Creativity, care and ‘messy’ drug use: A collective history of the early days of peer-led needle exchange in Dunedin, New Zealand.

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ABSTRACT

Established in 1988, the New Zealand Needle Exchange Program (NZNEP) was the first needle exchange programme in the world to operate nation-wide under legal sanction. As in other countries, the ground for legislative reform was laid by activist action among the affected communities and their allies. In context of growing HIV/AIDS notifications, the provision of injecting equipment was positioned as a necessary, albeit politically contentious, public health priority. The NZNEP operated under a unique organisational model, with a national network of peer organisations formalised and supported to provide ‘user pays’ needle exchange. Unlike many other programmes of community empowerment instigated in response to HIV/AIDS, the NZNEP has over the past thirty years retained a significant degree of community control. Not without tensions, this history requires commemoration. The body of this essay was originally written as a chapter, focusing on the history of DIVO (Dunedin Intravenous Organisation), for a book to commemorate thirty years of the NZNEP. Under the auspices of a ‘secret Facebook group’ seven peers who worked at DIVO in the late 1980s and early 90s contributed the memories that make up this piece. As one of these peers, the author collated, coded and thematised these remembrances to create the story of DIVOS early days. From strategic positioning as a drug user organisation ‘under wraps’ DIVO garnered enough community support and institutional confidence to be ‘out and proud’ in advocating for the human rights of PWID. Ingenuity and action necessitated ‘bending the rules’ to protect against hepatitis C, and a community of care was recreated in the warmth of reconnection among the Facebook peer group. Tensions are inevitable in a peer-based organisation innovating in a context of precarious legitimacy, and they weave throughout this essay. This collective history is, however, primarily celebratory – of the achievements and legacy of a network of peers who were instrumental in providing care for their communities and advocating publicly for the rights of PWID in New Zealand.

INTRODUCTION

“DIVO stuck to the harm reduction kaupapa [philosophy] and had an awesome creative way of doing it.”

On the 16th of May 1988 the world’s first legal nation-wide needle exchange programme opened. This was in New Zealand, a country with an established population of opiate injectors dating back to the late 1970s who, from the early 1980s, had turned to using ‘do it yourself’ injectables sourced from converted pharmaceuticals and the Papaver somniferuim poppy (Harris, 2013). In a context of rising HIV/AIDs notifications, the then Conservative New Zealand government passed controversial legislation to allow for the formation of the New Zealand Needle Exchange Program (NZNEP). This was to operate under a unique organisational model, with ownership devolved to organisations of people who inject drugs (PWID) contracted to the government as charitable trusts. In 2018 the NZNEP celebrated thirty years of peer-led needle exchange, holding a Harm Reduction conference to commemorate the occasion. Presenting at the commemorative conference I reflected on my time as one of those peers and the uneasy irony of being fired from NZNEP for being too ‘messy’ in my drug use only to return some 20 years later as a plenary speaker. I used the opportunity to raise questions, also posed toward the end of this essay, relating to the role of ‘high intensity’ drug use in peer-based and harm reduction organisations and the supports available (or not) for employees or volunteers navigating the complexities of this criminalised practice in contexts of constraint.

A book on the history of NZNEP was also planned, to coincide with and launch at the conference. The body of this essay was originally written for that book, a publication that never eventuated. I had been asked to write a chapter dedicated to DIVO (the Dunedin Intravenous Organisation) – one of New Zealand’s early peer-led Needle Exchanges, still in operation. I had worked there in a ‘volunteer’ capacity in the early 1990s, at the time firmly ensconced within a network of long term PWID. Albeit an honour to be an invited author, I baulked at this request. My memories of this time were fragmentary, blurred, partial. I was a bit player in DIVOs history, if that. There were others who needed to tell this story, those who had foundational roles, who had stayed longer than I. I still had some contacts from those years. One suggested generating a ‘secret Facebook group’ to help find and bring together the peers who were around in the early days, to call for remembrances and collectively create a history for publication. Over the following year we did so, only to find that the planned book was not to come to fruition. Our chapter has sat with me since then, waiting for a home. This uneasy homelessness or ‘unheimlichkeit’ has weighed heavily, given the time and investment of a cohort of peers, brought back together to collectively remember and re-create the early days of DIVO.

The body of this essay tells our collective story. Rather than lay claim to providing an authoritative history of DIVO's beginnings, we offer a partial, subjective account, prone to the warping effect of memory and time. This essay therefore occupies an uneasy place between a social history and a critical reflection on the process of history generation. A process of remembrance, generating emotion, affection and some tension. In instigating and bringing together these recollections, this was a tension perhaps more personally than collectively felt. The subject matter at times felt too close to the bone, particularly in relation to memories of personal 'dysfunction' as detailed toward the close of the piece. Methodologically also, there is a tension – while collectively authored, this piece is subject to a sole authorial voice. This was in part, a pragmatic decision, given the vast quantity of recollections received: more befitting a book than the planned chapter. My voice and memories are incorporated, but also overlay others. The original chapter (from 'Early Days') was not written with an academic audience in mind and – to retain the original spirit and intent of each contributor – it has not been edited for this purpose. I offer, instead, a synopsis of the international and local context to foreground our memories, closing with a brief reflection on tensions and challenges faced by early PWID peer organisations.

INTERNATIONAL CONTEXT

New Zealand, albeit the first country to officially launch a government supported nation-wide and peer-led needle exchange, followed important precedents. Acknowledged in the fractious debate preceding the NZNEP legislation was the "politically courageous" move of New South Wales "to become the first Australian state to provide low-cost disposable needles to drug addicts" (Parliamentary debates, 1987). In neighbouring Victoria, around the time of the New Zealand amendment, the peer-led organisation VIVAIDS (Victorian Intravenous AIDS Group) opened a needle exchange, followed by NUAA (the New South Wales Users and AIDS Association) in 1989. Crofts and Herkt in their 1995 history of Australian drug user organising note the influence of international activism – particularly the pioneering role of the Rotterdam Junkiebond ('Junkies Union') in instigating peer-led NSP with support from the Municipal Health Service in 1984. In a less politically supportive context, North American networks of PWID risked legal sanction to distribute needles and syringes to their community from the mid-1980s, leading the way for Canadian organisations such as VANDU (Vancouver Area Network of Drug Users) formed in 1998, to mobilise harm reduction programs, such as an unsanctioned peer-run injection room, through an organic, member driven process (Jozaghi et al., 2018; Kerr et al., 2006).

As McLean (2012) notes, many of these first needle exchange practitioners actively sought to contest a politics that "excluded and abandoned drug users, publicising their cause through acts of civil disobedience". The case for needle exchange was, however, most effectively publicised and fought through the strategic collaboration of activists with like-minded researchers and policy makers, whereby epidemiological data regarding HIV prevalence among PWID was crucial in overcoming political resistance to legalising NSP, particularly in relation to heterosexual and neo-natal transmission impacting broader communities (Barreras and Torruella , 2013; Byrne & Albers, 2010; Madden & Wodak, 2014). Herein lies a tension, evident also in the accounts of DIVOs origins below. For NSP to be legally supported, particularly when led by organisations of PWID, the political and broader human rights impetus of its implementation had to be subsumed to that of a public health imperative. This public health imperative provided a new legitimisation for drug user organisations and activists, including though policy involvement. However, for many, this legitimisation was conditional on the strategic silencing of protest about the broader social, political and economic contexts which framed exclusion and health inequity among PWID (McLean, 2012; Crofts & Herkt, 1995).

In this way the history of needle exchange intertwines with the emergence of HIV/AIDS, and later hepatitis C (HCV), as a public health threat. The first notifications of AIDS among PWID were in New York City in late 1981, with the development of an HIV antibody test in 1985 revealing HIV prevalence rates as high as 50% among PWID in North American and Western European cities (des Jarlais et al., 1993). A BMJ article from the time frames AIDS among PWID as “the real heterosexual epidemic” as “three quarters of those who have contracted the disease heterosexually have done so from index cases who were intravenous drug users” (Moss, 1987). It was in this context that counties such as the United Kingdom, Australia and New Zealand moved in the late 1980s to legalise NSP demonstrating a shift from a purely ‘war on drugs’ prohibitionist drug policy toward one encompassing harm reduction principles (des Jarlais et al., 1993). It was not until 1992 that the New York city followed suit, following nearly a decade of grassroots NSP provision in contravention of the law. This was the first city in the United States to do so, a move first proposed in 1985 by the NYC Health commissioner but rejected due to deep resistance from the police and Black Community leaders, the latter who saw the proposed provision of injecting equipment among their communities as akin to ‘genocide’ (Barreras and Torruella, 2013).

THE NEW ZEALAND CONTEXT

In 1987 the New Zealand Government passed the Misuse of Drugs Amendment Bill allowing for the legal supply of needles and syringes to PWID through dedicated services. As noted above, and in relation to Australian state based NSP implementation (Madden & Wodak, 2014), NSP legalisation in the late 1980s was a bold political move. Parliamentary debate transcripts from this time highlight the issues at stake. New Zealand was experiencing an increase in HIV notifications, including among PWID. The then Minister for Health, Dr Michael Basset, introduced the 1987 Misuse of Drugs Amendment bill as a pragmatic step when weighing a ‘balance of awfulness’:

> *"I do not think it is possible to have the perfect solution to the problem when the position is one of a balance of awfulness … the real distinction has to be the fatality of the two problems with which one is dealing. Nobody recovers from AIDS; one can be cured of drug abuse. That is therefore the factor that determines one's attitude to the matter."* (Parliamentary debates, 1987)

As in other countries (Bluthenthal, 1998; Crofts & Herkt, 1995; Frank et al., 2012; Jauffret-Roustide, 2009), the ground for policy change was laid by activist agitation and acts of civil disobedience by the affected community, their organisations and friendly allied health professionals. In New Zealand, this included a small number of pharmacists who supplied syringes to PWID illegally, in defiance of their professional body, as well as organisations such as the New Zealand AIDS Foundation (NZAF) formed in 1985 and the IV League (comprised of current and former PWID and allied health professionals) formed in 1986 (Kemp & Aitken, 2004; Luke, 2007). Parliamentary debate records, including the quote above from Dr Basset, illustrate the uncomfortable space in which PWID activists and their supporters operated at the time. Here, the discursive framing of HIV/AIDS and illicit drug use/rs as comparable 'evils' meant that arguments for the instigation of NEP were more likely won when demonstrating threat to the 'wider community' from PWID as vectors of transmission rather than in relation to improving the health or human rights of PWID (Parliamentary debates, 1987; Luke, 2007).

Hailed as "one of New Zealand's most successful public health programmes" (NEST, 2020), the history and unique origins of the NZNEP have been detailed (Kemp & Aitken, 2004; Luke, 2007). Less well known are the permutations of the individual peer-led organisations, each responding to and operating within markedly different drug using contexts and cultures. The first four peer-based organisations to form as charitable trusts for the purpose of providing injecting equipment and harm reduction information to their PWID communities were the Auckland Drug Information Outreach (ADIO), Wellington Injecting Drug Education (WIDE), Christchurch Intravenous Drug Users Resource Group (CIVDURG) and the Dunedin Intravenous Organisation (DIVO). All formed in 1988, acting in concert with community-based pharmacies to act as fixed sites for the purchase and return of injecting equipment. Of note, was the decision of the New Zealand government not to involve drug treatment services in the delivery of NSP. This ensured the centrality of peer-based organisations in the roll out of NZNEP.

The decision to preclude drug treatment services from NZNEP was primarily ideological. In order to lessen political and community opposition to injecting equipment provision, NZNEP was positioned as a 'bridge to treatment'. Critical here, was a geographical demarcation between spaces of wellness or "cure" from those that continued to "support" continued drug use. This saved state-funded drug treatment services not only from the "invidious position" of diluting an abstinence-based message (Parliamentary debates, 1987), but also from the complications of participating in a commercial sale and return system. In line with New Zealand's neoliberal politics of the time, the NZNEP providers were to ensure user pays' full cost recovery for needle and syringe provision, with syringe disposal costs to be met by the state. Supply was initially limited to a ten-pack (comprising ten 3ml × 26 g needles and syringes, a sharps container, condoms and AIDS information) at the price of NZ$10, reduced to NZ$7 if accompanied by returns (Lungley & Baker, 1990). This rapidly devolved into selling single syringes for cash, counter to NZNEP regulations, before the introduction of a variety of 'pick and mix' equipment (for sale) and then, in 2004 the introduction of a free, one-for-one needle and syringe exchange system (Luke, 2007). Syringes without returns and other equipment, such as filters for pill preparation, are still only available for purchase.

The drug market was also unusual. The mid-late 1970s were the 'Mr Asia' years, with quality heroin imported into the country by the drug syndicate of that name. The murder of 'Mr Asia' Marty Johnstone in 1979 coupled with tighter New Zealand border controls led to a heroin drought – sustained from the early 1980s to the current day. In response, 'do-it-yourself' methods for producing injectable opiates were innovated and disseminated amongst local PWID communities (Harris, 2013). These included 'homebake' heroin manufacture from codeine-based pharmaceuticals and conversion of morphine sulphate tablets into injectable heroin using black market acetic anhydride (AA). In season, gardens were scoped and raided for opium poppies, the sap converted into an injectable heroin solution with AA (Harris, 2013). Diversion and injection of methadone, Ritalin and Temazepam 'jellies' were common. This was an injecting culture – smokable heroin was non-existent, most conversion methods produced liquid solution. Drugs used impacted on equipment provided. Rather than 1ml 'insulin' syringes, common to most countries, 3mls were the standard, with detachable 26- or 27-gauge needles. Five- and ten-ml syringes were also available (the latter for injecting methadone) as well as catheters, butterfly needles and a variety of micron 'wheel' filters for removing bacteria and preparing pill-based injection solutions. These ancillary items were all outside of the official NEP remit, with provision driven by each local trust responding to PWID need and demand.

METHOD

The body of this essay focuses on the history and early days of the of DIVO, the Dunedin Intravenous Organisation. As noted, it was originally written as a chapter for a book commemorating and celebrating thirty years of the peer led NZNEP. The book never materialised but, partially due to the methods employed, our collective remembrance requires an audience. The contributors to this chapter came together under the auspices of a 'Secret Facebook group' initiated in August 2018. I had links with a few of the peers who had been involved in the early days of DIVO through Facebook and hoped that by this means we might attract more. The group was titled “Celebrating DIVO: the first 10 years” and featured an opium poppy frontispiece, appropriate to the New Zealand context of much of our drug use.

Celebrating DIVO: The first 10 years

Secret group

Figure 1. Secret Facebook group

Below this frontispiece I explained the chapter remit and asked for help*: “I need your voices … I’ll write some hazy memories but would love to weave them together with yours … please invite others who were involved at that time.”* In total 13 ex-DIVO staff members and volunteers joined. All were current or former PWID. I asked for contributions of memories, photographs, drawings – anything – to help collectively form a history. The response was overwhelming and moving. Many sent through carefully written pages of personal reflections. Mike Lee, the founder of DIVO, preferred to be interviewed – which I was able to do in person, when we were both at the NZNEP Harm Reduction conference later that year. He brought memories from the time, faded copies of newspaper articles on DIVO from the late 80s, a copy of the poster that inspired DIVO’s original name (Figure 2). His interview was audio-recorded with consent and transcribed. This, with each person’s recollections, were treated as ‘data’, inductively and thematically coded to consolidate, to tell a story, and yet retain – where possible – the spirit of each account. Each contributor has read the final draft, and all have chosen to have their real names (either in full, or by first name only), rather than pseudonyms, used in this piece. Collaborators were determined, in part, though access and inclination toward social media. We note, therefore, that this can only ever be a partial account –not necessarily covering all key players or events in DIVOS history.

EARLY DAYS: DIVA TO DIVO

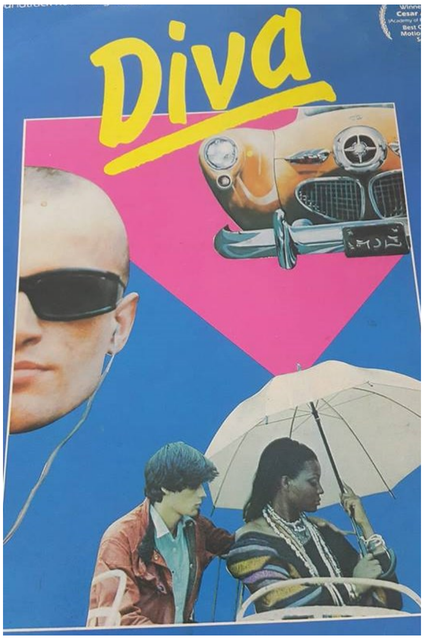

Figure 2: DIVA film poster

DIVO first started out in 1988 as DIVA, named by Mike Lee after a French film, poster resplendent in pink and blue (figure 2). He reflects on the pre-DIVA days:

It was the end of the Mr Asia scene, it was polydrug use, it was very messy and the needle exchange side of things was non-existent, so you had to get them from other users … there was no security in the hospital, I could get them from there … But when you were really stuck, and you couldn't get into the hospital it was a case of getting them from the rubbish bin and sometimes they had blood in them, and we washed it out.

Gradually some chemists began to provide needle exchange, but as Mike noted, it was a flawed service: *"[pharmacists] were saying 'you shouldn't be buying these things, you are on the methadone'"*. The autonomy of NZNEP from drug treatment services and methadone prescribers protected from some of these constraints, with DIVA providing a welcome alternative to pharmacy-based restrictions and judgements. Mike illustrates the organic and slightly haphazard instigation of DIVA; his lead role seeming to rest on a few misplaced stamps:

> *There was an envelope of how to set the needle exchange up and they (the* Christchurch Intravenous Drug User Resource Group*) sent it to this guy in Dunedin, but they didn't put enough stamps on it and he wouldn't pay the extra postage, so they gave it to me … they gave me a contact at the health department, she flew me up to Auckland and introduced me to a woman involved in starting up ADIO* (Auckland Drug Information Outreach)*, who guided us.*

He took to this role with a passion, emphasising the urgency of acting to curb the spread of HIV in his community: "*I just wanted to do it very quickly, I knew there was this virus out there*". While not discounting this urgency, the emphasis on DIVA as solely an HIV/AIDS prevention organisation (figure 3) also operated as a strategic move to aid pubic acceptability:

> *We had some opposition, Christian fundamentalist groups were a bit scared, but I was articulate with them, went on TV, did newspaper stories, we were quite professional. It was a drug user organisation, but that was kept under wraps. We were there to stop the virus; we didn't want to get this closed down … There was a lot of fear. But the opponents dropped by the wayside pretty quickly.*

Figure 3: DIVA door sign.

Simon Clayton remembers: *"During 1989 - 1990, I had used DIVA, the newly established needle exchange, a few times. You could buy a pack of ten syringes for ten dollars, the infamous whack pack."* The exchange was peer-led from the start; Simon soon moved to an employee role: "*In 1991 I was asked to come and help with some administration stuff, at the by then renamed DIVO now located on Moray Place in central Dunedin."*

The community support garnered through HIV-focused public education was important in helping the organisation survive. Simon recounts early crises and the important role of trustees in consolidating DIVOs remit:

> *There had been some problems, Ministry of Health were about to pull funding from DIVO. After some more crisis meetings, a regime change, and strong community support we won a reprieve … The first decision the new DIVO trust made was to extend the opening hours to 365 days a year. Staffed by peers, if you brought a syringe you were served by a peer: someone you might know from your community.*

Karen Blacklock, who joined DIVO in 1993, reiterates the value of peers and provides a needed definition:

> *My job involved coordinating a group of volunteers. In our small Dunedin IDU (intravenous drug user) community we pretty much all knew each other. I was unequivocal about who could work as a volunteer – they had to be current IDU. This, I believed, was the only way in which the community would truly take up the messages we were trying to spread – by creating and owning the information ourselves.*

She recalls her first task as daunting: speaking before a 100-strong audience at the World AIDS Day Candlelight Memorial in Dunedin Octagon. Here she advocated passionately not only for DIVO as a public health necessity but for the "value of the lives of people on the margins of society". This marks a new confidence; no longer (as in 1989) is the identity of DIVO as a drug user organisation being "kept under wraps".

Karen, in that first speech, compared "*the rate of HIV amongst IDU in the US, where there was no needle exchange, to the very low rate in NZ, the lowest in the world."* Before long, a 'shockwave' of hepatitis C diagnoses among the injecting community brought new urgency to DIVOs remit. It is crucial to acknowledge, as Karen does, the important role of an in-house GP in facilitating those diagnoses:

> *We were, I think, the only needle exchange to have a resident GP*[1]*, who - with a weekly clinic at DIVO - was at the frontline of testing and diagnosing our people. As the community hub we were at the frontline of supporting people with hep C. No one knew a lot about it and people were devastated and scared about what it meant. A lot of people were given misinformation by the wider medical establishment - people were told they would not have long to live; people were told to go home and stay indoors; people were seen last in the day at the dentist.*
>
> *We were all reeling from this unexpected virus hitting the community – soon it was known that up to 80% of IDU were hep C positive. DIVO began researching and helping the community as best we could. Peer support became important in giving accurate information, dispelling myths and misinformation, and offering emotional support. We also had a crucial role in rethinking the disease prevention information we were advocating. The 1+1+1 method of cleaning syringes with bleach might have been adequate for killing the HIV virus, but it was not effective against hepatitis C.*

Just as PWID in the United States and the Netherlands pre-empted policy change through co-ordinating underground needle and syringe distribution (Friedman et al., 2007), DIVO also adopted innovative and responsive action to a community crisis – regardless of the repercussions:

> *To deal with the inevitable time lag in life saving knowledge becoming implemented in official policy we started bending the rules to keep our community safe. We were only allowed to sell boxes of 10 syringes back then. We started off by letting people buy one syringe at a time out of "their" box. Soon we just started selling single syringes. Our attitude was that if we could morally justify our actions then we would do what was best practice despite dinosaur regulations. I loved what we did there – we were leading the way in terms of hepatitis C prevention, education and support.*

ADVOCACY IN ACTION

Hilary joined DIVO in the early 90s, and like other DIVO peers, skilled herself in the language of funders and providers to courageously advocate for the needs of the using community:

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[1] Later projects also adopted this model. For example, the Drugs and Health Development Project (formerly WIDE) in Wellington established NZs first community-based hepatitis outreach clinic at their needle exchange site in 1997 (Moriarty et al., 2001).

> *I wrote submissions, talked to MPs, applied for funding, and sat in rooms full of health professionals from sectors relating to alcohol and drug dependence. I tried to speak up for all those folks whose day-to-day problems I saw … I tried to bring our customers point of view to places where it didn't use to get heard at all.*

She reflects on her role behind the counter – one comprising emotional support, information provision and advocacy as well as the provision of injecting equipment:

> *I didn't really have words to describe the simple - yet not - interactions I had with regular customers. We talked about … everything - relationship problems and breakups, major and minor health problems relating to being an IDU, moral dilemmas that were all part of the lifestyle, legal problems, problems with the clinic and methadone, problems with not being able to even get on methadone, the desire to stop and seek help, money woes...... Some folks just wanted to get in and out, and barely talked. And I used to respect that too.*

Just as Mike had worked to educate and reassure would-be detractors, his successors kept public education firmly within the DIVO remit. This facilitated a supportive environment for the continuation of needle exchange in Dunedin, with the aim also of improving professional attitudes and practices towards PWID. As Karen relates:

> *Over the seven years I worked at DIVO (from 1993-2000) I lectured regularly to the Medical school students, Health promotion students, Drug treatment staff, Prison staff AND inmates, University Club members, and other groups .... These talks generally went down very well – I found that everyone was fascinated by injecting drug use and were generally persuaded that the needle exchange programme was a vital and successful health intervention for New Zealand.*

Not all health care workers were 'community-friendly', however. DIVO directly addressed this through their valued in-house GP service, and information to help PWID navigate external providers. For example, Hilary "*helped write newsletters, pamphlets, posters and compiled lists of places where our customers could seek help if that's what they chose (everything from a non-judgemental GP for routine health stuff, to help with giving up, to legal advice).*"

COMMUNITY SOLIDARITY & CREATIVITY

It is evident from these recollections that DIVO's role and legacy is multifaceted. At DIVO harm reduction in practice was holistic – extending well beyond the exchange of needles and syringes. A list of achievements collated by the Facebook group, runs to 29 items, some of which include:

- DIVO conducted research into harm minimisation in the home preparation of heroin, in conjunction with the Otago university school of pharmacy;
- DIVO participated HBV/HCV/HIV seroprevalence studies 1998, 2004 and 2009
- DIVO partnered with other organisations to form a HIV "working together group"
- DIVO presented at international harm reduction and hepatitis C conferences
- DIVO published a kick ass magazine
- DIVO took HIV, hep C education sessions into the prison (and left all the fits and filters behind while the guards turned their backs)
- DIVO liaised with police drug squad trying to educate and lobby them to support harm reduction efforts, eg stop busting people for syringes.

And last, but not least: “DIVO built a supportive community”. As Karen writes:

> *Our staff were welcoming and on the level with all the clients. DIVO became a hub for the using community – people were always gathered there having cups of tea, talking about safe using and drug law reform activism, making art and writing articles for the DIVO news; seeing the doctor at her weekly clinic, talking to me as a fledgling Methadone Advocate about their problems and battles with the Methadone Clinic (which at the time, was the antithesis of harm reduction and a cause of much disempowerment and distress amongst people on the methadone programme).*

This sense of community was not confined to those who came up the DIVO stairs but extended beyond – to PWID who for geographical or other reasons may not have wanted to access the needle exchange. Among the many benefits of peer-workers was, as Simon writes, that they carried the message with them, demonstrating harm reduction through practice in their using circles:

> *This investment, in the capacity and capability of individuals benefited the whole community. Because they were peers, they were living in a community they didn’t just work for eight hours and go home to the suburbs, they were sharing their knowledge 24 hours a day; they were living harm minimisation ambassadors in the community.*

Community solidarity was perhaps most effectively disseminated through DIVO News – a publication unequivocally by and for PWID, unapologetically celebratory of the community’s strengths and condemnatory of shared injustices faced. On starting this project I hunted around to see if I did in fact still have a stash of DIVO mags, and yes – they had hitched a 20 year ride across the world with me, hanging on, while my personal diaries, for example, were jettisoned to ‘clear space’. Opening their pages was like looking into another world – the passion, directness and detail of information conveyed better than any harm reduction material I had come across in years. Karen speaks of that time:

> *We were such a tight and active group of people at DIVO. We were all using drugs, and this got a bit loose at times, but all in all, the creativity and activism of our group still inspires and amazes me. What a collective energy we had. Some of the most creative people I knew were a part of DIVO. The DIVO news was the epitome of our creativity. Between us we wrote articles, book reviews, harm reduction posters, poetry, personal stories and political manifestos. We created art – the dedication and talent of the DIVO artwork is evident in the DIVO news that we made in those first 10 years. Others of us were writers, too many to name … the success of John Mark's heroin programme in England; and many articles on harm reduction and drug law reform. The magazine came together organically.*

Figure 4. DIVO News

> *People like to say that drug users are unmotivated – this was not true for us – we were energised by each other and our mission. When a bunch of content had come together for the magazine we collected it all, in later issues we laid it out on the new computer technology… and printed it off. We photocopied and stapled it together, and it was distributed to the clients as well as across the town – to the methadone clinic, the AIDS foundation, the Pharmacy School, the University Health Promotion department, the Prison, as many groups as we could think of. Our magazine was not restrained for the general public – it was pretty out there in both written and graphic content and fearlessly included drug law reform advocacy as part of our wider harm reduction message. It was by users, for users, and shared freely with anyone else we thought could benefit from it. We were out and proud!*

CULTURES OF CARE

> *DIVO was a breath of fresh air after a lifetime of being stigmatised criminalised and discriminated against for my addiction. It was non-judgemental; it was a peer service, people from my community.*

As Simon writes above, DIVO acted as a needed respite from stigma. It provided an impetus toward community solidarity – even though this could be tested in practice. It is important not to romanticise DIVO or the using scene at the time – pressures of criminalisation, often-scarce drugs and over-inflated prices invariably act to generate rifts, frictions and various shades of shitty behaviour. However, there was a care there, manifest again in the process of sharing memories though our secret Facebook page. I provide an example of this, in relation to a photograph uploaded. This is a great image: Duncan Vaughan, an old friend, standing as if to incorporate himself with a poster of someone injecting on the DIVO wall – the 2D arm morphing into his cheeky figure. He is in the Facebook group and responds to the post with the following quip: “hair still got colour there”.

With this, we are travelling back, re-establishing contact … finding out:
Heath: “Do you still have that bone carving? It was a fish I think’
Karen: “Is your hair grey now?”
Duncan’s reply would do Bukowski[2] proud:

> *Bone carving broken hair turned white doing detox at Kennedy Centre Christchurch came off the done[3] on a slow taper but convinced myself was ok to swallow 100 miggers of slow release morphine cause it wasn’t ‘done think I hold the record for longest shower at Kennedy took me a year to come reasonably sane after that and by then was using just occasionally you know little on the Monday cause a bit seedy from the weekend nothing on Tuesday coz asleep all day Wednesday cause a friend dropped by Thursday hay its payday wee celebration and then shit it’s the weekend most of you know how it goes 47 years on & off sure glad though not having to go through medical waste to score a fit drive underneath Auckland Hospital and throw box of used sharps in the boot take them home a bit of sort and boil up in a big pot yuck it was great when a diabetic dude showed up but I missed the ampoules with a wee tad left in them some bizarre cocktails synthetic adrenalin is not nice IV either so the NX was mana from heaven for what’s left of my generation clean gear with the added bonus you didn't have to give it a sharpen up on the side of a matchbox and the chances of a dirty hit went way down yahoo DIVO.*

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[2] German–American poet and novelist, who writes from experience and with stark emotion of life on the margins of urban American society. See: https://www.poetryfoundation.org/poets/charles-bukowski

[3] ‘done’ refers to methadone. Miggers to mgs. IV is intravenous injection. NX stands for needle exchange.

This post elicits more questions, for example, Karen: *"are you in detox now, go well my friend …"*, culminating in the following offer from Heath: *"I have a taoka pounamu toki*[4] *I would be honoured to see you home if you want, Duncan."*

For me, this is an incredibly poignant exchange – one illustrating a selfless care born out of empathy and shared sense of community. My recollections of DIVO, posted early on to illustrate why I needed additional input, also centre around the role of care and community:

> *Sitting in the toilet, just out and to the side from the DIVO entrance, hitting up, trying to find a vein. Buying and selling drugs. All the things you are not meant to do. Stashing needles for my own use. The feeling of camaraderie, of belonging somewhere. The couch, the welcoming environment, pot smoke billowing down the stairs on a weekend, contributing to DIVO magazine, Rosemary Friend the Doctor who came once a week and diagnosed me with hepatitis C. The only doctor I would see – totally non-judgemental – in front of others just baring my arms would be an affront. Someone telling me they remembered me there, behind the counter, in a black lace top, sleeves stretched down around hands. Despite my efforts, red raw track marks visible beneath.*
>
> *It was a family, and there was a lot of care there. I don't know what to think of the 'me' then – the state of me. Being yelled at on the street by a stranger: 'put on weight', being followed around shops, chemists. Identified, obvious. One of 'them.' But at DIVO there was a home, acceptance, other renegades, a community of users, artists, thinkers – people who wanted to make a difference, or at least commit to living with an intensity of feeling, to operate in a style not accepted by the mainstream. Mine was a rebellion fed by a diet of Burroughs, Patti Smith, books on drugs and alienated outsiders from library shelves; an early sense of connection for a very disconnected teenager. In DIVO, the thrill of a fellow group of outsiders, perhaps.*
>
> *And that we were running this organisation now brings tears to my eyes. I'm rubbish at writing about this. So much deeply felt and not being able to be translated into words, onto the paper. Perhaps I am stuck/caught at the memory of who I was then – the disjunction. Or worse – more likely, that the disjunction is not enough. I have recently been told that I have a 'heroin aesthetic', 'I look like a junkie'. Shit. Time to eat some pies*.

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[4] A greenstone (pounamu) pendant. Traditionally toki (adze) was a ceremonial tool used by Maori chiefs. Worn as a pendant around the neck it symbolises strength, reverence, courage and bravery.

TENSIONS & QUESTIONS

This memory precipitated a somewhat challenging conversation. Starting with a well-taken complement: *"of all the freaks to have Ritalin with, you were one of best"* (Heath). Then after a little back and forth:

> *Simon: Didn't your peers at DIVO become so concerned about your safety they asked you to take a break from working there till you could get it together? I seem to remember someone saying this ten years ago when your name was mentioned, apologises if its untrue.*
>
> *Karen: Yes, sadly it was me that fired Maggie as both me and other volunteers thought she was "too" messy at the time. We were all doing the same things pretty much but there was a feeling of things may be getting out of hand. There was a sort of tightrope I think, of being peers and being able to exist alongside the wider community. I remember feeling conflicted and anxious at the time and not easy about this decision. If I had more skills back then on how to better support staff I would've done things differently. We were all learning on the job back then which mostly was great and contributed to the amazing energy and creativity of the times. We didn't have to have a bloody University diploma in peer support like people do nowadays*.

I remember this time well, and it was somewhat confronting to revisit it in our 'secret group'. Karen was a friend and – thankfully – has remained one. Her post acknowledges the tensions as well as benefits of working with peers and the lack of support – for us all, I think – in grappling with these difficult situations. Here I draw on Simon's contribution, as he also reflects on the challenges of working with peers, but with a slightly different perspective on supports available and how decisions around 'problematic' use were made:

> *The prevailing health philosophy at the time was the Ottawa Charter which had a strong emphasis on developing the capacity and capability of the community to meet its needs. To reach the marginalised stigmatised and criminalised community of PWID DIVO served it was essential to develop and build skills of this community by employing predominately active peer drug users.*
>
> *The DIVO trust [management committee] recognised this would be a challenge to manage but was essential to reach this marginalised community and enable it to effectively respond to challenges such as HIV and Hepatitis C. DIVO trust supported and encouraged our staff, recognising many were living with the challenges of addictions. There was regular external supervision counselling and support for employees.*

> *You couldn't hide problematic drug use from your peers at the needle exchange. It was stand down until you had dealt with your addiction or could manage it in public. It was a sympathetic and pragmatic approach to addiction which ensured DIVO's effectiveness in developing the IDU community to meet their own needs.*

As there are tensions in running a peer-based organisation, there are tensions in working with peers to co-create a remembered history. Not all memories cohere and support each-other. Tensions can be productive – challenging assumptions and illustrating the multiple truths comprising one story. For me, these accounts provoked some (stroppy) questions about the nature of care and support in a peer-led organisation:

- At what point does drug use become 'problematic' or 'too messy' for those employed due to their lived experience? At what point is the 'messy' line crossed and who decides this? Is this a part of policy, provided in induction information, or applied ad hoc on a case by case basis?
- What supports are offered to those asked to 'step down' until they can 'deal with' or 'manage' their drug use? What does "manage it in public" look like – invisibility? Being like everyone else?
- What about those who, being asked to 'stand down', cannot get back up again? Is there anything in place to catch them? For me, dismissal precipitated a free fall, the loss of the one last anchor holding it all together. The organisational safety net, out for repair at the time.
- Is there room to work with or even celebrate the messy intricacies of dedicated drug use? Is there support and recognition for the structural and political constraints to 'reliability', such as unexpected arrest and detainment, or is this seen as indicative of mess?

There is obviously a strong argument for ensuring that those on the front desk, in interaction with clients, have their drug use 'in control'. However, I wondered then if this could be overstated. As a stigmatised population it feels imperative to appear functional, accountable, responsible – to refute the negative expectations and stereotypes of drug user dysfunction. It is difficult to embrace dysfunction then – to work with it, but perhaps we could think more broadly. Provide those in positions of responsibility with understudies, to step in when things go wrong and/or wider networks of support to catch before people fall. I remember, for example, being apprehended and detained by the police on the way to my DIVO shift and my overwhelming anxiety about not being able to make it there or being allowed a phone call to let someone know. I acknowledge also, that my questions arise from my personal experience – but also from a genuine curiosity about to what extent these conversations have been had and worked through in other peer-based organisations.

A LEGACY

Contributors spoke with pride about DIVO, with passion about being part of a peer-led organisation, and of how this could empower and capacitate beyond the DIVO doors:

> *And another part of my life away from DIVO started happening. It's totally different, yet bits are very much the same. Many of the skills I gained still serve me well. Many of the things I learnt - like trusting those who know from first-hand experience - continue to be what I do. (Hilary)*
>
> *Most rewarding to me now, is to see how many of our peers went on to achieve amazing things in the following years. DIVO played a fantastic role in our community for its first decade building community capacity and capability. Collectively we achieved a massive amount of harm reduction slowing the spread of HIV Hepatitis C and building a stronger community. (Simon)*

And to return to my favourite Bukowskiesque post, where survival strategies of pre-needle exchange days are viscerally rendered:

> *go through medical waste to score a fit / drive underneath Auckland Hospital / throw box of used sharps in the boot / take them home a bit of sort and boil up in a big pot yuck … so the NX was mana from heaven for what's left of my generation / clean gear with the added bonus you didn't have to give it a sharpen up on the side of a matchbox …Yahoo DIVO! (Duncan)*

Here needle exchange is evoked as "mana from heaven". Yet, the rest of that sentence "for what's left of my generation" is a reminding rebuke that for many users it was too late and for most – it is still not enough. While celebrating DIVO, celebrating 30 years of needle exchange in New Zealand is warranted, it can only ever be a circumscribed celebration – given the harms continued on people who use and inject drugs through exclusionary practice and policy, of which prohibition is only the most obvious. In continuing the early DIVO legacy, and through providing 'more than needle exchange', it is hoped that NZ Needle Exchange as a collective will continue to advocate for the "value of the lives of people on the margins of society".

AFTERWARD

> *"I found controlled forms of health co-existing with unpredictable possibilities of desire and risk." (Luke 2007, 16)*

Recently, while re-framing this chapter for *IJDP*, I discovered the work of Stephen Luke, and then that he had died only a year after being awarded a PhD in Sociology for his remarkable exposition of peer-based needle exchange networks in New Zealand. Titled "The Emergence of Peer Professionals" Luke's thesis commences with personal reflections on the ambivalences of working for and with the Christchurch peer based NEP in the late 80s and early 90s: 'the whole area seemed inherently troubled while also feeling as if it was accomplishing something genuine and solid” (2007:16). This sense of precarity, of organisational tensions and antagonisms is echoed in other histories of peer-based harm reduction, including through the pressure of creating formal structures, including those of democratic representation, within a stigmatized community with little history of formal organising (Bennett et al., 2011; Crofts & Herkt, 1995; Friedman et al., 1988; Jauffret-Roustide, 2009). For the Australian peer organisation VIVAIDS, each development was an innovation, there were no local model processes or protocols to draw on when they opened Victoria’s first peer-based needle exchange in 1987 (Crofts and Herkt, 1995). The challenges and isolation of developing organisational structures from scratch is also noted by Luke, particularly in regard to peer training protocols: “no other models for group work were available, which meant that the training for IDU ‘peers’ became a concept which resisted formal prescription”. As with the early days of DIVO, much of the networking and representation around peer health at the Christchurch NEP was highly informal and the meaning of these connections ‘difficult to record” (Luke, 2007).

This essay works with and illustrates some of those ineffable connections in order to generate a history of DIVO, the Dunedin Intravenous Organisation. As noted, this is not premised as an authoritative account but a partial and collective act of memory. While the unique origins and formation of NZNEP is of significance, the early days of the Dunedin Needle Exchange may seem esoteric in their specificity. This essay however, aims to provide more than a partial history but to act as a basis to explore or at least contextualise the issue of ‘tension’ as it relates to the personal and professional intertwine of drug use, as explored in this *IJDP Special Issue*. To speak as a peer, as an illicit drug user, is always political. What constitutes a ‘peer’ is necessarily contested. To stay active as a peer-based NEP requires strategic positioning, claims making and silences – some of which may not cohere with activist or personal principles. The accounts in this essay evidence these tensions and silences, but also ingenuity, a steadfast resolve to employ people who were actively injecting drugs, and the growing confidence to speak not only for the public health need for NZNEP but for the human rights of PWID. This history encompasses the emergence of hepatitis C and the innovative and responsive action of peers, that – as elsewhere - pre-empted an official response. Above all, it evidences the creativity, solidarity and cultures of care manifest among people who injected drugs in New Zealand in the late 80s and early 90s. This contrasts to a prominent discursive framing of PWID as in deficit, vulnerable and/or ‘at risk’ – whether by circumstance, bodily incapacity or the relentless hustle of scoring and using (Boyd & Boyd, 2014). While also subject to these constraints, the early history of DIVO evidences an organisation built and run by people who continued to inject drugs, and who were active and instrumental in advocating for change.

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REFERENCES

Barreras, R. & Torruella, R. (2013). New York City's struggle over syringe exchange: A case study of the intersection of science, activism and political change. *Journal of Social Issues, 69 (4):*694—712.

Bennett, T., Jacques, S. & Wright, R. (2011) The emergence and evolution of drug user groups in the UK. *Addiction Research and Theory, 19*(6): 556–565.

Bluthenthal, R. (1998) Syringe Exchange as a Social Movement: A Case Study of Harm Reduction in Oakland, California. *Substance Use and Misuse 33*:1147-1171.

Boyd, J. & Boyd, S. (2014) Women's activism in a drug user union in the Downtown Eastside. *Contemporary Justice Review, 17*(3): 313-325, DOI: 10.1080/10282580.2014.944797.

Bryne, J. & Albers, E. (2010). Coexisting or conjoined: The growth of the international drug users' movement through participation with International Harm Reduction Association Conferences. *International Journal of Drug Policy, 21*:110-111.

Crofts, N. & Herkt, D. (1995). A history of peer-based drug-user groups in Australia. *The Journal of Drug Issues, 25*(3), 599-616.

des Jarlais, D. C., Friedman, S. R., & Ward, T. P. (1993). Harm reduction: A public health response to the AIDS epidemic among injecting drug users. *Annual Review of Public Health, 14*, 413e450.

Frank, V. A., Anker, J. & Tammi, T. (2012). Drug User Organisations in the Nordic Countries – Local, National, and International Dimensions. *Substance Use & Misuse, 47*: 462-473.

Friedman, S. R., de Jong, W. M., & Des Jarlais, D. C. (1988). Problems and dynamics of organizing intravenous drug users for AIDS prevention. *Health Education Research, 3*(1), 49–57.

Friedman, S. R., de Jong, W., Rossi, D., Touzé, G., Rockwell, R., Des Jarlais, D. C., & Elovich, R. (2007). Harm reduction theory: Users' culture, micro-social indigenous harm reduction, and the self-organization and outside-organizing of users' groups*. International Journal of Drug Policy, 18(2), 107 - 117.* doi:10.1016/j.drugpo.2006.11.006.

Friedman, S. R., Schneider, E. & Latkin, C. (2012). What We Do Not Know About Organizations of People Who Use Drugs. *Substance Use & Misuse, 47*:568–572. DOI: 10.3109/10826084.2011.629707

Harris M. (2013) The 'do-it-yourself' New Zealand injecting scene: implications for harm reduction*. International Journal of Drug Policy, 24*(4):281-3. doi: 10.1016/j.drugpo.2012.06.007

Jauffret-Roustide, M. (2009) Self-support for drug users in the context of harm reduction policy: A lay expertise defined by drug users' life skills and citizenship. *Health Sociology Review, 18*(2): 159-172, DOI: 10.5172/hesr.18.2.159

Jozaghi, E., Greer, A.M., Lampkin, H., Buxton, J.A. (2018). Activism and scientific research: 20 years of community action by the Vancouver area network of drug users*. Substance Abuse Treatment, Prevention and Policy 13*(1), 18.

Kemp, R. & Aitken, C. (2004) The development of New Zealand's Needle and Syringe Exchange Programme. *International Journal of Drug Policy, 15*: 202–206.

Kerr, T., Small, W., Peeace, W., Douglas, D., Pierre, A. & Wood, E. (2006). Harm reduction by a "user-run" organization: A case study of the Vancouver Area Network of Drug Users (VANDU). *International Journal of Drug Policy 17*(2), 61-69.

Luke, S. (2007). *Needle Exchange Networks: The emergence of 'peer-professionals'*. Unpublished Doctoral thesis, University of Canterbury.

Lungley, S. & Baker, M. (1990). *The Needle and Syringe Exchange Scheme in Operation: An Evaluation of the First Year*. Wellington: Department of Health.

Madden, A. & Wodak, A. (2014). Australia's response to HIV among people who inject drugs. *AIDS Education and Prevention, 26*(3):234-244.

McLean, K. (2012). The biopolitics of needle exchange in the United States. *Critical Public Health, 21*(1): 71-79.

Moriarty, H., Kemp, R. & Robinson, G. (2001). Hepatitis services at an injecting drug user outreach clinic. *New Zealand Medical Journal, 114*(1128): 105-106.

Moss, A R., (1987). AIDS and intravenous drug use: the real heterosexual epidemic. *British Medical Journal, 294* (6569): 389 – 390.

Needle Exchange Services Trust (NEST). (2020). A New Leader for The New Zealand Needle Exchange Programme. *Scoop Independent News*, 16 October 2020. https://www.scoop.co.nz/stories/GE2010/S00079/a-new-leader-for-the-new-zealand-needle-exchange-programme.htm

Parliamentary debates (1987). 17 June Misuse of Drugs Amendment Bill. v.481, pp. 9607-9614. Available from: https://babel.hathitrust.org/cgi/pt?id=uc1.l0107625261&view=plaintext&seq=305&q1=needle