

BECOMING PEER



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Becoming Peer

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INTRODUCTION

This publication offers a toolbox for reimagining harm reduction through discussions of common but contested concepts: peer involvement, health, and evidence. Through peer involvement we explore the relations between harm reduction stakeholders. How might harm reduction be reimagined if people who use drugs, service providers, and researchers relate to each other more as peers that share common interests and have mutual respect for each other's identities, work, and knowledge? Through health we explore the values and goals embedded in harm reduction strategies. How might harm reduction be reimagined if good health is understood to emerge through collective, everyday practices of peer-to-peer care as much as through biomedicine? Finally, through evidence we can explore the authority granted to certain harm reduction strategies, or how what works is established. How might harm reduction be imagined if evidence is generated not as objective proof of what has worked but a living archive that might inspire new ideas about what could work?

Particular relations of power between stakeholders, understandings of health, and forms of evidence mutually reinforce each other. Unsettling one unsettles the others. Accordingly, each chapter builds on and speaks to the others. Cultivating meaningful peerness across stakeholders, supporting existing peer-to-peer practices of care, and generating new forms of evidence depend on and shape each other. The purpose of this publication is not to dictate how meaningful peerness is defined, which practices of care matter, or what evidence is best but to open up questions and provoke discussions. These questions and discussions are not new, they emerge in conversation with others. Throughout this publication footnotes reference writing by organizations of people who use drugs, harm reduction service providers and advocacy groups, other activists, and academic researchers. I hope these references also serve as jumping off points for any reader looking to engage further with the ideas presented here.

This publication has two main intentions. Firstly, for readers who may not have much knowledge or experience with harm reduction, it offers an introduction to common frameworks for approaching peer involvement, health, and evidence building. More knowledgeable and experienced readers may find these introductions helpful as well, in particular the critical questions each opens up about the assumptions that existing frameworks rely on. Secondly, for readers of all stripes and stakeholder roles, it offers meeting points and common ground from which to collectively imagine other possibilities for practicing harm reduction.

HISTORY OF HARM REDUCTION

Harm reduction is commonly understood as “policies, programmes and practices that aim to minimise negative health, social and legal impacts associated with drug use, drug policies and drug laws.”¹ Harm reduction can also be understood as a grassroots movement for social justice that coalesced in response to the 1980s HIV/AIDS epidemic amongst people who inject drugs. As HIV and the associated moral and public health crises spread across Europe, exacerbating social inequalities, so did ideas and practices of harm reduction.

While there is a history of fragmented public health interventions intending to reduce drug-related harms (stretching into the early 20th century), many of today's prominent harm reduction interventions have roots in movements and communities of people who use drugs. In other words, they came from within the contexts of drug use, the everyday lives and needs of people who use drugs. For example, needle exchanges emerged

1. Harm Reduction International. “What Is Harm Reduction?” Harm Reduction International, 2020. <https://www.hri.global/what-is-harm-reduction>

from user-led distributions of sterile injecting equipment, such as those in the Netherlands that formed before the existence of HIV testing, helping to impede disease transmission.

At first, harm reduction strategies developed in cities, where communities of people who use drugs collaborated with local organizations but without the support, or despite the interference, of the state. As harm reduction continued to gain international recognition and legitimacy in the 1990s, it was increasingly integrated into national drug policies and in the 2000s it was promoted by drug policy guidance of the EU and UN. The spread and institutionalization of harm reduction through the EU was facilitated by the lack of an explicit shared definition, resulting in its widespread presence but in a diversity of forms; for example, as a grassroots social movement, method for street outreach, international human rights movement, drug policy directive, or public health response.

LEARNING FROM NIGHTLIFE

Harm reduction can provide an alternative to the prohibition, legalization, criminalization, and perhaps even medicalization paradigms for addressing drug use. Harm reduction has traditionally focused on so-called “problem” drug use associated with adults, particularly those who inject drugs, the forcibly unhoused, sex workers, and other marginalized groups. Meanwhile, so-called “recreational” drug use associated with young people and “party drugs” has tended to be addressed through prevention and abstinence-based strategies. Today, harm reduction increasingly addresses

“recreational” drug use and is found throughout nightlife. While harm reduction ideas and practices related to so-called “problem” drug use have provided inspiration for harm reduction ideas and practices related to so-called “recreational” drug use, the reverse has been uncommon.

People who use drugs are often already engaged in peer-to-peer networks and practices of care.

Health and social services have traditionally focused on supporting individuals and communities considered unable to care for themselves. People who use drugs are often considered “in need of attention, care and treatment in order to improve their health, facilitate social reintegration and reduce stigma and marginalisation.”² However, the growing enthusiasm for and reported benefits of peer involvement suggests that the ways people who use drugs can and do support and care for each other should be recognised and valued.

What does this mean for the way organizations approach harm reduction? How can they best support communities that may already also be supporting themselves? What would this mean for not only how people who use drugs are included but what we consider peer involvement?

The pursuit of pleasure is fundamental, not tangential, to drug use and harm reduction. In nightlife, the pleasures of drug use are foregrounded and thus pleasure and care can be more palpable in ideas and practices of nightlife harm reduction. For example, Peer Education in Nightlife Settings: Good Practices reminds that “drug use can be both pleasurable and risky” and that “being healthy means different things to different people and different types of drug-users or partygoers.”³

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2. EMCDDA (2017) Health and social responses to drug problems: a European guide. Luxembourg: Publications of the European Union.
 3. Noijen et al., “Peer Education in Nightlife Settings: Good Practice Standards,” 34.

As Kane Race, a queer scholar with lived experience of drug use, explains, “the binary distinction between ‘recreational’ and ‘problem’ drug use, which is a feature of popular and expert discourses on drugs, reserves pleasure for the privileged, in a move that can retract any recognition of the capacity for pleasure and agency among subordinated bodies.”⁴

What would it mean to take the pleasures of drug use as seriously as we currently take the risks? What would that mean for not only how we work to promote health but how we understand health?

The experiences of people who use drugs form a body of tacit knowledge that grounds lived practices of harm reduction. All harm reduction initiatives draw on (utilize) peer networks, practices of care, and tacit knowledges of people who use drugs. Peer-to-peer, peer-mobilized, and peer-led initiatives are also based on the expertise, experiences, and connections accumulated by people who use drugs. Online networks and bodies of knowledge produced by and for people who use drugs, often through experiences in nightlife or “recreational” settings, suggest that knowledge and evidence for effective harm reduction may not be immediately legible as such to outside frameworks and evaluations.

What does that mean for how efficacy and evidence-based practices are established? And, more so, for how we understand evidence in the first place?

4. Race, *Pleasure Consuming Medicine*, 168..

2

CULTIVATING MEANINGFUL PEERNESS

FROM PEER INVOLVEMENT
TO POSITIONALITY

People who use drugs have largely been excluded from envisioning, designing, operating, administrating, and evaluating most services, policies, and research relevant to their everyday lives. In recent years, such exclusion has been widely recognized as a problem that negatively impacts drug- and health-related services, policies, and research as well as people who use drugs and their communities. Similar, often interconnected, problems and criticisms of policy and services are common amongst marginalized groups, such as sex workers and people living with HIV. In accordance with wider trends in policy development, service implementation, and academic research, there has been growing interest in frameworks for participation, inclusion and peer involvement.

This chapter asks, first, how is involvement understood and what forms does it take? Second, it explores different forms of peer work to ask how peerness is commonly understood. With these ideas in mind, this chapter offers a tool to reimagine peerness by considering the different positionalities, the similarities and differences, of those involved in harm reduction. What kind of relationships already exist or are possible beyond those of provider-client and professional-peer? Finally, returning to the question of how to facilitate meaningful peer involvement, it asks what it might mean to cultivate meaningful relations of peerness between stakeholders.

QUESTIONING INVOLVEMENT AND PEERNESS

/ Involvement (n):

1. an act or instance of being included, of including someone or something, or participating in an action, process, group, etc.
2. the act of giving a lot of time and attention to something you care about; the enthusiasm that you feel when you care deeply about something
3. an act or instance of having one's interest, emotions, or commitment engaged by someone or something; a close relationship with somebody, especially a romantic or sexual relationship
4. an act or instance of taking part in a crime, conflict, or other troublesome situation

People who use drugs can be involved in harm reduction programs and projects in all manner of roles. The Canadian HIV/AIDS Legal Network has developed a “pyramid of involvement”⁵:

- / **Audience:** people who use drugs targeted or addressed en masse, not as individuals.
- / **Contributors:** people who use drugs are marginally involved, generally when an individual is already wellknown.

5. Canadian HIV/AIDS Legal Network, “Nothing About Us Without Us: Greater, Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical, and Human Rights Imperative,” 28.

2. Cultivating meaningful peerness

- /. **Speakers:** people who use drugs are used as spokespersons or brought into meetings and events to share views but otherwise don't participate.
- /. **Experts:** people who use drugs are recognized as important sources of information, knowledge, and skills and participate on the same level as professionals, in design, adaptation, and evaluation of policies or services.
- /. **Implementers:** people who use drugs carry out real and instrumental roles in interventions.
- /. **Decision-makers:** people who use drugs participate in policy- and decision- making processes and their inputs are valued equally to all others

The different roles that people who use drugs can play in harm reduction entail different kinds and degrees of participation. The Correlation - European Harm Reduction Network identifies seven types of participation⁶:

- /. **Passive participation:** professionals have complete control of the programme, including the planning, and the organisation of activities. People who use drugs are only informed about what is going to happen.
- /. **Participative information-giving:** people who use drugs participate by answering questions from researchers, services, or policymakers but have no influence on the decision-making processes.

- /. **Participation by consultation:** people who use drugs are invited to express their views and needs, and their feedback can (but does not have to) be taken into consideration by policymakers, hence influencing the decision-making process.
- /. **Participation for material:** people who use drugs provides specific resources, such as labour, in exchange for money or other material incentives. They can influence the work setting, but not processes and strategies.
- /. **Functional participation:** people who use drugs contribute to predetermined objectives, but control and responsibility is not in their hands.
- /. **Interactive participation:** all stakeholders cooperate, working in partnership using interdisciplinary methodologies and sharing knowledge to gain common understandings and develop common actions.
- /. **Self-mobilisation:** people who use drugs make their own choices and decisions and have complete control of the planning and implementation of activities. Professionals remain in the background or do not play any role at all.

While there is widespread support for the involvement of people who use drugs in harm reduction, concerns have also been raised about superficial or empty involvement and tokenism. Three characteristics have been suggested for the meaningful involvement of people who use drugs in harm reduction: (1) people who use drugs participating in decision-making about programs

6. Schiffer, "Nothing About Us, Without Us": Participation and Involvement of Drug Users in Health Services and Policy Making," 14.

2. Cultivating meaningful peerness

and services; (2) recognition of and respect for the expertise of people who use drugs; (3) people who use drugs implementing services or programs as peer workers.

PEER WORK AND PEERNESS

Peer work generally refers to “a freestanding initiative or a collaboration between community members and an agency, aiming at meaningful involvement of peers and based on principles of mutuality and empowerment.”⁷ Peer workers are “people with lived experience of drug use [who] work both behind the scenes and at the forefront of needle distribution services, harm reduction education, peer support, and community-based research initiatives.”⁸

Peer work can generally be divided into peer education and peer support. Peer education involves harm reduction organizations engaging members of a target community in the dissemination of health information and encouraging or discouraging certain attitudes and behaviours. Peer support, on the other hand, goes beyond unidirectionally disseminating information, usually involving more reciprocal activities of mutual aid amongst peers and more meaningful collaborations between stakeholders. The European Peer Support Manual, first published in 1994 and widely used since, distinguishes between peer education and peer support:

Although the concepts of peer support and peer education have a lot in common, there are important differences. One major difference is that peer education implies and emphasises a disparity between the educator and the educated. In an HIV/AIDS prevention project for drug users based on the idea of peer education, it is the task of the educator to teach other drug users the rules of safer use and safer sex. Within the concept of peer support however, the idea of mutual support is prevailing and is seen as a broader concept than education. The emphasis is more on community and equality. Support does not only mean influencing other drug users towards safer use and safer sex, it can also imply creating better conditions for safer use and safer sex: For example, the distribution of clean syringes and needles. Because peer support entails equality and is a broad ranging concept, it fits well into the work of a drug user self-organisation—especially an interest group⁹.

There are a number of commonly cited benefits of peer involvement in harm reduction¹⁰:

- /. **Credibility:** Peers are often considered more credible sources of information within a group or community than outside experts. Service providers can also become more credible through peer involvement, by improving their services and enacting their principles.
- /. **Empowerment:** This might be by recognising peer knowledge and expertise, providing sources of employment and income, lifting up people who use drugs as role models, and

7. Kools, “Peer Involvement.”

8. Marshall et al., “Peering into the Literature.”

9. Trautman, “The European Peer Support Manual,” 7.

10. “Peerology: A Guide by and for People Who Use Drugs on How to Get Involved”; Noijen et al., “Peer Education in Nightlife Settings: Good Practice Standards”; “Peer Engagement Principles and Best Practices: A Guide for BC Health Authorities and Other Providers.”

2. Cultivating meaningful peerness

encouraging the self-worth of workers and communities.

/. Efficiency: Peer volunteers and employees are cost effective, they take advantage of established means of communication, reinforce interventions through regular contact, and can extend reach of services.

/. Sustainability: Peer involvement can help ensure project longevity through integration between service and community.

A critical commentary has also emerged, driven in part by peer workers themselves, that points to the barriers and potential harms of peer involvement; for example, tokenism, exploitative working conditions, anxiety and exhaustion, and even the term “peer” itself¹¹.

The word “peer” is generally used to emphasize something shared, similar, or collective between individuals. But peer groups also contain meaningful distinctions, unequal divisions, and significant differences between individuals. In theory “peerness” can seem composed of only similarities but the lived experience of peerness is messily made through shifting similarities and differences. Consider how employment as a peer educator necessarily produces important differences (for example, socioeconomic divisions between paid workers and their peers) even as it provides potential for strengthening shared senses and practices of peerness and solidarity.

However, research about and with peer groups has suggested internal differences are often ignored or disavowed so as not to undermine peer authenticity. The question of who qualifies as an authentic peer is always open; and the boundary work involved produces material differences in access to resources, authority, and security. Some peer workers have described peerness as an active process that requires particular performances in order to “pass as peer”:

As individuals who are brought into intervention projects, peer work must act as bridge work. Our bodies work, as bridges do, to connect fractured lands. Peers work to bridge the divide between abject and respectable bodies. As peers, we need to be both. This is complicated identity performance. To be a peer you have to pass as ‘authentically peer’ to professionals, to the homeless mentally ill, and to each other as peers. On the one hand, we have to negotiate ourselves both as street authentic enough in professional fields, yet still remain professional enough in such settings to remain incorporated. On the other hand, when working with clients, we have to perform our marginalized experiences so that they are rendered visible to the client. We also have to be recognizable to each other as peers¹².

Peer support has been suggested to offer a direction alternative to client-service relations¹³. In the following section we explore how other relations of peerness might be imagined between stakeholders.

11. Greer et al., “Peer’ Work as Precarious”; “Peerology: A Guide by and for People Who Use Drugs on How to Get Involved.”

12. Voronka, “Troubling Inclusion,” 208.

13. Kools, “Peer Involvement.”

REIMAGINING PEERNESS: POSITIONALITY

This chapter offers a tool to reimagine peerness by considering the different positionalities, the similarities and differences, of those involved in harm reduction. What kind of relationships already exist or are possible beyond those of provider-client and professional-peer?

The tool for reimagining harm reduction addresses the messy tangle of similarity and difference by considering peer positionality across three interconnected fields: **identity**, **activity**, and **knowledge**. In other words, who one is in the world, what one does to the world, and how one knows of the world. The term **positionality** simply means that these “fields” are relational; identities, activities, and knowledges are in constant interaction, making and remaking each other anew. (At risk of belabouring the point: who one is in the world shapes what one does to the world shapes how one knows about the world shapes who one is in the world shapes, and so on, not necessarily in that order). Positionality doesn't prescribe stable categories for describing the world but draws attention to shifting and contested standpoints of relating to the world.

IDENTITIES

A number of peers spoke of learning of difference through contact with other peers. In particular, non-Indigenous peers spoke about the value that the proximity to Indigenous peers gave them.

Like everyone, peers inhabit multiple identities at once and over time. These involve intersecting forms of discrimination and privilege, advantage and disadvantage, like race, gender, sexuality, ability, class religion, ethnicity, and physical appearance. Any meaningful peer relations will be made amongst and with all this difference. Our identities don't simply exist, they are continuously made and shaped in interactions with others.

ACTIVITIES

In the same way as the organisation of labour structures the self-understanding, the action repertoire, and the fate of the labour movement, the trends of drug use, the organisation of services for drug users, and spaces of interaction among drug users are extremely important to drug user organisations and to drug users' participation¹⁴.

Social, gender, racial, spatial divisions of work profoundly structure our everyday lives. Work includes not only wage labour but all manner of paid and unpaid practical activity, from domestic “chores” to keeping a caring eye on the neighbourhood. Simplistically: who does what, where, and why do they do it? Patterns of everyday activity and particular identities go together. Engaging in shared or similar activities is an important contributing part of identifying as a peer.

2. National Harm Reduction Networks in Europe: An Overview

Intersectional identities are experienced and made sense of in everyday life.

KNOWLEDGES

A peer support worker draws from their experiential knowledge—the happenings, emotions, and insights of their personal lived experience—as they listen to, interact with and support peers. Research tells us this authenticity helps to create a shift in attitude and results in greater feelings of empathy and connectedness with the peer support worker¹⁵.

Knowledge is often imagined as something lofty, transmitted through exclusionary systems of education. However, knowledges about the world also emerge in ongoing mundane interactions. How one is positioned by intersecting identities and the division of labour/activity also positions one's way of knowing. Knowledge, in other words, is situated, always partial to the position from which it was produced. Recognizing situated peer knowledge means having to recognize that expert, professional, and scientific knowledges are always situated as well.

to cultivate meaningful relations of peerness between stakeholders?

Positionality has three implications for thinking about harm reduction strategies. First, it draws attention to the multiple intersecting forms of marginalization and oppression experienced by people who use drugs. Second, it draws attention to how difference is also generative of different understandings of the world that come from different positions and are meaningful in different ways. Third, it also positions policy makers and service providers in more complex ways—not simply as the already involved. Cultivating meaningful peerness then would mean imagining strategies for building mutual respect and equal standing between stakeholders' different identities, kinds of activity, and knowledges.

MEANINGFUL PEERNESS

Returning to the question of how to facilitate meaningful peer involvement, what might it mean

15. Sunderland and Mishkin, "Guidelines for the Practice and Training of Peer Support."

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SUPPORTING COLLECTIVE HEALTH FROM RATIONAL CHOICE TO PLEASURABLE CARE

Harm reduction is often considered to take a value-neutral approach to drug use by being non-judgemental and pragmatic (“meeting people where they are”). A common tenet of harm reduction strategies is centring concerns about (public) health and human rights over those of criminality and immorality. Even though definitions of health are regularly questioned and debated, the value of health is usually unquestioned. Health is assumed to be natural and good. However, far from being value-neutral, understandings of health are fundamentally value-making: health frameworks determine what is healthy and unhealthy, good and bad, normal and deviant. Accordingly, different understandings of health make possible different visions and practices of harm reduction.

This chapter asks, first, how is health understood and modeled? Keeping in mind the importance of positionality (from the previous chapter), where and who do these health models come from? What grants them legitimacy and authority? This raises another question: where else and from who else might other understandings, models, and practices of health be found? This chapter then offers a tool to reimagine health by paying attention to the practices of care that already exist amongst people who use drugs, which are often as concerned with amplifying pleasures as reducing risks. Building on the above discussion about cultivating meaningful peerness across stakeholders’ various identities, activities, and knowledges, what would it mean to take seriously and support these peer-to-peer models and practices of health?

MODELING HEALTH AND HARM

/. Health (n):

1. a state of bodily and mental vigour; freedom from disease, pain, or defect; normalcy of physical and mental functions; soundness
2. the general condition of body and mind; as in poor health; physical, mental, and social well-being
3. the condition of any unit, society, etc.; soundness or vitality, as of a society; as in the economic health of a nation

Health can refer to a factual state of the body (it’s being) as well as a valued condition of the body (it’s well-being). But health is not limited to bodies or organisms, it can also refer to the condition of a society or a city or a planet¹⁶. In the natural, social, and health sciences, there are innumerable models for understanding health, disease, and illness. These are not necessarily mutually exclusive; they can overlap and inform each other.

HEALTH AS BIOMEDICAL

Biomedical models define health simply as the absence of disease and the presence of normal functioning. Biomedical models are put into practise by doctors and health professionals to diagnose, cure, and treat disease. In these

16. It’s worth noting how nearly all discussions about environmental, urban, national, or planetary health use the term “health” as a euphemism for a collection of measurements and indicators.

interactions the doctor is an active expert who intervenes upon the passive patient.

Basic biomedical models can only understand drug use through binaries: disease is either present or absent, system functioning is either normal or deviant. Binary models produce binary worlds. Biomedical models of drug use produce binary categories of drug use and people who use drugs: either normal or pathological, either a non-addict or an addict.

HEALTH AS BIOPSYCHOSOCIAL

Biopsychosocial models added social, psychological, and emotional dimensions onto a biomedical model. Biopsychosocial health is defined as physical, mental, and social well-being; understood as an assemblage of biological, social, and psychological factors. In biopsychosocial models, individual health and well-being are inseparable from the social and cultural environment. Unlike with biomedical models, an illness is not necessarily attributed to disease or pathology of an individual body, biopsychosocial models can take into account factors like lifestyle and environmental conditions.

Biopsychosocial models contributed to significant transformations to how (public) health was understood and practiced. In paying attention to social determinates of health and health contexts, especially, factors like lifestyle, the biopsychosocial health professional must rely on tacit knowledge from the patient (about everyday life) as well as their own expert knowledge in terms of diagnosis and treatment. Furthermore, illness is

not only something to be diagnosed and treated but prevented through, for example, change in lifestyle and habits. In this way, the responsibility for “health” was redistributed across doctors and patients. The role of individual choice, absent in biomedical models, became central to ideas about health. Passive patients now needed to be active clients, users, and consumers who choose health.

HEALTH AS PROMOTIONAL

The new public health that emerged in the 1980s was based on this new division of responsibility and accountability, emphasizing the involvement of individuals and communities in their own self-care by offering information and choices about health services. New public health focuses on risk reduction, understanding the role of public health to be identifying risk factors, educating the public about prevention, and promoting “healthy” changes in individuals and organizations. New Public Health seeks to improve population health by accumulating and applying evidence, which requires continuous monitoring and the adoption of standard management, evaluation and planning best practices.

From the late 1980s into the 1990s, drug policy shifted away from the treatment of dependence and towards the management of health. Medical concerns about the pathology of addiction gave way to public health concerns about drug-related risk factors. The addict and abuser are replaced by the user who is regarded as a consumer capable of making rational choices and of discerning between costs and benefits, risks and rewards, in terms of commodities on the market as well as everyday

behaviour. This might be thought of as a logic of choice supplanting a logic of care¹⁷.

HEALTH AS COLLECTIVE

In addition to the institutionalized and authoritative health models above, communities of people who use drugs also care for their own health collectively. When harm reduction is steered by public health professionals, the focus can be more technical and research based, whereas in the case of collective health practiced through peer-to-peer networks of mutual aid, they arise from tacit knowledge and everyday experiences. As activist-scholar Dean Spade puts it: “As its best, mutual aid actually produces new ways of living where people get to create systems of care and generosity that address harm and foster well-being.”¹⁸

REIMAGINING HEALTH: PLEASURABLE CARE

This chapter offers a tool to reimagine health by paying attention to the practices of care that already exist amongst people who use drugs, which are often as concerned with amplifying pleasures as reducing risks.

How do people who use drugs care for themselves

and care for others within often hostile contexts, both micro (such as immediate physical environments of drug use) and macro (such as national laws and the prison system). While health and social services have tended to explicitly target practices of risk, service providers also often consider fostering practices of self-care to be of particular importance. Far less attention has been paid to inter-personal, collective, or “unexpected” practices of care¹⁹.

To avoid assuming that care is only “proper” if it has observable biomedical impact or is focused on the individual, we might begin with becoming sensitive to care for substances, bodies, and environments; sometimes considered the basic components of drug experiences. Such an understanding has roots in communities of psychedelic drug use, who have emphasized the importance of “set and setting”—meaning one’s mindset and surroundings (or milieu)—since the 1960s. Those partaking in psychedelic experiences—often for reasons they describe as “therapeutic”, “medicinal”, “spiritual”, “recreational”, “pleasurable” and/or “productive”—actively and intentionally care for set and setting²⁰. In contrast, “problem” drug use is often assumed to be impulsive, chaotic, and unplanned with people who use drugs recognized more as passive victims of set (ie. their addiction or impulses) and setting (ie. their socioeconomic position) who must turn themselves into active consumers of health services. However, such assumptions are out of line with the researchers, practitioners, and people who use drugs themselves who suggest peer-

17. Mol, *The Logic of Care*.

18. Spade, *Mutual Aid*, 2.

19. Hardon, *Chemical Youth*; Enoch, “Taking Back What’s Ours! A Documented History of the Movement of People Who Use Drugs.”

20. Mishra, *Drug-Craft*.

to-peer practices of care are already prevalent (if fragile) in their everyday lives²¹.

Furthermore, there's no reason to assume that care cannot be taken in impulsive, chaotic, and unplanned situations—in fact that's where care is most important.

SUBSTANCES

Dominant understandings of health and drug use often locate harm and risk in the psychoactive substances themselves, logically concluding that preventing or reducing drug use is the best or only way to reduce harm. However, people who use drugs are just as likely to consider substances as pleasures and even medicines that are caringly prepared and administered²². For example, people who use drugs are concerned with proper substance storage, testing their purity, choosing and preparing the right dose, ritual practices of all kinds, and using clean and safe instruments. In one study of ecstasy use, participants desired reliability and familiarity with their source—they cared about how to procure the substance—considering the largest risk to be consuming a substance falsely sold as ecstasy²³. Care is not the opposite of harm or risk, it's their embodied navigation and transformation.

BODIES

Dominant understandings of drug use often consider it to inherently imply a lack of care for one's body. However, people who use drugs often care for their own and others' bodies before, during, and after drug use. This can involve physically preparing body (ie. stretching, eating or fasting) and mind (ie. calming thoughts, setting expectations), keeping hydrated, taking time to cool off from dancing, touching and caressing each other. Care goes into eating and sleeping and resting afterwards. Even for those who have no "choice"—those without access to a market, as in those forcibly unhoused—care goes into where to sleep²⁴. Care is not romantic, traditional, pure, feminine, or stoic; it is found in the nitty-gritty of everyday life. people who use drugs also collectively organize to better care for their bodies in demanding housing and food assistance. In everyday life, substances, bodies, and environments are always intermingling.

ENVIRONMENTS

Caring for the immediate environments of substance use can involve attending to lighting and music, providing food and water, ensuring a safe(r) chill out room, cultivating trust amongst peers. Outreach peer workers have described the importance of caring for the environment they are

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21. Research has suggested that these practices and networks of care are not limited to people who use drugs but reciprocally extend to people who sell drugs as well. This provides a glimpse at how centring practices of care challenges the separation of "demand" from "supply" that organizes most drug policy, and thus challenges the idea that it is possible to distinguish and treat the former "medically" and the later "criminally". See Kolla and Strike, "Practices of Care among People Who Buy, Use, and Sell Drugs in Community Settings."
 22. Race, Pleasure Consuming Medicine; Hardon, Chemical Youth.
 23. Shewan, Dalgarno, and Reith, "Perceived Risk and Risk Reduction among Ecstasy Users."
 24. Nettleton, Neale, and Stevenson, "Sleeping at the Margins."

inviting other people who use drugs into: “having something concrete to offer besides information is important: this can be as basic as water, a hot meal, or harm reduction materials such as safer smoking kits.”²⁵ In other words, (good) caring for situations makes possible (good) dissemination of information. Creating a warm, safe, friendly and welcoming environment is described as part of making services low-threshold for those often in environments of marginalization, violence, vulnerability and instability.

As much as these practices of care may be about reducing risk and harm, they are also about caring for pleasure.

COLLECTIVE HEALTH

Building on the above discussion about cultivating meaningful peerness across stakeholders’ various identities, activities, and knowledges, what would it mean to take seriously and support these peer-to-peer models and practices of health?

Reimagining health through peer to peer care, shifts its location from the individual body to collective practices of everyday survival. In this way, health emerges as a shared resource or common. Cultivating practices of care means highlighting the importance of agency and community building amongst people who use drugs as well as the barriers (structural and otherwise) that limit the emergence, forms, and possibilities of peer-to-peer care—not only individual-to-individual but the self-organisation of people who use drugs in demanding and creating healthy conditions, from safe-injection rooms to universal healthcare.

25. “Speed Limits: Harm Reduction for People Who Use Stimulants.”

4

GENERATING PRODUCTIVE EVIDENCE

FROM STATISTICAL ANALYSIS
TO LIVING ARCHIVES

The proliferation of harm reduction ideas and interventions has also raised questions about the efficacy of different models and strategies. Furthermore, what works well in some settings may not in others. Establishing evidence-based best practices and standards are two common ways of trying to improve harm reduction efficacy and implement successful health promotion strategies. While service provisioning has become more complex, the demands for accountability from policymakers and other stakeholders have increased. These changes in the environment in which service providers operate have contributed to the growing emphasis on evaluation and evidence. Evidence can be used to evaluate and communicate the efficacy of harm reduction interventions across contexts, however, there remains a tension between developing evidence-based best practices and maintaining respectful sensitivity for local situations and cultures.

This chapter asks, how is evidence understood and what does it do? Considering the positionality of harm reduction stakeholders and the uneven power relations between them (chapter 1), what counts as evidence and what grants authority to some forms of evidence but not others? If evidence is about establishing “what works,” considering the above discussion about how different models of health contain different values (notions of good and bad) the question becomes what works for who and according to who? This chapter offers a tool for reimagining evidence through living archives that collect experiences and material cultures of harm reduction. Returning to the question of what evidence can do, living archives are less about preserving the past than creating a body of knowledge that can inform the present and inspire visions of the future.

EVALUATING EVIDENCE AND EFFICACY

/. Evidence (n):

1. knowledge on which to base belief; the available body of facts or information indicating whether a belief or proposition is true or valid.
2. an indication that makes something evident; signs or indications of something.
3. information drawn from personal testimony, a document, or a material object, used to establish facts in a legal investigation or admissible as testimony in a law court.

Evidence is a collection of knowledge or information that can be used to tell stories about the world. Evidence is often called on as a neutral arbitrator between competing interests and ideas. This casts evidence as the “key” to consensus, the missing piece.

Evidence-based practice suggests that scientific evidence should form the basis of service and policy decision making. The goal of evidence-based practice is efficiency, the intent is to eliminate ineffective or inefficient practices by shifting the basis for decision making to “firmly grounded scientific research”.

According to evidence-based practice there is a hierarchy of evidence that establishes how valid or biased different forms of evidence are. However, no single universal hierarchy can be agreed upon (more than 80 have been proposed for medical evidence alone). In general, at the top, considered

the least prone to bias, are systematic reviews of randomized controlled trials; followed by, in order of increasing susceptibility to bias, individual randomized controlled trials, systematic reviews of cohort studies, individual cohort study, systematic review of case-control studies, individual case-control study, and case series; leaving, biased at the bottom, expert opinion, ethnographic information, anecdotes, and other qualitative forms of data.

Systematic reviews and meta-analyses that compile and combine randomised control trials are almost always considered best. This evidence claims to show “what works” based on statistical analyses of massive amounts of standardized data from various experiments performed into different conditions. Meanwhile, all forms of qualitative data are either on the bottom level or entirely unmentioned by these hierarchies of evidence.

The idea of evidence-based practice implies cycles between evaluation, evidence, practice, and again evaluation. Evaluations are about much more than determining whether or not something has been successful after the fact—best practices in both harm reduction and peer involvement recommend ongoing, iterative evaluations²⁶. Peers as well as experts, professionals, researchers, policy makers, funding agencies and anyone else (meaningfully) involved in evaluating harm reduction are not detached observers but active participants in the worlds they are evaluating. They interactively shape them by monitoring indicators and collecting (generating) evidence deemed relevant for guiding future practice and policy. Evaluation is necessarily about establishing both what is and what ought to be.

REIMAGINING EVIDENCE: LIVING ARCHIVES

This chapter offers a tool for reimagining evidence through living archives that collect experiences and material cultures of harm reduction.

Archiving is a process of storing and organizing information of all kinds. This can be observations, research, and writing but also photographs, video, audio, and other kinds of media and cultural objects. Archives are about details; they move us away from sweeping generalizations. Archiving knowledges and artifacts generated through harm reduction strategies doesn’t distinguish ahead of time what may or may not be useful or meaningful in the future.

EXPERIENCES AND STORIES

When people who use drugs collectively create, advocate for, contribute to, or provide harm reduction services, their starting point is knowledge grounded in individual and collective lived experiences. Peer-to-peer harm reduction strategies have not only relied on the knowledge and participation of people with lived experience of drug use but have also treated this knowledge as a starting point for developing strategies and interventions. Sharing and collecting experiences and stories through a living archive allows them

26. Noijen et al., “Peer Education in Nightlife Settings: Good Practice Standards”; Nilson et al., Evaluation.

to be contributed, aggregated, organized, reorganized, and appropriated to inform, provide evidence for, and transform ongoing harm reduction strategies.

Online collections of drug experience reports provide an example of how the knowledges of people who use drugs become useful and meaningful through their compilation, preservation, and appropriation²⁷. These everyday experiences and stories of drug use provide others with all kinds of practical knowledge, from dosing measurements to emotional descriptions. That includes those of service providers and other harm reduction stakeholders.

OBJECTS AND ARTEFACTS

Through a living archive, objects and artefacts can be understood to embody practical knowledge, transmit memories, and become evidence of what works for ongoing harm reduction strategies to draw on. The material culture of harm reduction might include particular tools of drug administration, buildings and community spaces, and informative or promotional materials.

DIALOGUES AND THEMES

Dialogues and themes here refer to critical perspectives that extend from everyday experience out into wider social, economic, political, and historical contexts. A living archive doesn't collect and preserve these perspectives, it fosters them through, for example workshops or exhibitions.

PRODUCTIVE EVIDENCE

Reimagining evidence through living archives means not only producing and collecting evidence but allowing evidence to become productive in new ways. As long as evidence is equated with expert knowledge or only seen as useful when produced through particular scientific methods there can be no meaningful peerness between people who use drugs, policy makers, and service providers. An archive, on the other hand, doesn't prefigure how it is used, doesn't dictate what's useful and what's not. Archives don't foreclose the future—they allow it to be open ended.

Archives are used to preserve knowledge and artefacts, but also for research and education. Evidence itself, in this case, is less important than education and the collective making of new material knowledge. Archiving peer-to-peer knowledge in a way that allows it to be meaningful and useful for people who use drugs, service providers, and policy makers also allows it to become pedagogical. Pedagogies are about ways of teaching, learning, and transforming the world.

Peer-to-peer archives and pedagogies are not simply about justifying or validating the lived knowledge of people who use drugs, they're about sharing knowledge amongst peers, across difference, that can contribute to the making of new harm reduction strategies that work, most importantly, for people who use drugs. They also provide a base of knowledge, sentiments, and evidence that can inspire and inform new imaginations of harm reduction and a different, better world.

27. Boothroyd and Lewis, "Online Drug Scenes and Harm Reduction From Below as Phronesis."

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