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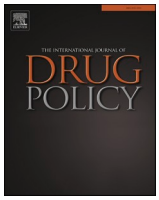

Research Paper

How do relational practices co-constitute care for people who use drugs? The social and political dimensions of peer-led harm reduction

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ABSTRACT

Introduction: People who use drugs have a long history of mobilising to reduce harm within their communities, significantly influencing harm reduction efforts globally. Peers with lived experience contribute through needle exchange programs, harm reduction education, and community-based research. Despite facing stigma, their initiatives have generated multiple benefits for communities. Collaborations between peers and researchers are increasingly recognised, emphasising meaningful participation in decisions affecting their lives. This paper focuses on the role of peers in mitigating drug-related risks and harms through community care.

Methods: Semi-structured interviews were conducted with 30 people who use drugs, exploring peer support and harm reduction. Data were analysed by the lead author and a coding framework was developed in which key theme-categories were organised. Theoretical framing from science and technology studies informed analysis, recognising the political dimensions of research.

Results: Peers play a crucial role in bridging gaps in formal services, offering stigma-free, relational care spaces. These spaces, both physical and social, affirm dignity and solidarity, countering marginalisation. Participants highlight the importance of peer involvement in driving change, promoting safer use practices, and advocating for a holistic harm reduction approach that considers systemic factors.

Conclusions: Our data highlight the vital role of peer connections and peer-led harm reduction practices in fostering safety, solidarity, and connection among communities of people who use drugs. Future research should continue to explore peer-led initiatives within evolving healthcare contexts, considering broader social dynamics and employing innovative conceptual frameworks to promote equitable peer-led harm reduction strategies.

Introduction

People who use drugs have an extensive history of mobilisation in coming together to reduce harm among the community and have, consequently, played a central role in shaping harm reduction efforts across the world (Marshall et al., 2015). Referred to commonly as peers, those with Lived-Living Experience (LLE) of drug use actively contribute to reducing harms including through needle and syringe distribution services, harm reduction education, peer support, and community-based research initiatives (Francia et al., 2023; Lobo et al., 2020; Satinsky et al., 2021; Silano et al., 2022). In this context, "peers" refers to individuals with LLE of drug use who are active within the community but may not hold a formal role in the workforce. "Peer workers," on the other hand, are individuals with LLE who are actively involved in the workforce, either as volunteers or paid employees (Greer et al., 2019). Consequently, peer workers (who are also peers by nature) are collectively involved in the creation, implementation, and assessment of harm reduction services, whether provided through mainstream public health agencies, community health settings, or organisations focused on people using drugs.

There is growing recognition of the vital labour and expertise of peers. For instance, peer involvement in HIV and harm reduction services in low- and middle-income settings has been linked to positive outcomes such as reduced HIV incidence, increased service access, and decreased stigma (Chang et al., 2021). Peers have also played a vital role in hepatitis C prevention, and in helping to advance testing, treatment

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and elimination agendas in the age of cure (Kagan et al., 2023; Lancaster et al., 2015). Scholars have shown that peer-based interventions can significantly shift social norms within networks, leading to both individual and collective behaviour change (Latkin et al., 2003, 2010). Latkin et al.'s (2013) work emphasises the bidirectional relationship between norms and behaviours, where individuals' actions both shape and are shaped by the prevailing norms of their social circles. By facilitating discussions around health-promoting behaviours, peer-based interventions can reduce barriers to behaviour change, enabling these norms to diffuse throughout the network. Of course, there are also challenges in studying and documenting the work that peers do. For instance, while research has been instrumental in highlighting the importance of peers in health promotion, there is also the possibility that work which focuses on changed behaviours, norms and risks framing people who use drugs as principally responsible for the prevention of drug-related harms, thus reinforcing neoliberal notions of individual responsibility and blameworthiness (Seear, 2023b; Fraser, 2004). Of course, peer work is also complicated by structural forces such as criminalisation, stigma, and under-resourced health systems (Allman et al., 2006; Piatkowski & Kill, 2024). Indeed, a growing body of research examines the stigma peers face across various settings, including in general healthcare services (Carl et al., 2023; Farrugia et al., 2021; Fomiatti et al., 2022; Kagan et al., 2023; Paquette et al., 2018). Researchers have argued that peers encounter stigma across every area of their life when accessing healthcare and that it is deeply woven into the fabric of their everyday lives (Fraser et al., 2017). The prevalence of stigma has important implications for the sustainability of the workforce, and workforce capacity, as well as for individual workers who must deal with the personal toll of such stigma. Furthermore, analysis indicates that the overdose crisis and the responses to it are inextricably linked with stigma (Fadanelli et al., 2020; Piatkowski et al., 2024b; Selfridge et al., 2020), making it impossible to separate the two neatly. This stigma not only complicates public and institutional responses but also affects the efficacy of peer-led interventions, as peers often face the same societal biases that impact the broader harm reduction efforts. In spite of these conditions, some of the most successful harm reduction strategies, such as needle and syringe programs (Crofts & Herkt, 1995; Harris, 2021), peer-delivered naloxone (Bennett et al., 2018), and community-based drug checking (Barratt & Measham, 2022), originated from the initiatives of peers well before gaining widespread support from the broader public health community. Chang et al. (2021) argue that peer involvement remains under-theorised, with a need to better understand the mechanisms and contexts that influence its effectiveness in this complicated climate of criminalisation and stigmatisation, where the risks of responsibilisation and blame are high, as we noted earlier. Our study situates itself within these debates and the call for more work on peers. While recognising that peer interventions are valuable, we argue that more work is needed to understand how peers navigate their roles within the context of broader social, political, and structural constraints. By focusing on how peers contribute not just to behaviour change but to identifying emerging challenges in drug policy and harm reduction, our work shifts the focus from individual responsibility to collective knowledge and action, and considers some of the relational dynamics that make peer work possible.

As we will explain, our approach also fills a critical gap in the literature by emphasising the importance of integrating the LLE and expertise of people who use drugs into policy-making and research, not just as research 'subjects', but as key contributors to research itself, with the capacity to identify important issues for analysis and guide the direction of future inquiry. To this end, collaborations between peers-as-experts and researchers are being more readily undertaken (Farrugia et al., 2022; Fraser, Fomiatti et al., 2020; Neale et al., 2022; Piatkowski & Cox, 2024) and, thus, given increasing levels of recognition among practitioners and policymakers. Although community engagement encompasses various approaches, it frequently includes participatory elements in social planning, policy advocacy, and operational decision-making (Farrugia et al., 2022). Central to this approach is the core principle that individuals should have meaningful opportunities to influence decisions that directly impact their lives (Harris, 2021; Seear, 2020). The expertise of people who use drugs is utilised in extant qualitative work to improve the relevance and acceptance of various programs, advocacy efforts, policymaking initiatives, and research projects across different fields (Fomiatti et al., 2022; Fraser, Moore et al., 2020; Neale et al., 2022; Rance et al., 2018; Rhodes et al., 2017). In harm reduction settings, peers have played key roles in designing and implementing programs such as methadone maintenance and hepatitis C prevention (Carl et al., 2023; Goodyear et al., 2021; Kagan et al., 2023; Silano et al., 2022; Wu et al., 2023). These types of partnerships have also extended to overdose prevention research, through collaborative qualitative work (Conway et al., 2021; Faulkner-Gurstein, 2017; Fomiatti et al., 2022; Natale et al., 2023; Neale et al., 2022). Globally, a significant body of work examines people's experiences of opioid overdose (Chang et al., 2019; Mansoor et al., 2022; Paradise et al., 2023; Piatkowski et al., 2024b). Research on overdose underscores, among other things, that various structural factors contribute to and shape overdose (Selfridge et al., 2020), and that peers' everyday experiences of overdose sometimes conflict with public health messages and approaches (Chang et al., 2019). This type of collaborative work posits that, by leveraging the social networks of people who use drugs, such interventions have the potential to transform these relationships into health-promoting and protective ones (Faulkner-Gurstein, 2017; Neale et al., 2022; Piatkowski & Cox, 2024; Pienaar et al., 2017). Building on this body of work, it becomes clear that peer involvement extends far beyond specific interventions like take-home naloxone, encompassing a wide range of harm reduction efforts. As such, there is a growing need to explore not only the tangible outcomes of peer-based interventions but also the underlying social dynamics that drive their success in diverse community settings. Notably, this paper is co-authored with peers who have been instrumental in identifying and prioritising the issues we study, ensuring that our research is deeply rooted in the lived experiences and insights of those directly impacted.

For these reasons, this paper focuses on the role of peers with LLE of overdose. We investigate how peers leverage their firsthand expertise and social networks to reduce substance-related harms, including overdose, through in-depth interviews. These interviews explore the formal and informal work peers undertake to mitigate these harms. We also examine how peers navigate and experience this work, including in the complex climate of criminalisation and stigmatisation that we described earlier, and consider the nature and value of relational dynamics in both structuring and sustaining peers in this work. The overall aims of this study are: to understand how peers currently reduce harm in their communities by drawing on their personal narratives and experiences, and how they can be supported to continue to perform this complex, challenging work.

Approach

Our analysis examines the social networks and interpersonal relations of care within harm reduction among drug-using communities through the lens of onto-politics and care as process-oriented practice. To this end, we draw on work from Science and Technology Studies scholars John Law (2002) and Annemarie Mol (1999), who suggest that the world does not pre-exist efforts to study it through research, as if waiting to be merely 'discovered' through research practices. Rather, research practices create specific relationships between subjects and objects, including humans, non-human entities, and technologies. These perspectives have proven particularly useful for researchers in the field of alcohol and other drugs, including those focusing on hepatitis C (Fraser & Seear, 2011), drugs and overdose (Farrugia et al., 2017; Fraser, 2013). This type of critical scholarship offers valuable insights into questions of care (de La Bellacasa, 2017; Dennis, 2017; Dennis & Farrugia, 2017; Duff, 2015) and suggests that 'drug problems' are

shaped by multiple forces, including structural and systemic forces (such as drug criminalisation), and other dynamics in service provision and care, including in the extension of respect, compassion and fairness to people who use drugs and utilise services (Mol, 2008).

According to these approaches, care is understood not as a static or universally applicable concept with a fixed meaning, but as a dynamic, situated practice that emerges through the specific interactions between human and more-than-human actors, technologies, and broader societal structures. Mol (2008) articulates care as a 'logic of care,' contrasting it with a 'logic of choice.' While the logic of choice is individualised and goal-oriented, grounded in predetermined evidence and decisions, the logic of care is relational, embedded in social contexts, and enacted through specific, localised practices. It focuses on the values and particularities of practice, rather than abstract principles. De la Bellacasa (2017) extends this understanding of care by emphasising its entanglement with the material and affective dimensions of life. She suggests that care is not only an ethical practice but a political act, one that shapes and is shaped by the worlds in which it is enacted. This perspective is crucial for our analysis, as it acknowledges that the practices of care located within harm reduction are co-constituted with the very knowledge and interventions, we, as researchers, produce.

By focusing on care as a process-oriented and relational practice, our approach seeks to understand how harm reduction and peer support are both conceptualised and enacted within peer communities. We conceptualise drug-related harms, and the way these are experienced by people who use drugs, as interconnected with broader networks of relational and material practices, rather than as isolated incidents or individual choices. Following the work of Suzanne Fraser (2020), we also adopt an explicitly 'onto-politically-oriented' approach to this research. As Fraser explains, ontopolitically-oriented research is research that sees research methods as *shaping* realities, rather than as documenting a single 'reality' that pre-exists our efforts to know it. In other words, research practices (including methods, theoretical tools, research questions, recruitment strategies and more) work to constitute the very realities, dynamics and problems being investigated, and are thus intrinsically political and ethical, with major implications for the communities being researched. According to Fraser (2020), this way of thinking about research practices has important implications for how we approach research. She argues that 'researchers have the obligation not only to track the realities being made by their research, but to approach the design and conduct of the research with this action in mind' (Fraser, 2020). So, she enjoins researchers to 'consider the realities we wish to "research into being" and formulate our aims, questions, data sets and analyses accordingly, unconstrained by untenable aspirations to neutrality'. In the spirit of ontopolitically-oriented research, then, we also approach our task here as one that sees research into peer and community-led harm reduction as inherently political. The issues we choose to focus on have the potential to make worlds, with real political implications, including (for instance) in terms of how the value of this work is understood, and for dynamics of agency, responsibility and blame of the kind we described earlier. With these issues in mind, we examine how various forms and practices of peer-led harm reduction are valued and made significant within these communities, emphasising the nuanced ways in which care is both enacted and experienced. We also consider the dynamics and relations that support and sustain such work, on the basis that such work is vital, and that its sustainability should be a policy priority.

Method

Geographical and sociopolitical context

In Australia—the setting for this study—drug policy is shaped by a harm minimisation framework that includes harm reduction, supply reduction, and demand reduction strategies (Australian Government, 2017). However, despite this framework, Australian jurisdictions continue to have strict criminal penalties for drug offences (i.e., up to 25 years in prison for possessing illicit drugs), with significant variation in sentencing based on the type and amount of drugs involved. Australia has experienced a troubling increase in drug-induced deaths in recent years, particularly from pharmaceutical opioids and stimulants (Penington Institute, 2024). Despite these trends, recent years have seen a decline in funding for harm reduction services, with only 1.6 % of federal and state government expenditure in 2021/22 dedicated to harm reduction initiatives, compared to 65 % for law enforcement (Ritter et al., 2024). This complex sociopolitical environment underscores the critical role of peers, as they often find themselves having to navigate the need to advance harm minimisation strategies in a resource-constrained environment, while simultaneously working within a punitive legal landscape.

Sampling and recruitment

The study recruited 30 people who used drugs who identified as peers in the community. The study's recruitment strategy leveraged the research team's networks, including two peer-researchers (TP & EK). This approach involved consulting with peers, utilising social media platforms (e.g., Instagram), engaging in face-to-face discussions within their peer networks (e.g., at local needle service providers) to aid in recruitment by explaining the importance and relevance of the research to their community. Invited individuals received a clear statement in plain language and were given the choice to participate or decline. Those who agreed underwent individual interviews, during which verbal consent was obtained. Participants were recruited and interviewed between November 2023 and January 2024. Participants were assured of their right to withdraw from the study at any stage. As a token of appreciation for their time and expertise, participants received a $90 AUD gift card. Ethical approval was obtained from the University Human Research Ethics Committee (2023/782). We assigned pseudonyms to protect participant identities.

Data collection

A single interviewer (SR) conducted all interviews using a semi-structured interview guide, developed by the research team, and informed by both existing literature and lived experience. This approach ensured that the questions were not only grounded in academic knowledge but also resonated with existing insights from communities on substance use and overdose. The interview guide incorporated insights from the team's own experiences with substance use and witnessing overdoses, which shaped the way questions were framed and ordered, ensuring sensitivity to participants' lived experiences. This method facilitated a nuanced exploration of participants' narratives, fostering an empathetic dialogue. Example questions include: What preventive measures or strategies, if any, do you and others you know practice to reduce the risk of harms? How do you perceive the role of peer and community support in addressing overdose? Have you or others you know engaged in any peer-led interventions or initiatives related to overdose prevention? To validate the questions and enhance researcher confidence, two pilot interviews were conducted with individuals possessing expertise in lived experience, drawn from the research team's network. The pilot interviews ensured alignment with research objectives and contributed to refining the interview process. Interviews were scheduled based on participant availability and conducted via the Microsoft Teams platform. They were open-ended and automatically transcribed, with manual review and correction by the research team to ensure accuracy. Data were then imported into NVivo for analysis.

Data analysis

The lead author utilised NVivo 12 (QSR) to organise and code

interview transcripts. An iterative inductive approach was employed for analysing the interviews (Neale, 2016). The lead author conducted a thorough review of transcripts and notes to identify potential categories. Initially, deductive codes were developed based on key themes identified in the study's research objectives, such as "peer support dynamics," "harm reduction practices," and "navigating stigma." In parallel, inductive codes, including "community knowledge sharing," "trust-building," and "informal care networks," emerged through collaborative team discussions as new patterns and insights surfaced during the analysis. These insights were shared and discussed by the team, leading to the development of a comprehensive thematic coding framework (Neale, 2021). Our analytic approach was further informed by the theoretical framing of Science and Technology Studies, as noted earlier, emphasising the co-productive relationships between individuals, society, and technologies. Drawing on this perspective, we recognised the inherent political dimensions of research on peer-led harm reduction processes, acknowledging that our inquiries involve ethical and political considerations that shape and are shaped by the landscapes we study.

The research team, comprising individuals with diverse experiences and expertise, engaged in a reflective process during data analysis. The two peer-researchers (TP & EK) brought critical peer-researcher perspectives that enriched the interpretative process. Their insights, rooted in LLE, provided nuanced understandings of the practices and challenges faced by people who use drugs. In partnership with (KS), the team included a law and sociology professor whose extensive expertise in Science and Technology Studies, human rights, and drugs added a robust framework to the analysis. Additionally, a PhD student (SR) conducting research related to substance use, contributed to collaborative discussion. Throughout the analysis, the research team actively engaged in discussions about their positionality, recognising how their diverse backgrounds, experiences, and perspectives shaped the interpretation of the data.

Findings and discussion

Interviews ranged from 47 min to 1 h and 49 min, with a median interview time of 1 hour and 7 min. Of the thirty participants aged between 25 and 73 years old ($M = 47.3$, $SD = 10.18$), 18 identified as women, ten as men, one as non-binary, and one as gender fluid. In this section, we present our findings. We focus on three theme-categories: Solidarity, connection, and safety; Peers making 'safe' care spaces; and Peer-led harm reduction and expanding community care practices (see Fig. 1).

Solidarity, connection, and safety

First, we highlight the transformative power of LLE in shaping behaviour and knowledge dissemination within peer networks, inextricably linked to peer *solidarity, connection*, and *safety* principles. As Elias explains:

> Elias [43, male]: Once someone's seen something work or know something works like they […] you know, saw a guy [overdose] and he got Narcanned [Naloxone administered], thought 'this shit works. Man should go and get it, it worked'. You know, word of mouth. It's very powerful tool. If a peer is wisening them up about that, well then other people will start listening.

In examining these dynamics through the lens of onto-politics, we highlight how peer-led harm reduction practices are not merely technical solutions but deeply entangled with the relational and social dynamics in which they are enacted. These social and affective relations help shape practices of care by fostering a sense of trust and credibility unique to peer interactions. Witnessing the effectiveness of interventions like naloxone administration firsthand encourages people to share these experiences within their networks, facilitating the dissemination of vital information. The emotional bonds and shared experiences among peers create a supportive environment where advice and knowledge are readily accepted and acted upon. Thus, peer networks serve as conduits for behavioural change and knowledge transfer, grounded in mutual respect.

Several participants highlighted the transformative power of peer connections in reclaiming identity from stigmatising labels like 'junkies' and 'addicts'. By transcending these negative perceptions and terms, peers create a sense of collective belonging, empowerment, and safety. This process of redefining their identities allows them to assert their humanity in a context where people who use drugs are often marginalised or dehumanised (Keane, 2002; Seear & Fraser, 2010; Seear, 2023a). This not only enhances peer connections but serves as a testament to the resilience and agency of individuals with LLE. As Mila explains:

> Mila [44, female]: [on Peer connection] Through education, through solidarity, through representation, I think it's about, you know, breaking down that self-shame, being able to identify with others. And I think also shaping our identity as well, like we're not or you know that horrible word 'junkies'.

Mila's perspective underscores how peer connections foster a stronger sense of self and 'Peer solidarity,' enhancing mutual respect and trust. This solidarity is built on shared experiences of navigating stigma and adversity, and is vital to the work that peers are able to do. Peers, therefore, establish profound connections through these shared experiences, as Leilani reflects:

> Leilani [51, female]: You know if somebody 'gets it'. Book learning people can be very, it can be frustrating at times because they just don't see […] and they can't because it has not been their experience. So yeah, the peer workforce I think is absolutely essential in, especially in AOD.

Here, we focus on care as a social 'practice', in which Peers described seeking out information about 'using' and supporting each other to reduce risk. When considering care practices, Mol et al. (2010), encourages scholars to consider 'what is sought, fostered, or hoped for, then and there: what is performed as good' (p. 12). This evaluation of 'good' care prioritises addressing the immediate, specific needs of individuals in their current situations, which we relate back to the principles underpinning harm reduction. Collectively, this socio-affective relationship which underpins peer care, translates to what we term here as 'peer safety'.

> Ava [47, female]: That process happens naturally, like people who use drugs get their information and support from other people who use drugs. You know, there's a lot of things when you use drugs that you know, I guess you become part of this other world or subculture of people. And you know, it's difficult for other people who aren't

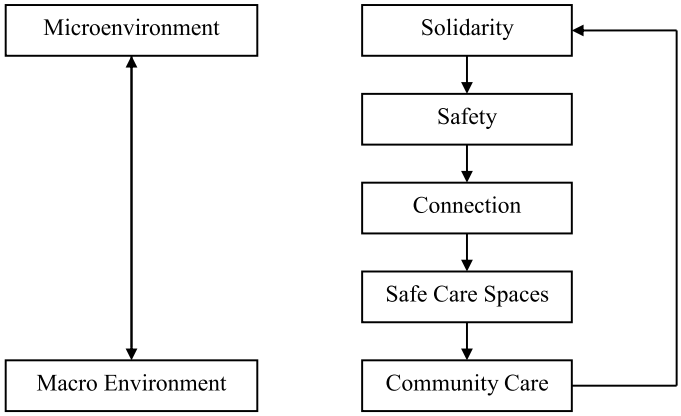

Fig. 1. Visual representation of findings.

involved in that world to understand some of the nuances of it. So, you tend to just talk to other people who are in that world and who are kind of using or injecting drugs as well because you can be open and honest with other Peers. And I feel like there's, you know, higher level of trust, you know, in those voices and in those connections.

In this way, the practices of care and solidarity among Peers serve as a powerful counter-narrative to the stigma and marginalisation often faced by people who use drugs, highlighting their resilience and capacity for compassionate care.

Peers making 'safe' care spaces

Despite the availability of community health and harm reduction services, the absence of peer support often leaves individuals feeling disconnected and unprepared to navigate challenges, such as ceasing methadone. Informal peer support, provided by peers with LLE of substance use, plays a crucial role in addressing these gaps. Peer workers, who are formally trained and employed, utilise their expertise to support clients in accessing health services (e.g., pharmacy, hospital, medical practices) and to challenge stigma within these settings. Peer workers ensure safety, privacy, and confidentiality, operating without judgment and preserving clients' respect, dignity, and self-determination. Their roles are integral to maintaining social, emotional, and spiritual well-being, providing a sense of community and shared experience that formal services often lack, as Paisley reflects:

Paisley [41, non-binary]: I remember like I was 22 years old trying to get off methadone and I remember saying to [service] like, 'is there, like, who can I talk to?' No one educated me about how awful getting off methadone was right? Like it was just like this thing. And I remember at the time being like, 'I just wanna talk to someone'. And they were like, 'there is no one available, no one'. So, I mean to get off the methadone I started using heroin again because I didn't know how to do it and I think now like the role of peers is just, it's so good, right? Like cause now you have people that have used and have overdosed and who understand this, talking to people and being like, 'hey, there is a different way, you can'.

Embedded within accounts such as Paisley's is the importance of 'safe spaces'. The relationally-driven nature of peer support questions the traditional view of 'formal' interventions and their effects as fixed and stable. Instead, we propose that the interventions and the care 'spaces' which surround them, are relational and emergent, thereby multiple rather than singular (Mol, 1999). This perspective challenges the dominant presumptions in the enactment and practice of mainstream evidence-based health intervention paradigms that separate the physical and social, nature and culture, and evidence and practice. As scholars have indicated previously (de la Bellacasa, 2017; Fraser and Seear, 2011; Rhodes, Azbel et al., 2019) these elements are entangled in material practices. For instance, our participants, including some who were peers working within the community in support roles, noted that people who use drugs were inclined to seek assistance in more 'inviting' environments. These 'enabling' spaces are not only physical (Duff, 2011) but are importantly, less stigmatising. These safe care spaces serve as vital conduits for human connection and solidarity, affirming individuals' dignity and offering a lifeline amidst challenging circumstances, as Levi explains:

Levi [46, male]: People come here [frontline health and harm reduction service] when they need help, even injecting. They do it for people because there is someone they can ask and talk to there. They really just need someone because these people worry about this shit, they don't wanna die doing it. But no one cares. So like if they come to some place like this, all they are is just trying to tell themselves that they do care, that people do care, and don't hate them.

By exploring care spaces in this way, our approach affords us to expand the notion of agency beyond human actors to include more-than-human actors, such as drugs, paraphernalia, and health service spaces (Duff, 2012; Vitellone, 2017). This focus on materiality orients towards ways of thinking ontologically about health interventions that do not privilege human objects or their sciences as the primary agentic force (Law, 2008). Instead, it calls all objects, human and otherwise, into view, as Aria explained:

Aria [34, female]: When we talk about overdose prevention interventions, I think it's a lot around the lack of harm reduction education, because you know, we know obviously the best way to avoid overdose is to not use. But we know that that's not really realistic. So, I think it's just changing the context and making the place, where you have a client, be a safe place for them to disclose without judgment. Cause if people aren't disclosing and then you don't actually get that opportunity to provide them any messaging. So, I think you know, I think to even get to the point where we're providing an overdose intervention, we need to make that early safe space for people.

Peer interventions are inherently relational, relying on the shared experiences and mutual support among peers. This relational dynamic is essential for helping individuals navigate challenges like methadone cessation and overdose. Peer support workers, through their interactions, maintain social and emotional well-being, offering non-judgmental, respectful, and dignified care. This relational and emergent nature of peer support adds weight to the current evidence base, and further underscores the importance of integrating peer workers into health interventions, recognising their unique contributions to the overall effectiveness and adaptability of these programs.

Sebastian [49, male]: One of the things that I love about being a peer support worker and about peer support workers is - so their ability to connect with people on a level, where [other] professionals can't […] or their ability to connect people with [other] professionals in that aspect. And so I was able to, as a peer support worker, talk to and connect with people with empathy and connect with people because I could say, 'look, I've been where you are. I know what you're going through because I've done it and I've been there and by the way, you can trust this person' and then connect them with the professional and say, 'look, this person is a really good person, you can trust them'. And they'll go 'ohh. Look, if you trust them, I'll open up and trust them as well'.

Isla [51, female]: I get so much more because when I talk to people at the [needle and syringe program], I kind of like they know that I'm a user too, and I'm a peer and then they like open up to you. And like it puts them at ease really, you know, it's and not being judged and that's huge. Like really the brief interaction you have on the [needle and syringe program] counter is just like really – because I've been in that experience before, I've been in between full addiction and partial sobriety and it's such a lonely place. And like, I mean, a chat to someone can make your day.

Participants emphasised the crucial role of peer workers in bridging gaps between communities and services. This aligns with Fraser and Moore's (2011) findings, demonstrating how emotional connections and interactions at sites like the Sydney Medically Supervised Injecting Centre reduce client shame and foster new identities. Many participants highlighted the unique ability of peer workers to connect with empathy and understanding, fostering trust that facilitated further engagement with healthcare professionals. They underscored the necessity for strategic collaborations between LLE, peer support, and other professionals to enhance the overall safety and wellbeing of people who use drugs.

Peer-led harm reduction and expanding community care practices

We build on our approach to draw on Mol's (2008, 2009) work on

care practices. For instance, Maverick critiqued the gap between those with LLE and professionals who lack direct engagement with drug use:

> Maverick [73, male]: If you're the police or you're the courts, or you're the doctor, you don't know, you don't do drugs, you're abstinent. As far as I know. So don't tell me shit about shit that you know nothing about.

This highlights a key aspect of care as a relational and situated practice (de la Bellacasa, 2017). Maverick emphasises that effective harm reduction relies on the LLE of peers, who bring practical and empathetic insights that formal services often lack. His perspective reinforces the idea that care is co-constituted through these interactions, demonstrating how peer-led interventions can address the nuanced needs of people who use drugs more effectively than those who are detached from their experiences. Importantly, such accounts also underscore the importance of trust, rapport, positionality and identity in making care possible. Such care is also not simply about reducing or preventing harms (although this matters a great deal, of course) but about fostering belonging and inclusion in and between one another, and in developing solidarity, confidence, and strength in an otherwise complex, hostile, criminalised and stigmatising environment. These relational dynamics, affects and effects are significant for people who use drugs, and important ways of thinking about the value of peers and peer workers.

Peer care functions within a complex web of social and material relationships, rather than in isolation. To fully appreciate the effectiveness of peer-led harm reduction, it is crucial to consider these broader dynamics. By focusing on practices and relationships that attribute meaning to innovations, as de la Bellacasa (2017) suggests, we shift from viewing harm reduction tools—such as new treatment technologies—as static objects to understanding them as part of a relational network that includes expressions of creativity, care, and resourcefulness. Our participants echoed this sentiment, emphasising that the involvement of people who use drugs is crucial for effective communication and dissemination of information. As Abigail notes:

> Abigail [47, female]: Look, I think it's imperative that drug users are involved in bringing these changes about, because without that the information doesn't get out there. If with as many pamphlets as you've got, many websites as you've got, still the most current and the most believed way of getting the information to others seems to be through word of mouth, unfortunately. And so, to do that, you need people like us to actually infiltrate the community in terms of that information.

By integrating these harm reduction strategies, community members engage in relational and context-sensitive practices, which scholars (de la Bellacasa, 2017; Mol, 2009) would describe as part of the broader network of care. These practices—such as using only half of a substance initially, avoiding solitary use, and being cautious about tolerance—reflect a dynamic approach to safety and risk mitigation. This approach emphasises the importance of informed decision-making within the context of drug use, highlighting how care and safety are co-constructed through ongoing interactions and adjustments within the community, for instance:

> Aria [34, female]: So, we definitely do a lot of education around, you know, use half first. Don't use alone. Be careful of tolerance around, you know using if you have had a break.

Other peers expounded on these principles of safer use and there was a profound level of importance placed on peer communication in promoting safer use practices. The interviewees encouraged individuals to connect communities that intersect around drug use, establishing a network of support and vigilance. The role of peers in sharing information about the quality and potential risks of substances is a way of fostering a collective approach to harm reduction. Others advocated for a harm reduction strategy, advising others to start with a small amount and gradually increase, emphasising the principle of "*start low, go slow*", sharing parallels with harm reduction messages among other drug-using cohorts: "*less is more*" (Piatkowski et al., 2024a). Collectively, we draw these narratives together to underscore the role of promoting peer-led harm reduction messaging and practices within communities of people who use drugs:

> Olivia [48, female]: I would just use a little bit, you know, the start low, go slow, kind of thing and I would tell other people that, you know, just have 1/4 of it, have 1/2 of it and just see how you go because you can always have more.

> Elijah [63, male]: Tell your friends: 'Look I've had a few things, can you just keep an eye on me every now and then'. You know, that's the best thing to do. If you're used to taking drugs and you've taken a party drug or something, just letting your friends know. Just say 'hey, keep an eye on me'.

While these practices of care matter, it is also important to consider what they might foreclose or efface in an environment that continues to be structured by punishment, stigmatisation and violence. In other words, as Fraser (2004) has previously asked, might there be pitfalls of focusing on individualisation and responsibilisation in drug policy in the ways described here?

Fraser's work critiques health promotion materials that emphasise individual responsibility for hepatitis C prevention and safe injecting. The imperative to care for oneself and one another, undoubtedly made more urgent by the criminalisation of drugs, stigma and an ongoing overdose crisis, can inadvertently create ethical expectations for people who inject drugs to adhere to rigid social and hygiene-related conduct, potentially leading to blame if harms eventuate. Fraser argues that this individualist approach reflects Western cultural norms and can cause people who inject drugs to internalise responsibility and blame, which has significant social and health implications. Of course, it is worth remembering that people who use drugs are often also at risk of prosecution in these circumstances, including through so-called 'drug induced homicide' prosecutions (Beletsky, 2019). Nourse et al. (2024) build on these critiques by emphasising the need to frame harm reduction within a broader social and structural context. They argue that effective peer-led harm reduction should account for both systemic influences and individual needs. Policymakers should recognise the interplay between structural determinants and the LLE of people who use drugs, ensuring that harm reduction strategies address both systemic issues and individual responsibility without perpetuating blame or stigma. In our account, we argue that there is great value in the solidarity, connection, and safe spaces that peers and peer workers can help to constitute. These dynamics are integral to care and harm reduction, as we have argued here, and important forces in its production. But they are also an important good in and of themselves, especially given the profound hostility, stigma, social exclusion and marginalisation that are enabled by criminalisation. In this article, we have argued that these dynamics are also important, highly-valuable dimensions of peer work, and that they confer meaning for both peers/peer workers and service users. Sustaining and supporting these dynamics is vital for the future of peer work, and for efforts to foster inclusion, belonging and care.

Conclusions

While peer roles in harm reduction are distinct in their focus on drug use, they share similarities with peer roles in other areas of health and social care, particularly in their emphasis on community engagement, participatory decision-making, and the co-creation of interventions (Greer et al., 2020; Mutschler et al., 2022). However, the role of peers in mitigating drug-related risks and harms is uniquely grounded in the LLE of drug use, offering a perspective that differs significantly from peers working in other health contexts. This experience allows peers to navigate the complex sociocultural and legal landscapes of drug use, where

traditional healthcare interventions may be less effective (Paradise et al., 2023). To do so, peers operate within and are shaped by the social network structures and norms that surround them (Latkin et al., 2003), and which they, in turn, help to shape. These structures and norms play a critical role in shaping behaviours and attitudes within communities (Latkin & Knowlton, 2015). Research has underscored that peer roles in harm reduction services, while primarily focused on education, counselling, and referrals, were often constrained and underutilised, reflecting broader issues of marginalisation and responsibilisation (Moorthi, 2014; Le et al., 2015; Stengel et al., 2018). Despite some evidence suggesting effective peer-driven models and the potential for expanded roles in management and advocacy, however, Chang et al. (2021) revealed limitations in extant work particularly when evaluating the impact of contextual factors and underlying theories. We unpick these theoretical concepts within the context of the harm reduction and safety-focused networks of the peers in the current research study.

By engaging with recent work in Science and Technology Studies, we have interrogated the co-productive relationship between individuals, society, and technologies, building understandings of how care is constituted by peers in the context of harm reduction work. The findings presented in this study underscore the transformative power of peer connections and the importance of peer-led harm reduction practices in promoting safety, solidarity, and connection within communities of people who use drugs. Despite constraints, such as stigma (Cox et al., 2024; Stengel et al., 2018), peers demonstrate agency by crafting powerful identities which they employ to advocate for, and practice, harm reduction. Through this lens, we underscore the transformative potential of agency within the context of harm reduction advocacy and envision a trajectory towards expanded autonomy for peers. Peer solidarity, connection, and safety principles foster trust, credibility, and the dissemination of vital information, enhancing supportive relationships within communities. These socio-affective relations challenge traditional 'formal' healthcare structures by highlighting the relational and emergent nature of peer-led care. By leveraging these dynamics, existing interventions can be augmented, improving consumer receptivity (Brien et al., 2023). This may contribute to the way peers establish safe care spaces, equipping individuals to navigate challenges like overdose (Sherman et al., 2009). For instance, peers who participate in overdose prevention and naloxone distribution programs can effectively disseminate learned skills and information to others, even those who have not attended the training, through both actions and conversations (Sherman et al., 2009). This peer diffusion is crucial in reaching stigmatised and hard-to-recruit populations. However, effective interventions must foster collaborative efforts between peers, policymakers, and healthcare professionals to address systemic inequities and environmental influences contributing to drug-related harms.

Moving beyond these systemic considerations involves acknowledging the broader social and structural context shaping drug use (Fadanelli et al., 2020; Selfridge et al., 2020) and recognising that harm reduction is not solely the responsibility of the individual. In Australia, punitive drug laws and rising drug-induced deaths, particularly from opioids and stimulants (Penington Institute, 2024), heighten the need for both formal and informal peer roles. Peers not only offer harm reduction in formal settings, but act as trusted intermediaries, navigating the legal and social barriers that often deter people who use drugs from seeking help (Francia et al., 2023). These data further indicate that leveraging insider knowledge and community connections, peers create environments of trust and safety, emphasising the need for collaboration between peers, healthcare professionals, and policymakers to address systemic inequities and reduce drug-related harms. To remain pertinent to community care, we call for further inquiries into peer-led harm reduction in the alcohol and other drug sector. This entails investigating the evolving contexts where peer-led or co-opted initiatives are being introduced, as well as the established ones. In addition to assessing the efficacy of Peers in reducing risk and drug-related harm in community, researchers must contextualise this emerging implementation within the broader shifts occurring in healthcare landscapes. Moreover, researchers should explore the implications of peer-led initiatives and peer harm reduction on social dynamics, healthcare practices, and perceptions of stigma, expertise, belonging and social inclusion (Rance & Fraser, 2011). To be clear, this work would not be about 'evaluating' the extent to which peers afford one another new ways of belonging and safety in an often-hostile world, or otherwise 'fail' to do so. Work that is evaluative in these ways risks instantiating harmful logics of responsibility and blame, and may imply that problems such as stigma exclusion and social alienation are the product of insufficient efforts at organising on the part of peers. These dynamics are, as we have argued throughout this article, shaped by other forces such as criminalisation, and it is not the responsibility of peers to forge connection and belonging in the midst of these hostile social, political and legal frameworks. Our point, instead, is that peer work affords much more than harm reduction, and the value of this work could be more deliberately examined, harnessed and supported, including through expanded resourcing to peer sectors. Drawing on innovative conceptual frameworks rooted in post-materialist theoretical approaches can enrich our understanding of the social, medical, and cultural dimensions in this area (Fraser, 2020a, 2020b; Pennay & Duff, 2023), as can ontopolitically-oriented approaches (Fraser 2020) which embrace our responsibilities as researchers to work with affected communities and identify and bring into being the issues of importance to them. By interrogating the field through these lenses, we can generate fresh insights into the role of peers in health policies and envision strategies for promoting peer-led initiatives that are equitable, as well as more careful, inclusive and worldmaking.

While this study highlights the transformative potential of peer-led harm reduction practices, several limitations must be acknowledged. One limitation of the study is the underrepresentation of diverse gender identities in the sample. Future research should aim to target a more diverse sample to explore the potential relevance of intersectionality within these populations. This could provide deeper insights into how gender and other identity factors interact with drug consumption and peer-led interventions, and the possible importance of these dynamics in shaping or constituting belonging and inclusion in the context of multidimensional exclusion, violence and prejudice. Additionally, the role of peers in mitigating harm is shaped by broader systemic factors, such as criminalisation and social stigma (Friedman et al., 2021; Selfridge et al., 2020), which can limit their ability to foster safety and belonging within hostile environments. Finally, while the study advocates for expanded peer-led initiatives, it is crucial to recognise that the responsibility for harm reduction should not be placed solely on peers but should involve collaborative efforts with healthcare professionals, lawmakers and policymakers to address the structural inequities that generate, exacerbate and magnify drug-related harms.

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CRediT authorship contribution statement

Timothy Piatkowski: Writing – review & editing, Writing – original draft, Resources, Project administration, Funding acquisition, Formal analysis, Conceptualization. **Kate Seear:** Writing – review & editing, Writing – original draft, Formal analysis. **Steph Reeve:** Writing – review & editing, Investigation, Data curation. **Emma Kill:** Writing – review & editing, Writing – original draft, Resources, Project administration, Funding acquisition, Formal analysis, Conceptualization.

Declaration of competing interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests:

Emma Kill is the CEO of Queensland Injectors Voice for Advocacy and Action [QuIVAA], and Dr Piatkowski is a Director on the Board the organisation. QuIVAA is a non-government owned and not-for-profit 'Drug-User Organisation'.

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