Glasgow Caledonian University
Research Centre for Health (ReaCH)

SDF Scottish Drugs Forum

SCOTTISH DRUG DEATHS TASKFORCE

A Mixed Methods Evaluation of Peer-to-Peer Naloxone Training and Supply

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Background: The drugs death crisis continues in Scotland, with opioids implicated in the large majority. Naloxone is an opioid antagonist which provides a window of opportunity for emergency services to attend and treat overdoses. In 2017 the Scottish Drugs Forum (SDF) and NHS Greater Glasgow and Clyde (NHS GG&C) developed a peer to peer naloxone distribution programme.

Methods: A mixed methods evaluation of the programme was carried out, with supply data from the national naloxone programme analysed to assess increase in supply, and qualitative interviews conducted with people who facilitated the programme (n=5), peers who worked on the programme (n=8), and recipients of naloxone (n=6) to identify strengths and challenges of the approach. This was carried out between January and July 2021.

Programme strengths:

Shared lived experience resulted in rapid, authentic, empathetic engagement and trust

You've already been where the guys are at… we just know how to approach them. People will approach a peer more than a worker… we make that connection quite easily

They'll go places where workers fear to tread… you meet people's needs better if you go to them

Peers used local knowledge and understanding to **target spaces and times** to engage groups who were usually marginalised to services

Peers **instilled hope**, and provided relevant, local, salient and personal advice and **signposting** through their own **grounded** experience

Most of the peers have come through that, and just getting that one-to-one with [gives recipients] that wee bit of hope. That hope is powerful as well, you can't beat that, you can't

Programme Challenges:

Stigma in services was the greatest challenge, with peers treated negatively in some services, including experiences of direct prejudice.

"I would say, 'look, that didn't work. Your staff never bought into it', they'd come up with all these excuses, 'right, come back again', and the same would happen again. So, if the organisation didn't buy into it, it was really, really difficult.

Diversity of peers lead to **training challenges**, with some requiring significantly more support to build confidence and technical skills. This was addressed through group and individual support.

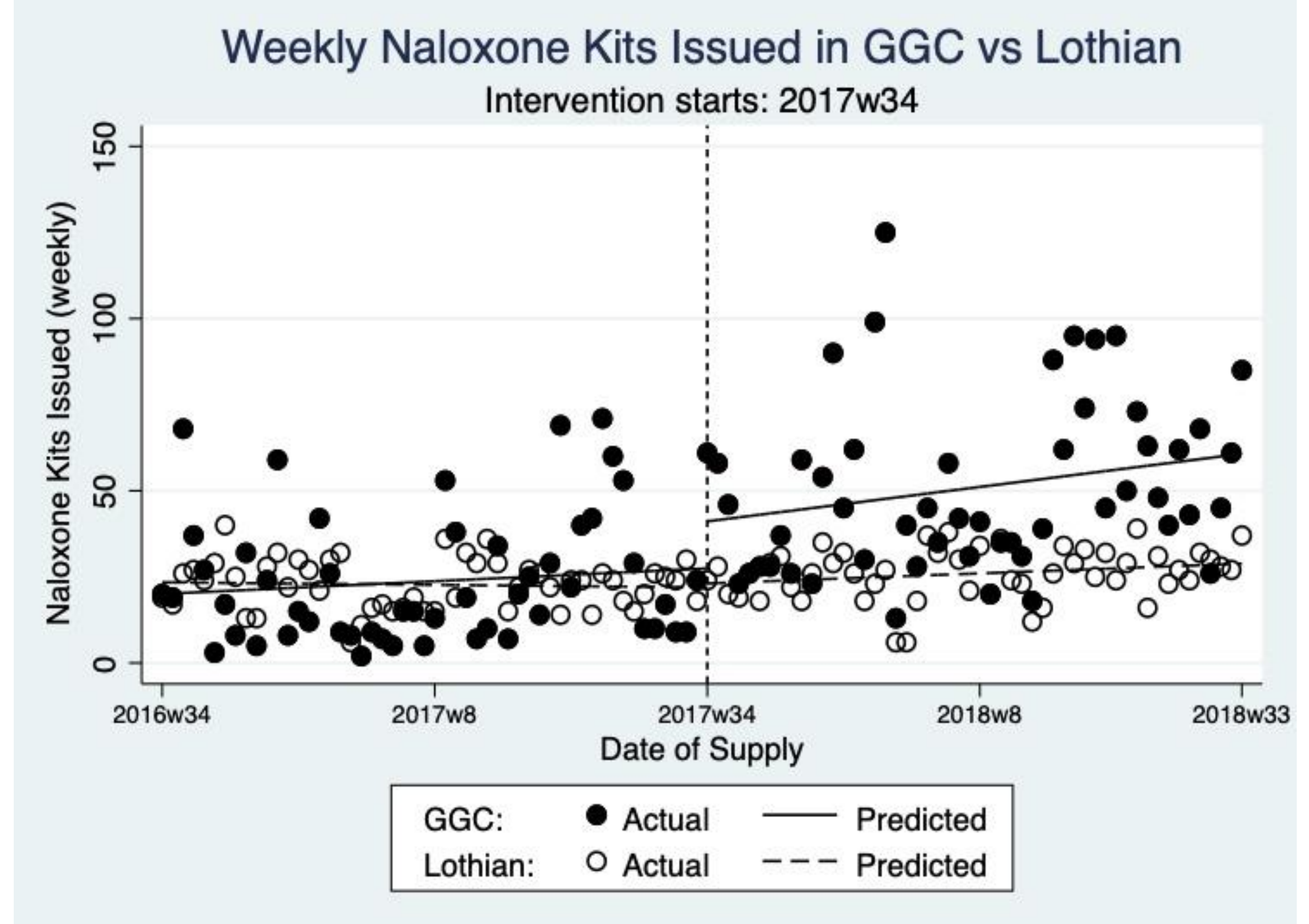
There was lots of work done to make sure that they felt confident because this was new to them… That was an issue for some, but because of the nature of the support, they were able to overcome that."

Some peers **put great pressure on themselves** within the role due to perceived responsibility in the context of the drugs death crisis

you feel a level of responsibility, get as many kits out as possible… All the drug deaths are preventable, you know, and I also find that it's a struggle

Supply data:

The programme was associated with an increase in supply of 25.47 (95% CI: 14.07-36.87) naloxone kits per week after adjustment for the best available geographical control. In Lothian, there was a 3.40 (95% CI: 1.31-5.50) increase during the same period. The increase in naloxone supplies driven by the NPSTP was particularly pronounced in older adults (45+) and women when compared to naloxone supplies overall in GG&C over the same period.



Future improvements:

Payment of peers should be a priority, this would address peers feeling that they were used within the broader system, improve issues of attrition of peers by giving them career prospects internally, and potentially help combat stigma, both internalised and externally experienced.

Programme targets should be expanded to cover BBV testing and broader harm reduction in order to take advantage of the unique lived experience based trust built with service users.

The programme should be scaled up across the UK, but this would have to be suited to local contexts, and use local peers/resources.

Recommendations: 1) Peers should be front and centre of the drug deaths response. 2) Training built on lived experience. 3) Peers must compensated for their work. 4) Services must be targeted to combat stigma. 5) Peer support must be well resourced. 6) Programmes flexible to engage marginalised. 7) Programmes sensitive to needs of peers diversity. 8) Pools of peers are needed for sustainability. 9) Programmes should target broader harm reduction activities. 10) Programmes should have internal progression.

Conclusions: The programme demonstrated an innovative and successful approach to naloxone distribution. Peers represent a wealth of knowledge and experience, and a unique opportunity to connect that cannot be replicated by those who do not have such experience. There is no reason that peer to peer naloxone efforts should not be utilised across Scotland and more broadly. Peer to peer naloxone distribution, and perhaps a broader programme of peer-based interventions, must form a core part of the response to the drugs deaths crisis.

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