LA TROBE UNIVERSITY

Australian Research Centre in Sex, Health & Society

AUSTRALIAN RESEARCH CENTRE IN SEX, HEALTH AND SOCIETY

August 2016

What Works and Why (W3) Project

PWUD Peer Service Provision and Policy Participation System Logic and Draft Indicators

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Suggested citation: Graham Brown and Daniel Reeders (2016). What Works and Why – PWUD Peer Service Provision and Policy Participation System Logic and Draft Indicators, Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University.

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Introduction

This document provides a detailed description of the people who use drugs (PWUD) Peer Service Provision and Policy Participation system logic diagram developed in stage 1 of the What Works and Why (W3) Project. This work draws on a series of workshops conducted in 2014 with Western Australian Substance Users Association (WASUA), and supplemented by discussions with Australian Injecting and Illicit Drug Users League (AIVL) and Harm Reduction Victoria (HRV).

This document should be read in conjunction with

> Graham Brown and Daniel Reeders (2016). What Works and Why – Stage 1 Summary Report. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University. Available at www.w3project.org.au

The above report provides details of the project background, methods and the W3 Framework. An excerpt from the report is provided below.

> **Executive Summary**
>
> The Australian HIV and hepatitis C response is undergoing the most rapid change in decades. Community and peer-led programs needed a better way to demonstrate their unique role and contribution to achieving the goals of the National strategies, their capacity to adapt with the rapid changes, and the role of the HIV and hepatitis C partnership in supporting this role.
>
> Working in collaboration with ten peer-led community organisations, the What Works and Why (W3) Project used systems thinking and participatory methods to develop a better understanding of how peer-based programs work, formulated a framework to evaluate the role and contribution of peer-based programs, and developed quality and impact indicators and tools to best capture and share insights from practice. This involved a series of 18 workshops ranging from one to two days each with the ten peer-led community organisations working with gay men, people who use drugs, sex workers and people living with HIV. Some workshops were with single organisations and some with up to four organisations, and over 90 people were involved across the workshops.
>
> *W3 Framework*
>
> We found that peer-led programs are operating within and between two interrelated and constantly changing sub-systems – the community system and the policy (or sector) system. We found there are four functions that are required for peer-led programs to be effective and sustainable in such a constantly changing environment:
>
> - **Engagement**: How the program maintains up to date mental models of the diversity and dynamism of needs, experiences and identities in its target communities
> - **Alignment**: How the program picks up signals about what's happening in its policy / sector environment and uses them to better understand how it works and to achieve better synergies
> - **Adaptation**: How the program changes its approach based on mental models that are refined according to new insights from engagement and alignment
> - **Influence**: how the program uses existing social and political processes to influence and achieve improved outcomes in both the community and the policy/sector.
>
> The combination of these functions is required for peer based programs to: demonstrate the credibility of their peer and community insights; influence community, health, and political systems; and adapt to changing contexts and policy priorities in tandem with their communities.
>
> *Feasibility Trial of Indictors and Tools*
>
> We worked with nine of the W3 project partners to develop tailored indicators under each of the four functions, and then piloted a range of different tools for gathering insights against the indicators and functions with peer-led projects within seven organisations. The main aim was to identify what would be feasible within the resources of community and peer-led organisations.

Generating System Logic Diagrams for Peer Based Programs

The W3 Project applied a systems thinking approach that conceptualises peer based programs, and the communities and policy environments they engage with, as complex adaptive systems. We held a series of workshops with each of our partner programs to map out the complex flows of knowledge and influence that underpin their effectiveness within their target communities and policy environment. The result was 'system logic' diagrams that were used in conversation with partner programs to identify four key functions at which a peer and community based program needs to succeed in order to be effective (W3 Framework – see www.w3project.org.au).

The system logic diagrams illustrate the contribution of peer insights and leadership at the individual level in service provision; in health promotion targeting networks and cultures of sexually adventurous men within the broader gay community; and in positive leadership and policy participation at the state/territory and Commonwealth jurisdictional levels.

For each one we drafted a range of indicators that could inform program evaluation and quality improvement.

We worked with four groups of programs from Australia's responses to HIV and hepatitis C, chosen because they have the longest history of using peer and community based approaches:

- Western Australia Substance Users Association (WASUA) and Australian Injecting and Illicit Drug Users League (AIVL) – PWUD peer service provision and policy participation map
- Victorian AIDS Council (VAC) and Australian Federation of AIDS Organisations (AFAO) – GMSM peer network-targeted health promotion map
- The Positive Action Group (PAG) consisting of the National Association of People Living with HIV Australia (NAPWHA), Positive Life NSW, Queensland Positive People, and Living Positive Victoria – PLHIV peer leadership and policy participation map
- Scarlet Alliance, the National Sex Worker Association and members. This map contributed to the area of sex worker peer leadership and policy participation, however has not yet reached a level of completion to be released publically

Full details of the methods and processes are described in:

> Graham Brown and Daniel Reeders (2016). What Works and Why – Stage 1 Appendices. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University. Available at www.w3project.org.au

Reading the PWUD Peer Service Provision and Policy Participation System Diagram

Theory statement	• A high level description of the approach: how practitioners and program managers think it works, in plain English.
System logic diagram	• A diagram of the causal loops and processes that shows how the program engages with the community and its policy and funding context.
Explanatory text	• Brief definitions of the items and key relationships from the system logic diagram.
Strategic dynamics	• Aspects of the map that practitioners said they'd most want to monitor in order to confirm and revise their understanding of the system and whether the program was working.
Worked example	• We take one strategic dynamic and talk through the mechanism that produces it -- the causal loop and other structural features of the map -- as well as indicators that could be used to monitor it.

Peer service provision and policy participation

This case study is based on the West Australian Substance Users Association (WASUA), which uses peer workers in needle and syringe program (NSP) service delivery. It supports both peer and professional staff to represent the service in sectoral advocacy using insights developed through practitioner and organisational learning from knowledge exchanged by clients during service delivery, educational and outreach activities. The service also trains PWUD in peer leadership skills to participate in consumer representation opportunities. The service is well-respected in West Australia and sought out for policy advice and partnerships. This reflects its strategic role as a source of real-time knowledge about emerging issues and trends affecting people who use drugs in that state, as well as its reputation for making careful and consultative efforts to understand how best to respond to emerging issues.

a. Program theory statement

Peer work in an agency that combines service delivery, practical education, and advocacy can be understood as involving circuits of knowledge that operate over different time scales. The knowledge circuits include:

- Personal experience
- Noticing cues and meeting needs
- Noticing patterns of need including new needs
- Practitioner learning
- Organisational learning
- Demonstrating outcomes
- Advocating for quality and defining success
- Valuation and resource allocation

The service exists as a complex adaptive system nested within multiple other complex adaptive systems: it is a program of services within an organisation within the alcohol and other drug (AOD) and mental health service sectors and the health and judicial systems in a state in a federation.

One way of grasping its complexity is to describe it as a *highly flexible program* that is capable of recognising and responding to very diverse needs presented by clients, operating with few exclusion criteria and able to improvise and adapt procedures ‘on the fly’.

As such it is difficult to imagine in advance a single measure or indicator of success that would apply to all of the great variety of episodes of service, but it is possible to see ‘a win’ when it happens and to tell a story that conveys the outcome in its context and scope.

(Or, equally, when things aren’t working.)

A key task of management is to develop and support a knowledge system that reviews practitioner learning to select and develop a pool of these stories about what worked for whom and why (or why not), so they can be used in quality improvement, demonstrating outcomes and advocacy.

Because of its flexibility, the agency occupies a role of ‘safety net’ within the broader alcohol and other drugs sector in which other agencies use exclusion criteria to select clients with simpler, easier-to-meet needs. The timescale for an ‘episode of service’ in service usage data is flexible: a single episode may last for up to 3 months. As such, compared to other services on the number of episodes of service, the peer service may appear inefficient, and a key advocacy task for the service is defining and demonstrating success in ways that

acknowledge its context. At the same time, it needs to manage the perception that it can 'run on the smell of an oily rag', as this can be an obstacle to securing fair resourcing.

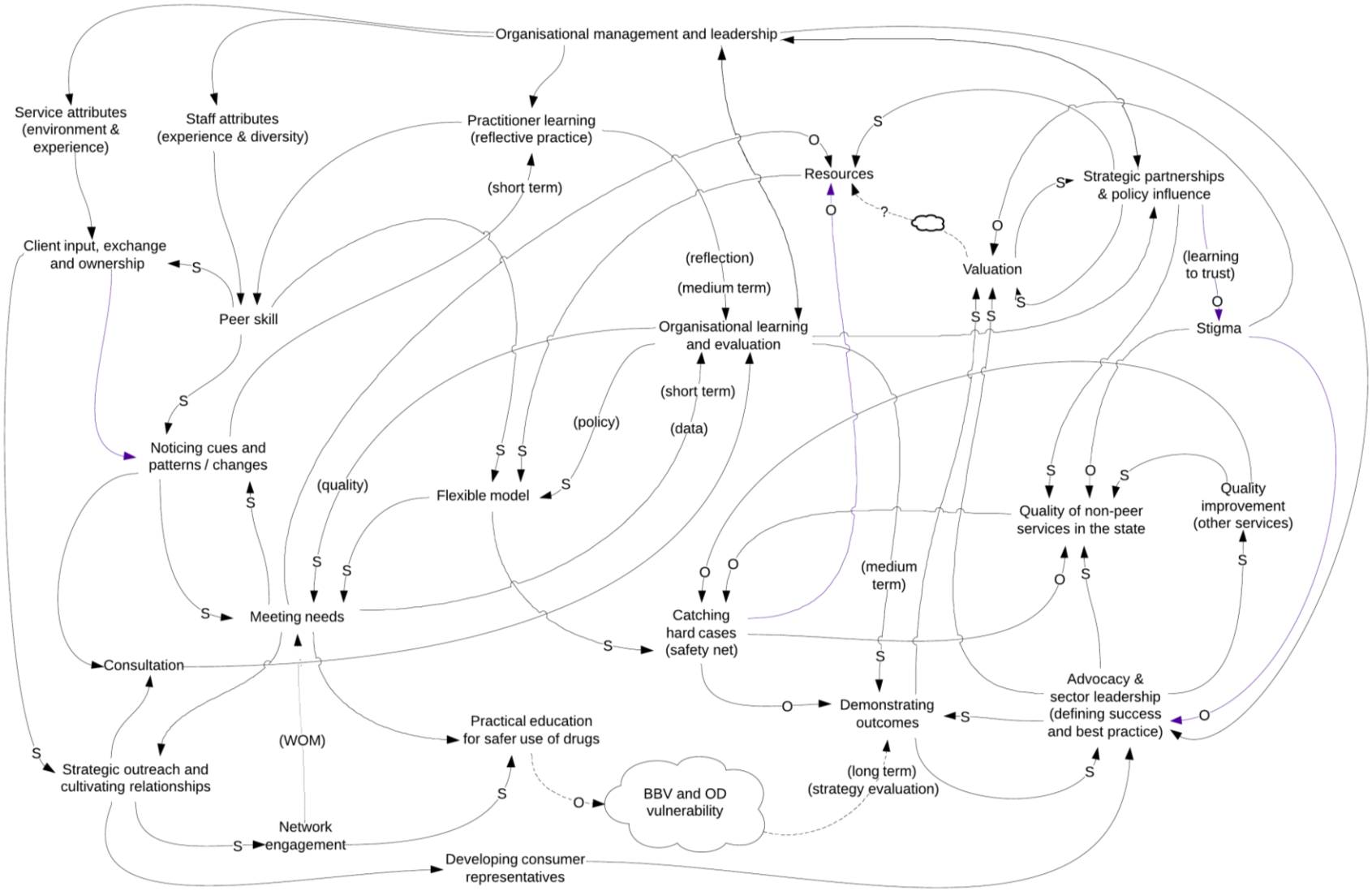
The service makes a point of listening to and reflecting on what clients tell peer workers about their needs and recent developments and trends in drug use. As a result, clients don't come to the service empty handed: they always have knowledge to exchange for service. The service's commitment to acting on the knowledge they impart is what sustains clients in a sense of ownership. In addition, it enables the service to offer services that in turn enable it to extend its reach into new pockets of networks of people who use drugs.

In the alcohol and other drugs sector this also makes the service the closest source of real time knowledge. This is both a strategic advantage but also a source of reputational risk: identifying an emerging trend in sector advocacy is partly noticing patterns but partly making a prediction about their likely impact and future trajectory. When a new issue is identified, the service enacts a consultative process of 'progressive approximation' towards a more certain understanding that includes taking different peer and practitioner perspectives.

Management and leadership are a team effort including the service manager, the Board, and the senior workers. They play an active role in facilitating practitioner and organisational learning and supporting both staff and volunteers to participate in consultative processes and advocacy for individual and systemic issues within the sector and policy environment. This highlights the *structural contribution* of knowledge built up through peer service delivery, and of peer leadership within the philosophy and processes of consumer representation.

Finally, the service engages with stigma towards people who use drugs, peer workers, the peer model, and the organisation itself, particularly within the alcohol and other drug and mental health sectors and the broader health system. This manifests in having to work harder to be taken seriously, advocacy around poor quality being dismissed as 'just junkies whinging', and old stories of peer staff behaving badly being continually retold. Stigma can be understood here as the cultural production of knowledge that justifies social inequity.

b. System logic diagram



c. Explanatory text

Immediate service provision (left side of the map)

Service attributes (environment and experience)

This component captures an extensive discussion of the way WASUA works to provide a friendly, welcoming, approachable, respectful, low-key, down to earth, non-clinical environment and experience for people who access their service. It was seen as enabling *client input, exchange and ownership* (see below).

Client input, exchange and ownership

Clients feeling ownership enabled them to give feedback on the service and share their knowledge of drug quality, police operations, experiences of other services, PWUD and supplier networks, etc, with peer staff.

In return for *meeting needs, peer skill in noticing cues* enables peer staff to undertake *strategic outreach and cultivating relationships* within PWUD networks, which increases its *network engagement* (reach) and generates word of mouth (*WOM*) about WASUA.

The potential for exchange of information and access to relationships means that WASUA clients never come empty-handed into the service encounter. It can be contrasted with the deficit model applied to them by the design and experience of non-peer services.

Staff attributes (experience and diversity)

Much of the literature on peer approaches conceptualises 'peer' as a close-enough match between the peer worker/volunteer and the client/participant on demographic features, such as age, gender, education, class, ethnicity, and/or relevant identity (such as sexuality) or experiences (such as current or past use of drugs).

The workshop participants saw relevant experience as necessary but not sufficient: peer workers are not employed simply because they have experience using drugs — a stereotype of peer workers held by many professionally qualified helpers — instead, it was wholly mediated by *peer skill* (defined below).

Participants emphasised the importance of diversity rather than literal similarity with clients: diversity of interests and experiences as well as identity and community affiliation enables the service to *meet needs* and enhances its *flexibility* (see below). They used the term 'cultural peers' to emphasise what PWUD share in common despite individual differences.

Peer skill

This was described as the ability to use personal experience effectively to establish rapport and communicate with clients. They don't need to have the *same* experiences as the client – peer skill enables them to draw on *different* experiences in a way that seems relevant. This is related to *noticing cues and patterns* (defined below).

Peer skill mediates both *staff attributes* (above) and *practitioner learning* (defined below) and enables *client input, exchange and ownership* (above), *noticing cues and patterns* (below), WASUA's *flexible model* (below) and via those last two *meeting needs* (below).

Noticing cues and patterns (including changes)

This was evident from the very beginning of the workshop, when we presented participants with a scenario about person who uses heroin with her partner. The discussion immediately identified cues – subtle features that hinted at the client's potential needs for information and services. These needs could be unstated or even unrecognised by a client presenting for a fit pack.

In combination with WASUA's *flexible model* (defined below), *noticing cues* enables peer workers to *meet needs* more effectively than non-peer services – meeting a wider range of needs and meeting time-sensitive needs before they eventuate in a crisis.

Noticing cues was enabled by *staff attributes* (particularly relevant experience) mediated by *peer skill* enabling workers to manage emotions in the encounter, quickly gauge timing and approach, elicit more information to confirm their first impressions, etc.

Participants also identified that the scenario had been written by someone who was more familiar with an amphetamine-type stimulant pattern of use. *Noticing patterns* (including changes in the patterns of cues and needs over time) is linked through *practitioner learning* and *organisational learning* to responding to improve the alignment of services and needs within WASUA's *flexible model* (defined below).

Meeting needs

Something that came through loud and clear in this workshop is that WASUA workers saw their primary mission as *meeting the needs* of anyone who walks through the door and the broader community of people who use drugs (PWUD). This was enabled by its *flexible model* for service delivery.

Richard Rumelt, teacher and writer on strategy, emphasises the way in which strategy is about *choosing what not to do*. The WASUA flexible model is not *unstrategic*, though: it was equally clear that WASUA leadership has a clear vision and strategy for achieving the *valuation* (credibility, see below) and *resourcing* (funding and policy leeway, see below) required to enable and support the *flexible model*.

Flexible model

Participants emphasised that WASUA will see anyone who asks them for help, including for example family members of people who use drugs. Unlike most other services in their sector in Western Australia, WASUA has no exclusion criteria for clients (but see Catching hard cases (safety net) below). It does not ration equipment and stocks a wider range than other NSP services, enabling it to serve clients with a wider range of use patterns and to meet a wider range of needs than just preventing BBV infection, such as vein care and aseptic injection. It operates on an exchange basis, which avoids upfront costs to clients and helps reduce used equipment being discarded in the community. It directly provides or works in partnership with other agencies to provide a very wide range of other services, including access to nursing and GP care and counselling, referral and treatment support.

Strategic outreach and cultivating relationships

Enabled by *client input, exchange and ownership* and *meeting needs* via *noticing cues* and *peer skill* (see above), WASUA staff can identify and provide outreach NSP to 'pockets' or networks of PWUD who lack easy access to NSP services. This is one of the ways in which WASUA cultivates relationships with networks that increase its *network engagement* (defined below) as well as identifying 'talent' – potential volunteers/workers with strategically valuable *personal attributes* and *peer skill* (above).

Network engagement

Participants emphasised the way that networks of PWUD are constantly evolving in response to variations in supply, police operations, new people entering and others either leaving the area, serving time or suspending use of drugs.

Network engagement is not just making links once and for all – it is a constant and ongoing process of re-making them. Although it is a moving target, it was seen as essential in generating word of mouth about WASUA's services as well as providing *practical education* (see below) to PWUD on the safer use of drugs.

Practical education for safer use of drugs

When this was raised on day two of our workshop we were drawing participants' feedback directly onto a live system map projected on a screen. One of the participants had been with the service for a long time and (we gather) part of his role is informally training up new staff in the relevant skills and philosophy of a peer organisation. He talked about *strategic outreach* and *network engagement* as opportunities for *practical education for safer use of drugs* – working one-on-one with clients through multi-step processes like safe injecting.

The facilitator operating the laptop entered this on the map as 'adult education' but this was swiftly rejected by the group, who were unfamiliar with the jargon – and unwilling to be translated into jargon. This has been a key methodological concern for us in this project – finding the balance between articulating the workshop outcomes in language that people not familiar with WASUA will recognise and understand, and preserving the language used by the workshop participants and in particular the values and concerns embedded in it.
We think the key thing to understand here – what could easily get 'lost in translation' – is the difference between 'health information' and 'health practices'. *Practical* refers to practices.

Role within the BBV sector and broader service system (right side)

This section details components that emerged from discussion in the afternoon on day one with WASUA's Operations Administrator and the SiREN project worker, and on day two of the workshop, with contributions led by WASUA's manager and Board chair. The components here reflect the stated focus of the workshops and the W3 project more generally on where the peer-based service model fits in a broader strategic mix of peer and non-peer services.

The key flow that defines the function of this system is *knowledge*, produced over different time scales by reflective practice (both informal and formal), data collection and reporting, and evaluation; knowledge is translated and shared in different ways, including via advocacy and demonstrating outcomes; and it impacts on valuation (credibility) and resources (such as policy scope and funding) as well as feeding into strategic partnerships and policy influence and raising the bar for quality and client access in other NSP and AOD services.

Many arrows on the map are labelled with an S or an O, indicating whether the target rises with the origin (S for 'same') or falls (O for 'opposite'). Where the arrow isn't labelled, we think the arrow is more contingent – it may or may not happen – or its effects are mixed/uncertain.

Where the arrows loop through other components and back around as inputs into the starting place, we might recognise a feedback loop. For instance, *noticing cues and patterns* and *meeting needs* have 'S' arrows in both directions, describing a reinforcing loop, marked with an R in a circle. (Also known as a positive feedback loop.)

That's an extremely tight, rapid – almost instantaneous – feedback loop. It's pretty important to WASUA's effectiveness as a service, because it's probably how it manages to identify and respond quickly to needs, enabled by its flexible service model.

As an individual worker goes through that cycle on a daily basis, she or he is probably conscious of getting better at it, as well as thinking actively about encounters where the cycle broke down – this is the arrow leading into *practitioner learning (reflective practice)* (defined below). From here, it loops back to *peer skill* as part of personal professional development and rejoins the original feedback loop as the worker is able to notice and respond better to cues. So far, the process remains entirely personal/individual.

In the W3 project we have a particular interest in whether knowledge produced through individual reflective practices, both informal and formal, flows into more formal, collective processes of *organisational learning and evaluation*.

Practitioner learning (reflective practice)

This refers to the practices, both formal and informal, individual practitioners undertake in order to develop their skills, and answer questions or solve problems arising in their work. Both the arrows leading into and out from *practitioner learning* are not marked with an S or an O. It remains a contingent practice – it happens sometimes and not at other times. Although participants talked about being reminded by the manager to record episodes of service and encounters with other agencies via standardised data recording forms, they also said there were many stories that could be used in advocacy but were not captured.

Practitioner learning is linked to *peer skill* (as part of the loop described above) and via another contingent link, over a longer time scale (medium term), to *Organisational learning and evaluation* (defined below).

Organisational learning and evaluation

Organisational learning and evaluation includes all the formal and informal collective practices of monitoring, evaluation and learning (MEL) and quality improvement (QI) that WASUA undertakes in order to improve its services, support and develop its model with policies, *demonstrate outcomes* to stakeholders, and develop *advocacy* positions.

The inputs into organisational learning are *noticing cues and patterns* via *practitioner learning* as well as monitoring data from *meeting needs*. The inputs are complementary, in that workers noticing patterns can provide a sense of 'why' peer clients' needs are shifting – the 'big picture' knowledge (or a piece of the puzzle) that non-peer services don't have.

The main outcomes of this activity are quality improvement in *meeting needs* and refining policy to better support WASUA's *flexible model* of service, as well as in the medium term *demonstrating outcomes* to stakeholders.

Demonstrating outcomes

Demonstrating outcomes refers to the way WASUA can use the knowledge generated through *practitioner learning and organisational learning and evaluation* to demonstrate the individual and population health benefits from *meeting needs, peer skill*, and WASUA's *flexible model* of service provision.

In a side conversation during a break at the workshop, one of the co-facilitators talked to a recent social work graduate about what was needed to persuade her professional peers to take WASUA seriously. Although everyone loves to listen to a story, in order to trust it, they also want to get a sense of the perspective and some data.

Perspective refers to how the storyteller is situated; does it reflect a limited perspective, e.g. the people walking through the door, or a wider perspective, informed by WASUA's location within multiple and broader networks of PWUD. Meanwhile, having some relevant data helps listeners assess the seriousness of the problem or challenge at the heart of the story.

In their paper on how to evaluate complex community-based initiatives, Judge and Bauld (2001) recommend using a mix of methods that enable 'careful triangulation of evidence' (p. 20) to learn about what works in health promotion. Demonstrating outcomes may involve packaging up *stories and data in perspective* to persuade different stakeholders.

Demonstrating outcomes goes hand in hand with the next component, *advocacy and leadership (defining success and best practice).* It is also linked to *valuation* (below).

Advocacy and leadership (defining success and best practice)

Participants talked about advocacy in terms of providing feedback to other services on where their service models were falling down, i.e. failing their clients, who then came to WASUA and told peer staff about their experiences. Advocacy in the form of policy leadership needs to – and is needed to – challenge stigma towards people who use drugs,

as well as peer workers from this community and WASUA as a peer organisation.

The key tasks for advocacy are *defining success* (for the peer model) *and best practice* (for non-peer services). Effective advocacy on what should count as the measure of a good outcome will add value to WASUA's work in *demonstrating outcomes*.

As discussed at the workshop, success can't be defined and measured according to changes in *BBV and OD vulnerability*, at least in the short or medium term, since it is driven by too many things outside of WASUA's control. (In the longer term it is quite clear that access to needle exchange and the community-based peer organisations has contributed to Australia's lower incidence of HIV among people who use drugs.)

Advocacy and leadership and in particular *defining best practice* is linked to the *Quality of non-peer services in the state* (defined below).

Quality of non-peer services in the state

Workshop participants talked about the many ways in which non-peer services have failed WASUA clients. For example, they have exclusion criteria that screen out people who are still taking drugs for programs intended to help people stop taking drugs. Or they exclude clients who have concomitant mental health conditions, which are prevalent among people who use drugs. Others report great success in using pharmacotherapy but reportedly exclude anyone who drops out of the program from their statistics on treatment success.

This contributes to WASUA *Catching hard cases (safety net)* (defined below) and its opposite linkages to *resources* (below) and *demonstrating outcomes* (above).

One of the challenges discussed at the workshop was the way that WASUA's *flexible model* and commitment to *meeting needs* might take the pressure off non-peer services to accept more challenging clients and provide culturally safe, non-stigmatising experiences.

From a strategic point of view it may suggest a focus on *defining success and best practice* in ways that suit WASUA better and put pressure on other agencies to improve.

Quality improvement (other services)

This refers to the training and audit activities WASUA provides to non-peer services.

Catching hard cases (safety net)

Because of WASUA's *flexible model* with no exclusion criteria, it is frequently the service of last resort for clients who have been excluded from other programs and services. These clients have more complex needs, require more resources to assist, and take longer to work with. As a result, this component has an opposite relationship with *resources* (below) and *demonstrating outcomes* (above).

The strategic response is not to introduce rationing or exclusion criteria, since these run strongly counter to the WASUA service model articulated by workshop participants; instead, the causal loop suggests investing in *advocacy and leadership* and *quality improvement (other services)* (above) to challenge the exclusion criteria and poor experience at other services in order to reduce demand for WASUA's role as a *safety net* in the WA sector.

Stigma

Based on an earlier workshop with AIVL the facilitators expected stigma to be mentioned a lot more frequently than it was at this workshop. It was primarily mentioned in relation to the lack of respect for WASUA's workers, perspective and policy contribution. Participants said these were dismissed as 'just junkies' or 'junkies complaining'. In addition, lack of the helping professions' understanding of the peer model led to them undervaluing *peer skill*.

Stigma worked to justify poor service provision and poor client experiences at non-peer services; participants had many examples of this, but a particularly shocking one was a hospital based NSP service where clients ring a buzzer in a delivery bay at the rear of the

hospital and fit packs are flicked through a two-inch gap under the roller door.

For this reason stigma has an opposite relationship on the map with *valuation* (defined below) as well as *advocacy and leadership* and *quality of non-peer services* (above). It has an opposite input from *strategic partnerships and policy influence* (below).

Strategic partnerships and policy influence

This refers to the relationship of trust WASUA has with its funders, the peak body WANADA (whose CEO also chairs the WASUA Board and attended the workshop), and with other agencies in the sector as well as academic stakeholders who can carry its message. Because *stigma* is so pervasive and is reproduced through thousands of daily acts of devaluation and discrimination, advocacy and leadership can't challenge it directly. The Learning to Trust argument (Sendziuk, 2003) suggests that peer organisations achieving Strategic partnerships and policy influence can demonstrate the capability of stigmatised communities and in that way shift public and policy attitudes in their favour. This is recognised by the focus of the service manager on setting standards for WASUA staff that will challenge stereotypes of peer workers within the broader BBV and health sectors.

Valuation

Valuation is a process referring to the way WASUA gains or loses credibility within its policy, funding and stakeholder environment, as well as understanding of the value of its model within the broader strategic mix and the beneficial outcomes it is able to demonstrate.

Credibility rises with improvements in *demonstrating outcomes, advocacy and leadership*, and *strategic* partnerships and policy influence. Credibility declines as *stigma* towards PWUD and peer workers/organisations rises.

The main outputs of valuation are resources (below) and strategic partnerships and policy influences. The link between valuation and resources is contingent, or to put it another way, it's a complex process in its own right.

Resources

Resources are diverse: they include funding for existing and new service provision and projects, as well as funder and policy support ('leeway') enabling WASUA to tackle sensitive issues and try out innovative approaches.

Resources increase with valuation and strategic partnerships and policy influence but they decrease with meeting needs (due to the cost of service provision) and catching hard cases.

Again, we emphasise that the strategic response here is to invest in demonstrating outcomes and advocacy and leadership rather than rationing meeting needs.

Organisational management and leadership

This item describes a process facilitated by the service manager as well as the Board and her team of Senior Workers. It is concerned with developing the human and knowledge resources of the organisation in a way that helps the organisation maintain its existing functions and develop new ones to achieve its overall mission – meeting the needs of people who use drugs.

It connects up with service attributes and staff/team attributes as the primary way in which particular attributes (such as peer experience and skill and non-judgmental attitudes) are selected and strengthened. It has a crucial, two way relationship with organisational learning and evaluation, which is a major input for strategy, leadership and governance, but also requires constant facilitation and reinforcement by management.

Developing consumer representatives

This refers to the work WASUA does to identify, train and support people who use drugs to

volunteer for the organisation and participate as consumer representatives in focus groups, consultation processes, and committees formed around change processes and policy review. Supporting consumer representation is one of the ways in which WASUA can influence developments in policy and practice within the AOD, mental health and other related sectors in West Australia. It connects from *strategic outreach and cultivating relationships* up to *staff attributes* (recruiting new staff and volunteers) and links into *advocacy and leadership* and *quality improvement (other services)***.**

d. Strategic dynamics

Strategic dynamics are higher level strategic considerations that emerge from interactions among the processes and relationships depicted on the system logic diagram.

For example, #12 shows how low *quality at other services* can interact with WASUA using a highly *flexible model* to *meet needs* to create a situation where clients with the most complex needs regularly end up being serviced by WASUA – it has become a 'safety net' service. However, these clients place more demand on *resources* required to sustain the *flexible model*, so there is a question of sustainability. This dynamic highlights the importance of WASUA *demonstrating outcomes* and engaging in *advocacy (defining success and best practice)* within its sector environment – to improve *quality at other services* and reduce the need for a safety net, and to ensure the *valuation* and *resourcing* of its service is based on criteria and metrics that adequately reflect the complexity of the caseload it services.

1. Peer skill enables client exchange.
2. Peer skill and shared experiences and culture enable peer workers to recognise cues to unstated needs
3. Peer workers reflect on encounters with clients and adjust their approach in a process of continually refining their peer skill.
4. Over time peer workers notice patterns of need and this enables them to notice qualitatively new and unmet needs
5. The service has a highly flexible model, reflected in policy, leadership and its inventory, enabling it to adapt rapidly to meet new needs.
6. Recruitment focuses on individual skills and experiences as well as obtaining the necessary diversity within the team.
7. Organisational management and leadership makes a priority of service and staff attributes that contribute to client input, exchange, and ownership.
8. Knowledge from practitioner reflection and learning is captured via organisational knowledge practices as an internal asset.
9. Packaging real time (timely?) stories and data for use outside the organisation.
10. Learning to trust.
11. Opportunities are taken during service provision to extend the service's reach among networks of PWUD.
12. Flexible services as a safety net for complex cases.
13. Defining success.
14. Working effectively with uncertainty in deciding how to respond to emerging issues.
15. Drawing on knowledge and peer leadership in achieving effective policy advice (advocacy)

Indicators for peer service provision and policy participation

Drawing on the W3 Framework (www.w3project.org.au) and the program theory, system diagram, and strategy dynamics described above, the following indicators were drafted.

The wording of these indicators are subject to change according to feedback from the Western Australian Substance Users Association (WASUA), Australian Injecting and Illicit Drug Users League (AIVL) and Harm Reduction Victoria (HRV).

Domain	Draft indicators
Engagement	Program workers use personal experience and cultural knowledge to communicate and work effectively with clients who are may be quite different from them
	Clients feel they have something to contribute and a sense of shared ownership in the service
	Strategic opportunities to create new relationships with people and networks in the community are identified and taken during service provision and program activities
Learning and adaptation	Turning information acquired through service provision into organisational knowledge and using it to adapt the service in order to improve its influence
	Program and organisational learning and leadership
	Packaging strategically relevant knowledge for influence on diverse stakeholders
Influence	**Influence within the community system –**
	Reducing the gap between preparedness (skills, knowledge and required equipment) and the short and longer term pressures on people who use drugs
	Reinforce and contribute to sustaining an ongoing culture of safer use amongst PWUD
	Influence within the complex policy system –
	The contribution of peer leadership in consumer representation and policy advocacy is recognised and sought out
	Knowledge produced from peer insights in service provision is shared and used in the broader sector and policy environment
	Policy advice, consumer representation and training using peer insights and packaged knowledge to improve quality and inclusion for PWUD at other services
	Sustaining and strengthening policy support for a peer and community based approach in harm reduction and BBV prevention
Integration	There are enough flexible resources to support learning and adaptation
	Organisational leadership supports a peer approach in workplace culture and organisational strategy
	Performance indicators and funding mechanisms reflect the complexity of the service provided
	The broader sector and policy system includes and values the peer approach and insights it generates
	The organisation has strategic and supportive relationships with key players within its sector, policy and funding environment