Peer naloxone supply project:

An evaluation of three pilot areas.

SDF
Scottish Drugs Forum

Content

Executive Summary

Introduction

Naloxone is a crucial part of efforts to tackle Scotland's drug-related death public health emergency as it can reverse effects of an opioid-related overdose for long enough for professional medical intervention and thus save someone's life. Supply of naloxone has increased across Scotland and peer supply programmes are proving to be particularly effective at reaching target populations.

To build on previous work, Scottish Drugs Forum (SDF) sought to maximise peer to peer naloxone supply with a coordinated and supported approach by delivering high quality training to peers who have experience of substance use, providing ongoing support, and developing a national peer network to enhance the delivery of naloxone provision by people who have experience of drug use. This project was funded by the Scottish Drug Deaths Taskforce Innovation Fund.

This evaluation aims to explore the peer-to-peer naloxone programme within three pilot areas (one prison, one rural, one urban) and will focus on novel approaches in this programme compared to previous service provision, including effects of paying peers and exploration of local challenges.

Methods

The evaluation used a mixed methods approach, including qualitative semi-structure interviews conducted by SDF peer research volunteers and a staff member. Peer researchers are individuals with living/lived experience of substance use who are trained and supported by SDF to participate in all stages of evaluation and research projects such as this.w

The peer researchers interviewed peer workers/mentors involved in the naloxone project from each setting. The SDF staff member interviewed workers directly involved in the development and running of the project in each setting. Quantitative data on the number of naloxonwe kits supplied during the pilot stage are included to provide context for qualitative findings.

Findings

Prison Setting

• Project went live November 2021

• Kits were physically supplied to individuals who participated in training by the peer mentors on the night before their liberation, marking the first time this has been done in a prison establishment

• Total kits supplied Nov ’21-Apr ’22 = 183; 145 of these were the first time someone had been supplied with naloxone

• There was strong interest when project initially advertised; majority not taken forward as peers following internal security checks; learning taken from this regarding future recruitment to focus on smaller numbers

• Active peers in April 2022 = 5 (4 interviewed for evaluation)

• 3 staff interviewed for evaluation, all employed by Greater Glasgow and Clyde Prison Healthcare and working from the Health Improvement Hub within the establishment.

** Any reference to the hub within the prison setting, it is the Health Improvement Hub.*

Challenges & barriers

• SPS staff - There was initial resistance experienced by the peer mentors from the Scottish Prison Service (SPS) staff to the project, mainly around concerns about how the project would work and whether it would create more work for them. It was felt by peers and hub staff that officers were stigmatising towards the peer mentors based on their pasts and substance use.

• Workload - There was an imbalance in workload amongst the team of peer mentors due to logistics within the establishment as most could not travel between settings/halls to provide training. The role did impact time mentors had for other things, especially in the evenings during which they would normally have activities such as visits and recreation.

• Barriers to supply – Some people in the prison did not want the training as did not want to be associated with drugs/drug use due to stigma.

• Payment – The SPS system prevented the mentors being paid for their time despite Health Improvement staff advocating for this. The peers would feel more valued if they were paid for their time and effort in the project.

• Resource – Staff felt more time than the two days of co-ordinator time allocated per week (with a view for this time to ultimately be spread across three prison sites) was needed for the project to be run consistently. There were concerns that having shorter term funding would mean the project may be less impactful.

Benefits & facilitators

• New opportunities – The role gave the peer mentors a unique activity to develop skills and provide satisfaction during their time in the establishment. They had also achieved their Community Achievement Award which the prison had joined up with the peer naloxone role.

• Peer recovery – There were cases of the peer project having a positive impact on mentors' own recovery as they had something to focus on and received continued support from the staff involved.

• Skills and development – Peer mentors gained many transferable skills from their involvement in the project, such as communication, confidence, and organisation. Some peers had already been offered opportunities, such as involvement in similar projects and employment, based on this skill development for when they went back to the community.

• Staff relationships – Peer mentors had very strong relationships with the Health Improvement team which were valued, and the project had improved their relationships with SPS staff who were seen to have become more supportive and look at the mentors differently than they did initially.

• Improving naloxone provision – There was more uptake in the training and supply of naloxone due to peer mentors providing this instead of staff. SPS staff were happy to have more naloxone within the establishment and some were asking peers how they could get training as well.

Urban Setting

- Project went live April 2021
- Total kits supplied Apr ’21-Apr ’22 = 813 (first supply = 304)
- Active peers in April 2022 = 6 (5 interviewed for evaluation)
- Two staff interviewed for evaluation

Challenges & barriers

- Managing expectations – Peers had high expectations about what they could achieve and wanted to do this immediately, so staff had to manage this, especially initially.
- Needle exchange – Peers had spent some of their time working in the needle exchange where they may have been filling in gaps left by other staff, rather than their primary role. One peer felt there was not a lot of footfall in the exchange.
- Practicalities – Peers received less training in person due to Covid-19 restrictions. Staff also had to support and remind peers about paperwork and other admin related to their role.
- Apprehensions – Some peers were initially nervous about certain aspects of the role, including approaching people on the street to offer training; working alongside other staff/services; and joining meetings remotely using unfamiliar IT.
- Stigma – Some peers had experienced stigmatising and judgemental attitudes from the public and people accessing services when offering naloxone training in various settings.
- Continuation – Staff and peers both felt strongly that the peer project should be continued long-term but were concerned about whether there would be sufficient funding and resources to do this.

Benefits & facilitators

• Recruitment – The host service already had a peer framework in place, thus making recruitment more straightforward. The peers were also therefore welcomed immediately into the team by other staff.

• Peer involvement – All staff and organisations involved were positive about peer involvement in the project and they were seen to have skills and capabilities other staff did not for naloxone training and supply. They were given the opportunity to use their experience and initiative to approach the role creatively.

• Skills and development – The training helped peers to develop knowledge and confidence for their role and the work allowed them to build transferable skills. Peers were seen to have improved employability throughout the project and half of the peers had been offered opportunities leading from this role.

• Payment – Staff felt the peers being paid was very important as they were bringing key skills and time. The peers felt valued by being paid.

• Naloxone awareness and supply – All felt the project and peer role were meeting a crucial need for naloxone in the area. The role was seen as being key in helping to reduce drug-related deaths and the project had led to other opportunities for supply in the area, such as in colleges and A&E departments.

• Impact of project – The staff felt the project had showed that including peers was important and could be successful in other contexts/work. There was a desire for the peer project to be scaled up across the area.

Rural Setting

• Project went live October 2021

• Total kits supplied Oct ’21-Apr ’22 = 77 (first supply = 54)

• Active peers in April 2022 = 3 (all interviewed for evaluation); 4 others were originally recruited and trained but withdrawn from project following PVG check

• Two staff members interviewed for evaluation

Challenges & barriers

• Recruitment – The host service had not employed peers before so experienced barriers within the internal processes including, but not limited to, paying people and strict background checks. This led to long delays and the initial group of peers being withdrawn from the project, which had negative impacts on them personally and in their relationship with the service/staff.

• Stigma – There were some hesitancies from staff in services around employing people with lived/living experience. This was felt to have further delayed recruitment and peers being integrated into the team.

• Practicalities – Peers were spread out geographically in the area so there were difficulties in keeping in contact with them as was mostly done remotely. This was exacerbated by Covid-19 restrictions at certain stages of the project.

• Peer role – One peer had some initial concerns around how their past using substances may affect their ability to do the role and all were aware they may encounter difficult situations. They wanted to provide person-centred support beyond naloxone training and provision, but this was limited due to the remits of the project.

• Co-ordinator role – Staff felt more time needed to be allocated to managing the project successfully than was initially allocated due to funding.

Benefits & facilitators

• Learning – Staff reflected that they had learned significant things from the peers as well as vice versa and other services were said to have learned from the difficulties experienced to plan their own similar project rollout more effectively.

• Changes to staff attitudes – Staff within the host service and others had become more accepting and positive about having employed peers doing this work as time had passed.

• Payment – Being paid for their role was appreciated by the peers and seen as important by staff to reflect how valued the peers' skills and input were.

• Value of peers – Having peers in these roles was crucial in developing services and responding to drug-related deaths. They were seen to have unique and valuable insights not present in other staff and could relate and engage well with target populations.

• Skills and development – Peers were building skills and confidence through their involvement in the project. This was seen to be beneficial in equipping them for future opportunities.

• Reducing drug-related deaths – The peers felt positively about how their role would contribute to efforts to reduce drug-related deaths and staff felt the project was increasing awareness and supply/use of naloxone in the area.

Discussion & conclusion

There were clear benefits and challenges experienced throughout the pilot projects, with similarities and differences between the three settings. The peer workers supplied large numbers of naloxone kits, demonstrating the effectiveness of involving them in this work. Success was achieved across the three different environments, particularly around increased naloxone provision and positive outcomes for the peers, in terms of skills, opportunities and personal development.

Challenges around setting realistic expectations for their role, recruitment processes and practicalities/governance were experienced and were tackled by dedicated co-ordinators. The co-ordination of these projects indeed required substantial resource and time to reach the positive outcomes, and this must be accounted for when considering the future of the rollout.

Stigma, albeit often subtle or hidden, from staff and services about employing workers with living/lived experience and peer inclusion existed in two of the settings which hindered the project, particularly in initial stages. Encouragingly, the attitudes and responses from staff largely improved as the project progressed, showing that exposure to this type of work involving peers can help to overcome stigma. Staff and peers alike were strong in their feelings that having peers supply the naloxone kits was allowing them to reach more populations and engage with people more effectively than would be or had been otherwise achieved.

Therefore, with sufficient staff time and resource, including payment for peers, allocated to this project, and awareness of logistical and practical challenges, there are no reasons this approach could not be continued in these areas and rolled out in others effectively. There should be a confident assumption that this would contribute even further to the reduction of drug-related deaths in Scotland due to increased naloxone supply and broader efforts for peer inclusion.

Recommendations

01| Reduce barriers to employment – Any organisations employing peer workers must work to reduce, or ideally eliminate, barriers to employment for these individuals. The level of background check/PVG should be reconsidered in relation to the job role. Staff must understand how sessional/part-time employment may impact peers' benefits and address concerns around this. Long-term contracts with consistent hours should be sought for peers to overcome benefits being affected.

02| Payment for peers – All peer workers involved in projects of this kind, including those within prison settings, must be paid fairly for their time. This will allow the role to be recognised as important work and ensure peers are valued. Some peers chose to volunteer and did not want to be paid; this option should be considered as appropriate but must be chosen by the peers.

03| Full-time co-ordinator – Assigned staff co-ordinators in host services must be allocated sufficient time to dedicate to this project, more in line with full-time hours. Having time to support peers consistently throughout their time in the project and deal with barriers as they arise is crucial for success of the project.

04| Expectation setting – When peers apply and become involved with this work, clear expectations about the role and its parameters, and related processes must be explained to them, such as the need for ID and how long PVG/background checks may take. Staff should ensure these are understood and must adhere to them consistently, with opportunity for peers to discuss any concerns given regularly.

05| Service preparation – All staff within any services adopting this approach should be fully briefed on what to expect, given the chance to discuss concerns and receive inputs/training on living/lived experience inclusion and stigma. This should take place before peers are recruited and working with the team.

06| Long-term funding – Rollout of this work can take some time to get established and start achieving positive outcomes. Therefore, funding should be at least 3 years for time to be dedicated to overcoming barriers and foundations to maximise naloxone supplies built. Regarding this specific project, national support for the staff and peers is considered essential.

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Introduction

Background

Scotland remains in the grips of a public health emergency, having recorded 1,330 drug-related deaths in 2021. This was the highest rate in Europe and some 3.7 times higher than the UK rate (National Records of Scotland, 2022). Opioids (such as heroin and methadone) were implicated in 84% of these preventable deaths.

Naloxone is a competitive opioid antagonist that can temporarily reverse the effects of an opioid-related overdose (Orman & Keating, 2009). When administered in an overdose situation, naloxone allows a window of opportunity for more specialist medical support to get to the individual and thus can be the difference in fatal overdose prevention (Tobin, et al, 2018).

Since 2011, naloxone has been available to anyone in Scotland likely to witness an overdose or at risk of one themselves and does not require a prescription (Horsburgh & McAuley, 2018). Guidelines from the Lord Advocate during the Covid-19 pandemic now mean non-drug treatment services can train and supply naloxone kits to anyone likely to witness an overdose. Naloxone is available as Prenoxad injection, administered by a needle and syringe or Nyxoid, a nasal spray, from a vast range of settings, such as community pharmacies, GPs, substance use, harm reduction and homelessness services, plus click and deliver services (Public Health Scotland, 2022).

However, ensuring naloxone supplies get to the places most in need of them remains an ongoing challenge, evident from the National Drug Deaths Database (2018) report showing only a very small number of cases (8%) where naloxone was on the scene of the fatal overdose in 2015 and 2016. Peer workers with living or lived experience of substance use are ideally placed to increase distribution of naloxone, which has been argued to be significantly important in reducing drug-related deaths (McAuley, et al, 2012).

Indeed, as described by the European Network of People Who Use Drugs (2019):

> *"Peer to peer naloxone is underpinned by drug users' privileged access. Peer educators are able to enter and interact in drug using venues and they naturally interact with the local drug supply system…Peer educators...can all draw on their trusted status with those currently actively using drugs based on their shared…experiences and access to friendship and supply networks."*

Following a change in UK regulations to allow peer volunteers to supply naloxone, SDF and NHS Greater Glasgow & Clyde developed the first peer supply model in 2017, building on the success of the community and prison-based naloxone peer education programme. During the first year, a small number of peers provided over 1000 naloxone kits to people in their community, indicating the significant impacts involving peers in this work can have (Smith, et al, 2022).

Peer-to-peer naloxone supply project

To build on the existing work, SDF sought to maximise peer to peer naloxone supply with a coordinated and supported approach by delivering high quality training to peers who have experience of substance use, providing ongoing support and developing a national peer network to enhance the delivery of naloxone provision by people who have experience of drug use. Importantly, this included paying community peers as sessional workers.

The project was established, and now operates, on the understanding and acceptance that people who have experience of drug use are instantly credible among their peers when it comes to imparting harm reduction messages and in particular, overdose prevention strategies. They have a powerful reach in to communities and within the prison environment, which is unique to other forms of service provision.

Objectives of the project were:

01| Establish, embed, and support high quality peer supply of naloxone as a core service across Scotland.

02| Ensure those involved in peer supply have an active voice in delivery of naloxone and other harm reduction interventions, including the sharing and promotion of good practice.

There were three initial pilot areas for this project: one rural; one urban; and one prison setting. SDF worked with these areas and services to recruit peers, deliver training, and support these groups of peers to train others and supply naloxone kits in their localities. Allocated funding to support local staff time and sessional worker payments for peers was acquired and utilised. Each year following, this will be formally delivered across six other health board areas, with allocated funding to support local staff time and sessional worker payments for peers. In addition, SDF will support other areas that wish to take part with their own resources.

The local peer naloxone groups in the pilot areas, and subsequent groups, had regular support, were part of the local project steering group, and were provided with the necessary technology, equipment, training, and expenses to take part in this project.

Representatives from each group convened four times per year from across Scotland to form the National Peer Naloxone Network. The network shares examples of good practice and considers national policies and strategies to prevent drug deaths. Peers have been involved in local drug death prevention groups and maintain links to national structures, in particular the Drug Deaths Taskforce and the Scottish Naloxone Network.

Social media, websites and webinars have been, and continue to be, utilised to share information from the peer networks to promote their work and present at local and national meetings.

This evaluation

This evaluation aimed to explore the peer-to-peer naloxone programme within the three pilot areas and focused on novel approaches in this programme compared to previous service provision. This included effects of paying peers; viability of peer distribution in a range of settings such as prison; exploration of local challenges, for example rural compared to urban environments; varying roles of peers, for example in strategic decision making and how this affects engagement and success; and intended/unintended outcomes of the approach. The evaluation explored both outcome measures and emergent issues over the first year of practice and aims to develop a comprehensive understanding of the project as a whole.

Methodology

The evaluation used a mixed methods approach, including qualitative semi-structure interviews facilitated by Scottish Drugs Forum peer research volunteers and a staff member with peer workers from each setting, plus staff members directly involved in the project localities. Quantitative data about the project was also included.

Peer Interviews

A topic guide for interviews (Appendix 3) with peer naloxone workers was developed by SDF research staff and peer research volunteers. Interviews took place with the peers from the urban and rural areas in person on a day of refresher training for their roles, except for one from the rural area which took place via video call. The interviews were conducted by an SDF peer research volunteer and were audio recorded and transcribed.

After gaining approval by the Scottish Prison Service (SPS), an SDF staff member and peer research volunteer were able to attend the prison site to interview the peer naloxone mentors within the NHS Health Improvement Hub. Staff from the Hub were the main co-ordinators for the project in the prison and this was the site for much of the peers' training and support. The interviews were conducted by the volunteer and the staff member scribed the interviews as they were not permitted to be audio recorded. Quotes have been adapted to first person from the scribing.

Staff Interviews

A second topic guide (Appendix 4) for staff from each area who were directly involved in co-ordination of the project was developed by SDF research staff. In the urban setting, this was a team member from the host service and a partner from a pharmaceutical role. In the rural area, these were two staff from the host service. In the prison, these were three team members from the NHS Health Improvement Hub. These interviews were arranged and conducted by an SDF staff member via video call software and were audio recorded and transcribed.

Analysis

All transcripts were thematically analysed by SDF staff using Braun and Clark's (2006) method, aiming to identify both deductive and inductive themes. Data from across areas and from staff and peers were compared and main themes extracted for the report. The findings were considered and presented in terms of Challenges & Barriers and Benefits & Facilitators in each area.

Ethical considerations

All interview participants were given a Participant Information Sheet (Appendix 1) and informed consent (Appendix 2) was gained and recorded before the interview started. Participants were able to withdraw at any time with no consequences.

All data was anonymised and stored in a secure SDF database accessible only by the research team.

Findings

Prison Setting

Project information

There was large interest to become a peer mentor from those living in the establishment when the project was initially advertised. However, the majority were not taken forward following internal security checks on their prison record and any intelligence around activity such as drug dealing and bullying whilst living in the establishment. Co-ordinators took learning from this regarding future recruitment where the focus would be on smaller, more manageable group sizes with spread throughout the establishment.

This project was highly innovative within the prison establishment as involved people living in the prison offering and facilitating naloxone training to others living in the prison. The Health Improvement co-ordinator would receive Nyxoid kits corresponding to the number of people who were being released the following day. These would be distributed amongst the peer mentors based on which hall people were in and in the evening, the mentors would visit each person due to be released to offer them the training and kit. If an individual decided not to take the kit following the training, they could leave it behind.

The project went live in this setting in November 2021. The number of kits supplied by the peers between November 2021-April 2022 was 183. Of these, 145 were first supplies.

In April 2022 there were five active peers in the project and four of these individuals were interviewed for this evaluation. All of these peers were male. The fifth peer not interviewed had been recently liberated from the prison at the time of interviews taking place. Three female staff members involved in the project were also interviewed for the evaluation.

Challenges & barriers

SPS staff

The staff interviewed expressed that one of the difficulties was initial resistance to the

project from SPS staff:

> *"…I should say SPS staff were maybe a wee bit apprehensive around oh right, there's mentoring, what is it they're doing and…you know, how? How are they going to take that forward and has this been approved and, and obviously we were doing a lot of that background work to make sure that everything was… we were ticking all the boxes that needed to be checked..." (Staff 3)*

SPS staff were resistant due to concerns on how the project would run and whether it would create more work for them. Peers had also experienced some of this resistance, with one feeling that SPS would only be interested in being associated with it if it got positive publicity:

> *"Going into the halls at the beginning, there were barriers and I felt we weren't expected to make changes. Even the staff at first didn't even want to sign their name to it. The Health Improvement worker told me she gets attitude from staff about it so peers likely to get it even worse, she told me to just ignore it." (Peer 4)*

As highlighted above, there were some stigmatising attitudes from SPS staff about the project shown by many not wanting to be associated with the work. Going further, there was a feeling from staff that SPS may stigmatise the mentors due to things they know about their past or make assumptions about their involvement in substance use, as expressed by the senior co-ordinator:

> *"You can't unknow it and you can't un-judge it especially if it has a personal impact on you, whether that be the nature of the crime or the nature of the, the victim, you can't unknow that stuff… And it can be difficult for my colleagues to put that aside and see the best... That's my job to challenge that, not the guys who are, who are working in my programme...I'll fight with organisations for equity." (Staff 2)*

The peers reflected this through their own experience of stigma and felt this restricted the impact they were able to have:

> *"If staff were more understanding, they only take half of it in. We are trying to tell officers the same things as prisoners but there is still stigma attached and I think officers can still stereotype people for drug use." (Peer 2)*

Recruitment & workload

Due to logistics of the establishment, most peers that are recruited are only able to work within the halls they live in, except for "pass men", who can move more freely between halls. These internal structures of the establishment led to some imbalance of workload amongst the peers, with management required in one hall to ensure all peers got a turn and others having much more to do:

> *"…which has meant that the people who were able to, to plug that gap, I think there's been a considerable stress put onto them, which potentially hasn't been fair. Thinking with hindsight, we maybe would have done that differently." (Staff 1)*

Staff reflected that spread of workload across the halls should be balanced and will reflect this in future recruitment efforts.

Peers complete training and distribute the kits in the evenings, which can impact the time when they may have visits, recreation time or other responsibilities. Staff were aware of this and keen to avoid them missing out on these activities, as well as other programmes or work, due to their project role:

> *"I think it's difficult for some of the guys because we're asking them to give up their evenings. The evenings is when they get their visits. Their evenings is when they get free time, and we're asking them to give that up for an hour or two hours to go and train people. So yeah, I think the guys make, make some difficult choices." (Staff 2)*

One peer described how busy his schedule is and how the peer mentor role adds to this:

> *"The amount of work I do can be overwhelming. I teach rugby on Thursday so might have to rejig some things depending on how many kits there are that day. I work 8.30-12, 1.30-4 then in the evenings do naloxone. I'm done by 8.30pm so sometimes don't even get on the phone to my family. It keeps me busy which is good but would be helpful if there were more mentors." (Peer 4)*

Hesitancy about training

The peers described experiencing some stigma and hesitancy from potential training participants about naloxone/Nyxoid as say they do not use drugs or want to associate with those who do:

> *"A lot of people are reluctant in case having naloxone breaks their license. Staff have said it doesn't affect this. They don't want to take it because they don't want to engage with people who use drugs. I would like it to be looked into about whether it breaks people's license conditions or how I can explain it doesn't. I had someone refuse it as he said he wouldn't be engaging with anyone when he gets out. People don't want to be around anyone with drugs and can associate naloxone with this." (Peer 1)*

However, the peers described taking the time to dispel myths and felt people were more responsive to them than they would be to other people or staff:

> *"There is lots of stigma still attached to it, but it is easier for us to speak to fellow prisoners about it than anyone else. Giving people information they've not previously heard and getting it from me and other peer mentors. Sometimes you tell people stuff in here and they don't listen. Some stuff they don't know but think that they do." (Peer 2)*

Payment

Despite Health Improvement staff advocating for the peer mentors to receive payment for their roles, the SPS system prevented this as they limit wages people are able to receive:

> *"… so, we'll pay people an additional wage, but we're restricted to the Scottish Prison Service wage scheme, so people cannot be paid above the maximum wage in prisons. But what we're trying to do is take people up to the maximum wage." (Staff 2)*

Despite these barriers, staff interviewed felt it was very important that the peer mentors be paid accordingly for their time and effort. Indeed, the peers had been impacted by the SPS decision not to pay them:

> *"…when the mentors were informed a couple of weeks back that, that, that there was a final decision from SPS that they weren't getting paid, there was a real deflation in the room. There was a real sense of… They felt really valued I guess by Health Improvement and the role that they were doing for us, but they felt that being a peer naloxone champion by SPS wasn't valued and it was a real shame because it took away…I felt it kinda took the positives…positives away from the other things that they got from SPS…" (Staff 3)*

The peers echoed these feelings, suggesting being paid would show the role and them as peer mentors were valued and recognised by the establishment.

Resource

Staff discussed their workload relating to the project and felt there was more time required to run it effectively than the days initially allocated:

> *"I didn't probably have the understanding, again because we didn't know the*

> *processes of how much of my, my time and resource would've been used up. I think this programme initially was two days of my five-day working week… Which this program takes up a lot more time than that, and so I think, I think just kind of managing that alongside…the peer supply programme is not the only thing that I've got in my work plan...." (Staff 3)*

It was clear the staff were managing competing priorities but wanted to make sure they had the time needed to run the programme properly. This staff member went on to describe concerns about the project being expanded across another prison site and the impact this may have:

> *"…I think I'm probably just being mindful not to jeopardise the consistency and the structure, which we know is things that are positive in the programme, for the sake of obviously being split between both and the resource being a bit less frequent." (Staff 3)*

Similarly, staff were aware that resources were tight for the project but that they did not want to compromise the quality of the programme and experience for the peer mentors:

> *"…again, is the other unintended outcome is that our population...we hear it time and time again: see what happens is you start something really good, and it runs for a couple of months and then it just collapses. And we don't want that to happen, but we need to look at how we support our current team without running them into the ground…What service do you lose? Is it that you suspend…what do you compromise? What do you sacrifice? We don't know the answer yet." (Staff 1)*

As mentioned in the previous statement, being able to fully fund the programme on a more long-term basis was important to all the staff:

> *"…I don't think it's something that should, should stop just because it's kind of came to its… I guess its pilot period of time is done…I think a lot of the kind hard work and challenges of getting it introduced and the process in place has been done. So, I think there should be no barriers in terms of that. The only barrier might be staff resource to, to deliver that…" (Staff 3)*

Staff felt strongly that they did not want this programme to be replaced by something new when it was no longer the "in-thing" as it had already made an impact and had potential to be successfully continued.

Benefits & facilitators

Peer recovery

Staff described that being involved in the peer mentor project had positive impacts on individual peers' personal recovery:

> *"Two of our mentors, one of whom had naloxone used on him on Boxing Day last year and hasn't used a substance since and he says one of the things that keeps him off is the fact that he is as a mentor. You have got somebody else who struggles daily with substance use. It's being a mentor that keeps him focused and just building his self-confidence, stand that wee bit taller and you can see that. Before he often had been written off by SPS colleagues where he just…he was invisible. Whereas now…He can do, and he gets the feedback." (Staff 1)*

They also explained that allowing peers to remain involved during difficult times was important in supporting them to move forward personally. One peer also described supporting another when he was struggling, using humour to encourage him:

> *"I helped one of the other mentors who was taking legal highs, told him he needed to knock that on the head because I was getting run ragged!" (Peer 4)*

Development & opportunities

Staff and peers reflected that the role gave people an opportunity to do something different within the establishment and utilise time positively:

> *"There actually was good appetite, I think because it was something different*

> *and I think post Covid there was quite a significant number of people that were thinking, they were looking for, a new challenge, looking for a reason to get out." (Staff 1)*

Staff stated that the peers have developed and gained many transferable skills, such as communication, emotional literacy, timekeeping, and confidence, as well as achieving Community Achievement Awards. These things were due to training, observation of staff and support from the team and each other:

> *"Unbeknown to us that the mentors are actually observing the way we communicate things with staff. And so, one of the mentors actually fed back around what he's learned about communication and effective communication through observing the way that Health Improvement staff communicate the challenges within the hall which was, that was really nice to see." (Staff 3)*

Staff also described that involvement in the programme was helping who had received naloxone training, and especially the peer mentors themselves, build social capital:

> *"I think it's been really about the, the increase in social capital. I think it is about the, the increase in confidence that people have… If somebody can participate in the programme that everybody said would never happen and participate well and get good feedback. See if you're gonna do that: What's the next thing you can do?…The prisons in general have got a far greater appetite and recognize the value of peer-to-peer learning and peer support. So, I think this is just the beginning." (Staff 1)*

Staff felt the impact of this within and beyond the establishment was significant, leading to people and communities being safer. The peers also described learning they had gained from the programme from the training sessions which had given them confidence for their roles:

> *"Without the training, it would have been harder, but we are able to explain it how we want, have a laugh with people. Learning about the myths stuck out a lot for me and I think it's important for other people to realise them too." (Peer 2)*

Both peers and staff discussed that these skills were setting peers up for future opportunities and their liberation:

> *"I talk with staff about milestones I have – about my confidence, talking in front of people, time keeping. I want to continue this type of thing when I'm out. I've been linked in with someone from Simon Community and will be able to work with them when I get out. I'm excited to find out what I can do." (Peer 3)*

> *"…it's the way to go if we are going to support people, to have the opportunity to potentially enter the workforce on their liberation, we are providing a…a real skill and we're also making use of skills that people already have, that they might not realise they already have, like just to see how people blossom." (Staff 1)*

Staff were able to provide parole reports and references for future opportunities for the peers to have when they left the establishment. Indeed, one peer had already left and been immediately signposted to a similar project in the community:

> *"…he moved down to [area] and has engaged with one of the community organizations and has engaged with them to deliver naloxone training. So, it's potentially…the intent has always been that he, he may be open to become one of the sessional workers. That wouldn't have happened if we hadn't been doing this in here." (Staff 1)*

Staff relationships

There was consensus that peers really valued and were grateful for the Health Improvement staff and how they were treated by them, with one peer describing them as "brand new":

> *"So being spoken to as individuals, as people…rather than as prisoners. Which is always…as our kind of senior member of the team, that's always nice to hear and that's always what we've worked to, is that…we see a very clear delineation in that the people that we work with, the people living in prison are not our prisoners. They're our population." (Staff 1)*

It was clear SPS staff overall had become more supportive of the project despite the initial challenges. Staff and peers described how the project has led to more positive relationships between SPS staff and the peer mentors:

> *"…it has been fed back, kind of anecdotally by the mentors that they feel their relationship with SPS has improved, that they're seen in a different light if you want to say. For we have quite a lot of conversations, in particular within group learning around labels and labels that can be attached so I guess stigma...but in terms of when the guys are saying, you know, quite often you've got a label attached to you, whether that's for you know, your behaviours or if that's due to your substance use or whatever, whatever that is. And so, we have quite a lot of conversations about… Now as a peer mentor, which is a label that they've got, how some staff can often see them as their other labels and not as a peer mentor, but they now feel that that's kind of shifted." (Staff 3)*

One peer echoed this by saying they felt staff look at and speak to them differently now that he is a mentor, as opposed to how they did previously when he was using substances.

Improving naloxone provision

Peers described their motivations for being involved as largely being down to wanting to make an impact on drug-related harm and deaths. They referred to their personal experience of substance use and/or witnessing the impact on other people:

> *"Being involved in that life, losing my partner. The nurse in here saved me. That was my moment. All the peers have similar stories, something has happened to them that makes them want to be involved. I'm not looking for anything, just giving something back for everything I have taken. Doing something good for once." (Peer 2)*

Staff and peers both emphasised that having peers lead the naloxone training and supply had led to much greater uptake from people in the prison than would be possible with, for example, staff doing it:

> *"The amount of barriers that have been removed because it's a peer approach has been phenomenal and I think that was evidenced in our very first evening going live where initially the peer mentors weren't allowed to go on any of the landings. So, they weren't allowed to go to anybody's door. The staff member was asking them and then saying, well, if you want it you need to go down the stairs. And so, we had, I think it was two refusals, didn't want the training. And the peer mentor said, let me speak to them, went over and said listen, it's me that's doing the training. You know, it's gonna take 15 minutes. Do you want to come down? And he got them trained and they left with their naloxone, so I think for that to happen in our very first night was massive in terms of that kind of then influenced some changes around the peer mentor could go and ask them..." (Staff 3)*

Peers echoed this by describing that people had been more likely to refuse the training when offered by a staff member than when they approached them directly. Staff explained that information coming from peers is more accepted and appreciated by individuals living in prison than when it comes from staff:

> *"Evidence shows that people in prison listen to other people in prison. They're more likely to believe their peers than they are staff. So yeah, for me, that's what makes the difference. That's where we get the engagement, our peer mentors get engagement with people that won't speak to staff. So, that's why. Well, that's why it's been successful." (Staff 2)*

This was echoed by peers who explained how the culture of the prison meant word-of-mouth would spread the information between those living in the prison and their involvement meant people could be honest with them:

> *"There is lots of stigma still attached to it, but it is easier for us to speak to fellow prisoners about it than anyone else." (Peer 2)*

Overall, due to the peer project, there was felt to be more awareness and dialogue about naloxone within the establishment. An unanticipated positive outcome was that SPS staff were seeking out naloxone training for themselves, including from Scottish Families Affected by Drugs (SFAD) naloxone postal service:

> *"SPS staff looking for how to do it. So…again one of the mentors…the most confident person has directed people to the SFAD site and how to get a personal kit…and…to do the online training and to request a personal kit." (Staff 1)*

Indeed, one peer said he felt the programme was helping to "break down barriers" with staff about naloxone as he had had SPS staff ask him about naloxone.

One staff member went on to explain that SPS staff had become more welcoming to the idea of there being naloxone within the prison, feeling they understood the benefits of it better than at the start of the project:

> *"But I think there's been a bit of a turnaround within the residential areas that the staff are well, you know, if all it does is kind of like, overturn an overdose, then what's the worst thing? If there's a few units kicking about the halls. You're like, yeah, we know that, and we've actually had people saying, so if it's in the hall, if it's gonna save somebody from an overdose, then is that a bad thing?" (Staff 2)*

Peers had been taking other opportunities to raise awareness in the prison, such as within recreational areas and there was a feeling amongst staff and peers that the project had undoubtedly led to more naloxone leaving the prison and thus making communities safer:

> *"So even if people leave prison and they go back to using drugs immediately, they go back to using drugs in a safer way, because they go out with Nyxoid." (Staff 2)*

Expanding

Staff felt that the success of this model could be replicated and built on for a wider peer mentor harm reduction role and for future projects:

> *"I'd like it to be a full-time role. I'd like to expand the peer mentor role from naloxone, and we hope to do this. So although…every peer mentor will be trained to deliver the, the overdose and the save someone's life messages,*

> *hope to be able to increase their range of skills and topics that they can talk about so that we can have peer mentors employed in different areas of the prison and be employed as a peer mentor, not – it's not an add on for them, so instead of doing their job all day and being a peer mentor at night, I want them to be a peer mentor, and then they'll do early shifts and back shifts. So that they still get their time." (Staff 2)*

Staff hoped that the mentor role could develop to include other health issues, such as smoking, mental health and nutrition, utilising peers to share information and messages about these and how to get support within the prison.

Support from SDF

One staff member reflected on the positive impact having external support from SDF was in the rollout:

> *"…obviously having SDF as a partner within it as well has been amazing. Just for coordinating the peer supply groups and, and getting to hear what, what other people…people are delivering and how they're overcoming things and then trying to make that like prison specific…and the fact that, you know, [names] were like only at the end an email If you had any kind of questions or concerns or anything which yeah, that was…massive in terms of, I think, particularly because it was a new program and having that support there." (Staff 3)*

One peer explained that they had asked if there might be something like a monthly newsletter SDF could provide about the project across the country so they could see what else was going on and feel more part of the bigger picture. This had not been supplied but peers had taken part in a national networking meeting.

Urban setting

Project information

Peers were recruited by the host service. SDF were not involved in the shortlisting process. Once recruited, the group of peers were trained by co-ordinators from the host service and SDF on how to train others on naloxone amongst other relevant topics. They were supported to seek opportunities to deliver naloxone training and kits to the public, such as in pop-up stands in shopping centres, and at other support services.

The project went live in this setting in April 2021. The number of kits supplied by the peers between April '21-Apr '22 was 813. Of these, 304 of these were first supplies.

In April 2022 there were six active peers in the project and five of these individuals were interviewed for this evaluation (three males, two females). Two (one male, one female) staff members involved in the project were also interviewed for the evaluation.

Challenges & Barriers

Managing expectations

One staff member explained that the peers have high expectations about what can be achieved and want to do it all immediately, so staff have had to work to manage this as appropriate:

> *"…maybe sometimes reining it in a wee bit. A couple of the peers just wanted to kinda get the naloxone's in the bag and just get out and get in the town centre and do the outreach and all that… We have obviously our own risk assessments to kind of follow…as I say, it's listening to those creative ideas, but just kind of managing expectations in terms of what capacity…'cause, we don't want to spread them so thin." (Staff 2)*

The staff were conscious of not letting peers take on too much or have that impact the quality of their work. Harnessing the peers' enthusiasm and passion without allowing

them to burnout was required by staff, especially in initial stages.

Needle exchange

One peer and staff member described that the peers had started at a time of the team being short-staffed and this led to them working in the needle exchange as part of their role, which the existing staff teams were grateful for. This benefitted the peers as they felt embedded in the team and gained skills, but may have diverted them from their primary role in the project and had them filling gaps elsewhere:

> *"I work in the needle exchange, you see, and what happened was, I think it was because the needle exchange was very short staffed…I think a couple of the workers had left and they were waiting for new people to be employed, so a lot of the people that were working doing the naloxone project, they were actually working more kind of in the needle exchange. I think some of them were working in the needle exchange maybe one day, but they were also going out other days." (Peer 2)*

This peer went on to explain that he now works in the needle exchange for all his hours. However, there has been less footfall in the needle exchange, so peers do not get to give out as many kits when working in this setting:

> *"…we're not seeing the same amount of people anymore. It's completely different to what it was a couple of years ago. We don't really know why – we think it's maybe because people are using crack now rather than heroin. But there's also maybe people who aren't coming into the centre because they're maybe using, they could be reusing their equipment, it could be they're using like a local pharmacy." (Peer 2)*

Due to the decreased numbers in this service, the peer reflected it was positive that the project was providing naloxone in the community.

Practicalities

There were some practical aspects of the project which had created minor challenges

to overcome. Covid-19 and restrictions meant there was not as much training in person as would be the preference:

> *"…obviously we couldn't do much I believe because of – like, face to face- because the pandemic, yeah, but did quite a lot of stuff online." (Peer 1)*

Staff said peers can need some support/reminding to complete paperwork for their role, but that this was similar with all new staff:

> *"…if anything, maybe just a slight eagerness and maybe in terms of some of the paperwork…in terms of the returning some of the paperwork – we've had to maybe go back and say this is how it's got to be filled out." (Staff 2)*

There had also been some difficulty in getting peers to use technology to stay in touch with the team.

Training

Due to working hours and other responsibilities, one peer mentioned they will have to access additional training in their own time:

> *"Yeah, or we could just do it in our own time actually, I think that would be much better because, like, people are busy as well – like, still studying or working as well, like volunteering, or if I'm here now all day, every single day, obviously it would be easier for me even if I could do it at the weekend or after work, yeah." (Peer 1)*

Apprehensions about role

Some peers explained they had initial nerves about approaching people in the street to offer naloxone training:

> *"The thing that I've found difficult is just being out in the street and maybe having to speak to strangers and not really knowing, you know, how they're maybe going to react." (Peer 2)*

Another peer explained they had apprehensions about the role as did not expect certain aspects of it. However, they did feel more positive about this at the stage of their evaluation interview:

> *"I wanted to do support work for people with addictions anyway and that but I didn't realise that I'd have to be – cause I'm quite shy usually – so I didn't realise that I'd be going out to like promote it…I thought I'd be more like in a wee office, helping people get help, going into rehab and stuff like that so I wasn't sure, so this was totally out my comfort zone but I'm kind of glad that I just went for it…" (Peer 4)*

Stigma

Some peers described that they had faced stigmatising and judgemental attitudes from people when they were offering naloxone training in different settings. One explained that this could be frustrating for them to deal with:

> *"People's opinions on it and like, oh you're enabling people to use drugs and…or, why, why are you doing this because people…like even yesterday somebody's like, they've put themselves in that situation – only a select few people deserve it and…I'm thinking to myself, you're entitled to your opinion, I don't want to get into a debate about it cause I'm trying to act professional, but at the same time, I'm not enabling them and I'm just making sure people are safe so that's the main thing." (Peer 4)*

Another peer said they felt the stigma could be linked specifically to the needles in Prenoxad kits and that some people, even those accessing support services, do not want to be associated with intravenous drug use or substances that can be injected.

Continuation of project

Staff and peers were both passionate about the project being able to continue beyond the initial period contracted for. One staff member highlighted that funding and resources must be sufficient to do this:

> *"Yeah, it needs to have sufficient funding I think, and it's even things like the materials that the peers are using. So, we used a load of the free materials that we got from SDF, so like kind of naloxone pouches and things like that, and the pens and face masks and things like that. So, I think having those to start that conversation has probably been very, very helpful. So again, it's funding things like that as well going forward. So, the backpacks, the coffee cups and things like that, so that they feel part of the team and included, properly resourced." (Staff 1)*

The other staff member and a peer both felt strongly that there would be disappointment should the project be unable to continue:

> *"Just think it's doing brilliant, I think it's really doing good, know what I mean? And if we didn't get funding for more it would be a…it'd be a crime." (Peer 5)*

Staff were working to embed this work in their contract permanently so that it would not have to end when the initial phase was over.

Benefits & Facilitators

Existing peer involvement

The host service already had peer framework in place which made recruitment straightforward, especially as some peers were already involved here:

> *"…I think the process was pretty smooth in [area] and I think that was down to [service] and their ability to move quite quickly on that, and actually it was something that they already did so they were fine with getting that up and running." (Staff 1)*

Due to this existing framework for peer involvement, all participants felt staff and organisations across the area had been welcoming to the peers and project, with them seen as part of the team from the offset:

> *"My experience is that they are, the peers are viewed as equals. Certainly, I view them as equal and just as important as anybody else that participates in the programme and, you know, equal versus equal, good ideas, everything like that…so yeah, I think they are equal members of the team." (Staff 1)*

One peer reflected that in this paid role, they were able to make more decisions themselves rather than passing things to staff when they were volunteers:

> *"When I was volunteering, I kind of thought, oh I'm better signposting, know what I mean? Even though I knew what I was doing…it's like more of a part of the team kind of thing there." (Peer 5)*

Staff described why the peers were important in this project, as they brought an "authenticity", and that their capabilities are beyond that of staff for this work:

> *"Although we were doing it within staff, I didn't have the same capacity to do that as well. So, peers allow basically staff, more staff, to have a wider reach and having that credibility that they have as well gives the organization more credibility…" (Staff 2)*

The other staff member explained that in this role peers can focus specifically on naloxone and how to maximise opportunities for training provision more than other staff who have other aspects to their roles:

> *"It's much more outreach, I think, much more innovation as to where the peers can go, they're much more flexible as to where they can go and the times and coming up with all these new ideas and I think because, because this is their role, whereas for other staff, it kind of fits in around their role, it's kind of an add on, so they're kind of fixed as to what they can do..." (Staff 1)*

Going further, staff described how peers bring their own ideas and approaches to the project which is beneficial for everyone as they often think of things other staff would not have:

> *"I've been really impressed at how proactive they are, and you know, really*

> *taken ownership of the project. You know, it's definitely not us dictating to them as to where to go, it's absolutely them coming up with new places and new opportunities and reaching new people." (Staff 1)*

The peers were supported by other staff as needed to plan their time but were given freedom to try things out and act on what worked.

Skills & development

It was stated that the training the peers received equipped them with knowledge and confidence to be informed in their roles and to deepen their understanding of issues around substance use, naloxone, and other harm reduction:

> *"I did enjoy the whole training…probably the, not so much product knowledge, the information about the different kinds of drugs and the effects and what they look like and that sort of thing. That was a real eye opener for me. That's what really benefited me more…" (Peer 3)*

Staff felt the peers were learning "professional boundaries" and had developed transferable skills. One staff member commented on their experience of witnessing the change in individuals:

> *"The confidence that I've seen within one of the girls, in terms of like, the other day she was attending a case conference for someone that she'd seen around at a hostel, along with another worker and they've both been asked to attend because of their input and that relationship they've got. From the start of the pilot, I would never have thought that just based on that kind of confidence in [peer]. So…that's been great in itself." (Staff 2)*

With time, peers had been supported to overcome initial apprehensions. Overall, the role had allowed the peers to become more confident within themselves and feel valued:

> *"…outcomes from that very, the soft touch, that self-esteem and confidence and how that person can play a more valued role within their community, to*

> *how much that supports the organization as well." (Staff 2)*

Some of the peers described how the skills and experience they had gained in this role had boosted their self-esteem and would be likely to help them progress in their careers, either for specific paths or more generally:

> *"…my next step is still wanting to help people that are maybe homeless, people that are maybe like still using and things like that, so I want to go onto the next steps…" (Peer 4)*

Peers reported they had gained knowledge to apply to other roles, such as in counselling, and recognised this experience would help them make progress in their careers.

The staff members explained half of the peers had already moved on to part-time or full-time employment opportunities due to their involvement in the project:

> *"And [peer], who's one of the other ones…he's actually just picked up a 20-hour contract within the harm reduction centre and he had his interview and actually clearly said the peer role has massively increased his confidence. He was on our relief kind of pool for about four or five years but was always quite… Maybe never pushed his own recovery as much, whereas he said this has been a bit of a catalyst for him, for his own recovery and actually realizing that he can do more." (Staff 2)*

A few of the peers had also been given further opportunities to be involved with near-fatal overdose and outreach work:

> *"And I know through speaking with the peers their knowledge around other services, being a part of the non-fatal overdose call, doing assertive outreach and then linking in… one of the peers is currently linking in a guy that he supported who had a non-fatal overdose into our young people service and is doing a bit of the buddying work, taking that young guy to a meeting with one of the youth workers. So…that's been a really positive piece of work as well." (Staff 2)*

Peers were being invited to near-fatal overdose calls due to the relationships they had with individuals, and this was seen to give more chances to build their skills. It was also beneficial to other staff to have them involved in this important work as they could utilise the peers' networks and experience.

Payment

Staff members felt strongly that the fact the peers were paid for their roles was a very important aspect of this project, due to the nature of the work:

> *"…we all need to survive; we need to pay our bills and peers are no different than that. And if anything…it's more stressful and we're seeing higher tariffs and electricity and gas and food. So, people need to get paid…Yeah, I wouldn't see this being a volunteer role. I think by giving someone money as well, it gives them that…ownership and I don't think it should be any more increased responsibility, no more than me or you have increased responsibility because we get paid…" (Staff 2)*

All the peers said there were other aspects of the role that were important to them as well as being paid, but highlighted that this added to them feeling valued and their overall feeling about the project:

> *"It's not the most important thing but it helps, know what I mean? Cause I was, as I told you, I was volunteering too much…I was getting…they wanted to pay me! …and it's like getting sort of made to feel like more level with paid workers now, know what I mean?" (Peer 5)*

Naloxone awareness & supply

Staff and peers felt strongly the project was meeting a need for naloxone in the area:

> *"I mean, as I say, with the members of the public in [area], you're tripping over – I'm no being, I don't mean this bad – but you're tripping over addicts in the street, know what I mean? Everybody's…somebody in their family or that, know what I mean? So, it's been quite a…it's been good that way in [area], in*

> *that sense, know what I mean?" (Peer 5)*

There was a feeling that previous attempts by services to increase naloxone supply had not worked well and thus there was a drive to try something different to help tackle drug-related deaths. In line with this, other peers felt that without the project supplying naloxone kits the situation would be worse and thus the project was crucial:

> *"Definitely about saving lives, so…if you didn't do it there would probably be quite a lot of fatal overdoses…" (Peer 1)*

Indeed, two peers commented that they tended to give out two kits at a time, especially if they felt someone was particularly vulnerable:

> *"I try to hand out two at a time because sometimes one might not be enough, or people don't want to come again and ask for another one maybe because its embarrassment or something, so I always just try to hand out two at a time…" (Peer 4)*

Peers clearly felt their roles were important in reducing drug-related deaths and saw this as a key benefit of the project overall and their most dominant motivation:

> *"…the most important thing is the fact that you can actually train people to save lives…people don't want other human beings to die if they can help them and it's really straightforward. Everybody that I've spoken to, the majority of people – sorry, service users that I speak to – pretty much every one of them has seen an overdose and they've seen people pass away and they couldn't do things about it. There's other ones that have, that I've trained since I came up, since we started this that have seen people overdose and they've been able to save their life and that's a beautiful thing. It's amazing." (Peer 3)*

All participants felt the project has exceeded all expectations for number of kits supplied and one staff member described this from their perspective:

> *"…the number of kits that have been supplied in [area] is going through the roof and I can barely keep up with Naloxone supplies. It's an absolutely brilliant*

> *position to be in." (Staff 1)*

This staff member highlighted the significance of most of these being first supplies and was grateful for extra supplies they had received which allowed them to keep up with demand:

> *"I'd say one thing that really helped was...the Drug Death Taskforce, they were gifted a lot of naloxone from the manufacturer so I think they've got some, it's something like 10,000 kits and that was allocated out to the health boards and we were given some kind of direction as to particular things that we should kind of direct the naloxone to and one of them was peer supply…I did direct all our supplies to the peers because they were going through it…" (Staff 1)*

The other staff member discussed how the project has led to opportunities for more supply in different settings:

> *"I was recently at [area] College where we had a big stand and two of our peers were there just raising awareness of naloxone and as a result of that, they're going to be going back to deliver overdose awareness to some of the lecturers and First Aid team…it's hopefully going to be that [area] College will be one of the first colleges to then hold naloxone within their First Aid." (Staff 2)*

Plans were underway for an IEP vending machine within a hostel and looking at having peers permanently based in A&E to supply naloxone. Peers also discussed that they were targeting different groups of people with naloxone as it was important supply went to as many communities as possible:

> *"See in [area], it isn't actually that bad cause I've been doing community groups and that and it's all been…it's been members of the public that were interested because you can't really not know somebody with an addiction problem, know what I mean? And so, it's been good that way. I mean, we get asked that as well, we've not ran up against any barriers or anything in [area] really. Everybody's been well into…they're interested, know what I mean? They want to know…" (Peer 5)*

> *People being interested and engaged with the naloxone outreach seemed to be more common than experiences of stigmatising attitudes and reactions.*

Impact of project

As mentioned, participants felt the project was broadly welcomed by other organisations and staff. One staff member felt it could be utilised to show others that including peers is important and successful:

> *"…the other thing is with proving to other people as well, so every time I go to kind of the overdose prevention group or other national groups and stuff, that I can say look how well the peers are doing, look how good it is and actually being able to really advocate for other peer groups being established and kind of recognised for their really important part that I really do think they've got to play, particularly in the naloxone." (Staff 1)*

Staff felt it would be possible to scale up and start similar models in other areas, as well as potential to expand the peer role to wider harm reduction interventions:

> *"I think it'd be good to see a bit of widening of harm reduction, so it's very focused on naloxone, which is fantastic because that is what this project was about, but I think recognising that harm reduction is wider than just naloxone, so if they could be able to supply injecting equipment and things like that, I think that will be amazing." (Staff 1)*

Role of SDF

One staff member and peer described that the project running at the same time as the national How to Save a Life campaign (evaluation available here) on overdose awareness from SDF and Scottish Government had helped raise awareness and gained opportunities for them:

> *"The one in [shopping centre] was really based on one of the peers speaking to a manager in [shopping centre] who managed the centre. And when we seen all the posters the SDF were putting in the shopping centres around the,*

> *the carrying naloxone, on adverts, there was a pop-up shop that was created there. So, they approached that and got that up and going. So that was a real…that's huge and that's not something that we were kinda thought we'd be doing and now it's a thing that we're running twice a week so. All that has been unintended outcomes, which has been, which has been great." (Staff 2)*

> *"…what I've seen on [shopping centre], all posters are of naloxone so what is great to, you know, talk to people about it, to show them actually, it's safe, you can take it home…" (Peer 1)*

More broadly, the input from SDF was valued by staff and peers as provides, for example, opportunities for reflection and an external person to speak to and gain support from:

> *"…of course, there's SDF with [name], he's great with, great with me, he's great with all of the team and just kind of keeping everybody motivated and keeping in touch. You know, if there's any questions, you know, he gets things sorted out as well, so I think it's the fact that it is a team thing, it's not just one organisation. Everybody's behind it and I hope the peers feel really supported by that." (Staff 1)*

One staff member also felt that having the project running in other parts of the country at the same time was beneficial to the success:

> *"…there's been that nice two way and as well we're a part of a national program, a national pilot has given it, again, that more credibility and it's quite nice for the peers to be involved in that. So definitely has been a far better, more positive experience than other similar pilots that we've tried more just kind of locally across [area]." (Staff 2)*

Rural setting

Project information

Initially, four peers were recruited and had started training with the host service and SDF co-ordinators. However, due to issues with PVG checks and references, these individuals had to be withdrawn from the project. The second group of peers had been more recently recruited and, having been accepted based on PVG and reference checks, were completing similar training and activities as the peers in the urban setting. This included shadowing of staff providing naloxone training and seeking other opportunities to do so in community settings.

The project went live here in October 2021. Between October 2021-April 2022, 77 kits were supplied. 54 of these were first supply.

In April 2022 there were three active peers, all of whom were interviewed for this evaluation (two females, one male). Two female staff members were also interviewed for the evaluation.

Challenges & Barriers

Recruitment

As mentioned, there were problems experienced with recruitment of peers to the project. The organisation hosting the project had never employed peers before, so staff met many barriers in internal processes:

> *"…because this is the first time that any [service] service has recruited peers, there weren't steps in place to kind of get us off the ground running and also because the peers weren't sure what was expected of them because some of them haven't worked in years and just, just things like getting, getting ID for them, like a lot of them didn't have photo ID." (Staff 2)*

staff member highlighted there were particular barriers due to the possibility of peers who might be using substances being recruited:

> *"Not for somebody that might still be using drugs. So there had to be a whole policy shift and a policy written and the system I had to work with didn't include that group of people so I just hit barrier after barrier and saying no, you can't do that and you can't do that and you can't do that so they ended up, one: having to change their policies; and two: we had to write what that role was and then take it to HR and that went to a panel…" (Staff 1)*

Due to the problems with recruitment, such as not meeting enhanced disclosure, the first group of recruited peers had to be withdrawn from the project, despite starting to train, meet as a group and shadow staff. Staff members reflected on the impact of this, which left one feeling "frustrated and disappointed":

> *"…the first group I felt really bad for them because they were all really invested and then they didn't get through so... Actually, two of them don't speak to me anymore and I completely understand, and it's something that does upset me because they would have been so amazing at it. But unfortunately, because in order to be a sessional worker at [service], you have to have an advance disclosure done, so that's, that's why that is…" (Staff 2)*

The staff felt very regretful about these events and felt it had been their responsibility. One staff member went on to question the need for this type of disclosure check for peer roles:

> *"…I couldn't understand why it had to be an enhanced disclosure, because it's not as if they were going to be doing it with service users themselves, you know what I mean?" (Staff 1)*

The second staff member described lessons learnt from this experience and further impacts:

> *"…so, we decided not to have regular team meetings with them until they were through the PVG process this time because I felt it was really detrimental for*

> *the ones who were initially involved in the programme because they were so invested in it, but then they didn't actually get to take part in the end. So, then I felt that was really well detrimental to their mental health, really, and where they were in their recovery in some aspects, and so, yeah, so we're just waiting on the other peers coming through the PVG process and then we'll get the two day training and then get started" (Staff 2)*

It was seen to be important that new peers did not get set up to start their roles until PVG checks had been fully completed but, again, this had caused delays – with it taking a year to have active peers providing naloxone in the community.

Staff also stated that there had not been as much interest in the peer roles as they had expected and reflected on possible reasons for this:

> *"I don't know if there's maybe… that people think that it might impact their benefits, or they don't really want to be part of a service or yeah, I'm not, I'm not really sure. I think a lot…well, most of the people that we support in service are still using or drinking so the peers are people who are in, are in recovery, so there isn't such a big recovery community in the [area], so we've had to kind of go into the community and try to find people, rather than people who might be still in service or drop in or volunteers already so it has been quite difficult to find people…" (Staff 2)*

Stigma

One staff member discussed that they had experienced hesitancies around employing people who use/have used drugs from the host and other services/partners since starting to implement the programme:

> *"…I think that, although we say we do this, this and this, I think there's a hidden stigma in organisations around people that may still be using drugs or drinking, and I think there's lots of fear around that and that was certainly something I was coming up against. And I had sleepless nights over it because, like I was saying to my senior people, but, you know, we say we do this, and we don't and*

> *support me to implement this and succeed at it? So, like I was challenging them as well as they were challenging me and like really getting the organisation to think about like are we serious about what we do, and do we want to consider this group of people…so it was challenging to say the least." (Staff 1)*

These stigmatising attitudes were linked to recruitment delays as peers required two references, but NHS nurses were prevented from completing these. Staff felt this was because these partners did not support the role and project. Going further, there was some stigmatising behaviour and attitudes towards the peer workers from staff within their service:

> *"…I'd come in one day in the afternoon because I needed to access some things here and one of the peers were sitting in the waiting area…some of the team were walking about and I had the duty workers in the duty office and I asked why the peer was sitting at the front and they said, oh they're here to do something. I said, they're an employed member of staff, could we please treat them that way? So, I just went out and said, come on, find a desk, hang your coat up, help yourself, get tea, coffee in the kitchen. You know, you're a member of the team and when you come in you don't have to sit in the waiting area. So, I mean that doesn't happen now, you know, she'll come in and she has a desk and you know, she does her thing when she's here but it was interesting, you know, for the team to get their head around that and so it was really important to me that peers were treated equally and as a member of staff and as part of the team." (Staff 1)*

Indeed, this staff member felt some of their colleagues were stigmatising towards people being under the influence within the service and were failing to see past substance use and view people as individuals.

The two staff members also stated they had experienced some negative behaviour, possibly stemming from stigma about the project, when out with peers to do naloxone supplies:

> *"…[name] was kind of feeling like a couple of the drop-ins, when she went with*

> *promoting it to people coming in, but like the nurses stayed over there in the corner and never approached the table or talked about it…" (Staff 1)*

There had been one supermarket who did not allow them to have a stall to provide training and supply naloxone.

Practicalities

The rurality of the area means active peers are spread out which was seen to have created challenges in keeping them engaged, especially when communication was mainly done remotely:

> *"…see the rural area as well, it's so massive. That's a challenge, you know, you've got people, peers living in different places and trying to engage them in seven and a half hours and keep their motivation up and keep that contact up and, you know, I know they've got their WhatsApp group, but they don't look at it very often and they don't read their emails very often and, you know, so it… you need somebody who can daily stay on top of what they need to do their tasks, they were all barriers as well." (Staff 1)*

These issues in communication had led to inconsistent messages and information amongst the group.

Covid-19 was felt by staff to have negatively impacted accessibility to some venues for project activity:

> *"I don't think I really realized what, what was, what was in store, none of us did, but with lockdown and things that's been quite, quite tricky because the restrictions and things and a lot of the team meetings have been online and things where they might have been in person." (Staff 2)*

Staff reflected on adjustments they had to make to stay in line with restrictions within venues and services changing several times. One staff member also linked the pandemic with the limited interest in the peer role they had experienced:

> *"…recruiting people was really difficult and I don't know if that was anything to do with Covid but just my general recruitment is difficult at the moment and has been all the way through Covid trying to get new staff, so I don't know if its maybe similar what's happening there." (Staff 1)*

Peer role

The peers reflected on issues they were or had been concerned about within their roles. One described concern around how their past might affect how they come across to people they meet in the role:

> *"What I'm finding is just the way I might come across because I'm a recovering heroin addict…I feel like my words could be a wee bit harsher than other guys who are sitting at the table…" (Peer 3)*

Another peer expressed they felt they were likely to meet people dealing with difficult circumstances and how they hoped to deal with these appropriately:

> *"Just with some of the lives that people are living, I think you'll…that could come across challenges. I mean, I've seen the users that are using this service, some of them are just out of rehab or some of them are just going, you know, I've met people that have lost their kids and stuff, so I think it will be all different challenges with different people." (Peer 2)*

Peers were conscious about saying the "right thing" and felt they could overthink things due to nerves around this. Similarly, another peer described expecting to deal with difficult situations, as well as commenting on the rurality of the area:

> *"I would think the only thing that you'll find challenging is maybe get some verbal abuse. Personally, I've had none as yet but there will be times you will get some verbal abuse or maybe aggression. Either maybe somebody being a bit under the influence but that would…they would be the only challenges I would see. I mean the only other challenge I think is when – well, myself, I don't*

The peers described how they felt they wanted to provide more support to people they were meeting, beyond just training and provision of naloxone:

> *"I want to see things through better with these guys rather than just sending them on their way…kind of helping them that wee bit more, getting them into the right services, getting to the bottom of it rather than just giving them a kit and off they go…It's just the tip of the iceberg but, as I say, I'm just sort of finding my feet and I'm trying to run before I can walk." (Peer 3)*

Peers wanted to be able to help people more broadly in their recovery and saw themselves as being a good example to others.

Co-ordinator role

One staff member felt that the workload required by the co-ordinator of the project warranted more hours than had been allocated to carry out the project successfully and support the peers fully:

> *"It has to be a full-time worker on it, so to stay on top of the peers to make sure all their things are completed and they're doing their tasks and to really be able to organise and prepare events and support the peers to make sure they can get along to those events and to keep the motivation going to, you know, keep increasing, you know, the level of support that is needed and to be honest, I don't have time to go and chase everybody, I don't and it is the one thing I think that could have made it much more successful." (Staff 1)*

Dedicating the time and keeping motivation up for the project was seen as crucial to keep it going. The other staff member expressed feeling limited within their role during the challenges experienced:

> *"I just find it difficult sometimes because I'm really quite a proactive person and then this…there's been a lot of things that have been out with my control that I would have liked to have just fixed or gone ahead with kind of thing but I've not been able to, so yeah." (Staff 2)*

Benefits & facilitators

Learning from project

Staff reflected on what they have learned from the project, explaining that they felt they were gaining a lot from the peers directly:

> *"… from the peers that I've been working with so far in this project, I've learned so much from them and they don't realise that. It's sad that they don't realise their worth and now it's amazing that we're in…now in the position to be able to have them on board as, as equals, and that not only can they be paid, they can get training. They can be part of a wider peer network. They can be part of the fight to save their friends and family that they that they have been for years unable to save basically…You only need to hear them talk about people they have lost to an overdose situation or drug related death and now it feels like they've been empowered. So, it's, it's great to be on that journey with them. I see it as like a journey that I'm on with them and that they are on with me and vice versa. So, I've got things I can teach them and vice versa. And it's definitely a partnership approach." (Staff 2)*

This demonstrates how valued the peers were by these staff and some of the positive impacts their involvement had. The staff member also discussed how the challenges with recruitment processes have been learned from by the service and other areas for future:

> *"…now I know I should have done, what I should have done differently, but I did, I just kind of was learning as we went along kind of thing and I think what I said to the peers and I tell myself on a regular basis when I get frustrated about it is that this is, this is a pilot project for [service] and it's so future projects will not need to go through this difficulty because they'll learn from what we've learned." (Staff 2)*

Staff attitudes

The staff members felt that in their team and within wider services, attitudes have become more positive towards peers as time has progressed:

> *"Definitely, so as the project has gone on and we've talked more about it and they have a better understanding of what that is and what their roles are and you know, that we're actually doing it, I think the fear has subsided that people had, that senior people had, and I'm not really seeing that anymore so that's good." (Staff 1)*

Peers were now being treated well within the host service and other partnering ones. One peer also stated they felt very positively about their experience with the host service so far:

> *"This place has been brilliant. I was a…used it like a client at [service] for years. I was yeah, I built it up to now work. It's great that they give you a chance like this to change your life." (Peer 2)*

Payment & value of peers

Peers see being paid for this role as a bonus to something they are passionate about doing:

> *"I wouldn't say…I'm happy to be a volunteer but a wee bit extra is always handy for my wee boy, he's only five, so it would be nice to…but I dinny mind just being a volunteer as well. Like, I have been just volunteering up until now. I mean, I think [SDF staff member] has spoken about being paid, but it's not the be all and end all, but it would be nice, a wee bit extra." (Peer 2)*

Both staff members felt it was very important for the peers to be paid for their involvement in this project:

> *"Well, I think it's important because we've employed them as a member of staff and, you know, common slavery shouldn't exist in Britain, because that's exactly what it would be, you know, we're saying we want you and we kno*

> *you anything for it…so I think paying them is very, very important. I think that anybody that does work for us should be paid, I don't think we should expect it for free." (Staff 1)*
>
> *"…it's just about valuing them really and reimbursing them for what, for what they are offering to the team and to the people that we're going to be supporting and the community and the wider… that kind of ripple effect that if they train one person and then somebody might, might be in a position where they can pass on to somebody…" (Staff 2)*

Staff clearly felt the work was incredibly valuable and they offered the team unique skills so that must be reflected in peers being paid accordingly. Indeed, staff described the importance of having peers in these roles as they brought expertise and abilities to access communities that other staff cannot:

> *"…they have a unique kind of insight into what people, what people are maybe feeling and thinking, where they might be, how to reach them, how to bridge gaps, how to get the right messages to the people that might need them, who might then spread them wider…It's like they have, they have tools and resources within them that are transferable that they have learned over the years. It's as hard fought, hard won, there's some other things that some of them have been through and are still going through." (Staff 2)*

In line with this, it was important to staff to show the peers that they were seen as equal team members:

> *"I think one of the really important things is that they feel valued and that we're using their skills to implement a project that you know, has a lot of barriers and a lot of stigma attached out there in the community and I think one of the things that motivates them is us being open and they're being treated as a member of the team and having that guidance and support to be able to succeed in their role." (Staff 1)*

Peers echoed the feelings that they have the unique experiences needed to understand and relate to people they will be working with:

> *"It was solely because I had been obviously through the system for years, you know, majority of my adult life up until now and I just kind of got to that age and I just wanted to give something back. And I feel maybe I've got something to offer, you know? And I know what these guys – I know everybody's individual – but 90% of the time I know what these guys need, and I want, I want…I want to give something back, you know?" (Peer 3)*

They felt that because they had "lived it" and been through services, they could relate to how people might be being treated and can connect with individuals fully. One peer also explained that peers were important to act as examples for other individuals:

> *"So, I just want to help. I know that's…it's such a big problem and there's no enough people that care I think. You just get classed off as, oh they're just a junkie, know what I mean? That's a lot of people's opinion, ken like that, here. It's small minds and I thought I just want to make a difference, I'm proof that you can get clean, you can get help." (Peer 2)*

Skills & development

Staff and peers described that the training peers had received has contributed to building their confidence and skills:

> *"Yeah, I think they have gained experience, knowledge, training, value. They've built positive relationships, they've built in confidence, self-esteem. I mean, I don't think it can be underestimated, you know, the positive impact that it has had on the people that are doing it." (Staff 1)*

One of the peers explained that they are hopeful this experience will lead to other opportunities for them, such as full-time employment in the field:

> *"I'm looking to ultimately seek full-time employment…in some capacity, along the line somewhere. I don't know but one of the things now I'm getting into it, I see other possibilities opening up and you know it's a big spectrum…its, you open the door to one thing, and it leads many different ways so just trying to find my way, find where I can fit in best and contribute best, you know." (Peer 3)*

Impact on naloxone provision

All peers were motivated to be involved in the project as felt they were contributing to efforts to reduce drug-related deaths and utilising their experience positively:

> *"I'm no looking to get anything out of it, I'm just applying my experience and my knowledge to help others." (Peer 1)*

Having direct experience of drug-related harms and deaths was a powerful motivator for the peers to be involved. One peer expressed their understanding that being involved in this project could contribute to reducing drug-related deaths:

> *"I would say basically saving lives and getting more out there, getting education to other people and…where…obviously the myths of drug deaths and the facts are so clouded out there. Obviously, once you're trained in naloxone, you're getting facts out there…" (Peer 1)*

To echo this, one staff member stated they had heard of kits supplied in the project being used and the other staff member felt they were talking about naloxone more overall due to involvement in the project, adding to increased awareness and supply in the area:

> *"…indirectly I have been doing more training of naloxone just to other services that I probably wouldn't have done if I hadn't been in this role, and probably because I hadn't been really aware of how important it was before I, I took this role." (Staff 2)*

Support from SDF

One staff member expressed how important having external support and input from SDF had been for them:

> *"I've had a really good experience working with, with [name] from SDF. He's been an amazing support because I mean it has, it has been difficult for myself and [name] with this being such a brand-new project on top of the other work*

> *that we do as well and [name] is just always there. Like he's…if you want to give him a message or text or he's really good at setting reminders and things and we've got a WhatsApp group for the peers and he's always popping up links for events and training and things. And I always think oh thank god for [name], you know, he's been an amazing, amazing, amazing support and he's so knowledgeable as well…" (Staff 2)*

Discussion

It is clear the three pilot areas experienced some unique and some similar challenges and benefits throughout the project rollout. Comparisons between the areas can be made, but differences must be viewed in the context of the stage in the project they were at and how long peer supply had been live in each area.

Naloxone supply & awareness

The rates of naloxone kits supplied by the peer workers/mentors in each area were significant throughout the initial 6-11 months of the work being live. This is an undeniably positive outcome of the project, showing there are more kits in communities, directly because of the peers, and most of these were first supply suggesting they were indeed reaching individuals previous efforts had missed or failed to engage.

The number of kits supplied in the urban setting was significantly higher than the others as at the time of the evaluation this project had been live for longer, most likely due to quicker rollout of the initial stages, such as recruitment of peers. This was possible as this host service already had a framework in place for employing living/lived experience peers, whereas the other two settings had to establish these and encountered pushback from colleagues in doing so. Consideration of whether a service has effective processes in place to employ peers would be important for rollout of the project elsewhere, as this could delay getting started and thus how soon outcomes, such as kit distribution, will be observed.

All the areas reflected that the project had led to more supply and awareness of naloxone in unanticipated ways, as well as from direct provision from peers. In the rural area relationships had been established in multiple community locations to allow naloxone supply. Having the project running led to staff in the prison setting seeking information and training for themselves about naloxone.

Expectations of role

The peer workers/mentors across the areas discussed what they had expected from their role, and it was clear some had high expectations about what they would achieve. Whilst it was important for staff to encourage these aspirations, it had been appropriate for discussions to take place with some peers to clarify what their role was and what would be realistic, especially initially. This was particularly prominent in the urban and rural areas where peers wanted to do everything straight away and provide greater

levels of support to individuals than was in their remit.

Issues around recruitment within the rural setting, whereby the initial group of peers had to be withdrawn from the project after starting their roles, demonstrates the importance of clear communication and expectation setting. It is possible peers will not have experienced processes, such as background checks and providing references, before or recently so this must be explained thoroughly and efforts made by staff to minimise delays, should similar work be rolled out elsewhere.

Within the urban setting, peers had been working in the needle exchange service as part of their role, with one peer reporting they were here for all their hours, despite low footfall. Having peers working in a set service such as this does not directly meet the remit for their role and thus goes against expectation. It is important peers are involved in discussion with co-ordinators about their time and impact, with freedom to use their initiative and own ideas. Encouragingly, there was evidence of this in this setting but should be consistent across all peers.

Staff attitudes & stigma

The prison and rural settings experienced some similar challenges around staff from host and other services demonstrating stigmatising attitudes and behaviours towards the peer supply project, which was often observed and directly experienced by the peers themselves. The negative impact of this on these individual peers should not be underestimated and the staff co-ordinators in the areas did make efforts to provide support and overcome this stigma. Indeed, all peers said they had positive and supportive relationships with the staff assigned to co-ordinate the project.

It was clear that history staff may have with peers and concerns or biases about people with living/lived experience could impact how they viewed individuals and the project in general. Comparing the urban setting where some of the peers had already worked with the host service with the rural setting which had never employed peers shows how easy or difficult it can be to integrate them in the service depending on previous practice. In a similar vein, SPS staff were likely affected by their knowledge and experiences of the peer mentors within this unique environment.

Encouragingly, however, peers and staff in these areas reported significant improvement in attitudes as the project progressed and led to better engagement and support for the work. This shows that when exposed to peers and this type of work, backed by staff

who are championing it, staff are likely to feel more positively about these individuals and inclusion of team members with living/lived experience and peer work in general.

Some stigmatising attitudes from those living in prison and in the community settings around the idea of naloxone and its association with drug use/users was experienced by the peers. This could be frustrating for them and difficult, so staff were often required to support peers to reflect on these experiences. On the whole, the peers seemed to be learning how to overcome these issues and it was not putting them off continuing the work.

Practicalities & resources

There were various logistical challenges discussed in each area, with some similarities. Significantly, all staff interviewed expressed strongly that peers being paid for this work was important as it directly demonstrated the skills and expertise peers provide. This reflected that peers were seen as equal team members by these, and some other, staff. For the peers in the urban and rural settings who were getting paid, this was seen as a means of showing them they were valued. Failure to pay the peer mentors in the prison setting is a clear downfall of the project, reflected in the frustration this caused for them. Efforts must be made to overcome barriers in these environments for this project and future rollouts to show peers and the work are valued and valuable.

The prison setting also experienced logistical issues with recruitment and thus workload distribution amongst the peer mentors due to rules around movement between halls. Staff had already learnt from this and would be considering which halls to recruit more peers from based on this experience. The amount of time some peers were dedicating to the project and the uptake in naloxone training contributes to the argument made by staff that the peer mentor role should be a full job within the prison, instead of something people do on top of other jobs and roles. This would help to establish further grounds for paying the peers for this work, too.

Staff had to provide high levels of support to peers in terms of training and with practical aspects of their role, such as paperwork and maintaining contact. This was particularly true in the rural setting, where peers were more spread out, so face-to-face contact was less. For many of the peers, this was their first experience of employment of this nature or any kind in a significant length of time and thus required staff to spend time on these things with them. This reflects the feeling from all staff interviewed that they needed to provide high levels of support to all peers to gain the best outcomes and

there were concerns that if they could not do this consistently, perhaps with future rollouts, then the peers and project overall would be negatively impacted.

In line with this, staff and peers all felt there was need for the project to continue longer term as they were clearly achieving positive outcomes and establishing good practice within services around naloxone provision and peer inclusion. There was feeling that projects of this nature are usually only funded short-term and thus struggle to become fully embedded and achieve their potential. A desire to avoid this with the peer naloxone supply was clearly expressed across all areas. Sufficient funding, resources and staff time allocated would be required to allow this to happen effectively but the positive outcomes, not least in terms of kits supplied, demonstrate the value of the project.

Outcomes for peers

Peers in each of the settings had experienced various positive outcomes for their own personal development. Similar transferable skills, such as effective communication, organisation, and knowledge about the field, were built across the three groups through their training and time in their roles. Increased confidence and self-worth amongst the peers were other common themes discussed and should be celebrated as a key outcome of the project.

The peers and staff in all areas felt this personal development was equipping the peers for future opportunities, particularly around further employment in the field. Indeed, in the urban setting, some peers had already been offered and moved on to more permanent roles and involvement in things like assertive outreach. In the prison setting, links with community organisations were being set up to allow peers to move on to similar work when liberated.

Involvement in this project had allowed peers in all areas to dedicate time to something they were passionate and motivated about – reducing drug-related deaths and harm and raising awareness. Going further, there was an instance of the role and support from co-ordinators being instrumental in helping a peer in the prison with their own recovery. Overall, these positive impacts the peers experienced due to being involved in this work were significant and spread to various aspects of their life.

Role of SDF

In each area, the staff felt positively about the involvement of SDF in their rollout. They mentioned receiving large amounts of support when required and felt staff were knowledgeable and motivated to help both them and the peers. Having an external partner like SDF was beneficial in providing another person for staff and peers to talk to about their experiences and offer a different perspective. Peers welcomed being involved in the national network meetings when these happened, but there was suggestion from one in the prison setting that being more informed about what was going on elsewhere with the project would have been welcomed.

Conclusion

Overall, there were several tangible positive outcomes experienced in all three areas and significant learning had already occurred around challenges in running the project. This peer supply approach was, and continues to be, successful in increasing the number of people trained in naloxone and kits present in prisons and community settings, which is an important and significant achievement. Beyond this, there were other powerful impacts including, but not limited to, decreased stigma towards peers from staff, development of transferable skills and confidence amongst peers and instances of further opportunities and employment for these individuals.

Therefore, with sufficient staff time and resource, including payment for peers, allocated to this project, and awareness of logistical and practical challenges, there is no reason this approach could not be continued in these areas and rolled out in others effectively. There should be a confident assumption that this would contribute even further to the reduction of drug-related deaths and harms in Scotland due to increased naloxone supply and broader efforts for inclusion of people with living and lived experience.

Recommendations

01| **Reduce barriers to employment –** Any organisations employing peer workers must work to reduce, or ideally eliminate, barriers to employment for these individuals. The level of background check/PVG should be considered in relation to the job role. Staff must understand how sessional/part-time employment may impact peers' benefits and address concerns around this. Long-term contracts with consistent hours should be sought for peers to overcome benefits being affected.

02| **Payment for peers –** All peer workers involved in projects of this kind, including those within prison settings, must be paid fairly for their time. This will allow the role to be recognised as important work and ensure peers are valued. Some peers chose to volunteer and did not want to be paid; this option should be considered as appropriate but must be chosen by the peers.

03| **Full-time co-ordinator –** Assigned staff co-ordinators in host services must be allocated sufficient time to dedicate to this project, more in line with full-time hours. Having time to support peers consistently throughout their time in the project and deal with barriers as they arise is crucial for success of the project.

04| **Expectation setting –** When peers apply and become involved with this work, clear expectations about the role and its parameters, and related processes must be explained to them, such as the need for ID and how long PVG/ background checks may take. Staff should ensure these are understood and must adhere to them consistently, with opportunity for peers to discuss any concerns given regularly.

05| **Service preparation –** All staff within any services adopting this approach should be fully briefed on what to expect, given the chance to discuss concerns and receive inputs/training on living/lived experience inclusion and stigma. This should take place before peers are recruited and working with the team.

06| **Long-term funding –** Rollout of this work can take some time to get established and start achieving positive outcomes. Therefore, funding should be at least 3 years for time to be dedicated to overcoming barriers and foundations to maximise naloxone supplies built. Regarding this specific project, national support for the staff and peers is considered essential.

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Appendix 1

An evaluation of the peer-to-peer naloxone supply by people who have experience of drug use.

Participant Information Sheet

The evaluation

This evaluation aims to explore the peer-to-peer naloxone programme and will focus on novel approaches in this programme compared to previous service provision. It will focus both on performance and engagement to fill gaps in knowledge. This will include: viability of peer distribution in a range of settings such as prison; exploration of local challenges, for example rural compared to urban settings; varying roles of peers, for example in strategic decision making and how this affects engagement and success; whether peers can act as data collectors for ongoing programme development; and intended/unintended outcomes of the approach. The evaluation will explore both outcome measures and emergent issues over the first year of practice, and aims to develop a comprehensive understanding of the project as a whole.

Who are we?

The evaluation is being by conducted by The Scottish Drugs Forum.

SDF uses a peer research model to evaluate services, meaning all our researchers have a personal history of drugs and/or alcohol use.

Why have I been asked to take part?

You have been asked to take part as you we want to gather the views on the peer-to-peer naloxone supply.

What will I have to do if I take part?

We would ask you to:

- Look at this information sheet, and ask any questions you might have about

what is involved (now or later)

- Complete a consent form
- Take part in a face-to-face interview.

Interviews will last no longer than 40 minutes. These will take place in private to maintain confidentiality. With your permission, the interview will be audio recorded/scribed only, with researchers noting down key points and themes. Audio recordings and any notes will be stored on a secure server and will not be shared outside of the research team. You do not need to answer any questions you do not want to, and you can stop the interview at any time with no consequences, and have your interview removed from the evaluation. Your data will be anonymous, and your name will not be used in report writing.

Do I have to take part?

No, participation in this evaluation is completely voluntary. We would be grateful for your help, but you can choose not to take part with no consequences and without your role being affected in any way. You may also withdraw your data up until the point of publication by contacting the researcher. If you choose to do so, the information you provided will be destroyed.

Confidentiality

We guarantee that the answers you give, and anything said to our peer researchers will be confidential, although subject to normal legal requirements. This means If any information is disclosed in the interview relating to imminent harm to yourself or others, or anything in relation to child protection issues, the research team are obliged to contact relevant authorities. This will be discussed with you on disclosure, and you will be made aware that the research team will be contacting relevant authorities.

Your name or any other identifiable details will be removed from transcripts and will not appear in any reports. Answers will be grouped together to give overall responses; for example, **79% of people stated .....** We may use quotes you give when reporting, to

back up our findings. The quotes will be anonymised.

In accordance with GDPR, information is being processed on the basis of Article 6(1) (e) of the General Data Protection Regulation performance of a task carried out in the public interest.

What will happen to the results of the evaluation?

Interview transcripts will be analysed by researchers from the Scottish Drugs Forum and a report will be written. It will not be possible for anyone to link anything in the report to you.

Informed Consent

Before you start the interview, to show that we have given you this information, we must ask you to sign a consent form. This consent form will be kept separate from the survey data we collect and will be secured in a locked filing cabinet within SDF Offices. This is a normal process for participants taking part in a survey, to show that we are following an ethical approach.

What if I want to find out more or have a complaint about the evaluation?

If you want to find out more about this evaluation or have a complaint about this evaluation, please contact:

Samantha Stewart, Scottish Drugs Forum, 07747481305 , 0141 221 1175, samanthas@sdf.org.uk

If for any reason you cannot contact Samantha or are unsatisfied with the response you can also contact Katy MacLeod Peer Research Programme Manager 07980 548759 katy@sdf.org.uk

Please keep this sheet for your information.

THANK YOU FOR YOUR HELP

Appendix 2

Please tick the boxes, if you have read and agreed to each statement:

01|	I have read and understood the information about the survey, as provided in the Information Sheet.	❑
02|	I have been given the opportunity to ask questions about the evaluation and my participation.	❑
03|	I voluntarily agree to participate in the evaluation. I am aware the evaluation will take between 30 and 40 minutes.	❑
04|	I understand I can withdraw at any time without giving reasons and that I will not be penalised for withdrawing nor will I be questioned on why I have withdrawn.	❑
05|	The procedures regarding confidentiality have been clearly explained to me.	❑
06|	I know what will be done with the information I give	❑
07|	I understand that if I tell the researcher that I am likely to harm myself or others, the researcher will have to inform the appropriate people to ensure that myself and/or others are safe.	❑
08|	I understand that the interview will be scribed.	❑

Participants Name _____ ***Date*** _____

Participants Signature _____

Peer Researcher Name _____ ***Date*** _____

Peer Researcher Signature _____

Appendix 3

Peer Naloxone Qualitative Evaluation First Round

1.Demographics	***About 5 mins***
• **Can you tell me what gender you identify with?** • **Can you tell me which area you work in? (Dundee, Borders, Prison)** • **Can you tell me your age?** • **Current living situation?** *Peers: Own Home, Tenancy etc*	
2. Substance Use	***About 5 mins***
• **Can you tell me a bit about your experiences with substances?** *Peers: Does the participant have personal history, family history etc.*	
3. Role	***About 5 mins***
• **Can you describe your role in the project?** • **Can you describe what you expect a day in the life as a worker?** • **From your perspective what is the most important thing about the project?**	
4. Motivations	***About 5 mins***
• **Can you tell me what interested you in getting involved in this project?** *Spend some time getting to know your participants motivation for getting involved.* *Prompt: Can you tell me more about this?* • **What are you looking to get out of this training/project?** *Peers: Probe - personal development or specific training?* • **Is being paid important for you in this project?** *Peers – spend some time on this. Why is being paid important to them?*	

5. Challenges	
• **What do you think will be challenging about this role and being in the programme?** • **Do you think you'll find it challenging to engage with services or people in the environment you work in? (Prisons, Dundee, Borders)** *Prompt: Can you tell me more about this?* • **Do you think it will be easy or challenging to engage with peers in your environment environments?** *Prompt: being able to reach people that services cannot?* *Prompt: Any local area challenges for example specific challenges in prison/Dundee/ borders.*	***About 5 mins***
6. Training	***About 5 mins***
• **Do you feel confident in your role after the training?** • **What went well in the training?** *Prompt: Was there anything you wanted more of?*	
7. General	***About 5 mins***
• **Is there anything else you would like to add about the project or your role in it?**	

This form is kept separate from evaluation data.

Appendix 4

Peer Naloxone Qualitative Evaluation – Staff Interview

STAFF STATEMENT:

1. Demographics	
• **Can you tell me what gender you identify with?** • **Can you tell me which area you work in? (Dundee, Borders, Prison)** • **Can you tell me about your background in substance use services?** • **Could you please describe your role in this project?**	***About 5 mins***
2. Role	***About 5 mins***
• **Could you start by describing the peer naloxone programme?** • **Can you describe the role of peers in the project?** *What does a day in the life of a peer look like?* • **How do staff view peers within the staff team/professionals?** *You and other staff members?* • **What is the relationship of peers with the staff team?** • **How do the peers relate to each other?**	
3. Motivations	***About 10 mins***
• **What has motivated you to want to coordinate the peer project?** • **Can you tell me what has retained peers in the project?** • **What benefits have you gained from peers being involved?** *Prompt: employment outcomes for peers?* • **Is paying peers important for you in this project?** *Why is it important to pay them?* • **What aspects of the project have made a particularly positive impact?** *Where have things gone right?*	

4. Challenges	
• **What has been challenging for peers in this role?** *Prompt: Can you tell me more about this?* *Prompt: Challenges of giving Naloxone to family members?* • **What has been challenging for staff about having peers in this role?** *Prompt: Can you tell me more about this?* *Prompt: Challenges of excluding peers from participation?* • **What is different about this approach to normal service approach?** *What works about it and what doesn't work?* *Has anything gone wrong?* *Are you aware of any stigma from service providers or in other settings?* • **Have you noticed any challenges in (local area) with training/kits being received?** *Prompt: How do you work around this?*	***About 10/15 mins***
5. Training	
• **Did the training support the peers in their role?** • **Have there been specific times where peers haven't felt confident or have come across challenges?** • **Is there any training/further support that you feel could have helped peers with their role?**	***About 5 mins***
6 General	
• **What things have been different from your expectations of the role?** *Any unexpected or unintended outcomes?* • **Do you know if any of the kits that peers provided have been used?** • **Have there been times peers have been asked for advice about other forms of harm reduction or asked about services they could access?** • **Is there anything that could make the peer role more effective?** • **What are your thoughts on the future of this project?** *Viability across different settings?* *Potential to scale up and challenges involved?* *Biggest risks to the programme going forward?* *How might these risks be alleviated?*	***About 5 mins***

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Peer naloxone supply project:
An evaluation of three pilot areas.