Peer naloxone supply project:

An evaluation of three pilot areas.

Executive Summary

SDF
Scottish Drugs Forum

Content

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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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