before and after the survey. The review focused on the effectiveness and good practices for PWUD involvement in harm reduction programmes. Previous guides and literature were used as support or counterpoint for workers' experiences and recommendations when needed.

Once a first draft of the guide was ready, a **community review** took place, where study participants and other relevant stakeholders were invited to revise and feedback the document. The final revision resulted in the present guide.

The following pages describe the most common challenges confronting PWUD working in harm reduction programmes in South Africa. After that, recommendations per actor are drawn. To account for participant's anonymity, they were identified in the quotes by a P and a number, followed by their primary function.

CHALLENGES IN HARM REDUCTION WORK

Working in the field of drug policies and harm reduction can be challenging. The illegality of drugs often brings prejudice towards workers, and these challenges are heightened by structural factors like unstable or insufficient funding, non-ideal work conditions, and mental health strain. Challenges can be more complicated for those harm reduction staff with lived experience of drug use, who are confronted with homelessness, other adverse living conditions and community stigmatization and discrimination.

The following pages describe the most common problems experienced by harm reduction workers in South African programmes. These can be related to overall ideas and regulations about drug use and trade, culture and rules of organisations, relationships with managers and other team members, as well as personal issues.

Criminalisation, stigma, and mistrust

Especially at the management level, it always comes across that peers are fucking around and that they are unreliable. There always seems to be a prejudgment. There is no openness and trust to ask, 'what is happening'. […] Also, when something goes missing, it's always insinuated that it's the user. (P24, peer)

The criminal nature of drug use puts PWUD at frequent risk of police arrest or harassment, as well as of stigmatisation and judgmental attitudes by other care workers and society at large. Unfortunately, stigma and mistrust may also travel down to harm reduction programmes. Co-workers without lived experience of drug use may hold negative beliefs and attitudes towards their colleagues who use(d) drugs. These may lead to blaming and stereotyping in the workplace, making it difficult for staff who use(d) drugs to exercise their full potential at work.

He abstained for three years. He was like the perfect example, but then he relapsed. When people in the management found out, they threw a stigma on him, and that pushed him away. [They said] "How could you go back using? You were clean. You just love drugs". That demoralises the person. Then he went, and he used without control. He didn't care if he was coming to work or not, and he was a very responsible guy. No one supported him. No one wanted to know why he relapsed. All that people said was, "Oh, he just loves drugs". (P28, peer)

Lack of trust and prejudicial attitudes towards peers produce an unhealthy work environment, with narrow room for communication and understanding. Peers feel judged and not recognised in their efforts, which may lead to dissatisfaction and an inability to adapt to work routines. Moreover, peers may feel that they are not accepted at the organisation, which can lead to great work-related suffering.

A judgemental environment may also lead staff to conceal their drug use. Fear of repercussions often discourages employees who use drugs from opening up about difficulties or seeking guidance from non-using co-workers and supervisors when needed (35).

A supportive and non-judgemental setting is needed to foster and maintain trustful and open relationships between peers and employers.

Abstinence-focused attitudes and policies

Abstinence-focused views and policies inside a harm reduction programme can manifest in different ways. One of such positions is the assumption that a programme must give preference to hiring ex-drug users only, assuming they would be better equipped to work. There are several problems with that assumption:

- Drug use is rarely a fixed state: people in recovery can relapse, and people who are not using may choose to start using again.
- Harm reduction does not require abstinence.
- People can self-regulate: Many people who engage in drug use experience it as non-problematic and pleasurable and can self-regulate their use.
- It is vital to have a team with diverse backgrounds regarding drug use (8).

We are making harm reduction. If you can't make harm reduction in your own house, how can we go out and make harm reduction there? (P23, peer)

As an organisation, we have got our policies that were never explicitly designed to manage someone who has been struggling with drugs. […] the policy is against drug users, and we are engaging people who, at the point of engagement, we are aware that they are using or are ex-users. Then you have a policy that recommends testing staff for drugs. (P22, manager)

Another abstinence-focused attitude is the one leading to punishing policies for PWUD in the workplace. For example, a policy recommending testing staff for drug use is incredibly problematic in a work environment and is not consistent with a harm reduction approach.

Harm reduction policies are also good workplace policies for programmes involving peers (35). These are based on a non-prohibitionist and non-judgemental approach towards people who use drugs, whether they are service users or staff.

Unrealistic work expectations & lack of support

Frequently, harm reduction programmes demand too much from their workers. The workload is generally high, the staff is reduced, and salaries tend to be on the lower side. The severe living conditions of the target population bring an extra challenge to the work context, together with the criminalisation of drug use and insufficient resources to respond to the population's needs. Mental health strain is a collective experience, and yet, many programmes do not provide mental health support for staff.

In our field, we see many things happening, and it gets too much sometimes. Sometimes we start fighting among each other because we don't know how to deal with it. (P23, peer)

Such work context can be challenging even to the most experienced workers. Yet, many peer staff members may have limited work experience and may have been unemployed for a while. They may be unfamiliar to working in an office setting, using administrative and communication systems, working as part of a multidisciplinary team, and following a specific work code. Depending on their life context, staff may have difficulty in getting to work on time and may not be used to communicating non-attendance. Staff who are undergoing drug treatment may have problems

For substance users to work in a sort of environment, expecting them to work an eight-hour day may just not be realistic, number one. Number two, you must make allowances for substance use. […] If you're asking substance users, that's in the job description…. You can't employ them on that basis and say, "I'm sorry. You can't use during working hours," and put a discipline order (P2, manager).

in adapting working hours to treatment requirements. Some workers currently using substances, may not be able to cope with abstinence for eight hours in a row or might find it difficult to schedule their substance use for before and after working hours. Moreover, the frequent contact with drug scenes and the pressure of work might lead some peers to fall back into uncontrolled drug use.

Facing these difficulties certainly do not imply that peers cannot or should not be expected to behave professionally, nor should they be regarded as less reliable or capable than non-substance using workers. It implies, however, that work policies and expectations may have to be adapted to the context and possibilities of peers, and not the other way around.

Power relations and communication

Excellent communication is central to a healthy work environment. It allows information to flow and be clarified, and problems to be brought to light and negotiated. Developing excellent communication at a harm reduction workplace can be challenging. Stigma and mistrust are substantial factors hindering communication. When they intersect with power relations, the harmful effect can be even more significant. Power relations at work can be related to hierarchy, function, and having or not a diploma. It can also be linked to race, gender, lived experience of drug use, socio-economic background, and life history.

When the teams get ready and pack the vehicles to get out for the day, the peers are the ones that are lagging with stuff around, and the non-peers are waiting for the peers to do the work. (P25, manager)

Unspoken and non-negotiated power relations can bring several challenges to the workplace. The stigma around drug use can produce, for instance, a division within an outreach working team between those with lived experience and those who do not use drugs. This can translate into unfair work divisions that arise without a prescribed rule having been made.

The peer is not seen as a qualified person. Some complain about the peer not being very clean, or issues of late coming. Not because the other team members don't come late, but then if the peer does it, it becomes an issue. […] They are not seen as part of the contributing members of the team, although the whole programme is built around the peers. (P31, peer)

It may also be that the stigma around drug use intersects the relationship between peer outreach workers and other care workers with whom they need to establish networking relations, both within and out of their workplace. People who are already being stigmatised in their community, in the workplace again, may feel they are not received with dignity.

I think they (top management) are too busy to pay attention to us - Or maybe they don't want to? (P37 and P39, peers)

Lack of a formal educational qualification frequently couples with prejudicial perceptions around drug use generating a harmful view of peers as less capable of contributing to their programmes. Many peers have gone through the experience of repeatedly having their opinions diminished and dismissed. Often, this feeds a vicious cycle where peers keep their criticism and ideas for themselves, instead of bringing it to their superiors. At the same time, managers rely less and less on the staff's opinion for believing they either have nothing to say or have difficulties in expressing it.

In addition, managers, and especially field coordinators or site managers, occupy challenging positions in a harm reduction programme. They must act as a buffer and a

bridge between higher-level management and the staff working on the ground. They must attend to the demands and needs of both while complying with organisational rules and policies, as well as donor demands on targets. Managers must communicate clearly and effectively with both sides, handle tensions, and act as a mediator. A manager who understands the outreach team but cannot defend it or communicate its needs to superiors will eventually find him/herself amid distrust and tension.

> ***You'll find people in the team that's going to say, "Those people they don't want to listen to us, and they never do anything that we say." Then, if you go and look, they never actually approached anybody and said, "Listen, I've got a problem here and there." They will gossip and complain among each other, but no one will bring it to management's attention. (P27, peer)***

The complex role of a manager requires preparation and support, especially when the staff in question does not have previous experience in their roles. It is good practice, for instance, to have former peers in the role of a field coordinator. However, a peer without previous management experience will need support to handle the pressure of being responsible for a team, having to communicate with different organisational levels, and having to deal with becoming an authority.

Programme transitions and adaptations

Harm reduction programmes often undergo changes and transitions. It may be a shift in funding and consequent modification of service activities or targets; it may be a new management position or new rules and policies that ask for staff adjustments. While some changes may be experienced as positive, frequently, a need for change causes tension and doubts. A few concrete examples:

- The previous manager was flexible with the work starting time. Outreach workers could arrive at the office anytime between 8 and 9 AM if they left for outreach at 9. The new manager finds punctuality necessary and suddenly wants everyone to be at the office at 8 AM. Outreach workers cannot see the point of this policy and perceive it as repressive and mistrustful towards them.
- A new funding stream requires new monitoring systems and asks outreach workers to adapt to new ways of collecting data. Staff appreciate the new system but still find it hard to change their ways of registering their activities. They also question to what extent that will bring more insight into their work.
- New management has a different vision on how to approach the population in the field and pushes for ways that are distinct from what the outreach team has been carrying out for years and is satisfied. Outreach staff feel that their expertise and value are being dismissed by the management and fear they will lose clients with the changes in the fieldwork.
- New management brings in new partnerships that allow referring harm reduction clients to HIV, TB, or HCV treatment. This also requires outreach workers to change workflow and messages they deliver to clients. Staff is enthusiastic about the new possibilities but cannot understand the reason for the new workflows or explain them to clients. They fear this will be prejudicial to clients.

Even when changes intend to improve the programme, they may be perceived as going backwards. This could be either because people do not understand the reason why changes are being made, or because these changes are indeed not suitable for the staff or the service users. Clear communication and meaningful involvement of staff and peers are crucial in any change process. Top-down decisions are less likely to be embraced by staff

- Most of the solutions that we are trying to implement to the problems we have in South Africa are not locally invented; they are brought from somewhere.
- They are imported and are not tested. "It's a good idea, it should work", so it's just thrown in, and it's supposed to work. Then, unfortunately, without the understanding of the way people think, some of these things won't work. They are excellent, but not within the framework of thinking of this particular group of people. (P30 and P31, peers)

than decisions which are jointly made or count on staff input. Moreover, any new policy or technique must be adapted to the context in which it will be implemented to stand a chance of being useful.

Transitioning from service user to staff

Several peers working in harm reduction programmes went through a transition from being a service user to becoming a programme staff member. To many, this included several life transitions as, for instance:

- from living in the streets to living in a shelter or house
- from having to beg for money or making money illegally to receiving a salary
- from being able to determine their schedule freely to having a fixed one
- from being able to choose with whom they wanted to bond daily to having to deal with colleagues, they might not connect well
- from determining when and where they want to engage with drug use to having to coordinate the use and work obligations
- having to learn different forms of communication to operate as a bridge between the streets and the workplace
- from relating to programme staff as a service user to referring to them as colleagues
- and finally, from being a peer in the community to becoming their service provider.

I think peers especially need a lot more support. You get a guy and train him as a peer. In the beginning, he's motivated; he's on methadone, clean for the first three or four months, got a job, things are starting to work out. Then things of the old life that he's forgotten now start coming back, and he doesn't know how to deal with it. We've been out of society for so long, and we've learned a new way of life. To start doing that thing again of a 'normal life' as you want to call it, it's not easy. Some of us have forgotten how to. (P28, peer)

Life transitions frequently lead to feelings of fear and anxiety, which can contribute to relapsing into escape behaviours in search of relief. One of such behaviours can be uncontrolled drug use. Similarly, social stigma and discrimination, or distrust and suspicion from family friends and colleagues, may increase the possibility of relapse (37). In this context, service users transitioning to staff must get adequate support.

When shifting from uncontrolled to controlled drug use or starting to use methadone, people may become (more) aware of their physical and emotional pains. This might be challenging to handle without support. It may be that people have difficulties relating to others outside a drug-using scene and become isolated; they may have problems managing their budget, their house, or living alone. They may need re-learning to care for themselves and their peers while respecting their boundaries.

What we've learned is that everyone needs supervision. A lot of them are not in a place where they can handle exposure to the environment. Even if they had a prior engagement with OST and recovery and they're doing well. The consideration is how much the environment is going to impact that. (P2, manager).

Step-Up outreach team in action, Port Elizabeth. Image © Mainline

RECOMMENDATIONS & DISCUSSIONS

Pay attention to recruitment

Recruitment is the entrance door of a programme. A well-thought out recruitment process is fundamental to creating balanced and healthy work environment.

Involving staff

It is a good practice to involve both peers and managers in all steps of the selection process, from defining profiles and participating in job interviews and final selection of candidates. Peers can, for instance, be part of an interview panel, pre-interview the candidates, show candidates around the service or perform a "practical test" with candidates in the field, and feedback the board with their impressions (8).
When recruiting, harm reduction programmes must pay attention not only to the desired profile of peers but also of (peer) managers. Defining the desired profile and skills of new staff is a crucial task which must include both peers and managers.

Defining the profile of peers

Participants interviewed in this guide defined that an outreach worker must be:

- Able to connect with people who use drugs.
- Able to communicate in a clear and non-judgemental manner.
- Show that they are street smart.
- Able to demonstrate compassion for helping others.
- Able to demonstrate a good understanding and support for harm reduction.

Based on these criteria, it follows that having lived experience of drug use is not an absolute necessity to be an outreach worker in their view. Indeed, a mixed team involving peers and non-peers is recommended (8). Having people with different expertise and background helps to build a balanced team with a broader view of service users' needs and possible activities.

Drug use experience helps to understand people, and from the client-side, they relate more to outreach if they have experience. Some things you cannot learn from a book, you need experience. (P14, peer)

Most participants, nevertheless, affirmed that people with lived experience bring a much needed and specific added value to the team. When jobs are advertised, it is crucial that calls for applications clearly state that PWUD can apply.

People with different experiences on drug use and treatment will bring varied contributions to the programme. Peers who are currently using drugs, for instance, have the advantage of retaining close contact with developing networks of users and can approach these groups with greater ease. Those who have quit drug use and are engaged in OST may be better equipped to support people to manage their treatment and their relationships with prescribing doctors (8). Considering that options for drug use can change, it may be useful to check with candidates how much thought they have put into the environment that they are going to be working in and the potential impact that can have on their lives. Another essential feature is to what extent peers understand their own triggers for drug use. Finally, both for staff with and without lived experience of drug use, it is recommended to map the support systems they have (or miss): are they alone? Do they live in the streets or a

shelter? Do they have contact with family? Such mapping can serve as a basis for the organisation to systematise the needed support for future staff.

Defining the profile of managers

The profile of peer managers and higher-level management should also be carefully designed. People managing harm reduction programmes must have the openness and the breadth of knowledge to have honest conversations with staff who uses drugs without judgement. It is recommended that a manager has a good understanding of harm reduction, fieldwork, drug use, and drug dependence. It is good practice for a manager (both peer and programme manager) to join fieldwork with the outreach team periodically, for instance, once a month. This allows managers to follow the work development, and to be in touch with peers and better understand their needs. It is also fundamental that the manager has excellent communication and people management skills to be able to help a team cohere and work well together. Some skills, of course, might be developed along with the function, and non-experienced managers may need organisational support for that.

The selection processes

The selection process for peers and peer managers can be external or internal. When an organisation has many peer volunteers, for instance, it may wish to give them the chance to compete for a vacant position. One way of doing that can be by having "training posts". These can help people bridge the gap between volunteering and employment. Training positions can be created from vacancies, and sometimes it is possible to create two part-time training positions from a single, higher-paid, full-time job (8). Regardless of the path chosen, the process of developing and appointing peer volunteers or peer outreach workers needs to be transparent and fair. This can help to avoid misunderstandings and conflicts between hired staff and their former peers, who will now become their service users.

Offer diverse engagement levels

Staff may be willing or able to engage in different levels of commitment to work. Personnel transitioning from a service user position, for instance, may be facing various life adjustments. Those with limited work experience in the function will have to undergo an intense learning process . Others may not be ready to work eight hours a day or to act as a service provider in the same communities in which they were living or using/selling drugs. Stepping gradually into work might be a way to go through these adaptations in a safer and less harmful pace.

The establishment of different levels of engagement with work creates opportunities for PWUD to progress through the organisation while respecting their possibilities and needs at a given moment. Low-threshold employment is also an excellent alternative to illegal forms of income generation in which peers may engage (39). Listening to suggestions and ideas from staff is the best way to create successful options for full-time employment/ engagement when needed. A few ideas collected during this assessment are described and discussed below.

Part-time, ad-hoc and volunteering work

Offering full-time, part-time, ad-hoc tasks, and volunteering opportunities allow people to step into work gradually, and to shift between levels when needed. Supporting staff in each of these levels is crucial to strengthen their development in the workplace.

A full-time vacancy can easily be transformed into two part-time ones, where staff can either engage four hours a day or certain days a week only. For some people, fewer

working hours may be more manageable and could be more productive than a full-day schedule. Another possibility is to have working hours that are more suitable for service users and staff. It may be, for instance, more effective to work from 10 am to 6 pm rather than a typical workday from 9 am to 5 pm.

Another example of lower-threshold engagement could be programme "satellites" or "programme friends". In this model, peers who work from their homes, who sell drugs, or who make their homes available for people to use drugs could be paid to run community sites. These secondary sites could provide needle and syringe services and other materials such as self-testing kits. Besides being an excellent form of involving peers, satellites are very useful in providing information needed to engage PWUD in care (40,41). One could also consider the "gatekeeper" model, using people (who may or may not use drugs) who live or have their businesses in or close to drug use hotspots. The gatekeepers act as a distribution site for harm reduction commodities (needle and syringe services, condoms, etc.). The prime organisation should maintain regular contact with these sites in case of medical emergency and should monitor them for human rights violations. Harm reduction programmes from Kenya, Tanzania, and Indonesia funded by Mainline already collaborate with gatekeepers.

Ad-hoc or volunteering for specific tasks are other alternatives. This could help in the daily process of harm reduction services and could include, for instance, helping to clean or maintain the facility, taking care of service users' laundry or food in a drop-in centre, or collecting donations for the service. In Pretoria, for example, the harm reduction programme has developed a weekly rotating scheme where peers take turns to cook and clean in exchange for payment. It is also possible for organisations to invest in other activities that support the community, and, in addition, help create a positive and visible presence. This could include collecting needles and syringes, collecting trash, or engaging in community projects. Daily activities allow people to get pocket money that supports their daily needs and at the same time, offers structure and decreases the risks of engaging in illicit income generation (42).

Here they can learn to get up early, be in time for work in the day, every day. I encourage them not to use [drugs] during the cleanup; do their thing either before or after. Not everyone can at first […] There's no one shouting them around or forcing them to do something. As time goes by, they will be here earlier, and they won't be using during these two hours (P4, peer).

In Cape Town, a swiping team called Clean-Up project employs two groups of four PWUD each to work for two hours three times a week. They get paid 60 ZAR (~$3.50) each per day, and an additional 180 ZAR (~$11) at the end of the week. Peers are provided with breakfast before leaving to work, and once a month, they are offered toiletries and clothes. The income generated with the Clean-Up project helps participants to support their basic needs and allow the purchase of necessary items such as shoes, or a new backpack. Moreover, the activity gives a reason to leave known environments and roles for some time and experiment with new functions and tasks. The activity also helps to bring stability, control cravings, and opens opportunities to partake other support groups.

Providing food and transportation for ad-hoc tasks and volunteers is often a requirement. Keeping a low-threshold between volunteering and ad-hoc duties or part-time work can also facilitate shifts when necessary.

A challenge for part-time workers is a limited income. One possible response is diversifying the funded activities in which PWUD can partake, so that participants may increase their part-time working hours.

Clean up project, Cape Town. Image © Mainline

Diverse payment arrangements

Managing finances can be challenging for peers who are not accustomed to receiving a salary and for those who are still struggling with controlling expenditure on drug use. Special arrangements for payment as well as mentoring and training on financial management are good practices to overcome these challenges and should be done in consultation with peers. Those with more flexible working hours, who are following a lower engagement level scheme, who are just starting to work, or who are still in a situation of homelessness can be paid in cash daily. This allows the person to have enough money for daily needs such as transport, drugs, and food while helping to prevent excessive expenditure. Gradually the payment can be done weekly and monthly, according to staff needs and the strengthened self-organisation. It is also possible to pay staff half of the daily amount per day in cash and the rest as a lump sum through a card system at the end of the month. This helps staff to manage finances and save money during their first months of engagement while having enough cash for daily needs.

When it comes to money, is difficult. I did not have a bank account, and I did not have an ID. The first month I was paid wages daily. The second month, they started giving me a weekly salary. Then I got myself a bank account, and with that, by the fourth month, they began to pay me monthly. I give credit to [mentor] because he showed me the ways to survive. A month has four weeks, so he told me to divide my money into four weeks. I paid my rent, bought my groceries, and divided the rest of the cash in four weeks. I survived. […] That was slowly. My life has changed drastically, and I love where I am right now. Having ownership of your life again. (P28, peer)

According to the peers consulted for this assessment, non-monthly payments should not be carried out for too long in case of full-time employment. People need to be able to engage in usual societal activities that require monthly fees, such as rent, schools and other bills. Such engagement also helps to build ownership and accountability for oneself.

Forms of contracting

During the assessment, a few managers and peers recommended flexible contracting as a way of handling staff difficulties in engaging with full-time work, including absenteeism

Now because there is such a high rate of absenteeism and non-delivery, I think the best would be the consulting agreement because I think that would motivate them to deliver the work. Otherwise, they won't get the salary (P26, manager).

and lateness. They suggested that individuals are offered contracts where they would be paid only for the actual worked hours.

Flexible contracting, however, has critical side-effects, which were also acknowledged by some management respondents. Most importantly, this sets staff who is already in a vulnerable position into further work precarization (43,44). With flexible contracts, workers lose benefits such as medical aid subsidy, contribution to pension funds, and life group cover in case of accidents or deaths. While this might not be a problem for consultants with a higher hourly rate and a competitive profile in the work market, it certainly brings peers with low education and work experience in more precarious positions.

We must also know that we are a drug user or an ex-drug user. That's our CV. So if you lose the job that you are having now, I don't think you are going to find another one (P37, peer).

In addition, having non-stable contracts does not necessarily make workers more committed, nor does it improve job satisfaction or subjective wellbeing. Instead, it increases job insecurity (45). In a context of job dependence (a combination of lack of employability and economic need), this may lead to less job satisfaction and commitment with the organisation, and may enhance the intention to leave (46). Moreover, unstable contracts contribute to the creation of problematic situations within the family and private life (47) and may lead staff to feel less valued than workers who have stable contracts. The challenges that peers face in work engagement require more sophisticated solutions including stable agreements that cover staff needs and offer social security. In case of difficulties with adapting to work, providing staff with support – guidance and mentoring, and psychosocial support – is good practice.

Support staff at different levels of engagement

A harm reduction programme can support its staff in each of the different levels of engagement. It can promote workplace wellbeing at each level, help staff grow to higher levels of engagement, or transition to a lower level when needed.

Once the staff is hired, induction training can be used to ease the process of starting employment. It can clarify the values of the organisation regarding employing and meaningfully involving PWUD, policy on drug use in the workplace, the rights and support systems PWUD can count on, any options employees can choose from (e.g. pension funds), and any standard procedures adopted in the workplace. This can help staff to be aware of, and to (re)evaluate their commitment and agreement to the organisation's values and norms.

The *probation period* can be used not only as a "test" but also as an opportunity to help the worker to adjust to a new environment. During probation, the organisation can offer training, peer-mentoring, and promote an environment of understanding and support rather than punishment.

To help staff transitioning from a service user position or those with less work experience, the organisation can provide soft skills training. These can be related, but not limited, to accessing medical scheme benefits, opening a bank account, having a tax reference number (required in South Africa for employees), and personal finances management. For staff in all engagement levels, useful training may be on communication skills, conflict mediation, self-defence, time management and goal setting, and stress management or basic mental health skills. Finally, to promote transitioning to higher levels, organisations can develop a career plan, scaling up remuneration and tasks according to staff capabilities and aims.

Promote a harm-reduction approach to drug use

Sometimes harm reduction programmes fall into a prohibitionist approach towards drug use among staff, fearing that drug use will affect staff's performance or the organisation's image in the community. Ensuring job performance and the right image are essential and should be pursued, but prohibitionist regulations or punishment for drug use are not necessary.

Develop non-prohibitionist regulations

Employer-led mandatory urine testing to identify PWUD, for instance, is not recommended (35,37). It is not adequate, as it confuses drug use with problematic drug use. It is also counter-productive, as it undermines working relationships and the trust between management and staff who use drugs. It is best to identify problematic drug use through self-disclosure, which requires a supportive and respectful workplace.

Maybe you're not performing because you're using. Perhaps you're not performing because it's something else. Maybe there's different stress there, and that's why you're using more, and that's why now you're not performing. Doing urine testing makes it all about the drugs and not about the person (P24, peer)

Having a harm reduction approach to drug use among staff does not mean dismissing regulations. The existing guides recommend, for instance, forbidding staff from using, purchasing or selling drugs during work hours (35,37). Similarly, staff should not accept, request, or purchase drugs from clients (during working hours).

If you need to use something to be functional, so you can work up until we go home, and there's no way you can push up until 4:30, then you can use it [drugs], but not in public, and not in uniform. (P23, peer)

A general rule for all may result in problems of interpretation of different cases. Negotiations and arrangements are recommended if they respect two essential threshold points: staff readiness to work and the reputation of the organisation. Personal arrangements should made for staff who cannot undergo eight hours of work without substance use (35).

It's about the manager knowing, okay, three times a day or four times a week; the staff member needs to, say, go for 10, 15 minutes […] do their thing, and come back when they are ready. You do not want them absconding for long periods or feeling that they must flee to do it. We need transparency and not that kind of underlying secrecy. (P2, manager).

Existing guides (35,37) and participants agree that staff needs should be adapted to the work environment. Some staff may need to use their substance of choice before starting their work shift. When using a substance before working hours, staff should not be intoxicated to a level that interferes with their work performance. Most participants agreed in allowing use of substances where staff could not manage long periods of abstinence. This, however, was not consensual.

If someone is found to be using any illicit substance in the area that we're working, the office space, that would be addressed through a disciplinary process. […] If someone used before working hours and they are in a position where they can perform their duties for the day, then that's fine. (P25, manager).

A challenge when staff uses illicit substances during working hours is to determine where the use can take place. Given the illegal status of drug use in South Africa, it is not recommended that staff uses illicit substances at the office. It could harm the reputation of the organisation and could create conflicts among peers. Even when using drugs outside working hours, a question is whether staff may use with or purchase drugs from service users. The Alliance Guide (37) states that it is inappropriate for workers who use drugs and their clients to use or buy substances together during work hours; no restrictions

In my opinion, peers should be able to use it here, somewhere safe within the work environment, in an area where people know that they're using in case something goes wrong, but we're not there yet. We won't have a policy like this because it's illegal. In a perfect world, there should be a consumption room for staff (P24, peer)

These clients, they are your clients today, but when you are off, they are not your clients, they are your friends. […] You won't lose their respect for using with them. The point is that you must do what you preach (P28, peer).

or recommendations are offered for outside working hours. During this assessment, opinions on this matter were also divided. While some agreed with limits in the work setting, most peers thought that a prohibition on using with or purchasing drugs from service users was unrealistic, as service users are their long-term friends. Practising harm reduction while using with service users was perceived as more critical to maintain credibility of their services. This could mean, for instance, never sharing instruments, and practicing safer drug use rules when using with clients-friends outside working hours.

Focus on job performance, not on drug use

Peers are hired for having lived experience of drug use and to promote a harm reduction approach towards drug use. Therefore, it is not recommended to punish staff for drug use. The focus, instead, should be on work performance.

It's about how the company is not discriminating against substance use. We know many people use substances, even high-level people, but it doesn't affect their ability to do their job. It's crucial to say that. (P2, manager)

Through the development of individualised support strategies, managers should empathise but not compromise the effectiveness of services provided by staff (37). In this context, the primary objective is supporting workers to achieve self-management or abstinence (whatever their preference), or otherwise manage their drug use in a way that does not impact negatively on their work performance.

Promote and support self-management

The capacity of self-regulating drug use is widely acknowledged among PWUD and in the literature (e.g. 48–51). A central study by Zinberg(52) analysed how some people managed to use heroin in a non-dependent and controlled manner. Zinberg introduced the concepts of the *drug, set* and *setting* to explain that the effects of a drug in someone's life depend not only of the chemical properties of the *drug* itself but also on one's behaviour and mind*set,* as well as one's context (the *setting*). Of these three factors, Zinberg found the context to be the most important for self-regulating drug use. This means that the context found during fieldwork can indeed trigger desires of using drugs for some staff in specific periods. Similarly, it means that staff life's context is essential in this regard. At the same time, it also implies that both social and organisational support can play fundamental roles in helping staff to achieve and/or sustain regulated drug use.

We are faced with it every day. The temptations are there, the trauma and the things that you see tend to give you an excuse to start using again. Many peers do fall back after methadone and start using again. Some of them get their control system right. They're on methadone, and now and then, they're still using. There's no quick fix; it takes years. (P27, peer)

Harm reduction programmes can provide, for instance, a peer support or buddy programme, where more experienced peer staff can help colleagues to manage their drug use and work. For some peers, for instance, simply being paired to work with a non-using staff can act as a protection against triggers. It may help drug-using workers not to think about the substance while facing drug scenes in the field. Providing psychosocial support in groups or for individuals are also good practices helping to promote self-care and mental health. Staff who uses drugs can also be provided with tools to help to evaluate the risks they are facing, so to improve awareness. Alliance (37), for instance, offers a risk assessment tool where staff who use drugs can evaluate their risk related to personal/professional boundaries with peers/clients, the chance of getting into debt with suppliers, or risk of arrest on outreach or when buying drugs. Any evaluation of risks should be followed by a plan of action in case things develop in an unwanted way.

Another recommendation is to develop an emergency/rescue plan with peers at the beginning of employment. Managers can make agreements with peers on how they would like to be helped in case things get out of control, and act on that agreement when needed. Such a plan includes identifying resources to support the peer get back on the track if they wish. In a moment of crisis, the person gets into a position where they are unable to think clearly; a crisis plan can be helpful. It is essential to be open for different types of strategy: it could include help in finding treatment, but it could also be a "leave me alone and let me use" plan.

Most importantly, staff should be offered open dialogue and a non-judgemental environment where they can get to know themselves and the triggers leading to uncontrolled drug use. Workers must be supported in understanding their limits and without fearing for their job security. Only with an open and non-judgmental environment will staff be able to seek support and guidance from colleagues, management, and organisation at an early stage.

Foster a supportive and safe work environment

My manager is fantastic. The fact that she supported me through everything and that she's willing to try always is good. She continually reminds me that I'm an asset, that I add value, and that is great. (P24, peer)

Be appreciative and promote trust-building

A healthy work environment is an environment where staff can feel appreciated for their efforts and contributions. Being appreciative of staff does not mean ignoring their problems or failures. It is always possible to acknowledge staff's effort and to provide constructive feedback where needed. An open-door policy where peers can reach out to anyone in the organisation is a good practice. However, such open-door will not be effective if there is no trust and if peers do not feel appreciated. It is challenging to build such an openness amidst punishing policies and judgemental attitudes. In such cases, peers might not share their problems or needs for being afraid of reprimand or judgement, or for thinking that their needs will not be heard.
When problems arise, managers should first provide support measures before applying disciplinary rules. The easiest way to know why a staff member is not performing by directly asking him/her what is going on.

It is difficult for people to just trust; that you must earn overtime, and you need policies that enable people to trust. […] We should create an environment that makes it easier for peers to come and say, "I have a challenge". (P22, manager)

Based on an open conversation, managers could establish agreements for regular check ins with staff. Direct discussions with staff will promote trust-building. Building trust involves treating staff with dignity and respect, listening to and addressing their concerns, and working with them throughout the process of developing and implementing an intervention (38).

Managers, and especially those who become field managers after working as peer outreach, also need to be supported in their function. Besides having to manage and support peers every day, they must do the planning for the week, be involved in supplementing data, and respond to different levels of the organisation. The level of responsibility increases, and the tasks become complicated. However, most peers assuming peer management function do not have previous management experience.

You go from being a peer to suddenly being on the edge of peer responsibility, but no one's taking the time to tell you what that responsibility is or to coach you through it. (P2, manager)

The same support given to peers needs to be given to the managers of those peers, to help them to keep perspective and reflect on themselves. […] I've seen people who use drugs to lose their jobs because their managers have stopped managing them with care have just given up. They got frustrated and started sabotaging what could be a good relationship with a peer (P1, manager)

Being a peer manager requires not only having a good understanding of fieldwork but also having the skills to manage people. Non-experienced peer managers need support and close mentorship to learn how to communicate to avoid misunderstandings and hurt feelings, understand and sail through human resources processes, and perhaps also to learn office skills such as computer skills and data management. Moreover, they need team building and psychosocial abilities.

Providing high-quality materials, HarmLess project, Pretoria. Image © Mainline

Provide good work conditions

Peer outreach workers require good work conditions, complemented with enough relevant, and high-quality material. They must be provided with:

- Enough and high-quality materials to deliver to clients, such as tourniquets, cooking pots, syringes, and hygiene packs (containing soap, toothpaste, cloth, razors, sanitary pads, and sanitizers).
- Quality equipment to carry material to the field, respecting the occupational safety and health standards.
- High quality and regular training on risks and risk mitigation related to their work.
- A salary compatible with similar functions in other organisations in the field.
- An office reporting can be done, or peers can leave their belongings when going out to the field. Ideally, they should also have access to computers to capture data, prepare for group meetings, and communicate with others.
- Proper protective equipment to work on the field, including adequate gloves and instruments to handle contaminated material and protective shoes.
- Proper uniform, appropriate to the weather, for instance, hats for warm weather and jackets and raincoats for cold and wet weather.
- Adequate transport to reach the places and populations where peers work.
- Easy-to-use tents or gazebos or mobile vans for outreach, both as shelter from weather, but also to provide privacy when conducting HIV testing or screening or other services.

Support workers' self-care

Due to their work and perhaps personal choices, staff with lived experience of drug use might be more susceptible to infections from viral hepatitis, HIV or TB. Employers should consider prioritising peer workers for immunisation, when available, as a health protection measure. In addition, staff should be trained on TB prevention, and provided with post-exposure prophylaxis (PEP) where necessary (37). *Staff should be given priority in OST access if they opt for therapy.*

Treatment centres have different models of operation. Staff who use OST may benefit from take-home doses and less frequent dispensing arrangements. Nevertheless, OST often adheres to strict dispensing hours, either daily or frequently and from a fixed site. This may affect staff ability to be at work on time and can be addressed with flexible working hours (8).

Similarly, for HIV, TB or HCV treatment, staff may have to take medication or go to appointments during working hours. They might need to adapt to medicine and be unfit to work during the dose adjustment periods. For OST, for instance, dose adjustment may result in staff being sleepy during working hours. The organisation can support staff by:

- Having flexible working policies, including working from home or flexible hours when needed.
- Agreeing to allow for all or some of the health care appointments to be covered during paid hours.
- Providing health insurance for staff.
- Understanding temporary performance problems caused by side effects or dose adjustments.
- Supporting people who travel abroad in continuation of OST. This can be done by linking the individual to another OST site.
- Offering alternatives -- together with the human resources staff -- in the case of excessive (sick) leave. This could include offering reduced working hours, or the possibility to work from home, or even a period of (paid or unpaid) leave.

Besides health care, peers may have other basic needs, such as shelter, housing, or food security. The organisation can help by assessing these needs and partnering with shelters and social housing programmes, or food bank programmes.

What helped when I started working was the fact that we had a place to stay. If you're staying on the streets, it won't work. Most guys fail because they can't stay on the streets and maintain methadone and work at the same time. They will still need the drugs, and that's where the problem comes in. (P27, peer)

Shelter and housing are crucial in reducing substance use and its related harms, reducing stress and improving quality of life, personal safety and social inclusion (53–55). Housing first programmes have proved to help participants to develop healthy routines, healthier eating and stable sleeping patterns (56).

Reduce the harms related to police harassment and criminal involvement

Given the illegal status of drug use, PWUD are criminalised and often targeted by the broader community and the police. Police may target specific areas and are often unable to differentiate employed peers doing outreach from the clients. The employer must protect peers if they are harassed or arrested for carrying out their duties (e.g., carrying substance use

When our teams go out, we must get a letter from the municipality to cover them up. To be found with medical paraphernalia, it can be a crime against the medicine control act. (P22, manager)

material, engaging at a drug scene). Properly identifying outreach workers, arranging permission to carry materials, and developing suitable strategies to work with the local police (57) are good practices helping to prevent these incidents.

It should be noted that several peers may not have personal identification papers at the start of work. The employee can provide support to arrange documents when necessary. Some peers may also engage in criminal behaviours, based on a variety of reasons. They may engage in sex work, or commit a crime such as stealing money, equipment, or possessions, either from the office or outside the workplace. The employer should focus on the effects of the action on the reputation of the organisation (37) rather than on the actual crime. In case the act has caused damage, this should be assessed within the disciplinary policies of the organisation.

Peers might also be arrested for non-work-related crimes they have committed. The organisation can support peers during this period and also receive them back to work once they leave detention (35). Once back, staff can be offered counseling to reintegrate and debrief on their time in prison.

Provide and foster mental health care

Providing and fostering mental health care in the workplace is essential for a healthy and productive work environment. Mental health complements all other recommendations in this guide. Excellent mental health support can help peers to assertively deal with transitioning phases, internalized stigma, drug use, personal and professional boundaries, and work stress.

Psychosocial support groups for clients and Step-Up outreach team, Durban. Image © Mainline

As it is common for care workers, also peers tend to be very concerned with service users' needs. This might be exacerbated for peers, as very often they know their clients from before: from school, the neighbourhood, or the streets. Peers are frequently long-term friends and care about each other. Often peers tend to worry about service users more than about themselves, which may lead to crossing personal and professional boundaries and to mental health distress.

Debriefing sessions or other types of psychological/mental health support can be beneficial to help the peer learn how to deal with stressful situations. Programmes can offer psychosocial support, have a psychologist, or a trained counsellor to provide sessions for debriefing. While some staff may find it easier to talk about problems and challenges in a group, others prefer an individual session. Group sessions are essential to build team spirit and to foster good communication within the team. A good group counsellor should be able to manage different types of people. Nevertheless, individual sessions can be instrumental in handling more specific problems. When possible, various options should be offered.

I didn't see what I could bring to make a difference in somebody's life. And I was scared because I stopped using and was on methadone. I was worried that I was going to be tempted and would have easy access, so I was paranoid. And this guy [counsellor] had a very different way of thinking. He was like, "No, the fact that you are worried about it shows that you are aware". And once I was out sitting and talking to the guys, meeting people that I knew before, I could see that I was playing an important part. He helped me to see that (P30, peer)

An important point to note is that the main focus of psychological/professional support should be to provide staff who use drugs with the chance to reflect on their experiences, to manage their wellbeing, and to develop and strengthen their work performance (37). In any type of mental health support, the privacy of staff must be respected. Offering mental health support from an external provider, not directly linked to the employer, can help workers to trust and open about challenges.

I'd say, a peer would need sort of a peer as well to look after him. Just somebody that's maybe more experienced that has made it work, a next level if I can call it like that. (P28, peer)

Some peers interviewed for this assessment found essential to have a colleague peer as a mentor to deal with work challenges and to help with the transition from being a service user to programme staff. The fact that mentors had gone through similar life experiences, including having lived experience of drug use, was considered very important by these peers. For others, having lived experience of drug use was not an essential requirement for a counsellor, but valued the space to reflect.

Periodic debriefing group sessions are also essential to support the outreach team in coping with their field work experiences and should be offered at least once a month.

Besides being offered groups and individual sessions for mental health support, staff should also receive education on mental health. That will benefit the staff and support their work with service users. Training could include burnout prevention, stress management, and understanding symptoms and ways of dealing with primary mental health problems such as depression, anxiety, and paranoia.

Build and sustain boundaries

Establishing professional boundaries is important in the care field. Boundaries help to protect staff from unnecessary conflicts and emotional burdens. The proximity with peers can add an extra complexity to work, leading to inappropriate relationships and over-investment of emotions.

Sometimes we get too attached to a client. You want to help the person who is having problems. At the same time, you have your problems, but then you don't take care of it. (P38, peer)

Over-investment can lead to burnout and may allow the peer to cross personal and professional boundaries. There must be space to talk about such challenges when they occur and to help peers to reflect on how to manage the situation.

It is about having the consistency not to allow the line to blur. Like, the staff is using and comes to the manager and say, "I just need 20 Rands, or this happened with my landlord, and I need deposits and please, please, please". I have seen such situations, and it didn't work. Managers need to meet these boundaries around money, personal time, and crisis management (P13, counsellor).

If they've set their boundaries, they will better follow and stay with those boundaries because they've been engaged in creating those for themselves. (P25, manager)

Similarly, peer managers might over-inv\est and cross professional and personal boundaries when trying to help peers. Managers may, for instance, lend money to peers or frequently resolve issues during the weekend.

Building and sustaining boundaries also relate to being transparent about work policies and regulations and how they are applied to all staff equally. Keeping a clear line of communication about rules and consequences is essential to build and maintain trust within the staff group.

When building boundaries that staff will need to comply, it is fundamental to involve staff in the making of the rules.

Promote diversity and respect within the team

HarmLess outreach team, Pretoria, and Mainline staff, having a break in between site-visits. Image © Mainline

It is essential to promote a respectful, open and trustworthy environment within the team. Unequal power relations and stigma among staff need to be recognised and addressed through discussions. It can be useful to rotate tasks and functions where possible. It is good practice to provide all staff with enough time to explore and learn about drug use and drug-using scenes especially in a mixed group comprising people with lived drug use experience and others. This can help to build understanding and cohesion (37).

A diverse outreach work team is a richer team. Active users, ex-users, people on OST, people who live with HIV or HCV, or TB, all have specific life experiences that can be helpful when building a programme and relating to services users in the field (35,37).

The sessions helped to bring the team together. It also showed how to approach situations differently, because sometimes our approach would conflict, so what would work for me would not feel right for another person. (P37, peer)

It is also essential to recognize and value the differences within the team. Some peers, for instance, might be very talkative and active, while others tend to be quieter and are more sensitive. Very often, the chatty and enthusiastic staff tends to be considered more engaged and might be given more opportunities for growth when compared to introverted staff. Nevertheless, quieter workers might be excellent listeners. They may be the people whom clients will more often seek to talk about issues they have not been able to speak to anyone else. Each personal characteristic has its added value, and both benefits and differences must be acknowledged and respected in the team.

Team debriefing sessions can be a helpful way of clearing up and improving communication and mutual respect.

People must listen to what we have to say, whether they're going to use it or not. Sometimes, we think we have brilliant ideas. Sometimes we do, sometimes we don't, but we like to be recognised. That makes a huge difference. It motivates a person. (P27, peer)

Team investment can also be promoted in different ways. One example is physical team building, joint and fun activities the team, such as a game or a barbecue. Another is working on communication and a joint understanding of how to build and behave as a team successfully. Staff can also be trained in communication and conflict resolution. Finally, it is important to build a shared work vision, so that everyone is on the same page regarding what the team must strive for and why.

Promoting meaningful involvement

Meaningfully involving staff encompasses all other recommendations in this guide, for it is crucial to engage staff in decisions and policies. Meaningful involvement starts with an open and frequent recognition of peers' value for the organisation and of peer's ideas on how to run or modify it.

It is essential to have frequent meetings to get staff input on all levels of programmatic decisions, ranging from planning to development, and budgeting and evaluation, rather than just focusing on service delivery or when needed to develop a new strategy in the field. Programmes can foster, for instance, the participation of peer outreach workers in "case discussions" of clients who are also on OST or other programmes. Peers can offer valuable input on new services, methods for reaching targets, or how to improve organisation of services to meet clients' needs. Input from peers can occur informally, during normal team meetings, or through specifically scheduled monitoring and evaluation meetings. Twice a year, for instance, a programme can design a team day outside of the office to evaluate the work, discuss a shared work vision, and plan the future of the programme.

Sometimes the people making decisions that are affecting the peers are unaware of what the peers are facing. What's overlooked is that the peers are the experts. The theories are not the expert; the peers are the experts and their observations, if channelled directly through, can have a high impact. (P13, counsellor)

Meaningful involvement and respect. Outreach team, Port Elizabeth. Image © Mainline

Good practices are already happening in South Africa and these must be fostered and disseminated widely. The StepUp project operating in Cape Town, Durban, Pietermaritzburg, and Port Elizabeth was developed through an intensive process of consultation and engagement with the PWUD community. PWUD contributed to the determination of the needs of the community, and continually engage in and evaluate service delivery, document and advocate against human rights violations of PWUD, and partake in national policy decision-making process, including the development of the National Strategic Plan and National Drug Master Plan (2,58).

Finally, it is essential to consider that some peers might have internalised the stigma and find it challenging to share their ideas, to fight for them, or even to ask for further explanation when something is not clear. Peers might also fear that their opinion oppose their manager's orders, which could lead to punishment or problems at work. It is vital to create an open environment where questions and constructive feedback are encouraged. When needed, the organisation should foster peers' preparedness on how to give feedback, how to express their ideas in a professional environment, and how to plan, monitor and evaluate a programme. This knowledge will certainly strengthen the programme's effectiveness and the professional development of staff.

SUMMARY OF RECOMMENDATIONS PER ACTOR

Donors

1. *Support non-prohibitionist policies on (staff's) drug use in the workplace*
2. *Fund psychosocial and mental health support for peers*
3. *Fund peer-led programmes*
4. *Provide room and enough funding for contextual adjustments of objectives and targets of local programmes*

Harm Reduction Services

5. *Pay attention to and involve peers in the recruitment of new peers and managers*
   5.1 Have clear statements that PWUD can apply for the job in vacancies
   5.2 Jointly develop clear profiles for peers and peer managers with the team

6. *Offer diverse levels of work engagement for people who use drugs*
   6.1 Try to fit the work to people's possibilities, and not the contrary
   6.2 Consider offering part-time work, ad hoc tasks, and adjusting payment if needed
   6.3 Offer contracts which contribute to staff's social and economic security

7. *Promote a harm reduction approach to staff's drug use*
   7.1 Develop non-prohibitionist regulations at the workplace

8. *Foster a supportive work environment*
   8.1 Provide good work conditions, including fair contracting, good and sufficient work material, health insurance, and mental health training and support for staff
   8.2 Provide training and support both to peers and peer managers

9. *Meaningfully involve staff who use drugs in the service*
   9.1. Involve staff in all steps of the programme, from conception to evaluation
   9.2. Hire and pay people who use drugs
   9.3. Foster organisational cultures that support the leadership and meaningful participation of peers

Management (field coordinators and programme managers)

10. *Promote a harm reduction approach to staff's drug use*
    10.1 Focus on work performance, not drug use, to evaluate staff's work
    10.2 Promote and support self-management of drug use for staff who uses drugs. Build a joint emergency plan, and act on it when/if things get out of control

11. *Promote diversity and respect*
    11.1 Invest in team building and excellent communication
    11.2 Promote trust and transparency in the team

11.3 Treat staff with dignity and respect, listen to and address their concerns, and work with them throughout the process of developing and implementing an intervention

12. *Promote a supportive work environment*
    12.1. Be appreciative of the staff and provide constructive feedback when needed
    12.2. Foster a culturally appropriated and non-judgmental setting at the workplace
    12.3. Support staff undergoing health treatment by accommodating working hours and tasks when needed/possible

13. *Build, sustain and foster the development of healthy boundaries in the workplace*

Teams (colleagues)

14. *Foster open dialogue and respect within your team*

15. *Support your colleagues*
    15.1 Engage in mentoring programmes to guide less experienced colleagues
    15.2 Provide advice and understanding to colleagues who fall back into uncontrolled drug use

16. *Respect your colleague's time*
    16.1 It might be frustrating to try to help when colleagues do not listen or change. Understand that it is their choice. Keep supporting and advising in a non-judgemental way.

Staff who use drugs

17. *Know and demand your rights*
    17.1 Report experiences of discrimination and/or stigma within your work environment
    17.2 Demand and participate in meetings to evaluate your programme and organisation, making leaders accountable for ensuring a respectful and healthy work environment

18. *Promote self-care*
    18.1 Know yourself, your triggers, and your limits, and respect them
    18.2 Participate in debriefing and mental health support sessions
    18.3 Do not wait until something becomes a problem. Seek support and guidance from colleagues, management, and organisation at an early stage

SUGGESTED READING

- **Balian R, White C.** Harm Reduction at Work. A Guide for Organisations Employing People Who Use Drugs. New York; 2010.
- **International HIV/AIDS Alliance.** Good practice guide for employing people who use drugs. 2015.
- **United Nations Office on Drugs and Crime; International Network of People Who Use Drugs; United Nations Programme on HIV/AIDS; United Nations Development Programme, United Nations Population Fund, World Health Organization USA forIDD.** Implementing Comprehensive HIV and HCV Programmes with People Who Inject Drugs: Practical Guidance for Collaborative Interventions ("IDUIT"). Vienna; 2017.

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