Understanding the role of peer involvement in UK harm reduction interventions

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ABSTRACT

Aims: In recent decades British drug policy has shifted from a harm reduction approach to an abstinence-based recovery approach, changing the landscape of support available to people who continue to use drugs. People who use drugs (PWUD) are a highly stigmatised and marginalised population with high levels of mental health need, who often face barriers to accessing services. In other countries, peer work has provided opportunities for PWUD to deliver harm reduction interventions to their peers with a number of beneficial outcomes, but there is an absence of research on the experiences of peer workers in the UK. This study sought to understand the experiences of PWUD engaged as peer workers offering harm reduction interventions to fellow drug users in the UK.

Method: Semi-structured interviews were conducted with eight peer workers with living experience of drug use, recruited through a harm reduction organisation. Thematic analysis was used to interpret the data.

Results: Data analysis discovered four main themes: (1) Changing and Enhancing Perceptions of People Who Use Drugs, which referred to changes in the ways peer workers were perceived by others, allowing them to embrace a more positive perception of themselves; (2) A Unique and Valuable Role, which demonstrated the ways in which peer workers recognised their skills and, which made them feel valued and useful; (3) Positive Impact of Peer Work, which highlighted the changes that had occurred following involvement in peer work, including a reduction in drug use and improved mental health; (4) Fragility of Peer Work, which demonstrated the more challenging aspects of the work, including anxiety regarding the precariousness of the peer work role.

Conclusion: The study highlighted a variety of experiences of peer work, including positive experiences and more challenging aspects of the role. The findings have implications for both harm reduction organisations seeking to develop peer work programmes and mental health services that seek to support PWUD. Suggestions

for future policy development and research that builds on this emerging approach have also been discussed.

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1. INTRODUCTION

The utilisation of people with lived or living experience of drug use in the delivery of interventions to their peers has emerged as part of a harm reduction response to drug use. Literature which explores the experiences of peer workers demonstrates a number of benefits and challenges associated with the work, but little is known about the experiences of peer workers delivering harm reduction interventions in the UK.

This study aims to understand the experiences of UK-based peer workers who actively use drugs and are engaged in the delivery of a range of harm reduction interventions.

1.1. Chapter Overview

This chapter begins by providing a definition and brief history of harm reduction in the UK before considering the current policy context. Peer work is then defined and the role of people who use drugs (PWUD) in the development of harm reduction interventions is briefly explored. The chapter develops towards a scoping review of the literature regarding experiences of peer work in harm reduction services, before presenting the rationale and aims of the study.

1.2. Definitions and Context

1.2.1. Definition of Harm Reduction

Harm reduction refers to a “pragmatic yet compassionate set of strategies designed to reduce the harmful consequences of addictive behaviour for both drug consumers and the communities in which they live” (Marlatt, 1996, p.1).

Whilst there is no universally accepted definition of harm reduction, approaches are governed by a set of widely agreed principles, which include:

- an acceptance that illicit drug use occurs and its harmful effects should be minimised rather than ignored or condemned;
- a recognition that improved quality of life and well-being, not necessarily cessation of drugs, is an indicator of success;
- a commitment to non-coercive and non-judgemental provision of services to PWUD and their communities. (National Harm Reduction Coalition, n.d.).

Harm reduction interventions are any interventions “aimed at reducing the negative effects of health behaviours without necessarily extinguishing the problematic health behaviours completely” (Hawk et al., 2017, p. 1). At the heart of any harm reduction intervention there should be a commitment to providing services that do not judge or discriminate, that are non-coercive and do not require that people stop using drugs as a precondition of access (Harm Reduction International, n.d.).

1.2.2. Brief History of Harm Reduction

The first harm reduction intervention in the UK can be traced back to 1926 when the Rolleston Committee affirmed the practice of prescribing heroin to those dependent on it (Berridge, 2013). However, it was the advent of the global HIV epidemic in the 1980s, and the discovery that the high rates of HIV infection amongst injecting drug users (IDU) was linked to the sharing of needles (Robertson et al., 1986), that saw the approach gain prominence.

The urgency required to respond to the epidemic meant that “an immediate pragmatic response based on public health principles” was required (O’Hare, 2007, p. 142). In Merseyside, which reported high rates of heroin use at the time, one of the country’s first needle exchanges was established in 1986. The emphasis of the service was to reduce risk behaviour rather than drug use per se, with a reduction in the sharing of injecting equipment taking precedence over any objective to reduce drug use or promote abstinence. The needle exchange was run according to the principles of being user-friendly, non-judgemental, easy to access (‘low-threshold’) and open at convenient times. Methadone (an opiate substitute) was offered as a way to attract IDU to the service. For those that still didn’t attend, an outreach service was established to try to engage them (O’Hare, 2007).

This model, known as the Mersey model, spread nationally until the harm reduction approach was formally adopted by the Thatcher Government upon the 1988 recommendation of the Advisory Council on the Misuse of Drugs (ACMD). As one commentator put it, “the world of drug treatment shifted virtually overnight from a focus on treating individuals for their drug dependency to adopting a public health, population focused, approach aimed at reducing drug users’ HIV-related risk behaviour” (McKeganey, 2012, p. 277).

A rapid increase in the number and reach of needle exchange services followed, with almost 1500 outlets established in England and a further 250 across Scotland and Wales. Opioid Substitution Therapy (OST) also increased, alongside other HIV prevention activities and health promotion. The UK has been hailed as leading the world in developing a harm reduction response to drug use in the decade between 1987 and 1997 and in averting an HIV epidemic associated with injecting drug use (UKHRA, 2001, p. 2).

1.2.3. The Emergence of the Recovery Paradigm

Despite this success, or perhaps as a result of it, a focus on harm reduction as a public health approach fell out of favour in the late 1990s. As the threat of an HIV epidemic receded, the New Labour government shifted focus from public health to harm reduction interventions focused on reducing the crime associated with problematic drug use. Central to its strategy was significantly increasing access to OST. Whilst the Government was successful in expanding its OST programme, by the mid-2000s the strategy had increasingly become the target of criticism (Stevens & Zampini, 2018).

The right-wing policy think tank, Centre for Social Justice, criticised Labour’s approach, arguing that it led to “entrenchment” and “intergenerational cycles of substance dependency” (Centre for Social Justice, 2007, p. 10). The Centre proposed an alternative strategy based upon recovery as total abstinence from drug use. The BBC publicised data from the National Treatment Agency for the period 2006/7, which demonstrated that only 3% of those recorded as being in drug

treatment that year had completed it and left drug-free (Easton, n.d.), which spurred the debate. As the prevailing harm reduction approach was questioned, abstinence advocates put forward their case (Lancaster et al., 2015). Researchers at the Glasgow Centre for Drug Misuse highlighted a study they had undertaken with over 1000 PWUD which found that over half (56.6%) identified abstinence as the only change they hoped to result from drug treatment (McKeganey et al., 2004). Whilst there were limitations to the study, it has been argued that the finding was seized upon by those who sought ‘evidence’ which demonstrated abstinence as the foundation of recovery, with harm reduction portrayed as a negative and “oppositional philosophy” (Neale et al., 2011).

Proponents of recovery highlighted a new wave of residential rehabilitation facilities that were starting to achieve results with clients, including those who had not previously succeeded with conventional treatment. Post-residential support was offered by peer-led recovery communities, who mostly followed the 12-step philosophy, associated with mutual aid groups such as Narcotics Anonymous (Wardle, 2012).

As the debate became increasingly polarised between those advocating for drug abstinence and those favouring drug maintenance (Hayes & Dale-Perera, 2010), the UK Drug Policy Commission brought together key stakeholders in an attempt to reach consensus on the meaning of recovery. The Recovery Consensus Panel produced a definition of recovery as “voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society” (UKDPC, 2008a, p. 6). Members of the group described an intention for recovery to not become simply equated with abstinence and their desire for an acknowledgement of all types of recovery, not just those that were associated with ‘treatment’ (Wardle, 2012).

Despite this, the shift towards recovery as contingent on abstinence appeared to have become the accepted paradigm when Labour published its 2008 Drug Strategy, which referred to the goal of all treatment being the achievement of abstinence from drug dependency (HM Government, 2008). The subsequent drug strategies of the Coalition Government continued on this trajectory. The Coalition’s 2010 Drug

Strategy, ‘Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life’ was explicit in its shift from a harm reduction approach to a recovery approach, stating that the strategy would differ from those that had gone before it by no longer "focusing primarily on reducing the harms caused by drug misuse" but rather offering "support for people to choose recovery as an achievable way out of dependency" (HM Government, 2010, p. 2). The Strategy was criticised for retaining a focus on criminal justice at the expense of public health (Carlin, 2011).

The paradigmatic shift from harm reduction to recovery has been described as a period of "creeping moralisation" from 1998 onwards, characterised by a desire to change the behaviour of specific "problematic" populations, without addressing their underlying causes (Monaghan, 2012, p. 30). In a similar vein, Monaghan and Wincup argue that the shift can be explained by a desire to promote abstinence as a way to reduce worklessness by successive governments who consider the high proportion of PWUD claiming benefits as "morally unacceptable" (2013, p. 82). The 2010 Drug Strategy makes explicit reference to its aim to reduce the number of PWUD claiming benefits through the promotion of recovery (HM Government, 2010). However, Monaghan and Wincup (2013) argue that the intention to activate the labour market through a ‘work first’ approach does not accommodate the diverse needs of PWUD and have criticised the approach’s focus on individual, rather than structural, barriers to employability.

The paradigmatic shift to a recovery-based approach received strong criticism from drugs campaigners (McKeganey, 2014) and drug policy organisations (Release, 2010). A focus on recovery at the expense of harm reduction ignores the reality that some people cannot, or do not wish to, pursue abstinence. Gerry Stimson (2010), a harm reduction academic, has argued that "recovery is only relevant to a tiny proportion of drug users" (p. 14) and that, whilst options for recovery are necessary for those what want it and are able to achieve it, basing a whole strategy on it is "nonsense" (p. 14). He also highlights the risk of increased morbidity and mortality that occur when PWUD are rushed into abstinence (Stimson, 2010).

Amongst harm reduction advocates, there is a strong belief that harm reduction approaches can exist alongside services that support recovery, including abstinence, from drug use. The UN Office on Drugs and Crime has stated that harm reduction has been made unnecessarily controversial, that the supposed contradiction between drug prevention/treatment and harm reduction is a false dichotomy, and that the two approaches are complementary (Costa, 2007). Neale et al. (2011) argue that pitting abstinence and harm reduction as opposing forces is overly simplistic and highlight arguments that suggest it is more helpful to talk of a harm reduction to abstinence continuum. Marlatt et al. (2001) suggest that abstinence is the endpoint on the continuum of harm redution approaches, countering claims that harm reduction is anti-abstinence. However, a commitment to abstinence is not a pre-requisite for access to harm reduction interventions, even if many eventually choose to pursue it once they are within services.

Whilst the UK has experienced a rolling back of harm reduction approaches in favour of abstinence-orientated interventions, other countries, such as the Netherlands and Switzerland, have successfully maintained the harm reduction policies that were developed in response to the HIV/AIDS epidemic in the 1980s/1990s (Herzig & Wolf 2019; Van Santen et al., 2021). Other countries, such as Canada and Australia, have faced ongoing threats to their harm reduction provision but have managed to retain the operation of progressive services including overdose prevention services (OPS) (Canadian Drug Policy Coalition, n.d; O'Keefe et al., 2020). It is not possible to briefly describe the landscapes within which harm reduction ideology has endured, given that they are particular to each country and characterised by complex and heterogenous political ideologies, structures of governance and social welfare systems. However, it has been argued that a key element in the emergence and survival of harm reduction approaches has been activism, including by drug user movements (Byrne & Albert, 2010; Jauffret-Roustide et al., 2022). The UK has a history of drug user activism (Bennett et al., 2011) but the movement has faced many challenges (INPUD, 2020; O'Gorman & Schatz, 2021) which, it has been argued, has undermined the defence of harm reduction (Jauffret-Roustide et al., 2022).

1.2.4. Current Drug Policy

Evidence does not support the efficacy of pursuing an abstinent recovery-based strategy with minimal impetus for harm reduction. In 2021, deaths from drug misuse in England and Wales reached their highest levels since records began in 1993. 2,219 of the 4,859 deaths involved an opiate (ONS, 2022). In Scotland, there were an additional 1,119 opioid-related deaths in the same period (National Records of Scotland, 2022). Deaths have been increasing year on year for the past nine years and 2021's figures represented a 6.2% increase on the previous year (ONS, 2022). In 2018, the Scottish Drug Forum reported on an HIV outbreak in Glasgow that, at the time of reporting, remained uncontained (Scottish Drugs Forum, 2018). Whilst the spectre of the HIV epidemic may have receded, drug-related harms are still ever-present in the UK.

Despite this, the recovery paradigm continues to dominate current drug policy. One of three strategic priorities in the Conservative Government's current 10-year Drug Strategy, "From Harm to Hope", published in December 2021, is the delivery of "a world-class treatment and recovery system" (HM Government, 2021). It is made clear within the strategy that the Government's definition of recovery includes total abstinence from drug use. The Strategy's plans to support recovery include ensuring adequate provision of inpatient detoxification and residential rehabilitation and investment in improving access to accommodation and employment for PWUD. It also plans to provide funding to local authorities to embed peer-based recovery support services and communities of recovery into every drug treatment system. This will include mutual aid organisations such as Narcotics Anonymous and SMART Recovery, a Self-Management and Recovery Training programme that uses CBT and motivational tools and techniques, to change 'problematic behaviour' (SMART Recovery, n.d.).

The Strategy has attracted criticism from the UK harm reduction sector, which has criticised the pursuit of abstinence as the only acceptable outcome for addiction given that it is not immediately possible for all (Bunn, 2021) and questioned the absence of a number of harm reduction interventions, including Heroin Assisted Treatment (HAT) and the establishment of drug consumption rooms, despite these

being included in the Department of Health and Social Care's own Clinical Guidelines on treating drug misuse (Release, 2021).

1.2.5. Effectiveness of Harm Reduction Interventions

Harm reduction interventions comprise a number of "humanistic" and "pragmatic" interventions (Hawk et al., 2017, p. 1) whose effectiveness is well-evidenced. These include:

- Needle and Syringe programmes, which provide clean injecting equipment to IDU to support a reduction in transmission of blood-borne viruses and have been found to be cost-effective in reducing transmission of HIV (Wodak & Maher, 2010) and increasing IDU access to other medical and social services (Strathdee et al., 2006).
- Opioid Substitution Therapy (OST), which includes the prescription of methadone and buprenorphine, which is effective in reducing illicit opiate use (Mattick et al., 2009, 2014), reducing deaths, including those by overdose (Degenhardt et al., 2009) and improving physical and mental well-being (Lawrinson et al., 2008; Ward et al., 1999).
- Heroin Assisted Treatment (HAT), the prescription of heroin (also known as diamorphine) for those who do not respond to OST, which has led to improved treatment retention, reduction in illicit heroin use and criminal activity, and benefits for physical and mental health (Smart, 2018).
- Drug Consumption Rooms (DCRs), also known as supervised consumption facilities (SCFs) or overdose preventions services (OPS), where drug users can take drugs in clean and clinically supervised spaces with access to clean equipment, and in some cases, advice and support, have been demonstrated to be effective on a number of ways (Kennedy et al., 2017).
- Naloxone, a lifesaving drug that reverses the effects of opiates in the case of overdose. It can be administered by non-professionals following a brief training (McAuley et al., 2015) meaning it can be distributed to PWUD for use amongst their peer group (known as Take-Home Naloxone (THN)) and has been found to reduce overdose mortality with a low rate of adverse events (McDonald & Strang, 2016).

1.2.6. Harm Reduction in the Current Context

The significant evidence on the effectiveness of harm reduction interventions raises questions as to why the UK Government has chosen not to pursue harm reduction approaches as the threat of an 'opioid crisis' (Richards et al., 2022) has emerged. Critics argue that the Government is pursuing an ideological position (Bates, 2021). Professor Alex Stevens, former member of the ACMD and Chair of Drug Science's Working Group on Supervised Injection Facilities, suggests that the failure to utilise evidence-based interventions in responding to problematic drug use can be explained by the term "moral sidestep", which refers to a move towards "normative positions that rest on tough enforcement of conformity and purity rather than 'liberal' compassion" (Stevens, 2019, p. 445). He argues that those in power have institutionalised discourses which "deny fully human status to the people who suffer most from opioid-related deaths" (Stevens, 2019, p. 445).

Stevens (2019) argues that the Conservative Government has cast PWUD as 'vulnerable', not agents in their own right but objects of the Government's protection. By portraying PWUD as a homogenous, 'vulnerable' group, the Government renders them invisible in the discourse. Simultaneously PWUD are stigmatised as "passive, unemployable scroungers" (p. 447). All of which serves to deprive PWUD of a voice, disempower them and deny agency to those who suffer the most from problematic drug use. The Government is then able to contrast itself as a moral agent, portraying itself as safeguarding society from an external evil that poses a threat. It sidesteps evidence by arguing that its policies are based on moral rather than evidential grounds (Zampini, 2018). In the case of the Conservative Government, this morality is not one of compassion and care, but of abstinence and conformity (Stevens, 2019).

Epidemiologist Elizabeth Pisani, who specialises in HIV/AIDS, agrees with Stevens' position. She argues that politicians are willing to ignore scientific evidence when developing policies that benefit a minority that holds little influence over other voters, highlighting IDU as such a minority. Pisani asserts that "policies around addiction bulldoze happily through the scientific evidence in a quest to do what works best at the ballot box" (Pisani, 2010, p. 226). If such assertions are true this does not explain the willingness of the Thatcher Government to introduce harm reduction policies in

the 1980s. However, it has been argued that this approach was regarded as primarily motivated by a need to protect the in-group (referring to the healthy, law-abiding population) from the threat of drug users (seen as the infected/criminal population) (MacGregor, 2017) during a time of unprecedented societal risk.

Drug user rights advocates have criticised the “ideological drift” from harm reduction to recovery over the last 20 years, which they say has been exacerbated by budget cuts, localism and the demonisation of OST prescribing, all of which has created a “hostile environment” for harm reduction (Southwell, 2020, para. 4). Mat Southwell, an activist and former drug service provider who was involved in the development of pioneering harm reduction interventions in the 1980s and 1990s, argues that harm reduction has been “dangerously depleted” (2020, para. 5) but that there is an opportunity to rebuild the sector. He refers to the Covid-19 pandemic as demonstrating the natural instinct of the drug services sector to return to its roots of harm reduction and community mobilisation when a crisis occurs, much as it did when faced with the threat of HIV in the 1980s. During the pandemic, drug user groups displayed creativity and flexibility, providing self-support and mutual aid during lockdowns (Southwell, 2020) including the development of peer-based needle exchanges (London Joint Working Group on Substance Use and Hepatitis C, 2022; Keston et al., 2021) which many IDU reported to find preferable to the existing system of accessing equipment from pharmacies (Keston et al., 2021).

Southwell, who now provides consultation to the International Drug Policy Consortium and the European Network of People who Use Drugs, argues that the Covid-19 pandemic has been a catalyst for bringing together drug user activists who had been disempowered by years of inappropriate drug policy, providing an opportunity to revitalise harm reduction services. He believes that such services should be peer-driven to promote the “dignified and respectful treatment” of PWUD (2020, para. 9).

1.3. Peer Work in Harm Reduction

1.3.1. Definitions of Peer Support

Peer support has been defined as "a system of giving and receiving non-clinical support based upon the principle of shared experiences, responsibility, and cooperation" (Scannell, 2021, p. 1). In a harm reduction setting, the term 'peer' is defined as "a person with past or present substance use experience who uses that experience to inform their professional work" (Greer et al., 2021, p. 3).

It is important to note that the term lived experience is often used to refer to someone who has used substances in the past, but is now abstinent, as well as someone who is currently using them. In order to differentiate between the experiences of people who have used drugs in the past versus those who currently use drugs the term 'living experience' is used to refer to people who are active drug users. The term 'people who use drugs' (PWUD) also refers to active drug users.

1.3.2. The Role of Peer Workers in the Development of Harm Reduction Approaches

During the 1980s, the need for an urgent and pragmatic response to the HIV epidemic required a rethink regarding the conventional methods of service provision. Traditional 'provider-client' models were limited in their ability to reach drug users where they were based, communicate effectively and assure drug users that they could be trusted not to alert the police to their activities (Broadhead et al., 1995; Grund et al., 1992). IDU reported barriers to accessing fixed-site needle exchange services including lack of awareness, transport issues, limited opening hours, fears of being identified as an IDU and police harassment (Rich et al., 1999).

In recognition of the barriers preventing IDU accessing needle exchanges, drug services in the Netherlands began giving boxes of clean needles to key drug users, who could then distribute them to other users in their network (Grund et al., 1992). In the US, PWUD began distributing harm reduction paraphernalia and information and locating other PWUD who were eligible for services such as needle exchanges (Broadhead & Fox, 1990; Broadhead & Heckathorn, 1994; Cintron, 1998). PWUD

would also introduce outreach workers to their peers and vouch for them in new communities (Grund et al., 1992).

Such initiatives undermine the oft-portrayed image of the drug user as deviant (Jarlais et al., 1988) and antisocial (Broadhead et al., 2002). Rather they demonstrate the positive social relationships that exist amongst drug users (Battjes & Pickens, 1988). Research has identified that small friendship groups are the primary positive social relationship amongst PWUD, characterised by the sharing of information and the potential sharing of drug paraphernalia (Battjes & Pickens, 1988). Harm reduction interventions run by PWUD are able to "draw upon and strengthen the sharing rituals and norms of reciprocity that already underlie and sustain drug user networks in the first place" (Heckathorn, 2002, p. 91).

There is a wealth of evidence of informal peer support among drug users which has assisted in interventions and demonstrates the willingness of PWUD to help each other in "dealing with problems of mutual concern" (Broadhead et al., 2002, p. 236). An outreach project in Chicago reported that once IDU had become aware of the threat of AIDS they became "quite capable of assimilating a strong sense of social responsibility which can be readily channelled to include an assumed role of prevention advocacy" (Wiebel, 1988, p. 147).

Research has reported on the success of peer-run services and interventions in reducing drug-related harms, including a decrease in needle sharing and frequency of injecting among IDU, (Broadhead et al., 1998), promoting HIV risk reduction amongst PWUD who are not in treatment (Cottler et al., 1998) and increasing condom use and needle cleaning practices among IDU (Latkin, 1998). A rapid review of evidence of peer-based harm reduction interventions for IDU reported a range of positive outcomes, including with regards to engaging the most marginalised IDU (Wilkinson et al., 2020).

Early harm reduction interventions capitalised on the reciprocal relations already in existence within networks of PWUD, who performed peer education and health advocacy on an informal basis (Power et al., 1995). They relied on the altruism of PWUD who were motivated by concern for their community (Latkin, 1998) without

offering any direct reward or incentive for their work (Broadhead et al., 1998; Feldman & Biernacki, 1988). The directors of a San Francisco outreach pilot programme said of IDU who helped them to gather information on AIDS transmission "they generally looked favourably on such efforts to involve them voluntarily and encouraged their friends to co-operate in a similar fashion" (Feldman & Biernacki, 1988, p. 32).These narratives are at odds with stereotypes of drug users as irresponsible, selfish and unable to make a meaningful contribution to the community (Borchert & Rickabaugh, 1995; Ross & Darke, 1992).

1.3.3. Expertise of Peers

PWUD are able to embody many of the principles that characterise a harm reduction approach. One such principle of "meeting people where they are at" (National Harm Reduction Coalition, n.d.) can be enacted by PWUD both literally and figuratively. PWUD exist in networks of other drug users and this proximity puts them in a unique position. PWUD have "privileged access to drug venues, drug scenes and drug supply systems" (Southwell, n.d., p. 4). This proximity to other drug users is critical to the success of some harm reduction interventions, such as the provision of Naloxone. Distributing Naloxone to IDU for use amongst their peers is deemed to have life-saving potential in such contexts (Strang et al., 1996).

Peer workers have said that their experience of drug use has helped them to bring insights that would otherwise be absent and "create compassionate and non-judgmental" services (Austin & Boyd, 2021, p. 5), both of which are also characteristics of harm reduction. PWUD have been able to provide insights into the reality of drug use to ensure that proposed strategies and solutions will be acceptable and relevant to PWUD (Greer et al., 2016).

A number of studies highlight the ability of peer workers to develop trust with service users as a benefit of employing PWUD (Austin & Boyd, 2021; Bardwell et al., 2018; Pauly et al., 2021; Stengel et al., 2018), which may mitigate the barrier of mis-trust that has been found to exist in traditional provider-client services (Broadhead et al., 1995; Grund et al., 1992). The Australian Injecting and Illicit Drug Users League has stated that it is "critical" to involve people with lived experience in services because

of “the trust that exists within peer networks and their reach into communities of people who may not frequently engage with the health system” (International Drug Policy Consortium, 2018, para. 10). Research from the US (Weeks et al., 2006), Canada (Hayashi et al., 2010), Australia (Higgs et al., 2016), Russia (Hoffman et al., 2013) and Ukraine (Smyrnov et al., 2012) all demonstrates the effectiveness of peers in reaching marginalised PWUD who did not previously engage with existing harm reduction services.

Whilst the contribution that PWUD make to the harm reduction field is well evidenced, less is known about the experiences of undertaking harm reduction work. A scoping review of current literature on the experiences of active drug users delivering peer work has been undertaken and the findings are presented below. A scoping review allows for the inclusion of research utilising a variety of study designs and seeks to gain a broad understanding of a topic through comprehensive coverage of the existing literature (Arksey & O’Malley, 2005). The review provides an opportunity to consolidate the existing evidence-base and understand whether there is commonality across experiences of peer work. It will also identify gaps in the literature which will serve to inform the direction of future research. It is intended that this review will contribute to a better understanding of what harm reduction interventions are offered by peer workers and how these are experienced. This will include identifying any beneficial outcomes of peer work, with a focus on mental health and wellbeing, as well as any more challenging aspects of the work.

1.4. Literature Review

An electronic literature search focusing on the experiences of active drug users in harm reduction interventions was undertaken in PsycInfo, Academic Search Complete, CINAHL, PubMed and Scopus using the terms “harm reduction” and “peer*”. A hand search was also undertaken to identify additional literature (See Appendix A for flow chart). A total of 181 articles were screened.

Literature published up to 30th June 2022, before the commencement of this study, was included. Literature that focused solely on the experience of people who had

previously used drugs and were now abstinent, was excluded. In some instances, studies included participants with both lived (former) and living (current) experience of drug use and it was not always possible to distinguish between them in the data. As such, in some cases the experiences of peer workers with lived experience may have been included.

In total, 20 studies were selected. The search yielded no empirical data regarding experiences in the UK. The majority of studies hailed from Canada (n=14), with four from the US, one from Kenya and one from Senegal.

All of the studies utilised qualitative methodology, mainly interviews, but qualitative surveys, focus groups and observations were also used. Whilst details about type and duration of drug use amongst participants was not provided in the majority of studies, many participants had experience of opiate and/or crack use and some were using OST.

The selected studies describe a number of different harm reduction interventions, including outreach work, where peers were employed to distribute information and harm reduction equipment (needles, syringes, crack pipe paraphernalia etc.), training in Naloxone administration and the operation of OPS. A number of key themes which emerged from the literature are outlined below.

1.4.1. Benefits of Peer Work

One of the most common themes across the literature was the positive benefits that peer workers had experienced as a result of their roles. These can be divided into three sub-themes.

1.4.1.1. Inclusion and community: The literature highlighted the role of peer work in helping peers to feel a “good sense of community” (Kennedy et al., 2019, p. 12) “connectedness” (Marshall et al., 2017, p. 24) and “belonging” (Pauly et al., 2021, p. 5). A participant working in overdose response in Canada stated, “There [are] so many differences, yet there’s a commonality. We bond over the same things” (Pauly et al., 2021, p. 5). Another participant in the same study spoke of their workplace

providing a safe space where they could talk as freely as they wanted to, “everybody has some kind of addiction experience and it’s just like walking into a warm hug. Everybody’s there to support you and understands what you’ve been through” (Pauly et al., 2021, p. 5). A participant working in harm reduction services in Canada referred to their work as providing them with “the most genuine, raw, meaningful relationships” (Austin & Boyd, 2021, p. 5).

This sense of belonging appeared to be particularly significant to peer workers given the stigma and marginalisation that they usually face due to their drug use. Their work allowed them to move from a position of exclusion to one of inclusion. A peer worker who was trained in Naloxone administration in the US reported, “Everywhere during the time I was using, that was something that was stigmatized. That I was a drug user, all the behaviours that I went through. I was excluded from many places. So when I got here, and they included me, that was very significant to me” (Faulkner-Gurstein, 2017, p. 17). Another participant working in Canada said, “It wasn’t too long ago that what I had to say was dismissed based by appearance and how I lived my life. Today I have a voice and am able to use it to speak for those who have not found their own voice yet” (Austin & Boyd, 2021, p. 5), demonstrating how peer work had changed their status in society.

A participant working in a Hepatitis C service in Canada felt that that their peer work role allowed them to give back to the community so that they were no longer being looked at as a burden (Tookey et al., 2018). A study of peer health advisors (PHA) in US harm reduction services reported that peer work “allowed them to construct a new identity other than the irresponsible drug addict” (Weeks et al., 2006, p. 11).

A respondent to a survey of peers working across harm reduction services, including outreach, advocacy and education, said that involvement in peer work was beneficial for people who “had stigma” as it helped them feel less like “scum, a lowlife” (Austin & Boyd, 2021, p. 6). However, this was not a universal experience, as participants in the same study reported still having to contend with the stigma of their drug use and discrimination both inside and outside of work (Austin & Boyd, 2021).

1.4.1.2. Confidence and self-esteem: Studies highlighted how peer work had increased self-esteem and confidence (Marshall et al., 2017a) and supported peers to feel empowered (Austin & Boyd, 2021; Greer et al., 2021).

Participants in some studies spoke of the pride they have in their work (Olding et al., 2021; Mamdani et al., 2022; Marshall et al., 2017; Latkin et al., 1998). In a survey of 47 peers working in an OPS in Canada, 100% indicated that they felt a sense of pride in their job (Mamdani et al., 2022). In a Naloxone training programme in Canada, all six peer trainers described feeling proud of their involvement in the programme (Marshall et al., 2017). Participants in this study also spoke of the pride that others now had in them. Two participants spoke of their friends or family being proud of them, with one peer trainer stating, “Others they were proud, because for the first time the drug has given me a positive thing. There is not much positive to drugs” (Marshall et al., 2017, p. 23). In the US, peer workers in an HIV prevention service said that their peer work had “altered their neighbours' and friends' perceptions of them and increased their respect among both drug users and non-users” (Latkin, 1998, p. 156).

Being able to use their own experience of drug use felt particularly important to participants in some studies. A respondent in a survey of 50 peers working across harm reduction service in Canada reported, “It boosts my ego knowing that I am doing good by helping another human being. Knowing that my knowledge through lived experience is useful” (Austin & Boyd, 2021, p. 5). A participant in a study of peers working in overdose response in British Columbia spoke of their work making them feel like they are useful, “Makes you feel like all the shit that I’ve done in my life wasn’t for nothing. It actually comes in handy, and it’s nice to be acknowledged for having such a shitty, hard life” (Pauly et al., 2021, p. 5).

1.4.1.3. Acting as a role model: The theme of acting as a role model was reported across a number of studies and was considered to be a “powerful” term for peer workers to be considered as (Pauly et al., 2021, p. 5).

A peer working in Hepatitis C programmes in Toronto, Canada described the experience of being admired by programme service users, “having the community look up to me.... I have improved my own lifestyle, people take note of that…. I know a lot of the people coming into the program and a lot of people were looking up to me at the time because I had helped implement all these different programmes” (Tookey et al., 2018, p. 7). In this instance, the participant felt that the improvements he had made to his life were the source of inspiration for others.

Another study highlighted the power of peer workers in demonstrating that it is possible to succeed, even when using drugs. A staff member of a community health centre in Toronto spoke of accompanying a peer worker on outreach work and PWUD assuming the peer must be abstinent because they were working. They saw peer work as an opportunity to educate other PWUD that “you don’t have to be abstinent in order to be involved in something positive”, thus giving them hope that they too could be involved in positive activities even if they were still using drugs (Penn et al., 2016, p. 91).

1.4.1.4. Changes in drug use: A number of participants in the studies reported changes in their drug use as a result of being employed in harm reduction initiatives. In all of the included harm reduction interventions, employment as a peer did not require abstinence as a prerequisite. In some harm reduction services, there was an understanding that peer workers could use drugs, or be under the influence of drugs, whilst on shift, as long as it didn’t affect their work (Bardwell et al., 2018; Penn et al., 2016). One participant working in the Vancouver Area Network of Drug Users (VANDU) harm reduction service, spoke of how helpful it was not having to be secretive about his drug use, “Most places where I had a job I had to hide my dope...and you couldn’t go to work stoned. But you don’t have to hide being stoned this time, you know? If you’re a drug addict you can go [to VANDU] and they just don’t want your drug use to interfere with your job, right?” (Bardwell et al., 2018, p. 7).

A number of studies reported that, despite it not being a requirement of their role, participation in harm reduction work had led to a reduction in drug use. In a study on the experiences of PWUD trained as trainers in Naloxone administration in Canada,

one participant reported having reduced their quantity and frequency of drug use (Marshall et al., 2017a). Another Canadian study on peer workers in community health settings reported the same (Penn et al., 2016). A similar finding was reported in a study of PHA in the US tasked with providing education and harm reduction equipment to their peers. The study reported that PHA had indicated that involvement in harm reduction work had provided them with alternatives to getting high. As one participant reported, "I'm down to [using drugs] once a month. I don't have to do once a week like I used to or once a day. And I'm having a hard time with it still, but I've come a long way.... since I got in this program, the PHA, I love it because it taught me to stay clean" (Weeks et al., 2006, p. 11).

Change in drug use was a prevailing theme in many of the studies (Marshall et al., 2017; Tookey et al., 2018; Weeks et al., 2009; Penn et al., 2016). One peer worker employed in a Hepatitis C harm reduction programme in Canada reported continuing to use drugs on a daily basis, but doing so in a "better way", having learned how to practice drug use more safely through his role (Tookey et al., 2018, p. 7). These changes also extended to peers' own networks. One peer worker in the US reported giving harm reduction educational materials to people that used drugs in his home and described how they had changed their drug-taking behaviours as a result (Weeks et al., 2009).

These changes were described as happening without employers telling peer workers to make them. Rather the structure and support offered by their involvement in peer work, and a sense of responsibility to their work, facilitated behaviour change. As one (non-drug using) staff member of a community health service in Canada stated, "People organised their substance use in a more functional way so they could come to meetings more reliably. They were able to make those changes without us telling them […] They knew what they needed to work on and we just provided the structure, support and resources that they needed" (Penn et al., 2016, p. 90). In this study, peer workers associated changes in their substance use to the accumulation of physical and human capital, such as improved health, more stable housing and reduced involvement with the criminal justice system. This allowed them to focus on themselves rather than being preoccupied with meeting their daily basic needs (Penn et al., 2016).

At VANDU, where volunteers were paid a stipend for their involvement in a variety of activities, including peer education, distribution of harm reduction supplies and political activism, Bardwell et al. (2018) found that an “increased sense of responsibility… and regular contact with others offered a meaningful motivation to reduce drug use” (p. 9). In this study, this reduction in drug use, as well as the modest stipend the peers received for their work, also allowed several peers to reduce their involvement in other income generating activities, such as sex work or criminal activity (Bardwell et al., 2018). However, this finding was not universal across the literature, with many other studies highlighting the insufficiency of payment for peer work, which will be explored below.

One study, which focused on the experience of peer workers at an OPS in Canada, highlighted that peer work in this context had actually increased drug use as they attempted to deal with the grief and stress of their work. As one participant stated, “I ended up relapsing because I wasn’t able to process everything the way I should have, and I’m desensitized to, you know, death, and the overdoses…. So, because of those two things, and just continuing to work, work, work myself to the bone–[relapsing] was the easiest solution for me” (Olding et al., 2021, p. 8). The stress of working in such a context, which in this case led to relapse, will be explored further below.

1.4.1.5. Emotional demands: A number of studies highlighted the trauma and stress that was associated with peer work. This was especially the case for peers working in overdose prevention services (OPS) (Kennedy et al., 2019; Mamdani et al., 2021). A number of participants had witnessed deaths within their service or had been working closely with service users who had subsequently died. One peer worker in British Columbia described hearing a service user had died the day after they had been supporting them, “if you’re boiling someone an egg at 8:00 and by 9:00 the next morning you find out they’re dead, you know, it’s very jarring. But you can’t stop what you’re doing” (Greer et al., 2021, p. 5).

A study by Mamdani et al. (2021) reported that several peer workers in an OPS had spoken of constant exposure to trauma and loss of life being stressful and

emotionally taxing. The study highlighted how peer workers have a unique understanding of the lives of other PWUD and, as such, can deeply relate to others' experiences of trauma, thus amplifying their own stress response. Also unique to peer workers, as opposed to other healthcare workers such as paramedics, was the fact that peer workers are often supporting people that they know, making coping with their deaths all the more difficult.

A study by Kennedy et al. (2019) reported the experiences of two peer workers who had seen friends die. As one described it, "So on top of having all of these horrible things happening, your friends dying, your friends going down while you have friends dying, having to worry about your own life while your friends are dying... It's just bonkers. It affects every aspect of your life, and that's just crazy" (p. 19). One peer worker working in an OPS in Vancouver had tried to save the life of a friend, who had died, "It gets to you after a while, it really does. The last person that I did [i.e., administered Naloxone] I could not bring him back and he was my buddy. By the time the ambulance came, he already stopped breathing…I've known him over 30 years" (Fleming et al., 2019, p. 17).

This exposure to overdose death was reported to contribute to feelings of emotional exhaustion and anguish (Kolla & Strike, 2019; Masese et al., 2022) and contribute to burnout amongst peer workers (Mamdani et al., 2021). In a study by Olding et al. (2021) undertaken in an OPS in Vancouver, peer workers reported substantial psychological challenges related to their work, which they also referred to as burnout. Peer workers spoke of being exhausted due to challenging working conditions and the demands of overdose response. One participant explained, "it's just a weariness that you can't even explain to anyone who doesn't do this job" (Olding et al., 2021, p. 7).

1.4.2. Challenges in Peer Work

In additional to the emotional labour of peer work, a number of other challenges were highlighted in the literature and have been categorised into three sub-themes.

1.4.2.1. Compensation: The means of compensation for peer work was not consistent across harm reduction interventions. In a number of cases, peer workers were employed as volunteers and received a stipend for their involvement, which was often lower than the national minimum wage. Often the stipend was not commensurate with salaries paid to other staff in the organisation and this lack of equity was problematic. As one board member of VANDU described, “The board [PWUD] gets five bucks and the staff is in the same room getting twenty-five bucks an hour. I mean there is an imbalance, definitely. [It’s] never going to be perfect until everybody in the room is getting twenty-five bucks an hour” (Bardwell et al., 2018, p. 10).

Low wages were a source of “symbolic injury” for peer workers, who were aware they were paid less than other non-drug using staff, despite performing similar tasks (Olding et al., 2021, p. 10). Participants felt their labour was devalued because they were labelled as ‘peers’ and that pay inequities reflected ambivalence towards PWUD, with one participant stating “they don’t think that people deserve to live that are on drugs” (Olding et al., 2021, p. 10). Another peer worker at a harm reduction service in Montreal said that services should acknowledge that peer workers are victim(s) of the drug war and thus their (non-drug using colleagues) are more privileged than them. There was a sense of their involvement being “tokenistic” (Austin & Boyd, 2021, p. 6).

Peers in other harm reduction services across Canada noted the same. They felt inequity in compensation gave the perception that their expertise, time and efforts were not valued (Kennedy et al., 2019). The perception of unfair pay was reported to be a potential reason for burnout amongst peer workers (Mamdani et al., 2021). Some participants felt that organisations took advantage of the high supply of PWUD who were desperate to earn money, given that they would be unemployable elsewhere. That allowed programmes to keep wages low, which one participant referred to as “poverty pimping” (Greer et al., 2020, p. 4).

Low salaries from their harm reduction work meant that peers were still preoccupied with meeting their daily living needs. One peer worker at VANDU detailed how impossible it would be for a street addict to get involved with work at VANDU when

they had to prioritise finding a place to sleep and enough money to buy drugs. The study found that, for the most marginalised participants, the stipends they received were not sufficient in compensating them at the same level of other illegal income generating activities, such as sex work or drug dealing (Bardwell et al., 2018). Peer workers in Kenya reported the same experience, having to get a second job in addition to their peer work, with one participant collecting waste as a way to make ends meet (Masese et al., 2022).

1.4.2.2. Lack of advancement and job insecurity: Another theme in the literature was a sense amongst peer workers that they would be unable to advance further than their current position. Peer workers at VANDU spoke of an absence of opportunities for advancement into better paying positions for people who continued to use drugs. One referred to their stipendiary volunteer work as “kind of holding you down at the same spot” (Bardwell et al., 2018, p. 10).

In some instances, peer work was casual or informal, which led to a feeling of insecurity and vulnerability amongst peer workers. In a harm reduction service in British Columbia, participants spoke of peer workers being at risk of being fired arbitrarily, with one participant stating, “the fear for our jobs is used quite often” (Greer et al., 2020, p. 4). The sporadic and random nature of peer work made it difficult for peer workers to plan or feel a sense of financial and social stability (Greer et al., 2020).

Peers working in a Canadian OPS spoke of not having a contract or formal job description for their role, and felt that they were often assigned menial tasks and looked down upon (Mamdani et al., 2022).

The limited opportunity for advancement was seen to contribute to burnout in a study of an OPS in Vancouver. One participant, who had worked in the service since it had opened in 2016 said, “I actually had to quit for a while because of burnout, because I needed to get away and because there was no advancement opportunity, which was a big deal to me” (Olding, 2021, p. 10). A lack of opportunities for advancement

made some peers feel as if the job was a dead end, or “there’s nothing at the end of this” (Olding, 2021, p. 10).

1.4.2.3. Boundaries of peer work: Another theme that emerged from the literature was the tendency for peers to provide resources outside of the remit of their job description, be this financial or in terms of their time.

In a study of peer work in Senegal, participants reported providing support to service users on a voluntary basis over and above what was delivered formally by their service. This included providing medical care and prescriptions, or giving money out of their own pockets to service users (Stengel et al., 2018).

In Kenya, peer workers also spoke of performing tasks outside of their duty, including visiting ill service users at home or in hospital, supporting their medical care and using personal funds to transport clients to hospital and purchase medications and food. One peer worker described the experience, “Now if the client was my client, I have to take him to the hospital and take care for them until the day they are discharged. You have to visit, sometimes stay along with them [overnight] and maybe in the morning I can come to the drop-in-center and then go home, change and then go back. It is very hard sometimes” (Masese et al., 2022, p. 6).

Peer workers at an OPS in Canada reported performing a much broader role than overdose prevention, “We’re mental health workers, we’re bartenders, we’re babysitters. We’re moms, dads, you know, foster [parents]” (Olding et al., 2021, p. 11), all of which could feel overwhelming. Some reported using their own resources to support service users. One participant stated “If they need help we do housing, shelter, food….if someone’s homeless then we try to get them into a shelter....Detox, anything. We try to help them with everything” (Olding et al., 2021, p. 11). At the same service, peer workers often worked outside of their hours without additional pay (Olding et al., 2021). This was a practice that was seen in other OPSs, with participants feeling that they needed to remain “on call” (Fleming et al., 2019, p. 17).

1.5. Rationale for Current Study

The reviewed literature highlights a variety of experiences of peer workers delivering harm reduction interventions. Many benefits are described, including offering PWUD a feeling of belonging and connection, increasing their pride and self-esteem and enhancing their own standing within the community as role models. The existing research also suggests that peer work may support PWUD to reduce their drug use and make other positive behaviour changes. More challenging aspects of peer work were also highlighted. The emotional toll of the work, and its impact on the mental health and well-being of peer workers appeared to be particularly problematic for peer workers working in OPS. However, there were also challenges highlighted across all types of peer work, related to job security, boundaries of the peer work role and dissatisfaction regarding payment.

At the time of completing the literature review, all of the research on peer work delivered by active drug users had been undertaken in other countries, suggesting a need to develop a greater understanding of the experiences of peer workers with living experience of drug use within the UK. This is of especial interest given the shift away from harm reduction approaches in the last two decades in favour of abstinence-based recovery approaches, which has been argued to have resulted in inadequate provision of appropriate services for PWUD.

Developing a better understanding of the experiences of this population is beneficial for the field of clinical psychology given the high levels of mental health need amongst PWUD. Data demonstrates that 63% of people starting drug treatment have a mental health need (Office for Health Improvement & Disparities, 2022) and a history of drug or alcohol has been recorded in 54% of all suicides in people experiencing mental health problems (National Confidential Inquiry; 2016). Despite this, PWUD face multiple barriers to accessing treatment within both drug services and mental health services (Public Health England, 2017). The Government has committed to rebuilding the drug sector's professional workforce, to include more psychologists, and plans to ensure PWUD have access to talking therapies and psychosocial interventions (HM Government, 2021). Gaining a better understanding

of what interventions may support the mental health and well-being of PWUD and facilitate their access to services, is useful in this context.

Research on the experience of peer workers with living experience of drug use in the UK can provide an insight into the ways in which their mental health and well-being can be enhanced or challenged by their involvement in peer work, providing useful information for services seeking to support this population. As demonstrated above, peer workers have a long history of developing and implementing harm reduction responses that have been successful in reducing risk and promoting the health of PWUD. Understanding what motivates this involvement and the potential challenges involved is useful to those designing and operating services that seek to support PWUD.

Gaining greater insight into harm reduction principles and the ways in which they are delivered and received by PWUD will also be useful for mental health and drug services, including psychology services, who need to ensure that people with the greatest levels of mental health need are able to access services.

1.6. Research Aims

This study aims to understand the experiences of UK-based peer workers with living experience of drug use, who are engaged in the delivery of a range of harm reduction interventions, by answering the following Research Questions:

- What harm reduction interventions are delivered through peer workers?
- What are the views and experiences of peer workers in harm reduction services?
- How does delivery of harm reduction interventions affect the mental health, well-being and self-perception of those delivering them?

2. METHODOLOGY

This study utilised qualitative methodology to explore the experiences of active drug users who were employed as peer workers. This chapter provides details of the ontological and epistemological position taken and justification for the research design. The research process is presented and ethical considerations are discussed. The chapter concludes with an overview of the analytic process and details of the reflexive position of the researcher.

2.1. Design

2.1.1. Ontological and Epistemological Considerations

This research study was undertaken from a critical realist position. Ontology refers to what is real, the nature of reality (Fletcher, 2017). In critical realism, ontology is stratified into three levels: the empirical, the actual and the real (Nairn, 2012). The empirical refers to what a person perceives, such as what they see, feel and experience. The actual refers to the events that actually occur, and the real is "underlying mechanisms that may or may not occur" (Nairn, 2012, p. 7). These mechanisms can be physical, social or psychological and act as causal forces to produce events which appear at the empirical level (Fletcher, 2017).

Epistemology refers to our knowledge of reality (Fletcher, 2017). The epistemological objective of critical realism is to describe and clarify the relationship between observed experiences (the empirical within the stratified ontology), events (the actual) and the causal mechanisms underlying these (the 'real') (Lawani, 2020). By analysing the experiences of participants, critical realist researchers can conceive a description of the real world (Lawani, 2020).

Critical realism recognises the materiality of bodily, psychological and social experience, but conceptualises this to be mediated by language, politics and culture (Ussher, 2010). Critical realism thus acknowledges "an inherent subjectivity in the production of knowledge" (Madill et al., 2000, p.3).

Taking a critical realist position in this research acknowledges that the events and activities that constitute peer work exist and that they are experienced as real by those involved (the realist position). However, all of these experiences can only be understood within the cultural, social and linguistic context of both the participants and the researcher (the critical position). By analysing these 'real' events through this lens, the researcher can gain an understanding of the social and psychological causal mechanisms which underlie these experiences.

As this study seeks to gain a deeper understanding of peer work experiences, that is the social and psychological mechanisms which underpin these experiences rather than simply relaying these experiences at a surface level, critical realism was deemed to be the most suitable approach to this research.

2.1.2. Rationale for Qualitative Methodology

Qualitative research, which focuses on "exploring the details of people's lived experiences" (Neale et al., 2005, p.1) was considered to be the most appropriate methodology for this research study, which seeks to gain a greater understanding of the experiences of peer workers.

Qualitative methodology in drug research is deemed valuable in its ability to demystify drug use by providing information that accurately reflects the daily reality of PWUD, rather than the myths and stereotypes that exist about them (Neale et al., 2005). Whilst this research does not focus on drug use per se, it does seek to gain a greater understanding of the experiences of PWUD, seeking to understand the reality of their lives.

2.1.3. Rationale for Reflexive Thematic Analysis

Thematic analysis (TA) is defined as "a method for identifying, analysing, and reporting patterns (themes) within data" (Braun & Clarke, 2006, p.79). Reflexive TA emphasises the subjectivity that is inevitable in the coding and analysis of data and the active role the researcher plays in coding and generating themes (Braun & Clarke, 2022).

TA is “a set of theoretically independent tools for analysing qualitative data” (Clarke et al., 2015) that can be deployed within a critical realist framework (see Hayfield et al. (2014) for an example). Critical realism acknowledges both the ways in which an individual makes meaning of what they experience, and the ways in which the broader social context impacts on these meanings (Braun & Clarke, 2006). TA offers a method of both reflecting reality and unravelling the surface of reality (Braun & Clarke, 2006).

TA has been described as a “powerful method to use when seeking to understand a set of experiences …across a dataset” (Kiger & Varpio, 2020, p.847) making it appropriate for this research study, which aims to understand the experiences of multiple peer workers. As themes are conceptualised as “patterns of shared meaning, cohering around a central concept” (Braun & Clarke, 2020, p. 4) they allow the researcher to develop an understanding of shared experiences that are common to the role of a peer worker.

2.1.4. Developing the Interview Schedule

Semi-structured interviews were selected as the method of qualitative data collection for this study. Interviews have been described as the “quintessential instrument” with which realists can collect in-depth information from participants (Brönnimann, 2022, p.1). Interviews provide rich accounts of experiences and events and the processes or conditions that underlie them (Smith & Elger, 2014), allowing researchers to gain access to “a complex social world of causal interactions” (Brönnimann, 2022, p. 1) favoured by critical realist researchers.

Semi-structured interviews were utilised as they allow for interactivity with research participants, which can allow for the emergence of unexpected topics that can then be taken up by the researcher (Busetto et al., 2020). Many of the previous studies on active drug users involved in peer work from other countries have utilised semi-structured interviews (e.g. Faulkner-Gurstein, 2017; Greer et al., 2020; Marshall et al., 2017; Stengel et al., 2018), suggesting this is an appropriate methodology with which to explore this subject area.

The interview schedule was developed based upon the study's aims and a review of relevant literature and refined through conversations with the research supervisor. It began by asking participants about their personal characteristics including age, gender and ethnicity. A question was included about whether participants were currently engaged in drug use, and how long they had been engaged in this. This question was asked in order to ascertain whether peer workers were active drug users whilst engaged in peer work, given that the study seeks to understand the experiences of active drug users. It was also deemed to be useful to understand whether peer workers tended to be those who had engaged in longer-term or shorter-term drug use. However, I was conscious that drug-taking is so highly stigmatised that PWUD often experience feelings of shame (Lloyd, 2010; McPhee, 2013) and I did not want to risk participants having this experience during the interview. I consulted with the organisation employing the participants to ensure that this question would not be deemed inappropriate and made it clear to participants that they were under no obligation to share this information if they did not wish to. I also mitigated this risk by spending time before each interview explaining the purpose of the study and building a rapport with participants, and communicating throughout the interview to ensure they were aware that their experiences were being met without judgement.

The questions moved on to ask about the nature of work that participants performed for their organisation, and how they had got involved, before exploring their likes and dislikes about their involvement in the work and how their identity as a peer (with their own living experience of drug use) may be helpful, or not, in their role. The schedule concluded with questions about differences in the participants' lives as a result of their involvement in peer work.

2.2. Data Collection

2.2.1. Inclusion Criteria

Participants were identified based upon the following inclusion criteria:

- Adults aged 18 or over
- Actively using illicit substances
- Engaged as peer workers in harm reduction interventions.

2.2.2. Participants

Eight people from across the two HRO sites participated in the study. Of these, seven were male and one was female. Ages ranged from 37 to 55. The majority of participants (n=6) identified as White British. One participant identified as Mixed British Asian and one participant identified as Asian.

2.2.3. Recruitment Procedure

During scoping for this study contact was made with staff working in a national harm reduction organisation (HRO) which employs active drug users as peer workers to deliver harm reduction interventions. The organisation offered to consult with its peer workers working in two separate sites, based on information I had provided about the nature of the study, to ascertain whether they would be interested in participating in my research. The majority of those who were consulted subsequently attended the research interviews.

Purposive sampling, where “participants are selected according to predetermined criteria relevant to a particular research objective” (Guest et al., 2006, p. 61) was used in this study. There is no widely agreed criteria with which to determine the size of a qualitative dataset. The concept of “data saturation”, defined as “the point at which no new information or themes are observed in the data” (Guest et al., 2006, p. 59) has been suggested as an appropriate approach for determining the size of purposive samples in qualitative health research. However, Braun & Clarke (2021c) consider this to be a problematic approach for researchers utilising reflexive TA. They argue that the concept of data saturation suggests that the role of the researcher is to discover themes that exist within the data, which is at odds with a reflexive process of knowledge construction, where there is always potential for new understandings through ongoing engagement with the data, or reading the data from different perspectives. Rather, they suggest use of the notion of information power (Malterud et al., 2016), which suggests the researcher reflects on information

‘richness’ of the data and how this meets the aims of the study. Braun & Clarke (2022) suggest informational or meaning sufficiency as a more useful concept in deciding when to stop collecting data, which can only be determined in situ. Acknowledging the tension between competing theoretical/methodological and practical/pragmatic priorities, Braun and Clarke argue that a dataset needs to be large enough for the researcher to be able to confidently claim there is a pattern of meaning across cases, but not so overwhelming that the researcher is unable to do it justice (2022). In light of the considerations above, the final sample size of eight was deemed to be appropriate.

2.2.4. Interviews

Semi-structured interviews were conducted in person, using the interview schedule described in Appendix B. Interviews were held at the offices of the HRO employing the peer workers. This was chosen as it was felt to be the most convenient and comfortable place for the participants and would give them the opportunity to access staff support following the interviews should they require it.

The interviews varied in length from 18 to 66 minutes and were recorded on a Dictaphone.

At the end of the interviews, participants were debriefed, to provide them with an opportunity to raise any concerns or ask further questions. They were provided with a Participant Debrief Sheet (Appendix C) which contained information on sources of support and my contact details, should they wish to raise any concerns.

2.3. Ethical Considerations

Ethical approval for this research study was granted by the University of East London’s (UEL) School of Psychology Ethics Committee (Appendix D).

2.3.1. Informed Consent

Prior to the interview, participants were given time to read the Participant Information Sheet (Appendix E) and ask any questions they might have. They were reminded

that there was no obligation to participate and they had the right to withdraw from the research up until a specified time point. All participants were happy to continue and signed the Participant Consent Form (Appendix F) prior to the start of the interview.

2.3.2. Confidentiality

Participants were informed that the content of interviews would remain confidential and the interview transcripts would only be reviewed by me and the research supervisor. I reminded participants that they would be pseudonymised in my research and that any identifiable information would be removed from any data extracts published in the final report.

Data were stored securely on the UEL password protected storage system, with all identifying data removed before upload, and will be destroyed after three years.

2.3.3. Minimising Harm

I was aware that many of the participants in this research study live, or had lived, a life under increased scrutiny, be that from police or the general public. I was conscious that, in asking PWUD to participate in this research, I was also putting them under scrutiny, asking them to share details of their lives and experiences for my own purpose. I was very clear that participants did not have to take part, could refuse to answer questions or could withdraw at any time during the interview, although none of them chose to do so. Following the interviews, I provided a debrief to the participants and checked whether there was any part of the interview that the participants had found particularly difficult, or had felt uncomfortable about. I advised that participants could let me know if there were parts of the interview that they would prefer me not to include in the final report. No issues were raised by any of the participants. During the debrief I advised participants that they could discuss any concerns that might arise with HRO staff. They were also given contact details of organisations able to provide support, and the contact details of the researcher and research supervisor, should any concerns arise following the interviews.

2.3.4. Payment for Participation

There has been significant debate around the issue of paying participants who use drugs for their involvement in research (Fry et al., 2006; Ritter et al., 2003; Striley, 2011). This debate has been driven by concerns that offering payment to participants who are more likely to lack a stable income or access to sufficient resources may constitute undue influence, enticing someone to participate in a study when they might usually withhold participation (Festinger et al., 2008; Roth, 2012). However, there has been criticism that such a stance could be considered paternalistic (Roth, 2012).

There are also concerns that PWUD will use any cash received from research participation to procure substances (Brody et al., 2000; Charland, 2002) leading some research studies to only issue gift cards or vouchers that can be used to purchase a limited range of items (Festinger et al., 2008; Fry et al., 2006). There is a wealth of evidence that demonstrates that giving cash payment to research participants doesn't increase their drug use (Dempsey, 2008; Festinger et al., 2005; Festinger et al., 2008; Vandrey et al., 2007), which suggests that reluctance to offer cash to participants may stem from stereotypes of drug users as deviant (Ahern et al., 2007) or untrustworthy (Lloyd, 2010). Peer workers have expressed dissatisfaction with the use of stipends or gift cards as payments, arguing that their work is valuable and as such, they should be paid in money, rather than gift cards and stipends, to demonstrate equality with paid workers (Austin & Boyd, 2021).

The University of East London policy on payment for research participation stipulates that the only reimbursement that can be offered must be in the form of Amazon vouchers, which can be redeemed online. I had concerns that by offering a voucher I may be inadvertently playing into the narrative that PWUD should not be offered cash for research participation, a position that I strongly disagree with, and which may have undermined the trust I was seeking to build with the research participants. As such, I ultimately decided not to offer a voucher to participants. The organisation employing the peer workers advised me that the time each peer worker dedicated to participating in the interviews for this study would be counted as part of their peer work hours, for which they receive a modest stipend. This partly assuaged my concerns about not directly reimbursing the participants for their time.

2.4. Analysis of data

Braun and Clarke (2006) recommend six steps to conducting reflexive TA, which will be discussed below.

2.4.1. Becoming Familiar with the Data

It is recommended that researchers immerse themselves in their data to become familiar with the breadth and depth of the content through repeated active reading, which involves searching for patterns and meanings (Braun & Clarke, 2006). The process of transcribing the data is seen as “a key phase of data analysis within interpretative qualitative methodology” (Bird, 2005). Data was transcribed according to guidelines by Braun & Clarke (2012). After transcribing the interviews, I read the transcripts multiple times, taking note of initial reflections.

2.4.2. Generating Initial Codes

In TA, codes can be described as “the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon” (Boyatzis, 1998, p. 63). This research study utilised an inductive approach, which refers to analysis being “grounded in the data” as opposed to existing concepts and theories (Braun & Clarke, 2021b, p. 4). This means that the codes and themes derive from what is presented in the data, rather than using existing theory and research as a lens through which the data is analysed or interpreted, which is considered to be a deductive approach (Braun & Clarke, 2021b). As such, I worked systematically through each transcript, noting by hand anything interesting that I saw within the data that may come to form the basis of repeated patterns in the data set (Braun & Clarke, 2006).

Braun and Clarke argue that to achieve the complex and nuanced coding that is required of reflexive TA, the researcher must be deeply engaged in the data over a prolonged period, allowing codes to evolve organically as insights change. As the researcher’s interpretation of the data deepens and develops, codes may expand or contract, be split into additional codes or collapsed together with existing ones, and

coding labels refined (Braun & Clarke, 2022). I ensured that I devoted sufficient time to the coding of the data, allowing time to re-read and reflect on initial coding decisions and ensuring I kept a flexible approach, allowing sufficient opportunity for the codes to evolve.

2.4.3. Generating Initial Themes

Once each transcript had been coded, I reviewed the codes to explore where there was similarity of meaning, seeking to capture multiple facets that contributed to the same core concept and then clustered these codes together into provisional candidate themes (Braun & Clarke, 2021d).

2.4.4. Reviewing Themes

During this stage, I re-read each coded extract that had been allocated to a theme to ensure there was a coherent pattern within the theme. I then reviewed each candidate theme and determined whether it was an overarching theme or a sub-theme. Overarching themes were used as an organisational device, acting as an 'umbrella' under which a number of sub-themes would sit (Braun & Clark, 2021). This was a dynamic process where I would move candidate themes around, allowing time to review and reflect before finalising my overarching themes and sub-themes. A thematic map was used to aid this process (Appendix I).

2.4.5. Defining and Naming Themes

This stage of the analysis involved "identifying the 'essence' of what each theme is about and determining what aspect of the data each theme captures" (Braun & Clarke, 2006). I sought to define each theme, providing a description of the central organising concept and the scope of the theme. I then developed a name for each theme, aiming to communicate the essence of the theme (Braun & Clarke, 2021d).

2.4.6. Producing the Report

The final stage of TA is to create a report which provides a "concise, coherent, logical, non-repetitive and interesting account of the story the data tell within and across themes" (Braun & Clarke, 2006, p. 93). The Analysis chapter details my understanding of what the data evidenced and my interpretation of what patters in

the data mean, illustrated by selected extracts from the interview transcripts. The Discussion chapter expands upon this with an exploration of theoretical and contextual connections and implications of the themes (Braun & Clarke, 2021d).

2.5. Research Quality

Spencer and Ritchie's (2011) Quality Assurance Guiding Principles of contribution, credibility and rigour were used to evaluate the quality of this research. Spencer and Ritchie (2011) developed the Guiding Principles having identified a number of recurring principles that underpin concepts of quality across many epistemological perspectives. In addition, Braun and Clarke's best practice guidelines for reporting reflexive TA were followed (Braun & Clarke, 2022). Details on how the quality assurance principles and reflexive TA guidelines have been followed within the study are provided in the Discussion chapter.

2.6. Reflexivity

In undertaking this research it was important to reflect on my own position with regards to the subject matter. As a proponent of harm reduction approaches, and an advocate for the utilisation of those with lived and living experience of drug use in the development and provision of drug policies and services, I was aware that I was not entering into this research holding a neutral position. The subjectivity of the researcher is acknowledged within the critical realist position (Madill et al., 2000) and within the method of TA (Braun & Clarke, 2003). TA acknowledges that the researcher has to engage in "considerable analytic and interpretative work" (Braun & Clarke, 2021a, p. 39) in developing themes. The method requires reflexivity and the ability of the researcher to "reflect on their assumptions and how these might shape and delimit their coding" (Braun & Clarke, 2021a, p. 39). As such, it was important to be cognisant of this subjectivity when both conducting the interviews and analysing the data.

By consulting the research supervisor, I ensured that the questions in my interview schedule were not biased towards eliciting only positive feedback on peer work. I was also aware of potential for unconscious bias in responding only to positive data

regarding peer work as I analysed the interviews. As such, and in line with an inductive approach, I coded all of the data line-by-line (Maguire & Delahunt, 2017), to ensure that each extract was scrutinised and I was less likely to only take notice of data that aligned to my expectations or theories.

I also reflected on my position as a person without lived/living experience of drug use in conducting this research. Given that this research is about the unique position that PWUD hold in relation to working with other PWUD, there is a strong argument to be made for this research to have been undertaken by a person with lived or current experience of drug use. I recognise the privilege that my access to education and non-stigmatised identity has afforded me in being able to undertake this research with relative ease. With more time and resources my preference would have been to share the research skills I have been fortunate enough to gain throughout my education with PWUD, so that they could have had the opportunity to conduct the interviews and undertake the data analysis for this study.

3. RESULTS

TA was undertaken on the transcripts of the eight interviews conducted with the aim of developing an understanding of the experiences of peer workers. Four overarching themes and 16 sub-themes were discovered (see Table 1 below).

Table 1

Overview of Themes

Overarching Theme	Sub-themes	Participants' Quotes Featured
1. Changing and Enhancing Perceptions of People Who Use Drugs	- Changing Societal Perceptions - Changing Perceptions of Organisations and People Who Use Drugs - Changing Perceptions of Family - Changing Perceptions of Peer Workers Towards PWUD	P2, P3, P6, P8
2. A Unique and Valuable Role	- The Value of Lived Experience in Reaching and Connecting with PWUD - Feeling Valued by the Harm Reduction Organisation - Payment as a Recognition of Value	P1, P2, P3 P6, P7, P8
3. Positive Impact of Peer Work	- Lifestyle Changes - Reduction in Drug Use - Improved Mental Health and Wellbeing - Building Connection and a Sense of Belonging - Feeling Hope for the Future - Motivation to Continue	All participants
4. Fragility of Peer Work	- Fears Around Ending - The Need for Staff Support - Emotional Impact	P1, P2, P3, P5, P6, P7

In this chapter, an explanation of each overarching theme and sub-theme is provided, alongside direct quotes from the interview transcripts, which illustrate each sub-theme. An analysis which reflects on the meaning derived from the quotes is also provided.

3.1. Theme One: “People see you in a different light” - Changing and Enhancing Perceptions of People Who Use Drugs

Many of the participants were aware of the negative perceptions of drug users within society, which appeared to have been internalised into feelings of stigma and shame. Engagement in peer work allowed participants to demonstrate a different aspect of themselves, one of hard work, altruism and care for others. They believed that this had altered perceptions of them in the minds of others, including HRO staff, family, other PWUD and wider society. In the context of these altered perceptions, participants were able to embrace a new, more positive identity, enhancing their perceptions of themselves.

3.1.1. Sub-Theme One: Changing Societal Perceptions

Some of the participants spoke about their familiarity with negative perceptions of PWUD within society, suggesting they had internalised this stigma.

> “People just see drug users as trouble, leaving needles on the street, doing it in front of children, just putting everybody at danger.”
> **P3**

> “People see drug [use] …. it’s just a negative thing isn’t it, in society.”
> **P8**

> “Being a drug addict you're generally a nuisance in the community.”
> **P2**

Participants discussed feeling that their peer work allowed them to ‘give back’, enabling them to demonstrate a different aspect of themselves, one which focused

much more on care and altruism. Participants felt that this led to a change in how others perceived them and allowed them to internalise these more positive perceptions, enhancing their own sense of self.

> "We've done loads of clean-up [of syringes and drug paraphernalia]…. and the people we met were like so appreciative, they could not believe we were drug users. They couldn't believe it when they met us and they stood there speaking to us for like half hour and then we said, 'yeah we're users' and they're like, 'What?' and they couldn't believe it…."
> **P3**

> "A lot of people see drug users [as] quite a negative…. But for it actually to be seen in in a different light, that you're helping people…. I just think it's really great."
> **P8**

Doing peer work gave some participants a sense of normalcy and allowed them to embody a different identity to that of a 'drug user' or 'addict', which had previously only had negative connotations.

> "It feels like we've got a job and it just makes you feel like somebody who isn't using drugs, that goes to work and do all that."
> **P3**

3.1.2. Sub-Theme Two: Changing Perceptions of Organisations and People Who Use Drugs

Some participants discussed how involvement in peer work had led to a change in attitude towards them within the HRO and amongst other PWUD.

> "Now if you went to make a coffee and there's [HRO] staff members there, we'd sit and have a conversation, whereas before there wouldn't be a word said so just [a] positive thing I find's other members of staff are seeing and talking to us now."
> **P6**

"People that you're used to using with see you in a different light, 'cause like, if they've got any questions they come and ask you about 'em…. They're all happy about it as well, they all enjoy the fact that we're out and about and doing our thing."

P8

3.1.3. Sub-Theme Three: Changing Perceptions of Family

Others spoke about the ways in which their family viewed them had changed. Participants felt that families now had reason to be proud of them, when previously this may not have been the case, and this was a source of significant positivity.

"Well my family are really happy. [I told them] 'I've got a job now, I'm a volunteer drug worker'…. and my family are really proud of me."

P3

"It's good because family are proud that you're doing something positive."

P8

3.1.4. Sub-Theme Four: Changing Perceptions of Peer Workers Towards PWUD

Some participants discussed their commitment to the peer work, highlighting the difference between them and other PWUD who had been involved in the group initially, but subsequently dropped out. By demonstrating their higher levels of motivation and altruism, the participants appeared to be contrasting themselves with other PWUD who may not have had the same staying power, or only been motivated to engage in peer work because of the payment offered.

"The things we do during the month…. like doing the clean-up, we didn't get paid for none of that. We just done that off our own backs to be part of the [peer work] team."

P3

"Once the money stopped people stopped coming, apart from so many people, so we ended up using those people that were turning up without the

> money generally…. just because they're a little bit more enthusiastic about it more than anything, and if there's no money there they'll generally still be there."
>
> **P2**

3.2. Theme Two: "You're not just reading it out of a book, you've actually lived it" - A Unique and Valuable Role

All participants recognised the value of their own lived experience and deemed it essential to being effective in their role. This had a profound effect on the participants, who had previously internalised a narrative that, as drug users, they had nothing to offer. Peer work allowed them to acknowledge that they have a unique skillset which allows them to do work that would not be possible for non-drug users. This enabled the participants to see themselves as valuable and useful.

3.2.1. Sub-theme One: The Value of Lived Experience in Reaching and Connecting with PWUD

A number of participants spoke about their own experiences as drug users in helping them to know where PWUD were likely to be, and being able to approach them in a way that HRO staff would have struggled with. One participant spoke of being on "a level" with PWUD because he himself was a drug user and the people he was approaching were aware of this, and thus more comfortable with speaking to him (Participant 6). Participants felt that their status as drug users gave them privileged access to PWUD which professional staff would not have been given.

> "So our [HRO] mentors… I said they wouldn't have known where to go, they wouldn't have known what to do… it's because we've shown 'em where to go, what to do now and … they've got to speak to a lot more people because we were there and we made them feel more comfortable."
>
> **P3**

> "We can gain ….access to people…. we can reach people that members of staff wouldn't reach and if they did reach them the way the reaction would be,

between them or us, is totally different. Generally, we know these people and we can talk to them on a level. They know we use as well and so they know.… we're there for good basically."

P6

"It gives them confidence to open up a bit more if they see somebody that doesn't look as professional you know, sort of they come across…. to that person a bit better than somebody like dressed professionally or with a badge round them."

P1

One participant spoke of the ability to connect with those with more chronic drug use, who would likely be labelled as 'hard to reach'.

"I might talk to somebody who's been on treatment twenty times, he's been in and out of rehab, he's always in and out of prison…. he's heard it all before, seen it all before…. but he's only entertaining it 'cause I know him…. and he's entertaining me because it's me, but if it would've been, say a random worker from here, he'd have just been like 'no I'm good' and then walk away."

P2

Once participants had made contact with PWUD, they felt that their own experiences of drug use put them in a better position to offer support and advice and this was received more openly than it would have been had it come from HRO staff. Participants understood that they had wisdom that could be helpful to others.

"I think because I've been through it myself I can give advice, whether it's get to the hospital, what they should be doing, things like that."

P1

"It's lived experience, it's kind of because it's easy for me to talk to somebody about drugs when I've been and done the same drugs as they're doing."

P2

> "You're not just reading it out of a book you know, you've actually lived it, you've got lived experience. You know how it feels when you're withdrawing, you know how it feels when, you know, all the physical feelings that they're going through. You can't just speculate, you actually know what they're going through."
> **P8**

> "If they [PWUD] ask me anything I'd answer honestly…. which is why I think it works a bit as well 'cause…. they see it as it's more like having a natter to a friend almost, 'cause they know I use."
> **P6**

<u>3.2.2. Sub-theme Two: Feeling Valued by the Harm Reduction Organisation</u>

Some participants also spoke about how their own drug use allowed them to provide useful insights to the HRO, making them feel that they were a valuable asset.

> "I love being involved in the peer work because we can provide the other side to the coin…. we can give them [HRO] the inside knowledge, let's say, on what it's like to be a user and it's a two-way thing, the services are learning from the peers, just from us coming in each week and being involved and answering questions and making suggestions."
> **P7**

Participants had an understanding that they had a unique skillset and something to offer others, which made them feel worthwhile and useful.

> "I think it's knowing that, you know, years and years of using I've actually got a bit of experience to go and offer to people that are gonna understand what I'm saying. I find that positive."
> **P6**

“I think that what’s been nice is to feel wanted, that we’re part of something and…. we're valued for our opinion and our lived experience”
P7

3.2.3. Sub-theme Three: Payment as a Recognition of Value

Opinions differed on whether the value of peer work was adequately reflected in the remuneration provided by the HRO. Some participants shared that their initial motivation to get involved in peer work had been the payment offered, but that they had continued because they were very committed to the work.

“The idea of the money is what first entices you but when you actually realise how you’re how much you’re helping, and how much it’s helping you, it doesn’t really become about the money anymore.”
P8

“It was for the money why we came at first…. but the things we do during the month, like going out, like doing the clean-up, we didn’t get paid for none of that, we just done that off our own backs to be part of the [peer work] team.”
P3

Many participants spoke about the peer work not being like an actual job, because the payment offered was more of a token gesture than a wage. One participant felt that it was important that the peer work didn’t feel like a proper job as such, otherwise the lack of adequate payment would be problematic. Other participants regarded the peer work as a job, even if they felt they were undertaking it on a voluntary basis due to the limited payment.

“It’s good enough where I can squeeze it in around my life, but at the same time I don't want it to feel like work. Once you start [to] feel like it's work then you feel like I need compensating for it right, because it's work.”
P2

“It makes you feel like, even though we're only volunteers.… it feels like we've got a job.”

P3

For many participants, the benefits of peer work, other than the financial, provided enough motivation for them to continue, suggesting the role had significant meaning for them.

“We don't get paid, well we do once a month, but still it feels good. It just…. makes you feel good.”

P3

“It’s not about the money, I’m actually really enjoying it.”

P6

Some participants regarded payment as a way for the HRO to demonstrate that peer workers were valued and appreciated, contributing to their sense of worth.

“It is a nice reward actually. You know money’s tight and a bit of extra cash is always helpful, 'cause it's not voluntary, it’s almost like they’re showing us they appreciate what we are doing”.

P6

“We actually get paid…. which is brilliant, because we’re not undervalued, we’re actually treated, not necessarily like a full-time employee, but we’re treated with respect, that we're prepared to give up some of our time to help others let’s say.

P7

3.3. Theme Three: “It’s made me feel good about myself again” - Positive Impact of Peer Work

All of the participants spoke about the positive impact that peer work has had on their lives. For some there were demonstrable changes in their lifestyles, including with regards to their drug use. For others, the impact related more to how they felt, including reports of improved mental health and levels of motivation. Participants also described the social connections they had made with fellow peers, providing them with a sense of belonging, and a feeling of hope for the future, which had often been missing from their lives.

3.3.1. Sub-theme One: Lifestyle Changes

Many participants spoke about the changes that had occurred in their lives since they had become involved in peer work. Some participants discussed how their routines and levels of motivation had changed, whilst others referred to more practical changes, such as taking more interest in personal care and their environment.

> “My routine’s got a bit more stronger…. I’ve got into a good routine of getting up on a morning, I’ve got a drive to get here you know, like I want to be here.”
> **P1**

> “Even cleanliness, like [we] look after ourselves better and stuff”
> **P4**

> “All my flat’s been done, I’ve scrubbed my flat from top to bottom”
> **P3**

3.3.2. Sub-theme Two: Reduction in Drug Use

Some participants attributed the peer work to increasing their motivation to reduce or stop drug use. In other cases, participants’ use of drugs had reduced since being

part of the peer work intervention. Participants attributed this to having a sense of purpose and hope, and recognising that they did not want drug use to be a problematic part of their futures.

> "It's really strengthening my will to get clean and stay clean."
> **P1**

> "It kind of helped me to [be] more stronger, to be even completely clearing off the crack, even less and less every time, every month as well."
> **P5**

> "One thing, one massive bonus soon as I started doing this, my personal use has gone down so it's given me a bit of an aim you know."
> **P6**

> "I feel that this is a great opportunity for me to reduce or stop using, or just use my prescription medication. I was using every other day for years…. now I use literally once every week or couple of weeks or whatever."
> **P7**

3.3.3. Sub-theme Three: Improved Mental Health and Wellbeing

Some participants shared details of the mental health difficulties they had experienced and how peer work has helped with this. Doing something positive for others had given participants a sense of purpose and improved self-esteem.

> "Over 20 years I was using drugs I took hell of a lot out of my community, whether it be crime or just general being a nuisance….so just to put something back into it helps a little bit. Just for me personally, for my own mental health. Like it helps that I feel like at least that I'm trying to replace the things that I've taken."
> **P2**

> "It has helped me so much for my mental health."
> **P3**

> "One of the positives, I mean I suffer from depression as well, and a personal positive is that's been really okay like since I've started this, it's given me a personal boost and it's made me feel good about myself again."
> **P6**

> "The peer work definitely has played a part. I am in much more positive frame of mind."
> **P7**

3.3.4. Sub-theme Four: Building Connection and a Sense of Belonging

The majority of participants spoke about the social connection they had formed through peer work. One peer worker referred to it as being "part of a family" (Participant 3). Peer work provided a way to make connections and many participants spoke of feeling a sense of belonging.

> "You know just sitting and chatting with the lads on the group hearing, some of the stories…. I can't wait to get here on a morning and like just see everyone, hear everyone's voice y'know."
> **P1**

> "We've become a real tight-knit team and we actually look forward to it each week…. [we've] forged a friendship let's say which is based on similar goals and the peer work definitely has played a part, definitely."
> **P7**

> [We've] built like a quite good team here and we're working well together and it just makes you feel really good at the end of the day."
> **P6**

Participants shared a sense that they now felt part of something and were able to provide support to each other. This reduced feelings of isolation and increased their feelings of usefulness to others.

> "I feel part of something now which is nice, and made friends."
> **P8**

> "We're positive as a team and I think what's happened is that's rubbed off on to everybody."
> **P7**

> "I don't normally like doing group things and that, but I've really enjoyed doing this. It's helped me with my mental health, it's helped with me feeling that I'm giving back to the community, that I'm there for if somebody needs some(one)."
> **P3**

3.3.5. Sub-theme Five: Feeling Hope for the Future

Some participants spoke of feeling a sense of hope for the future, in contrast to a lack of hope they had experienced before their involvement in peer work.

> "Before I thought pretty much that's it for me, my life's done, but it's opened some doors where I can possibly see myself with a bit of a future in something now, and that's positive."
> **P6**

> "It's really helped me get back to thinking about the future rather than the past…. I've got an opportunity to do something different, I'm gonna take the opportunity if I can."
> **P7**

3.3.6. Sub-theme Six: Motivation to Continue

Hope for the future included a desire to continue engaging with peer work and deliver different harm reduction interventions. This suggests both an enjoyment of the work as well as it being something that offers the participants hope and motivation for the future.

> "I'm looking forward to getting out in the [harm reduction outreach] van…. I can't wait to get out doing harm reduction."
> **P1**

> "Every time we have a meeting there's something new to do, or someone's got a new idea."
> **P2**

> "I wanna do more with the group."
> **P3**

> "Personally, I'd like to try and carry on, I'd like to try and do something after."
> **P6**

One participant discussed their motivation to continue with peer work stemmed from knowing PWUD who had died from heroin overdose and their desire to be involved in something that could prevent this from happening to others.

> "By the time it started, a couple of people had died of overdoses that all of us knew, so that sort of determined me a bit more. If someone had been there with Naloxone it might have been a different story so I mean if we can dish out a hundred [Naloxone] pens and only one person uses them, it's worth doing."
> **P6**

3.4. Theme Four: "I don't want it to finish because it has helped me so much" - Fragility of Peer Work

A number of challenges regarding the peer work suggested that it was fragile and susceptible to disruption or potentially closure. This seemed to evoke anxiety in many of the participants, who placed great value on the work.

Some participants described the personal difficulties involved in undertaking work that could be emotionally challenging at times, suggesting such work needs to be well supervised to avoid distress among peer workers. There was a strong sense of HRO staff being crucial to the establishment and ongoing operation of peer work, which may raise questions about its sustainability.

3.4.1. Sub-theme One: Fears Around Ending

Participants who had been involved in the peer work for a longer period discussed fears of enthusiasm dwindling, giving a sense that it might not survive. Participants felt concerned about this, demonstrating the value they placed on the work.

> "It's not new no more, so you know when something's new like it's all good, but then novelty wears off a bit, that's what's kind of happened and I feel like if I stop going then it feels like I've lost it and then it'll fall away. And then when people stop going it's like 'oh well we're gonna have to sack that now, it's pointless'."
>
> **P2**

> "I don't want [peer work team] to finish because it has helped me so much for my mental health, it gets me to interact with people, I feel like I'm giving back, I really enjoy it."
>
> **P3**

3.4.2. Sub-theme Two: The Need for Staff Support

All the participants discussed how staff of the HRO were integral to the running of the intervention, and without them, it might fail. This might suggest a lack of

confidence amongst the participants in their ability to organise and manage the work themselves, despite this being the ultimate intention of the HRO in both sites.

> "The [peer work team] manager….runs the group and lets us know information and what we need to be doing, gives us appointments."
> **P1**

> "When [Consultant who supported the initiation of the group and provided training] did leave us, we was kind of lost…. not knowing who's gonna be taking over the team and obviously where we gonna be ending up and how we are gonna be…. a lot of people was kind of lost."
> **P5**

> **"**Because of Covid and staff shortages and things like that, we've only been [able to] meet once a month."
> **P2**

> "The only bad thing is we don't have enough supervision contacts and doing more stuff, that's the only bad thing, that we're not doing enough I don't feel like, I wanna do more with the group."
> **P3**

3.4.3. Sub-theme Three: Emotional Impact

Some participants also discussed some of the more challenging aspect of peer work, which may have contributed to feelings of fragility. This suggested there is a need for high levels of resilience and adequate supervision to prevent peer workers leaving the role and jeopardising the intervention.

> "When you're having a rough day and somebody stops you, 'Here y'are mate, I've got this issue man', and you're not feeling like stopping and chatting and going through what he was wanting you to go through like in the head, and

you feel horrible saying to the person, ‘look mate I’m sorry but I can’t deal with this today or I can’t deal with this now’. That messes the head up a little bit.”
P1

“I've had someone be quite aggressive with me and I found that awkward to deal with.”
P6

“The only negative thing was the initial, not fear but apprehension, of how will we be perceived, will we be accepted, will people see us [and] think ‘oh they’re someone who’s sold out or someone who’s working for them [HRO]’.”
P7

4. DISCUSSION

4.1. Chapter Overview

This study aimed to understand the experiences of peer workers with living experience of drug use who are engaged in harm reduction work. This chapter will first answer the research questions presented in the Introduction, with reference to relevant literature and concepts. A critical appraisal will follow, which will address issues of reflexivity and consider the quality, strengths and limitations of this research. The clinical, service level and policy implications of this research, as well as recommendations for future research, will also be explored.

4.2. Research Questions and Summary of Findings

4.2.1. What harm reduction interventions are delivered through peer workers?

The accounts given by participants across the two sites revealed three main harm reduction interventions being delivered by peer workers. These will be discussed in relation to the harm reduction principles outlined in the Introduction.

4.2.1.1. Naloxone Distribution: All participants had been initiated into peer work through training on the administration of Naloxone. The principles of harm reduction are well embodied by the distribution and administration of Naloxone. It implicitly demonstrates an acceptance of illicit drug use and a commitment to reducing its harms. It also serves to improve quality of life rather than encourage reduction or cessation of drug use, and provides an intervention in a non-coercive and non-judgemental manner. Peer-to-peer Naloxone distribution is a cornerstone of a number of peer work programmes employing active drug users in the US and Canada (e.g. Faulkner-Gurstein, 2017; Fleming et al., 2019; Kolla & Strike, 2019; Marshall et al., 2017).

Participants of this study were trained in the administration of Naloxone and basic life-saving first aid and then tasked with sharing this knowledge, and kits containing

Naloxone and information on basic first aid, with other PWUD in the local community. Peer-to-peer Naloxone programmes rely on active drug users having privileged access to other users and the areas where drugs are used, and the trust of fellow PWUD (Southwell, n.d). The results of the current study demonstrate that participants had privileged access to PWUD. As detailed in *Sub-theme 2.1: Reaching and Connecting with PWUD*, participants described their ability to locate PWUD through their social networks or due to knowledge of where they tended to congregate in their local area. Participants also described PWUD being more receptive to their offer of help than they would have been had HRO staff approached them, supporting findings of a recent review into the effectiveness of peer distribution of Naloxone (ACMD, 2022).

4.2.1.2. Offering harm reduction advice: Another area of intervention that peer workers were involved in was the offering of harm reduction advice and support to PWUD. This ranged from advising someone to attend hospital to get treatment for a drug-related wound, to offering support to someone experiencing heroin withdrawal. Participants had received training in the basics of harm reduction, but were not provided with a protocol or formal structure regarding the information they should offer to peers. However, they discussed how their lived experience helped them to feel qualified to play this role. As highlighted in *Sub-Theme 2.1: The Value of Lived Experience*, peer workers considered other PWUD to be more receptive to the advice they offered because of their shared status as drug users. Participants demonstrated the harm-reduction principle of being non-judgemental and alluded to the fact that they were more likely to be trusted by other PWUD because they themselves also use drugs. This has been highlighted as an essential foundation for encouraging PWUD to connect with services within a context of distrust that is exacerbated by the criminalisation of drug use (Le et al., 2015; Pauly et al., 2021). Building trust with services helps PWUD to feel more comfortable accessing them (Edland-Gryt & Skatvedt, 2013). Research with PWUD receiving interventions delivered by peer workers demonstrates that they feel they will be better understood by a peer worker than a professional. As such they feel more comfortable and more able to be open about their experiences (Kennedy et al., 2019).

4.2.1.3. Clearing Drug-Related Litter: Participants from one of the study sites were involved in the clearing of drug-related litter, including needles and syringes. Clear-up activities can be said to constitute a harm-reduction intervention, in that they are an attempt to minimise the harmful effects of drug use on the wider public, who find drug-related litter problematic.

Research in Scotland on public perceptions of litter found that drug-related litter elicited the greatest concern and most significant emotional reactions amongst research participants, irrespective of how often it was encountered (Zero Waste Scotland, 2015). A recent report highlighted that PWUD were aware of negative public attitudes towards drug-related litter and were motivated to find solutions (Room, 2005). In *Sub-theme 1.1: Changing Societal Perceptions*, a participant shares details of how their involvement in drug-related litter clear-ups challenged negative opinions previously held by the local community, suggesting this type of harm reduction intervention, which benefits communities, might be the most effective in challenging stereotypes and public stigma directed at PWUD. This finding supports research from Canada which demonstrates that where drug user groups have engaged in needle and syringe clean-ups of their local neighbourhood as part of a wider array of improvement activities, they have had a positive impact (Jozaghi, 2014; Kerr et al., 2006).

<u>4.2.2. What are the views and experiences of peer workers in harm reduction services?</u>

All of the participants regarded their peer work to be beneficial and the majority of experiences of peer work were described in positive terms. Many participants spoke about their enjoyment of the work and their motivation to continue. However, some challenges associated with the work were also expressed. The experiences of peer workers in the current study will be discussed within the context of existing literature on harm reduction interventions delivered by peer workers with living experience of drug use.

Positive experiences of peer work

4.2.2.1. Changing perceptions: The participants' accounts of their experiences demonstrated how others' perceptions of them had become more positive as a result of their peer work, as demonstrated in *Theme 1: Changing and Enhancing Perceptions of People Who Use Drugs*. Participants considered that they were now perceived in a more favourable light by members of society, members of staff at the HRO which employed them, and amongst other PWUD. Participants described family members who felt proud of them as a result of their peer work, which supports similar findings in a study by Marshall et al. (2017). Whilst other studies have briefly highlighted peer workers associating their work with an ability to change the status quo (Austin & Boyd, 2021), change the way that others perceive them (Latkin, 1998) or construct a new identity beyond that of the irresponsible drug addict (Weeks et al., 2006), the ways in which peer work can alter societal perceptions of PWUD has not been a particular focus of the existing literature, so the current study offers an opportunity to explore this in more detail. The impact of others' changing perceptions on the well-being of PWUD is discussed in further detail below.

4.2.2.2. Feeling valued: In *Theme 2: A Unique and Valuable Role*, participants highlighted a number of positive experiences of peer work. As demonstrated in *Sub-Theme 2.1: Reaching and Connecting with PWUD*, participants were able to recognise that because of their own drug use, they had privileged access to other PWUD. By vouching for HRO staff, participants facilitated access to services amongst PWUD who may otherwise have avoided them. This supports previous research which highlights the role that peer workers play as a "bridge" between PWUD and service providers (Chang et al., 2021; Pauly et al., 2021; Stengel et al., 2018).

The findings of the current study indicate that participants felt they could provide advice with authority because they had experienced similar issues, giving them the sense that they have something to offer. There was recognition that their drug use furnished them with the skills needed to be successful in the role, which is a theme that has been highlighted in other research on peer work (Austin & Boyd, 2021; Bardwell et al., 2018; Kennedy et al., 2019).

Participants had a sense that their “inside knowledge” on drug use was valued by the HRO, as highlighted in *Sub-theme 2.2: Feeling Valued by the Harm Reduction Organisation*. The stigma associated with drug use can result in PWUD feeling devalued (Muncan et al., 2020). The contrasting feeling of being valued by the HRO appears to have had a profound effect on participants, who describe how good they feel as a result of their involvement in the work. An existing study has suggested that peer workers can feel that their involvement in HROs is tokenistic when their experiential knowledge is not utilised (Greer et al., 2021) but the participants of this study gave examples of being directly consulted about their experiences by the HRO, which gave them the sense that their contribution is meaningful. Participants recognised that they are valuable to the HRO precisely because of their drug using experience, not in spite of it, which may mitigate a sense of shame that is often reported by PWUD (Rhodes et al., 2007; Snoek et al., 2021).

4.2.2.3. Personal changes: In *Theme 3: Positive Impact of Peer Work*, participants discuss the positive ways in which peer work has influenced their lives. In *Sub-Theme 3.1: Lifestyle Changes*, participants reported positive changes in their lifestyle, such as taking better care of themselves and their living environment. One participant credited peer work with an improved routine, which supports findings of a peer work study undertaken in Canada (Bardwell et al., 2018). The capacity for behaviour change has been linked to feelings of hope (Bernays et al., 2007). Participants discussed how peer work had given them a feeling of hope and allowed them to think about their future, as demonstrated in *Sub-theme 3.5: Feeling Hope for the Future,* which may have increased motivation to make behavioural changes. There is little discussion of hope and its relationship to peer work in the existing literature, with hope for the future mentioned in only two studies (Marshall et al., 2017a; Weeks et al., 2006).

The ability of participants to aspire to future goals was also demonstrated in *Sub-theme 3.6: Motivation to Continue*, where participants expressed a desire to continue with, or have increased involvement in, harm reduction interventions offered by the HRO. This increased motivation may be the result of greater levels of self-worth and

pride experienced by peer workers as a result of their work. Existing research into peer work suggests that the pride that peer workers take in their work, and the sense of belonging it engenders, act as motivators to continue (Pauly et al., 2021).

Reduction in drug-use and increased motivation to reduce drug-use was a common theme in the findings as demonstrated by *Sub-Theme 3.2: Reduction in Drug Use*. Numerous studies on peer work delivered by active drug users have reported similar findings, with participants reporting reductions in their use, or taking more care in how they use (Bardwell et al., 2018; Marshall et al., 2017a; Penn et al., 2016; Tookey et al., 2018; Weeks et al., 2006). This demonstrates the harm reduction effects of peer work on both recipients of the interventions and the peer workers themselves. A further exploration of the ways in which peer work may contribute to a reduction in drug use is provided below.

Participants discussed their mental health in relation to peer work. A number of participants reported improved mental health, as highlighted in *Sub-theme 3.3: Improved Mental Health and Well-being.* This finding appears to be in contrast with a number of existing studies which highlight the negative mental health experiences of peer workers. However, it should be noted that negative experiences are usually reported by peer workers operating OPS where they are frequently exposed to traumatic events, including the deaths of fellow PWUD, some of whom are known to them (Fleming et al., 2019; Kennedy et al., 2019; Kolla & Strike, 2019; Olding et al., 2021). The fact that participants in the current study were not engaged in such work, and thus not exposed to such significant levels of trauma, may explain why fewer negative mental health experiences were reported.

Peer work was highlighted as a way in which participants could foster connection and experience a sense of belonging, as demonstrated in *Sub-theme 3.4: Building Connection and a Sense of Belonging.* The stigma associated with drug use often results in PWUD being ostracised and marginalised (Room, 2005). The relationship between drug use and loneliness is well documented (see Ingram et al. (2020) for a systematic review of the literature) and existing literature on peer work highlights experiences of exclusion amongst PWUD (Faulkner-Gurstein, 2017). Participants of the current study described building friendships with other peer workers, which both

made them feel good and motivated them to continue their involvement in the work. These findings support existing research on the role of peer work in fostering connectedness amongst PWUD (Bardwell et al., 2018; Marshall et al., 2017a).

Negative Experiences of Peer Work

Participants highlighted some aspects of peer work which they found more challenging.

4.2.2.4. Fragility: An area of potential challenge for peer workers was highlighted in Theme 4: Fragility of Peer Work. Participants experienced anxiety that the peer work programme might end as a result of either peer workers losing motivation or the HRO not providing sufficient staff to facilitate the peer work groups. The HRO would eventually like the peers to be able to run the groups themselves, giving them autonomy over decisions on what interventions to provide and the organisation of their work.

Whilst the participants have had formal training in many areas related to their peer work, such as first aid and Naloxone distribution, their responses suggested that they were still very much reliant on direction from HRO staff regarding their work on a day-to-day basis. This may reflect a need for more dedicated support to build the confidence of peer workers in the daily operation of the programme so that they feel less reliant on staff. In a study of peer workers in Canada, Greer et al. (2021) highlighted how a lack of role support for peer workers can result in feelings of uncertainty and inadequacy about their roles. Peer workers in the study who received adequate role support expressed feeling empowered and valued by their employer.

A reliance on staff support may also reflect a lack of clarity regarding the peer work role. Mamdani et al. (2021) highlighted how an absence of permanent contracts or clear job descriptions led to a lack of role clarity, which peer workers found challenging. The lack of role clarity has been associated with feelings of disempowerment amongst peer workers (Greer et al. 2021). Although participants in the current study did not refer explicitly to role clarity, their reliance on HRO staff to guide them in their work suggests this may be an issue. This may be exacerbated by

the peer work groups in the current study being nascent and not yet well-established within the HRO. The use of job descriptions and clear outlining of expectations may help to mitigate some of these concerns.

A lack of formal structure to the role may also have contributed to some of the emotional impact of the peer work, as highlighted in *Sub-Theme 4.3*. A lack of formality in the role may have led to blurred boundaries about the remit of the peer work role. One participant highlighted the difficulty of being approached by PWUD at a time when they did not feel they were in the right frame of mind to offer help. This reflects some of the difficulties highlighted in other research, where peer workers describe feeling that they are always 'on-call' (Masese et al., 2022; Olding et al., 2021; Stengel et al., 2018). This, in turn, may have led participants to require more intensive staff support, as they sought to build skills and confidence in managing the more challenging aspects of the role.

The context in which peer workers operate may also contribute to challenging experiences of the work. Discussing experiences of burnout amongst community workers, Reynolds (2011) argues that those working to support vulnerable populations are at risk of experiencing burnout because they operate within a context of social injustice. Reynolds (2011) believes that burnout is not caused by the demands of service users themselves, but by a society which marginalises them and denies or abuses their human rights. Workers offering support to such service users face structural barriers to doing so, leading to frustration and hopelessness which can result in experiences of burnout.

As previously discussed, PWUD are a highly marginalised population who suffer the consequences of an apparent unwillingness of governments and social systems to adequately respond to their needs. By working with this population, peer workers are at risk of encountering social injustice in their work on a regular basis. In addition, peer workers' own status as PWUD means that they may also experience this social injustice in their own lives outside of work, making their role all the more challenging and exacerbating their risk of burnout. This indicates a need for organisations employing peer workers to ensure there is adequate support and supervision available to them.

Reynolds (2011) has argued that burnout resulting from social injustice can be resisted by justice-doing, referring to attempts to “change the real conditions of people’s lives rather than helping them adjust to oppression” (p. 29), which may include participation in direct action activism. Whilst HROs may seek to empower peer workers to engage in justice-doing, they must ensure that engagement in activism does not overburden peer workers, who may already be having to manage the weight of societal oppression in both their work and personal lives.

The potential loss of motivation amongst the peer work team that some of the participants highlighted as a concern may in part relate to issues around payment. In *Sub-Theme 1.4: Changing Perceptions of Peer Workers* one participant suggested that PWUD who had initially been involved in the peer work group stopped coming when payments became less frequent following the initial training period. Issues regarding payment are discussed in more detail below.

Experiences of payment

The ways in which participants experienced the payment they received and the meaning they attributed to this varied, as highlighted in *Sub-Theme 2.3: Payment as a Recognition of Value*. The mixed responses may have been, in part, due to differences in payment policies between the two sites.

When the peer work groups were established, peer workers were asked to attend trainings and they received a daily stipend for attendance. Following this, the amount and frequency of payments decreased. In site one, participants received £25 in cash when they attended a monthly supervision session of approximately two hours. They were then expected to undertake peer work between the supervision sessions, although there was not an expectation about minimum hours worked. In site two, peer workers worked for three hours each week on a set day (although they may have offered harm reduction advice or distributed Naloxone outside of these hours) for which they received £30 in cash. Their three-hour shift usually consisted of harm reduction work and supervision. In site two, peer workers also received payment to cover their travel expenses.

These different approaches to payment appeared to influence how participants conceptualised peer work. Participants from site one considered their role to be voluntary rather than a job, whereas participants in site two did not see their peer work as voluntary and considered it to be more akin to paid employment. Participants in site two experienced payment as a reflection of the organisation's appreciation of their work, which had the effect of making them feel valued. Participants from site one did not express similar views, which suggests that the lower and less frequent payment was not experienced as an expression of value in their work, although they did not consider the low rate of payment to be devaluing, as has been suggested in another study on peer work in Canada by Greer et al. (2020).

Participants from both sites discussed how they had initially been incentivised to get involved in the peer work groups because of the payment offered, but they had continued their involvement because of the non-financial benefits of the work, such as increased feelings of worth and pride. Some participants inferred that their enjoyment of the peer work was so beneficial that they would be willing to continue it without payment, echoing existing research from Canada where peer workers reported payment to be an initial motivator but also expressed that, having been involved for some time, they would be willing to work without payment (Bardwell et al., 2018). However, it contrasts with the majority of existing research that highlights low rates of payment as a major source of dissatisfaction amongst peer workers. Studies by Mamdani et al. (2021) and Olding et al. (2021) found that low payment rates were associated with burnout of peer workers.

Although participants of the current study did not discuss the payment they receive in relation to the salaries of other staff within the HRO, the discrepancy between the payment, and employment terms, of peer workers versus salaried staff within the HRO may be relevant to the future operation of the peer work teams.

Discussion on the utilisation of lived experience in mental health research and services has suggested that low levels of remuneration and the use of temporary payroll arrangements for people with lived/living experience can infer a lack of value placed upon their contributions. Instead, academic, clinical and professional knowledge is favoured, with the contributions of 'professionals' afforded more

credibility and influence than those with lived/living experience (Okoroji et al., 2023). Okoroji et al. (2023) argue that when people with lived/living experience are expected to share their knowledge, often expending significant emotional labour, without adequate recognition and remuneration, there is a risk of them becoming exploited by the organisations and systems that purport to value them (Okoroji et al., 2023).

Whilst participants of the current study seemed tolerant of their current stipend, one did suggest that if the peer workers were asked to undertake more work, the current rate of payment would be considered insufficient. Participants may be comfortable with the current stipend because their involvement in peer work is still relatively novel and they are finding the workload manageable. Should the peer workers take on more work or greater responsibility, there will need to be consideration as to how they are remunerated in order to mitigate risks of exploitation and the potential for burnout, which could lead to their withdrawal from the work. However, this may have implications for the HRO which, with a limited budget, may need to make decisions about how to distribute scarce resources, something that has been highlighted as a challenge in a study on peer work in Canada (Penn et al., 2016).

4.2.3. How does delivery of harm reduction interventions affect the mental health, well-being and self-perception of those delivering them?

4.2.3.1. Internalised Stigma and Increased Self-Esteem. In *Theme 1: Changing Perceptions of People Who Use Drugs,* participants referred to the ways in which others' perceptions towards them had changed. Participants reported experiencing a different response from members of the public, HRO staff, other PWUD and their family members as a result of their involvement in peer work. Participants spoke of others being appreciative of their work, seeing them in a different light and feeling proud of them. This appeared to have the effect of enhancing the self-perception and self-esteem of participants. The impact of changing perceptions on self-esteem can be understood in the context of the high levels of stigma that PWUD experience.

The stigmatisation of PWUD is well documented; a literature review of 185 studies found evidence of negative attitudes towards PWUD amongst the public and

healthcare professionals (Lloyd, 2013). Narratives surrounding PWUD are usually negative, exacerbated by language often present in hostile media reporting regarding PWUD (UKDPC, 2010b; Atkinson & Sumnall, 2020; van der Bom et al., 2018) and in the wording of Government legislation (HM Government, 2023). PWUD themselves can also stigmatise other drug users who they consider to be ‘lesser’ than themselves (Simmonds & Cooper, 2009). Experiences of stigma amongst PWUD have been associated with lower self-esteem and higher levels of anxiety and depression (Birtel et al., 2017).

Internalised stigma is an emotional and cognitive process that occurs when a person comes to believe that the stigma they experience is deserved (Fraser & Treloar, 2006) and come to hold the same negative perceptions about themselves as others, resulting in feelings of shame and low self-worth (Goffman, 1963). Research has demonstrated higher levels of internalised stigma amongst PWUD (Cama et al., 2016). The participants in this study demonstrated internalised stigma. For example, in *Sub-theme 1.1 Changing Societal Perceptions*, a participant refers to themselves as a “nuisance” who has “taken a hell of a lot out of their community”, suggesting a negative view of themselves. Internalised stigma is associated with depression and diminished self-esteem (Cama et al., 2016).

In *Sub-Theme 3.4: Building Connection and a Sense of Belonging*, participants discussed the social connection and sense of belonging they had experienced from being involved in peer work. Research has demonstrated that attachment to a community can mitigate against the effects of internalised stigma and increase well-being amongst PWUD (Brener et al., 2021). Being connected to those with similar experiences is a source of social support and can also help to highlight the social capital that exists within the group. In the case of peer workers, this capital is their lived experience, which allows them access to PWUD and affords them legitimacy when offering support and advice. Such connections are arguably even more important for PWUD who are amongst the most marginalised and excluded in society (Wesselmann & Parris, 2021).

By differentiating themselves from other PWUD who are not involved in peer work, participants in this study may also have succeeded in enhancing their own self-

esteem through a process of ‘downward comparison’ (Wills 1981). It has been suggested that being a victim of stigmatisation can motivate inter-group comparisons, with the stigmatising person who considers themselves to be part of the ‘in-group’ experiencing enhanced self-esteem (Tajfel & Turner, 1985). *Sub-Theme 1.4: Changing Perceptions of Peer Workers Towards PWUD* highlights the differentiation that participants make between themselves and other PWUD. Participants discuss how others who started the peer work programme with them have since dropped out, whilst they have remained, allowing them to demonstrate their tenacity and commitment in comparison to other PWUD. By talking about working “off their own backs” they also demonstrate a level of altruism that they may consider to be lacking in those who have not continued their involvement with the work. The participants are able to see themselves as a group doing something of value compared to other PWUD who have decided not to be involved. In doing so, this may allow participants to consider themselves with higher regard, distancing themselves from the negative stereotypes of PWUD and thus perceiving themselves more positively.

4.2.3.2. Building recovery capital and reduction in drug use: A reduction in drug use or increased motivation to reduce drug use was reported by participants in *Sub-Theme 3.2*. It is not possible to attribute drug reduction solely to involvement in peer work. Some of the participants who reported reduced drug use were also receiving other harm reduction interventions, including medication, which may have contributed to this reduction, and there may have been other factors involved that were not explored in this study. However, reduction in drug use has been reported in many other studies of active drug users engaged in peer work (Bardwell et al., 2018; Marshall et al., 2017; Penn et al., 2016; Tookey et al., 2018; Weeks et al., 2009) suggesting that peer work does have an influence on drug use.

The concept of recovery capital can be used as a framework to understand how peer work may have contributed to reduction in drug use. Recovery capital, conceptualised by Cloud and Granfield (Cloud & Granfield, 2001; Granfield & Cloud, 1999), is based upon research of people who were able to give up their drug use without the aid of formal treatment or mutual help (Cloud & Granfield, 2008). When asked about the strategies they had used in order to stop using substances,

research participants referred to engaging in alternative activities and relying on supportive relationships amongst a number of other resources. Cloud and Granfield sought to explicate these resources, referring to them as capital. They identified four types of capital that had aided successful cessation of substances, namely social, physical, human and cultural capital. A fifth component, collective recovery capital, was later added by Best and Laudet (2010).

In *Sub-Theme 3.4: Building Connection and a Sense of Belonging*, participants described forging friendships with fellow peer workers and feeling like they were part of a family. Involvement in peer work also enhanced participants' relationships with others, such as family members, HRO staff, and other PWUD. This suggests that involvement in peer work enabled participants to build social capital, defined as resources that are a result of relationships. Cloud and Granfield argue that membership of a social group provides individuals with information, supports and resources which they can call upon as they attempt to resolve problems. Social capital gives access to emotional support and opportunities that may support drug cessation efforts and can thus aid recovery (Cloud & Granfield, 2008).

The connections that participants have made with their fellow peer workers and the HRO staff may also have given rise to collective recovery capital, defined as community resources that support the recovery process. As peers begin to enter into their own phase of recovery and take up new opportunities, they may create a "recovery contagion" (Best & Laudet, 2010, p. 6) where others are encouraged to do the same. Participants of the current study discussed their positive mind-set rubbing off on their fellow peer workers, and feeling a sense of working towards shared goals. This suggests that collective recovery capital is being built within the peer work teams, which may act as motivation for individuals to work towards improving their health and well-being through drug use reduction.

As described in *Sub-theme 2.1: The Value of Lived Experience in Reaching and Connecting with PWUD*, involvement in peer work supported participants to recognise the skills they possessed in engaging and supporting PWUD because of their own experiences of drug use. Participants also received formal training and

developed communication and problem-solving skills through their day-to-day work. This may have helped participants to develop human capital, defined as inherited and acquired skills, aspirations and personal resources and positive physical and mental health. In *Theme 3 Positive Impact of Peer Work*, participants described more positive mental health since being involved in peer work and also demonstrated that the work had given them aspirations and hope for the future. This may have served to motivate participants to reduce their drug use in order to be able to continue, or increase, their involvement in peer work.

In *Sub-Theme 1.1: Changing Societal Perceptions*, one participant talks about how they consider their peer work to be like a job, which allows them to feel 'normal' and the same as non-drug users. Having a job is considered to be a social norm in UK society and being able to meet this expectation allows peer workers to share in social norms. This contributes to cultural capital, which refers to the extent to which an individual's values and beliefs align with social norms. Cloud and Granfield (2008) argued that sharing values and norms with conventional society is advantageous for overcoming addiction.

The area of recovery capital where peer work seems to have less impact is in the development of physical capital, which refers to tangible assets, such as income or housing stability (Penn et al., 2016). This is largely because the modest stipend peer workers received was not considered to be substantial enough to generate a significant increase in participants' tangible assets. Other research has demonstrated peer work leading to homeless peer workers securing housing as they continued their peer work, which was attributed to more 'managed' drug-use and improved well-being (Penn et al., 2016). Similar findings were not reported in the current study although this may be due to the short period of time the participants have been involved in peer work.

The above findings demonstrate the ability of peer work to increase recovery capital for PWUD and may explain why participants of this study have been able to reduce their drug use since their involvement in peer work. The extent to which peer work can be said to contribute to recovery is dependent on the definition of recovery used. If the broader definition, discussed in the Introduction, of "voluntarily-sustained

control over substance use which maximises health and well-being and participation in the rights, roles and responsibilities of society" (UKDPC, 2008a, p. 6), is used then the findings above suggest that peer work can contribute to the recovery of active drug users, echoing findings of a similar study in Canada (Penn et al., 2016). If recovery is equated with total abstinence then this study does not demonstrate peer work contributing to recovery as none of the participants had stopped their drug use completely. The recovery capital model itself makes no assumptions about abstinence (Faulkner-Gurstein, 2017). Cloud and Granfield acknowledge that recovery capital can also be available to those who continue to use substances, and may buffer the negative effects of those substances so that an individual is insulated from negative repercussions of their substance use (Cloud & Granfield, 2001; Granfield & Cloud, 1999).

4.3. Reflexivity

My main areas of reflection whilst undertaking this research were with regards to power and status. Issues arising from my relative power as a clinical psychologist and researcher, and my status as a non-drug user are explored below.

It has been argued that within qualitative research there is an inherent power imbalance between researcher and research subject (Råheim et al., 2016) characterised by the interviewer determining the topics that will be discussed, setting the agenda and controlling the interview schedule (Brinkmann & Kvale, 2005; Kvale, 1996). When analysing the data the researcher then has control and power over the data, becoming the 'storyteller' who recasts the story told by the participant into a 'new' context (Karnieli-Miller et al., 2009).

I was particularly aware of how this power imbalance might be experienced by the participants of this study, being cognisant of the disempowered status of PWUD in British society (Scottish Drug Death Taskforce, 2020) and my relative power as a trainee clinical psychologist. Because of this, it felt important to ensure that participants did not feel coerced into participating in the research. I tried to mitigate the risk of this by first engaging the HRO employing peer workers and asking them to

have a discussion with potential participants to gauge their collective interest. I presumed that potential participants may feel more comfortable raising concerns with their peer work supervisor than they would with me, providing them with more opportunity to decline if they wanted to. However, there is a risk that it may actually have put additional pressure on the peer workers, who may have felt there was an organisational expectation for them to participate. This may have been compounded by participants being told that their participation could be considered as part of their peer work for that week or month, thus making it feel like a work obligation.

I would have liked to have spent more time with the participants before the interviews to try and establish a basis of trust, which may have helped to prevent any risk of participants feeling obliged to take part. However, even with a short amount of time to build rapport, many of them felt able to communicate concerns to me, such as wanting to ensure the interviews were not too long in duration. This provided me with some degree of confidence that, if there had been any issues, they would have felt able to let me know. By holding the interviews at the offices of the HRO where they were employed, the peer workers also had direct access to their supervisors before and after the interviews, and could have raised any concerns with them had they felt it necessary.

Ultimately, peer workers who did not want to participate were able to simply not attend their scheduled interview time. This did happen in three cases, suggesting the peer workers were able to exercise their free will in deciding whether or not to participate. I also encouraged participants to contact me or their supervisors at the HRO if they had any concerns or misgivings about the research following the interviews, but this did not occur.

A status differential was inherent in the research by virtue of the fact that I am not a person who uses drugs and I am conducting research with people who do. Research has demonstrated that PWUD have reported feeling like “guinea pigs” when participating in research studies, expressing feelings that, by virtue of being a drug addict, they are seen as “something to be observed” (Bell & Salmon, 2011, p. 7). I tried to mitigate this by making participants aware of my position as a harm reductionist and ensuring they understood that the intention of the research was not

voyeuristic but an attempt to better understand experiences of peer work by active drug users as a way to advance this as a harm reduction intervention.

When participants spoke about their willingness to take part, they referred to their hopes that the research would highlight the benefits of peer work, and lead to an expansion of peer work programmes in the UK. This research has demonstrated many benefits of peer work, including its ability to foster changes in perceptions of PWUD, and to demonstrate to PWUD that they are valued. This increases their feelings of self-esteem and self-worth and can influence changes in their behaviour, including reduction in drug use. It has also highlighted how utilising the principles of harm reduction can be effective in facilitating access to services for PWUD and demonstrating the beneficial role that PWUD can play in providing harm reduction interventions. A number of recommendations for the ways in which services and policies can build upon the findings of this study have also emerged. However, knowing that the UK is hostile to harm reduction interventions and policies, even when there is a strong evidence-base for their effectiveness (Stevens, 2019), has made it challenging to be a custodian of the aspirations of the study participants.

My position has always been that drug policy in the UK is ideological, rather than evidence-based, with PWUD scapegoated to detract from a focus on the structural issues that cause problematic drug use. This has been achieved by drug policies that seek to criminalise PWUD and the use of hostile and demonising rhetoric by both politicians and the mainstream media. The recent introduction of the Government's 'Anti-social Behaviour Action Plan' (HM Government, 2023) provides a contemporary example of this. It has been hard not to feel demoralised knowing the current UK context is one which is prepared to disregard well-evidenced solutions in response to the harms caused by drug use, although recent developments provide some hope that harm reduction approaches may become part of the UK's drug response. In March 2023, Belfast City Council voted in favour of the establishment of an Overdose Prevention Centre (OPC) in the city, although a change in the law will be required before work can begin on its development (long, 2023). Peer workers have been involved in the operation of OPCs in Canada and the opening of a UK OPC may present an opportunity for UK peer workers to be involved in the establishment and running of the service.

Whilst undertaking this study, it was important to strike a balance between giving participants a sense that their participation in the research would be useful, and this was not simply an exercise in voyeurism, whilst also managing expectations about the impact that this, or any other research, will have in the current UK policy context.

4.4. Research Quality

Spencer and Ritchie's (2011) Quality Assurance Guiding Principles of contribution, credibility and rigour and Braun and Clarke's (2022) best practice guidelines for reporting reflexive TA were used to evaluate the quality of this research.

4.4.1. Quality Assurance Guiding Principles

4.4.1.1. Contribution: The quality assurance guiding principle of contribution is concerned with how current knowledge has been extended and what contribution it can make to research, policy and practice. As this research is novel in the UK context, it serves to extend existing knowledge from other countries on peer work conducted by active drug users. The research highlights a number of successes of peer work programmes currently operating in the UK, which may serve to inspire other organisations to establish similar programmes. By also highlighting some of the challenges that peer workers face in their work, and offering recommendations on how to overcome these, this research serves as a useful reference for those establishing similar programmes.

4.4.1.2. Credibility: Credibility refers to the believability and plausibility of the findings and how well quotes support the conclusions of the analysis. It also concerns processes to validate the research findings. In the Results chapter, each theme and sub-theme is illustrated by numerous relevant extracts from the data, with discussion of both the explicit and implicit meaning of what was communicated in the interviews. A number of criteria to assess credibility of qualitative research have been published across the literature. They include accounting for personal biases which may have influenced research findings (Morse et al., 2002). The attempts made to mitigate against this have been discussed in the Methodology chapter. Respondent

validation, where participants are invited to review the interview transcript and comment on whether they feel the final themes reflect what is being investigated, could also have been used to enhance credibility (Long & Johnson, 2000). However, both timing constraints, and concerns about not overburdening participants, meant that this was not pursued.

4.4.1.3. Rigour: The final principle of rigour concerns the transparency of the research process which includes a reflexive and well-documented process for data analysis, the utilisation of appropriate methodology and discussion of ethical issues. In good quality research, the researcher should keep meticulous records that demonstrate clear decision-making and ensure the consistency and transparency of data interpretation (Noble & Smith, 2015).

Interview transcripts were coded line-by-line as far as possible, to ensure that researcher bias did not influence some extracts of data being favoured over others. An example of a hand-coded interview transcript can be found in Appendix G. Once the transcripts had been coded by hand, NVivo software was used to organise and group together coded data so that these could be organised into themes and sub-themes (see Appendix H for an example of this).

Regular consultation with my research supervisor was undertaken whilst conducting this research, which provided an opportunity to reflect at all stages of the process. This included discussion on conceptualisation, data collection and analysis, as well as the development of the research report. During the development of my overarching themes and sub-themes, I consulted with my research supervisor to ensure that I was developing a coherent narrative that adequately reflected the content of my data.

<u>4.4.2. Best practice guidelines for reporting reflexive TA</u>

Braun and Clarke's (2022) guidelines suggest that good TA research should explain the context, rationale and aims of the study and detail the conceptual underpinnings of the research. The context, rationale and aims of the study, and a brief overview of harm reduction and peer work, have been provided in the Introduction chapter. Braun and Clarke (2022) suggest that reflexivity should be apparent throughout the

study, including consideration of the researcher's personal position with regards to the subject matter and participants. The researcher has discussed their own standpoint, perspectives and reflections under the headings of Reflexivity in both the Methodology and Discussion chapters.

Braun and Clarke (2022) suggest that rich and multi-faceted themes should form a coherent 'story' about the data and be supported by data extracts drawn from across the dataset. Details of the themes discovered within the interview transcripts, and data extracts to illustrate these, can be found in the Results chapter. As advised by the guidelines, conclusions and implications arising from the data, as well as evaluation and reflection on the study, have also been provided in the Discussion chapter.

4.5. Strengths

At the commencement of this study, there had been no research published on experiences of active drug users employed as peer workers in the UK. Since the current study was undertaken, an evaluation of a peer-to-peer Naloxone distribution pilot study in Scotland has been undertaken, including interviews with peer workers with both lived and living experience of drug use on their experiences of the work (Scottish Drugs Forum, 2023). The evaluation highlighted similar findings to the current study, such as that peer workers felt that their lived experience was useful to the role, that the work provided them with an opportunity to give back and that they felt valued because of the payment they received. Some of the challenges highlighted included issues of sustainability of the programme due to funding concerns. The current study builds upon this, and the existing literature from other countries, by highlighting experiences of peer workers delivering a range of different harm reduction interventions beyond Naloxone provision, and by offering experiences of peer workers employed in England.

Gaining a better understanding of peer workers' experiences, including both the positive and more challenging aspects of their roles, serves as useful knowledge for

HROs currently operating peer work programmes, or those hoping to initiate them. Whilst this study focused specifically on the experiences of peer workers themselves, the participants' responses also gave some insight into the ways in which peer work can be beneficial to both other PWUD and HROs.

Utilising qualitative research methods allowed peer workers to express their experiences in their own words, giving voice to a group of people that are often voiceless and demonstrating the humanity of a group of people who are often dehumanised (Brown, 2020; Sumnall et al., 2021). The majority of peer workers employed by the HRO participated in the research, suggesting that the research topic was of interest and relevance to peer workers and they were motivated to share their experiences.

The discourse about drug use in the UK, especially around the use of drugs such as heroin and crack, is frequently negative and problem-saturated (Lloyd, 2010). With its representation of many positive experiences of peer work and peer workers, this research provides an alternative narrative regarding PWUD, one which is much more strengths-based.

4.6. Limitations

Limitations regarding the sample were identified. Recruiting participants from two different sites of a national HRO provided both opportunities and challenges. Each site employed the peer workers in slightly different ways, in terms of expectations around working hours and remuneration. In one site, the majority of participants had been employed for over 18 months, whereas in the other site, participants had spent eight months as peer workers. This provided an opportunity to explore how experiences differed according to different contexts, which provides useful information for both the HRO and other organisations who may wish to establish similar programmes. However, it also made it challenging to collate comprehensive themes that reflected these nuances, whilst also protecting anonymity.

Interviews were relatively short in the majority of cases. Prior to the interview, some participants expressed concerns about having to sit and talk for an extended period of time, and adjustments were made to ensure that interviews did not last beyond the point that participants felt comfortable. In all cases, it was felt that participants had been given the opportunity to voice their experiences and, as a collective, the interviews provided rich data.

Participants were made aware, prior to the interviews, that all of their responses would be anonymised and any identifying details removed. However, some participants may still have harboured concerns about their interview responses being identified by fellow peer workers or staff at the HRO, and censored their answers accordingly. A commitment to ensuring the anonymity of all participants meant that some data, which would have offered a rich representation of the key themes, had to be omitted.

The majority of participants in this study were White British and male. One participant was female, one participant was of mixed Asian and British ethnicity and one participant was born outside of the UK and of Asian ethnicity. The homogeneity in terms of demographic characteristics within the sample means that those with intersecting identities are not well-represented. There may be experiences of peer work specific to gender, ethnicity, disability and other identities that were not explored by this research.

It would also have been useful to explore the experiences of PWUD who had decided not to participate in peer work, or who had been involved initially but then withdrawn, to better understand what may have influenced this. By interviewing only those peer workers who were still involved in providing interventions they may have been more likely to regard the work positively. Useful data regarding barriers to involvement, which could be utilised by services to improve access to peer work for active drug users, may have been missed.

4.7. Implications of Research

4.7.1. Clinical Implications

As highlighted in the Introduction, PWUD experience some of the highest levels of mental health needs, but are the population who face the greatest levels of unmet need due to multiple barriers to accessing treatment within both drug services and mental health services.

In recent years, the Government has produced guidance aimed at ensuring PWUD have adequate access to mental health services including IAPT (Improving Access to Psychological Therapies) (IAPT, 2012) and community mental health services (Public Health England, 2017). However, as the Government-commissioned Black Report (Department of Health and Social Care, 2021) highlighted, people with mental health problems who use drugs are often still excluded from mental health services until their drug use is resolved, and excluded from drug services that do not feel adequately equipped to address their mental health problems. In the report, Black urged substance misuse and mental health services to ensure “individuals do not fall between the cracks” (Department of Health and Social Care, 2021, para. 8) . Research demonstrates that barriers to access include drug services being too inflexible and bureaucratic (ACMD, 2019) and the use of ‘one size fits all’ policies in mental health services (Houghton et al., 2021). Negative and stigmatising attitudes among staff, including those who work in drug services, have also been highlighted as a barrier to access for PWUD (UKDPC, 2010a).

The embodiment of harm reduction principles by both drug and mental health services is a way of potentially reducing these barriers to services. As this research demonstrates, the utilisation of harm reduction principles by peer workers when delivering their interventions allowed for greater engagement with PWUD, including those considered ‘hard to reach’. Psychologists can play a role in embedding these principles in the services in which they operate, both by embodying the principles in their own practice, and supporting staff within services to do the same.

One principle of harm reduction is the promotion of 'low-threshold' access to services (Marlatt, 1996). 'Low-threshold' is defined as services that do not impose drug abstinence as a condition of use and aim to reduce other barriers to access (Islam et al., 2013). Current NICE quality standards (2019) recommend the proactive engagement of PWUD with co-occurring mental health issues, and advise that they should not be excluded from services for attending whilst intoxicated, or missing an appointment. However, research demonstrates that this guidance is not always followed (Houghton et al., 2021) and there may be benefit in supporting services to re-evaluate current engagement and discharge policies in relation to engaging this population.

In their own practice, clinical psychologists can practice according to the principles of harm reduction psychotherapy, which emerged in the US in the late 1990s. Harm reduction psychotherapy is defined as "psychological interventions that seek to reduce the harm associated with active substance use without having abstinence as the initial goal" (Tatarsky, 1998, p. 11). It is underpinned by a number of principles, including a focus on engagement in treatment, rather than reduction in drug use, as the primary goal of treatment, and not holding abstinence as a precondition of therapy (Tatarsky & Marlatt, 2010).

Clinical psychologists may also need to play a role in addressing stigma and discrimination within teams working with PWUD. Research demonstrates that PWUD experience stigma in accessing healthcare services, including drug services, which acts as a barrier to them seeking treatment (UKDPC, 2010a; NHS Addictions Provider Alliance, n.d.). A systematic review of stigma amongst health professionals working with clients with substance use disorders found negative attitudes were common and diminished clients' feelings of empowerment and treatment outcomes (van Boekel et al., 2013). The review found a lack of education, training and support structures for working with this client group and there is evidence that providing training to health professionals can be successful in reducing negative attitudes towards people with substance misuses issues (Silins et al., 2007; Strang et al., 2004). Clinical psychologists may hold positions within multi-disciplinary teams that would allow them to offer training or reflective spaces to colleagues in order to address negative attitudes towards PWUD, as well as supporting colleagues to meet

the demands of the work, which often requires significant levels of resilience and tolerance (NICE, 2019).

Clinical psychologists may also have a role to play outside of their own practice, in engaging in advocacy for reform. Dr Gillian Shorter, a psychologist and harm reductionist who led an evaluation of the first unsanctioned OPC in the UK (Shorter et al., 2022) has argued that psychologists can mobilise and use psychological knowledge to develop harm reduction interventions and advocate on behalf of those affected by drug-related harms. Shorter argues that psychologists can play a role in alleviating worry and psychological discomfort around harm reduction interventions, such as OPCs, through effective engagement and communication (Shorter, 2020).

4.7.2. Service Implications

The HRO hopes that, over time, peer workers will be able to operate the programme themselves, rather than working under the direction of a staff member. If this ambition is to be realised, a number of considerations will need to be made.

It will be important for the HRO to consider whether any future peer work programmes will be run by peers engaged as volunteers who are paid a stipend, as is the case now, or as employees. Some participants highlighted how they were initially incentivised to become involved in peer work because of the payment offered, even if this is not necessarily the reason for their continued involvement. There was a suggestion that the drop-out of some peer workers may have been a result of a decreased opportunity to earn payment, following an initial period where peers were paid frequently to attend trainings. It would be beneficial to understand whether PWUD who did not opt to become involved in the peer work programme, or who withdrew their involvement after the initial stages, were influenced by issues of payment. If the HRO opts to maintain the current payment arrangement, it will need to consider whether this will be sufficient to retain current peer workers and if the potential for unequal payment between peer workers and salaried employees will be problematic.

Guidance on user involvement in drug services recommends that volunteers are provided with adequate supervision, training and development opportunities, and role descriptions to outline boundaries and responsibilities (PHE, 2015). A lack of clear definition of the role has been highlighted as a challenge for peer workers and creating a well-defined occupational identity may help to integrate the peer role into organisations (Greer et al., 2021).

If peer workers become official employees of the harm reduction programme, they should be subject to the same terms and conditions of employment as other paid workers (PHE, 2015). This would require peer workers to be paid at the same rate as staff undertaking roles at a similar level, which may not be financially feasible, or may limit the number of peer workers that can be employed. There are additional considerations when employing peer workers, including the impact that sessional or part-time employment may have if peer workers are claiming benefits (PHE, 2015). Ideally, peer workers should be given consistent hours and issued with long-term contracts to avoid benefits being affected (Scottish Drugs Forum, 2023), but this requires organisations to have access to sustainable funding streams.

The recent evaluation of a Naloxone supply pilot programme in Scotland, which employed peer workers on sessional contracts, highlighted some of the challenges of employing peer workers (Scottish Drugs Forum, 2023). The pilot faced long delays in securing the necessary background checks required before issuing contracts, which led to an initial group of peers being withdrawn from the pilot. This had a detrimental effect on the peers personally and on their relationship with the service provider. The evaluation highlighted the need for clear expectations to be set and opportunities for peer workers to raise concerns throughout the process.

Participants in the current study have highlighted the need for co-ordination of peer work, citing a sense of waning leadership as a threat to the continuation of the programme. The Naloxone pilot programme evaluation supports this finding, highlighting the importance of the co-ordination role (Scottish Drugs Forum, 2023), although in both the pilot and the current study, the co-ordinator roles are held by permanent staff members of the service provider rather than by PWUD. This suggests that running a peer work programme with a flat hierarchy may be

unrealistic, which raises questions as to how the introduction of a peer worker hierarchy could affect the dynamic of the team. Guidance on the employment of PWUD highlights the importance of providing training, especially in cases where the employee may have been unemployed for some time and/or lack professional experience (International HIV/AIDS Alliance, 2015) and also the importance of supporting employees who use drugs to manage stress and mitigate burnout (Open Society Foundations, 2010).

There may also be questions about the extent to which staff at the HRO will feel able to relinquish control of the peer work programme, and manage the balance between being available for consultation and support whilst relinquishing control. A guide on good practice in empowering drug user groups highlights the high levels of 'ontological' vulnerability that can be experienced by drug user groups that have been initiated by service providers, as opposed to spontaneously created by PWUD. The guidance suggests that this vulnerability can be mitigated if services and groups of drug users can forge a relationship based on equality, with services required to relinquish the asymmetry that is inherent in the service provider-user relationship. This requires service providers to put aside their clinical or therapeutic perspective and treat service users as equal colleagues, taking a curious position that recognises the knowledge of PWUD and allowing decisions to be made by the group, even if they fill the service provider with unease (Correlation, 2008).

4.7.3. Policy Implications

Over the past two decades, the focus of UK drug policy on abstinence-based recovery has led to the marginalisation of harm reduction approaches, leaving a population of drug users who cannot, or do not wish to, pursue abstinence, with fewer options. This study demonstrates that harm reduction interventions for active drug users can be beneficial, not just for those who are engaged in them but for other PWUD and the wider community.

As highlighted in the Introduction, there has been a mis-held belief that harm reduction and recovery approaches are dichotomous. The Government's own Recovery Champion has highlighted the importance of not considering harm

reduction and recovery as opposing approaches, and to offer a full range of interventions to PWUD (Home Office, 2021). Future drug policies should encompass a variety of approaches which support a heterogenous population of PWUD and these approaches should be based on principles of public health and risk minimisation.

The voices of PWUD should be at the heart of any future policy development. As highlighted in the Introduction, the activism of PWUD has been credited with the development and endurance of harm reduction approaches across numerous countries. The document, ‘Nothing About Us Without Us’ developed by the Canadian HIV/AIDS Legal Network (2006) argues that PWUD should be meaningfully involved in consultative processes, decision-making and policy-making and invited to participate in all fora where policies or services concerning them are being planned, discussed, researched or evaluated. Despite the UK Government claiming a commitment to public involvement in the development of services (NHS England, 2017) there was a lack of public consultation during the development of the Government’s current Drug Strategy (Holland et al., 2022). PWUD are already a significantly marginalised population who are not given the opportunity to have their voices heard on the decisions that will affect them. Policymakers need to provide opportunities for engagement and PWUD need to be empowered to raise their voices in these discussions. As demonstrated by the current study, peer work enables PWUD to recognise the value of their skills and experience and to demonstrate to wider society that they have much to offer. Peer work programmes provide an opportunity to empower PWUD, which may result in a greater ability to engage in the debates and decision-making that affect them.

Central to the Government’s current Drug Strategy, and numerous ones before it, is the focus on promoting recovery through employment, which, as highlighted in the Introduction, some commentators have suggested is driven by a political ideology that stigmatises worklessness. The benefits of employment on mental health and well-being are well documented, including provision of social identity and status, social contact, support and a feeling of involvement, a sense of personal achievement, and a means of structuring and occupying time (Burton & Waddell, 2006; Khan & Boardman, 2017). Participants of the current study described

experiences of all of these positive effects, suggesting peer work can offer many of the benefits of others forms of employment.

Despite the numerous benefits of employment, people using opiates experience the lowest rates of employment in the UK (Black, 2016). Barriers include a lack of education and skills, health issues and social disadvantage experienced by PWUD, but also stigma amongst employers and a lack of support (Sutton et al., 2004; UKDPC, 2008b). PWUD may also fail to pursue work opportunities due to low self-efficacy (Henkel, 2011). In some ways, PWUD are caught in a vicious cycle. Being employed can improve mental health and well-being, and strengthen identity, but without those factors already in place, it can be difficult to access.

The Government has outlined a commitment to improved employment opportunities for PWUD in its current Drug Strategy, citing evidence that employment can support recovery from drug use (Black, 2016). Whilst the plan sounds promising, including £39 million committed to rolling out a programme which offers intensive, personalised support to PWUD in search of a job, followed by in-work support to employees and employers, the expectations around abstinence are unclear. The programme appears to be tailored to those who have either stopped drug use, or who have accessed treatment programmes with the intention of stopping use, which may mean those who continue to use drugs will be marginalised from employment opportunities. The Government has acknowledged that the programme will not be helpful to all people with addiction issues that require employment support (Black, 2016). As such, peer work programmes which employ active drug users may continue to be an important offer of employment to a group who are often excluded from such opportunities. In peer work programmes, a drug user's living experience is a valued prerequisite of the role, rather than a factor that may exclude them. Future policies should consider broadening peer work opportunities to support PWUD to access employment.

4.7.4. Future Research Implications

As this research is one of the first of its kind in the UK, it is intended to act as a foundation upon which other research can be built. Any future research would ideally

be undertaken in collaboration with PWUD. There are a number of studies that highlight the importance of collaborating with PWUD on research that affects them (Neale et al., 2017; Salazar et al., 2021) and the ways in which this can be done in a supportive and ethical manner (Allan, 2019) and without involvement of PWUD being merely tokenistic (Simon et al., 2021).

Further research, capturing a larger number of peer workers' experiences is recommended. Recruiting peer workers from other geographical areas, who are involved in providing different harm reduction interventions would allow for a broader understanding of experiences and offer recommendations for how to establish peer work programmes according to specific criteria. As the current study focused on the experiences of peer workers rather than the details of the work they were involved in, it may be useful for future research to more systematically collect information about the harm reduction interventions delivered by peer workers, to provide a greater understanding of the full potential of the role. The majority of participants of the current study had involvement with the HRO prior to being recruited into the peer work programme. It may be useful to understand more about the recruitment process and how PWUD who are not already involved with services can access peer work roles.

If additional harm reduction interventions, such as OPCs, are established in the UK, it will be important to understand the experiences of any peer workers involved in their operation. Utilising an ethnographic methodology to undertake research in an OPC, for example, may be a helpful way to capture myriad experiences of peer worker delivered interventions.

It may also be useful to understand the experiences of HRO staff working with peer workers and PWUD receiving interventions from peer workers. A number of the existing studies on peer work have also included the perspectives of staff (Penn et al., 2016; Stengel et al., 2018) and recipients of peer work interventions (Stengel et al., 2018).

As highlighted above, the research sample lacked diversity in terms of age, gender and ethnicity. These, and other identities are factors which may impact on the

experiences of peer work and would warrant further attention. Future research could also target PWUD who chose not to partake in peer work, or withdrew from the programme early, in order to understand the factors that influenced their decision and highlight potential barriers to involvement.

This research highlighted some of the ways in which peer work has had a positive impact on the mental health and well-being of peer workers providing harm reduction interventions. Concepts such as self-perception, self-esteem and recovery capital have been discussed but there has not been an opportunity to explore the mechanisms of these phenomena in significant detail. Research that allows for further exploration of these phenomena is recommended.

4.8 Conclusion

This is the first study of its kind focusing on the experiences of peer workers who are active drug users delivering a range of harm reduction interventions in England. Research from other countries has identified a number of benefits of employing PWUD in harm reduction services, as well as highlighting some challenges of the role.

This research has highlighted a number of positive experiences for PWUD involved in peer work in the UK context. Peer workers experienced a change in the way others perceive them, which can lead to a reduction in internalised stigma and improved self-esteem. Being engaged in peer work helped peer workers to feel valued, resulting in a sense of pride and self-worth, which contrasted with previous experiences of shame and marginalisation. Peer work was also found to enhance recovery capital, which may account for the lifestyle changes participants were able to make, including reduction in drug use.

More challenging experiences of peer work have also been highlighted, including complexity regarding payment and issues of fragility within peer work programmes. HROs interested in establishing or continuing peer work programmes need to focus on ensuring longevity of funding and providing adequate payment, role clarity and

support if peer workers are to be able to continue with their work or take up leadership roles in harm reduction interventions.

This study also demonstrates how harm reduction principles can be utilised to support PWUD, including those considered hard-to-reach, and demonstrates ways in which the mental health and well-being of PWUD can be enhanced, resulting in recommendations for clinical services seeking to support this population.

As peer work delivered by active drug users is an emerging field in the UK, there are many ways in which this research can be built upon to enhance the evidence-base for this approach. As this research highlights, there is a long history of harm reduction interventions being marginalised in favour of abstinence-based recovery approaches. This research demonstrates the benefit of utilising harm reduction interventions and principles to support PWUD and recommends that such interventions be offered alongside existing recovery approaches. Whilst a challenging policy landscape remains, there are potential developments that show promise, and in which peer workers could play a pivotal role.

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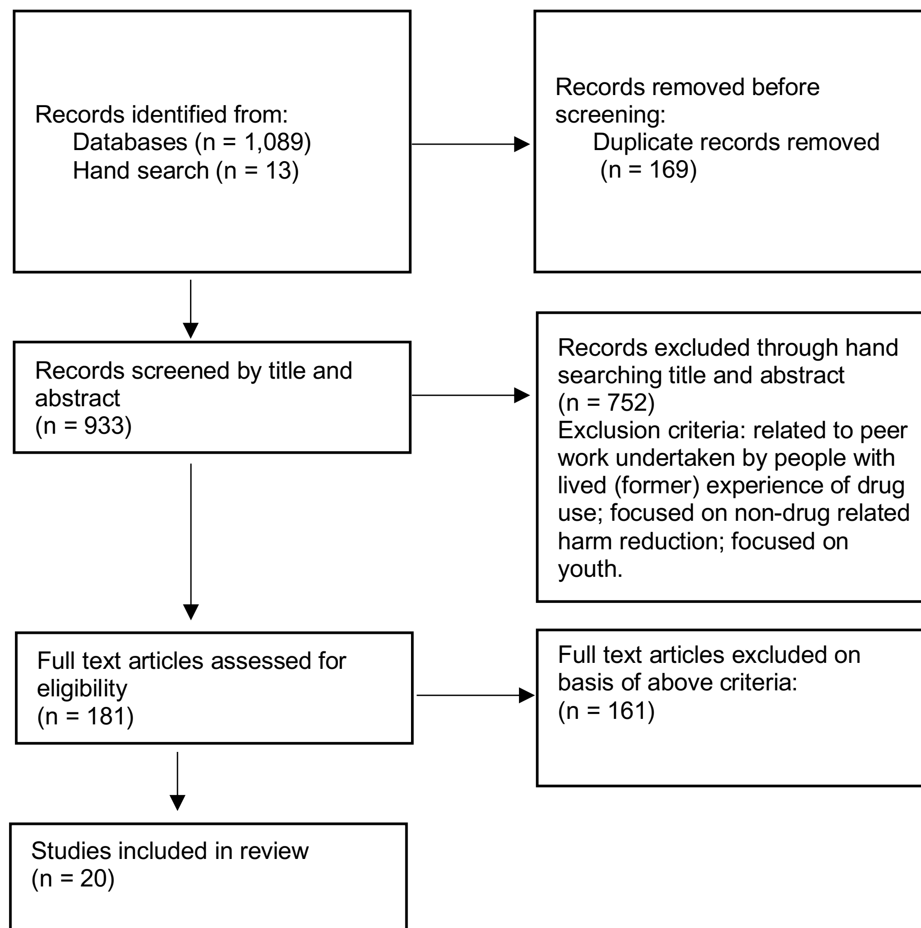
APPENDICES

Appendix A: Scoping Review Search Terms and Flow Chart

An electronic literature search focusing on the experiences of active drug users in harm reduction interventions was undertaken in PsycInfo, Academic Search Complete, CINAHL, PubMed and Scopus using the terms “harm reduction” and “peer*”. A hand search was also undertaken to identify additional literature



Appendix B: Interview Schedule

Q1. I'd like to ask you a little bit about yourself. How old are you? What is your gender? What is your ethnicity? What substances do you tend to use? How long have you been using these for?

Q1. What do you do for XX organisation? What sort of people do you support? Where do you work? What do you do? How many hours do you work? Do you get paid? Did you get any training? Do you have a manager/supervisor?

Q2. How did you get involved with XX organisation and why did you decide to do so?

Q3. What is it about being involved in peer work that you like/dislike?

Q4. How do you think peer work for people who use drugs is helpful/unhelpful? How do people respond when you work with them? Is there anything about being a peer that makes your work easier/more difficult?

Q6. Have you noticed anything different in your life since you started peer work (positive or negative)? Have there been any changes to your well-being, mental health?

Q7. Is there anything else you would like to add?

Appendix C: Participant Debrief Sheet

PARTICIPANT DEBRIEF SHEET

Understanding the role of peer involvement in UK harm reduction interventions

Thank you for participating in my research study on peer involvement in UK harm reduction interventions. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations, talks. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally. Any personally identifying information will replaced.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by Dr Lorna Farquharson for a maximum of 3 years, following which all data will be deleted.

What if I been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind.

Nevertheless, it is possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

- You may wish to talk to your colleagues/supervisor within your organisation. Your supervisor will be aware of this study and the type of questions you have been asked (although none of your answers will be shared with them).
- If you feel like you may need some additional mental health support, you can find details of services in your local area, and phone helplines, through Mind, the mental health charity: https://www.mind.org.uk/information-support/
- The Samaritans offers a 24/7 helpline to support anyone going through a difficult time. They can be contacted on 116 123.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Katharine Boaden
Email: u2075198@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Lorna Farquharson, School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: l.farquharson@uel.ac.uk

or

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking part in my study

Appendix D: Ethics Application and Approval

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL
FOR RESEARCH INVOLVING HUMAN PARTICIPANTS
(Updated October 2021)

FOR BSc RESEARCH;
MSc/MA RESEARCH;
PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

Section 1 – Guidance on Completing the Application Form (please read carefully)	
1.1	Before completing this application, please familiarise yourself with: ▪ British Psychological Society's Code of Ethics and Conduct ▪ UEL's Code of Practice for Research Ethics ▪ UEL's Research Data Management Policy ▪ UEL's Data Backup Policy
1.2	Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will look over your application and provide feedback.
1.3	When your application demonstrates a sound ethical protocol, your supervisor will submit it for review.
1.4	Your supervisor will let you know the outcome of your application. Recruitment and data collection must **NOT** commence until your ethics application has been approved, along with other approvals that may be necessary (see section 7).
1.5	Research in the NHS: ▪ If your research involves patients or service users of the NHS, their relatives or carers, as well as those in receipt of services provided under contract to the NHS, you will need to apply for HRA approval/NHS permission (through IRAS). You DO NOT need to apply to the School of Psychology for ethical clearance. ▪ Useful websites: https://www.myresearchproject.org.uk/Signin.aspx

	https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hra-approval/ ▪ If recruitment involves NHS staff via the NHS, an application will need to be submitted to the HRA in order to obtain R&D approval. This is in addition to separate approval via the R&D department of the NHS Trust involved in the research. UEL ethical approval will also be required. ▪ HRA/R&D approval is not required for research when NHS employees are not recruited directly through NHS lines of communication (UEL ethical approval is required). This means that NHS staff can participate in research without HRA approval when a student recruits via their own social/professional networks or through a professional body such as the BPS, for example. ▪ The School strongly discourages BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
1.6	If you require Disclosure Barring Service (DBS) clearance (see section 6), please request a DBS clearance form from the Hub, complete it fully, and return it to applicantchecks@uel.ac.uk. Once the form has been approved, you will be registered with GBG Online Disclosures and a registration email will be sent to you. Guidance for completing the online form is provided on the GBG website: https://fadv.onlinedisclosures.co.uk/Authentication/Login You may also find the following website to be a useful resource: https://www.gov.uk/government/organisations/disclosure-and-barring-service
1.7	Checklist, the following attachments should be included if appropriate: ▪ Study advertisement ▪ Participant Information Sheet (PIS) ▪ Participant Consent Form ▪ Participant Debrief Sheet ▪ Risk Assessment Form/Country-Specific Risk Assessment Form (see section 5) ▪ Permission from an external organisation (see section 7) ▪ Original and/or pre-existing questionnaire(s) and test(s) you intend to use ▪ Interview guide for qualitative studies ▪ Visual material(s) you intend showing participants

Section 2 – Your Details

2.1	**Your name:**	**Katharine Boaden**
2.2	**Your supervisor's name:**	**Dr Lorna Farquharson**
2.3	**Name(s) of additional UEL supervisors:**	**Dr Christina Trigeorgis** 3rd supervisor (if applicable)
2.4	**Title of your programme:**	**Doctorate in Clinical Psychology**
2.5	**UEL assignment submission date:**	**23/05/2023**

		Re-sit date (if applicable)

Section 3 – Project Details

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and purpose of your research.

3.1	**Study title:** Please note - If your study requires registration, the title inserted here must be the same as that on PhD Manager	Understanding the role of peer involvement in UK harm reduction interventions
3.2	**Summary of study background and aims (using lay language):**	The proposed study aims to provide a greater understanding of processes and interactions that occur within harm reduction interventions delivered by active drug users and how these are experienced by the people who deliver them. The study aims to understand how harm reduction principles manifest themselves in harm reduction interventions delivered by active drug users, and what psychological, social and emotional effects they have on people that deliver them.
3.3	**Research question(s):**	Research questions to be explored are as follows:- What harm reduction interventions are delivered through peers?- How are the principles of harm reduction (e.g. non-judgemental, non-coercive provision of services; avoidance of stigma; meeting people “where they’re at”) enacted within these interventions?- - How does delivery of harm reduction interventions affect the mental health, well-being and self-perception of those delivering them?-
3.4	**Research design:**	This is a qualitative study. Semi-structured interviews of up to one hour will be conducted with at least 12 peers delivering harm reduction interventions.
3.5	**Participants:** Include all relevant information including inclusion and exclusion criteria	Participants will be aged over 18 and will be people who use drugs who are involved in the delivery of harm reduction interventions.
3.6	**Recruitment strategy:** Provide as much detail as possible and include a backup plan if relevant	Participants will be recruited via organisations providing peer-delivered harm reduction interventions. Contact has already been made with XXXX, a harm reduction organisation

		operating services employing active drug users in XXXX, who are willing to participate.	
3.7	**Measures, materials or equipment:** Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc.	Participant Information Sheet, Consent Forms, Interview Schedule	
3.8	**Data collection:** Provide information on how data will be collected from the point of consent to debrief	Participants will be required to sign a consent form confirming they have read and understood the participant information sheet. Interviews will be recorded using a digital voice recorder and transcribed, after which voice recordings will be deleted. Participants will be provided with a verbal and written debrief.	
3.9	**Will you be engaging in deception?**	**YES** ☐	**NO** ☒
	If yes, what will participants be told about the nature of the research, and how/when will you inform them about its real nature?	If you selected yes, please provide more information here	
3.10	**Will participants be reimbursed?**	**YES** ☐	**NO** ☒
	If yes, please detail why it is necessary.	If you selected yes, please provide more information here	
	How much will you offer? Please note - This must be in the form of vouchers, not cash.	Please state the value of vouchers	
3.11	**Data analysis:**	Interviews will be transcribed and subject to thematic analysis. Transcripts will be read and re-read and notes on initial observations will be made to allow the Principal Researcher to familiarise themselves with the data. Initial codes will then be generated and assigned to the data, followed by identification of themes. Initial these will be shared with the DoS for input before reviewing these against the data. Final themes will be defined before being written up in the thesis.	

Section 4 – Confidentiality, Security and Data Retention

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

If a Research Data Management Plan (RDMP) has been completed and reviewed, information from this document can be inserted here.

4.1	**Will the participants be anonymised at source?**	**YES** ☐	**NO** ☒
	If yes, please provide details of how the data will be anonymised.		
4.2	**Are participants' responses anonymised or are an anonymised sample?**	**YES** X☐	**NO** ☐
	If yes, please provide details of how data will be anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.).	To protect anonymity of participants pseudonyms will be used. Minimal demographic data will be collected and presented at group level rather than in relation to individual participants. Given that the participants will be recruited from a small, close-knit community, and will thus know each other, every care will be taken to ensure that no data published in the report will allow a participant to be identified. As such, details of age, gender, or other potentially identifying factors will be removed. Any concerns about whether data intended for publication could identify a participant will be discussed during supervision. Participants will be informed beforehand that the final research may contain direct quotes of what they have said and will be shared with harm reduction organisations, but that all care will be taken to ensure they are not identifiable. During the debrief, participants will be reminded of this, and given the opportunity to highlight anything within the interview that they do not wish to be directly quoted.	
4.3	**How will you ensure participant details will be kept confidential?**	Documents and interview transcripts will be kept on the UEL OneDrive, a password protected cloud storage system. All identifiable information will be removed from documents before they are uploaded. Data will only be accessible to the Principal Researcher and DoS.	

4.4	**How will data be securely stored and backed up during the research?** Please include details of how you will manage access, sharing and security	Data will be stored on the UEL OneDrive a password protected cloud storage system, which is backed up at regular intervals. Only the Principal Researcher and DoS will have access to the data.	
4.5	**Who will have access to the data and in what form?** (e.g., raw data, anonymised data)	Raw data will only be accessed by the principal researcher. Anonymised data will be accessible to the principal researcher and Director of Studies.	
4.6	**Which data are of long-term value and will be retained?** (e.g., anonymised interview transcripts, anonymised databases)	Pseudonymised interview transcripts will be stored by UEL.	
4.7	**What is the long-term retention plan for this data?**	Following completion of the thesis, anonymised data will be transferred to the principal researcher's supervisor who will store this securely on their OneDrive for 3 years, before erasing it.	
4.8	**Will anonymised data be made available for use in future research by other researchers?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐
4.9	**Will personal contact details be retained to contact participants in the future for other research studies?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐

Section 5 – Risk Assessment

If you have serious concerns about the safety of a participant, or others, during the course of your research please speak with your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g., a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

5.1	**Are there any potential physical or psychological risks to participants related to taking part?**	**YES** ☒	**NO** ☐

	(e.g., potential adverse effects, pain, discomfort, emotional distress, intrusion, etc.)			
	If yes, what are these, and how will they be minimised?	In order to understand drug users' experiences, interview questions may cover challenging or sensitive subjects which may cause emotional distress. To mitigate this, interviews will be conducted within the organisations where harm reduction interventions are delivered, to ensure participants have access to colleagues or staff if needed. Information will also be provided to participants about sources of support available to them should they require it.		
5.2	**Are there any potential physical or psychological risks to you as a researcher?**	**YES** ☒		**NO** ☐
	If yes, what are these, and how will they be minimised?	Conducting interviews may expose the Principal Researcher to topics that are distressing. The PR has experience working in environments where people share difficult experiences, including people who have experienced problematic drug use. They are aware of some of the topics that may be discussed and have demonstrated an ability to deal with such discussions without any significant adverse effects on their mental wellbeing. If there are any issues that the PR does not feel able to manage on their own, these will be discussed with the DoS during one of the regular supervision slots.		
5.3	**If you answered yes to either 5.1 and/or 5.2, you will need to complete and include a General Risk Assessment (GRA) form (signed by your supervisor). Please confirm that you have attached a GRA form as an appendix:**	**YES** ☐		
5.4	**If necessary, have appropriate support services been identified in material provided to participants?**	**YES** ☒	**NO** ☐	**N/A** ☐
5.5	**Does the research take place outside the UEL campus?**	**YES** ☒		**NO** ☐

<table>
<tr><td></td><td>If yes, where?</td><td colspan="2">In the offices of harm reduction organisations based in the UK (precise locations TBD).</td></tr>
<tr><td rowspan="3">5.6</td><td>Does the research take place outside the UK?</td><td>YES
☐</td><td>NO
☒</td></tr>
<tr><td>If yes, where?</td><td colspan="2">Please state the country and other relevant details</td></tr>
<tr><td>If yes, in addition to the General Risk Assessment form, a Country-Specific Risk Assessment form must also be completed and included (available in the Ethics folder in the Psychology Noticeboard).
Please confirm a Country-Specific Risk Assessment form has been attached as an appendix.
Please note - A Country-Specific Risk Assessment form is not needed if the research is online only (e.g., Qualtrics survey), regardless of the location of the researcher or the participants.</td><td colspan="2">YES
☐</td></tr>
<tr><td>5.7</td><td colspan="3">Additional guidance:
▪ For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on ‘sign in’ and then ‘register here’ using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance.
▪ For on campus students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Director of Impact and Innovation, Professor Ian Tucker (who may escalate it up to the Vice Chancellor).
▪ For distance learning students conducting research abroad in the country where they currently reside, a risk assessment must also be carried out. To minimise risk, it is recommended that such students only conduct data collection online. If the project is deemed low risk, then it is not necessary for the risk assessment to be signed by the Director of Impact and Innovation. However, if not deemed low risk, it must be signed by the Director of Impact and Innovation (or potentially the Vice Chancellor).
▪ Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.</td></tr>
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<table>
<tr><th colspan="4">Section 6 – Disclosure and Barring Service (DBS) Clearance</th></tr>
<tr><td>6.1</td><td>Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?
If yes, you will require Disclosure Barring Service (DBS) or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project</td><td>YES
☐</td><td>NO
☒</td></tr>
<tr><td></td><td colspan="3">* You are required to have DBS or equivalent clearance if your participant group involves:
(1) Children and young people who are 16 years of age or under, or
(2) ‘Vulnerable’ people aged 16 and over with particular psychiatric diagnoses, cognitive difficulties, receiving domestic care, in nursing homes, in palliative care, living in institutions or sheltered accommodation, or involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak with your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible.</td></tr>
<tr><td>6.2</td><td>Do you have DBS or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project?</td><td>YES
☒</td><td>NO
☐</td></tr>
<tr><td>6.3</td><td>Is your DBS or equivalent (for those residing in countries outside of the UK) clearance valid for the duration of the research project?</td><td>YES
☒</td><td>NO
☐</td></tr>
<tr><td>6.4</td><td>If you have current DBS clearance, please provide your DBS certificate number:</td><td colspan="2">Please enter your DBS certificate number</td></tr>
<tr><td></td><td>If residing outside of the UK, please detail the type of clearance and/or provide certificate number.</td><td colspan="2">Please provide details of the type of clearance, including any identification information such as a certificate number</td></tr>
<tr><td>6.5</td><td colspan="3">Additional guidance:
If participants are aged 16 or under, you will need two separate information sheets, consent forms, and debrief forms (one for the participant, and one for their parent/guardian).
For younger participants, their information sheets, consent form, and debrief form need to be written in age-appropriate language.</td></tr>
</table>

Section 7 – Other Permissions			
7.1	**Does the research involve other organisations (e.g., a school, charity, workplace, local authority, care home, etc.)?**	**YES** ☐	**NO** ☒
	If yes, please provide their details.	Please provide details of organisation	
	If yes, written permission is needed from such organisations (i.e., if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation). Please confirm that you have attached written permission as an appendix.	**YES** ☐	
7.2	**Additional guidance:** ▪ Before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application or approval letter. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as 'my' or 'I' with 'our organisation' or with the title of the organisation. This organisational consent form must be signed before the research can commence. ▪ If the organisation has their own ethics committee and review process, a SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s.		

Section 8 – Declarations		
8.1	**Declaration by student. I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor:**	**YES** ☒
8.2	**Student's name:** (Typed name acts as a signature)	**Katharine Boaden**
8.3	**Student's number:**	**U2027198**

8.4	**Date:**	**17/07/2022**
Supervisor's declaration of support is given upon their electronic submission of the application		

Student checklist for appendices – ***for student use only***

Documents attached to ethics application	**YES**	**N/A**
Study advertisement	☐	☒
Participant Information Sheet (PIS)	☒	☐
Consent Form	☒	☐
Participant Debrief Sheet	☒	☐
Risk Assessment Form	☒	☐
Country-Specific Risk Assessment Form	☐	☒
Permission(s) from an external organisation(s)	☐	☒
Pre-existing questionnaires that will be administered	☐	☒
Researcher developed questionnaires/questions that will be administered	☐	☒
Pre-existing tests that will be administered	☐	☒
Researcher developed tests that will be administered	☐	☒
Interview guide for qualitative studies	☒	☐
Any other visual material(s) that will be administered	☐	☒
All suggested text in RED has been removed from the appendices	☒	☐
All guidance boxes have been removed from the appendices	☒	☐

Version: 1
Date: 17/07/2022

PARTICIPANT INFORMATION SHEET

Understanding the role of peer involvement in UK harm reduction interventions

Contact person: Katharine Boaden
Email: u2075198@uel.ac.uk

You are being invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information which outlines what your participation would involve. Feel free to talk with others about the study (e.g., friends, family, colleagues, etc.) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

Who am I?
My name is Katharine Boaden. I am a postgraduate student in the School of Psychology at the University of East London (UEL) and am studying for a Doctorate in Clinical Psychology. As part of my studies, I am conducting the research that you are being invited to participate in.

What is the purpose of the research?
I am conducting research into harm reduction interventions delivered by peers. My research will look at how people who use drugs are involved in peer interventions and experiences of delivering them.

Why have I been invited to take part?
To address the study aims, I am inviting people who use drugs and are involved in the delivery of harm reduction services to take part in my research. If you are a person who uses drugs who is involved in the provision of peer-delivered harm reduction services then you are eligible to take part in the study.

It is entirely up to you whether you take part or not, participation is voluntary.

What will I be asked to do if I agree to take part?
If you agree to take part, you will be asked to participate in an interview.

- During the interview I will ask you questions about the services you are involved in, how you came to be involved, ask you to think about what you like and dislike about your work and what you think has changed in your life as a result of doing peer work.
- The interview will last approximately one hour.
- You will be interviewed in a private and confidential space at the organisation that you work in.
- I will record the interviews using voice-recording equipment.
- If there are any questions that you do not feel comfortable answering then you will not be required to do so. The interview will be held at a time that feels comfortable for you so that you can access your support networks as easily as possible.

Can I change my mind?
Yes, you can change your mind at any time and withdraw without explanation, disadvantage or consequence. If you would like to withdraw from the interview you can do so at any time before or during the interview. If you withdraw, your data will not be used as part of the research.

Separately, you can also request to withdraw your data from being used even after you have taken part in the study, provided that this request is made within 3 weeks of the interview (after which point the data analysis will begin, and withdrawal will not be possible).

Are there any disadvantages to taking part?

- I will be asking you questions about your involvement in harm reduction work and there is a possibility that our discussion may require you to think about difficult or challenging experiences, which may cause some distress.
- I will provide details of organisations that you might wish to contact for further support.

How will the information I provide be kept secure and confidential?

- Participants will not be identified by the data collected, on any material resulting from the data collected, or in any write-up of the research. Your interview will be audio-recorded and when it is written up, you will be assigned a pseudonym so that your personal details will not appear in any reports.
- Contact details will be stored in a secure, password protected, digital folder until the study has been completed, and then they will be deleted.
- All data will be stored in a secure, password protected folder on the University computer system. Any transfer of data will be done over secure University email.
- Once the study has been completed, all raw data (such as contact details will be deleted. Interview transcripts will not include any personal details.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the 'public task' condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as 'special category data' in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

What will happen to the results of the research?
The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Registry of Open Access Repositories (ROAR). Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles and conference presentations. In all material produced, your

identity will remain anonymous, in that, it will not be possible to identify you personally as any personally identifying information will be changed.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by Dr Lorna Farquharson for a maximum of 3 years, following which all data will be deleted.

Who has reviewed the research?
My research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?
If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me:

Katharine Boaden
Email: u2075198@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Lorna Farquharson, School of Psychology, University of East London, Water Lane, London E15 4LZ.
Email: l.farquharson@uel.ac.uk

or

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking the time to read this information sheet

Student checklist for Participant Information Sheet (PIS) – *for student use only*

Information to include in PIS	**TICK**
Study title	☒
Who you are	☒
Purpose of research, including any advantages to taking part	☒
Inclusion/exclusion criteria	☒
What participation will involve: location, duration, tasks, etc.	☒
Right to withdraw participation: withdraw involvement at any point without the need to provide a reason or negative consequences	☒
Right to withdraw data: a time specified to do this within (typically a three-week window)	☒
Participation is voluntary	☒

Potential risks to taking part (pain, discomfort, emotional distress, intrusion)	☒
Attempts to minimise risks	☒
Contact information of supporting agencies/relevant organisations	☒
How data will be kept confidential	☒
When confidentiality might be broken	☒
How data will be managed by UEL	☒
How data will be securely stored (e.g., where, who will have access, etc.)	☒
How long data will be retained for, where and by whom	☒
Dissemination activities	☒
Clearly communicated that participants will not be identifiable in any material produced for dissemination purposes	☒
Your name and UEL email address	☒
Your supervisor's name and UEL email address	☒
The Chair of the SREC's name and UEL email address	☒

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Understanding the role of peer involvement in UK harm reduction interventions
Contact person: Katharine Boaden

Email: u2075198@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet dated 17/07/2022 (version 1) for the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	
I understand that if I withdraw during the study, my data will not be used.	
I understand that I have 3 weeks from the date of the interview to withdraw my data from the study.	
I understand that the interview will be recorded using voice-recording equipment.	
I understand that my personal information and data, including audio from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	
I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I agree to take part in the above study.	

Participant’s Name (BLOCK CAPITALS)

………

Participant’s Signature

………

Researcher’s Name (BLOCK CAPITALS)

………

Researcher’s Signature

……

Date

……

Appendix C: Participant Debrief Sheet template

PARTICIPANT DEBRIEF SHEET

Understanding the role of peer involvement in UK harm reduction interventions

Thank you for participating in my research study on peer involvement in UK harm reduction interventions. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Findings will also be disseminated to a range

of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations, talks. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally. Any personally identifying information will replaced.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by Dr Lorna Farquharson for a maximum of 3 years, following which all data will be deleted.

What if I been adversely affected by taking part?
It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

- You may wish to talk to your colleagues/supervisor within your organisation. Your supervisor will be aware of this study and the type of questions you have been asked (although none of your answers will be shared with them).
- If you feel like you may need some additional mental health support, you can find details of services in your local area, and phone helplines, through Mind, the mental health charity: https://www.mind.org.uk/information-support/
- The Samaritans offers a 24/7 helpline to support anyone going through a difficult time. They can be contacted on 116 123.

Who can I contact if I have any questions/concerns?
If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Katharine Boaden
Email: u2075198@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Lorna Farquharson, School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: l.farquharson@uel.ac.uk

or

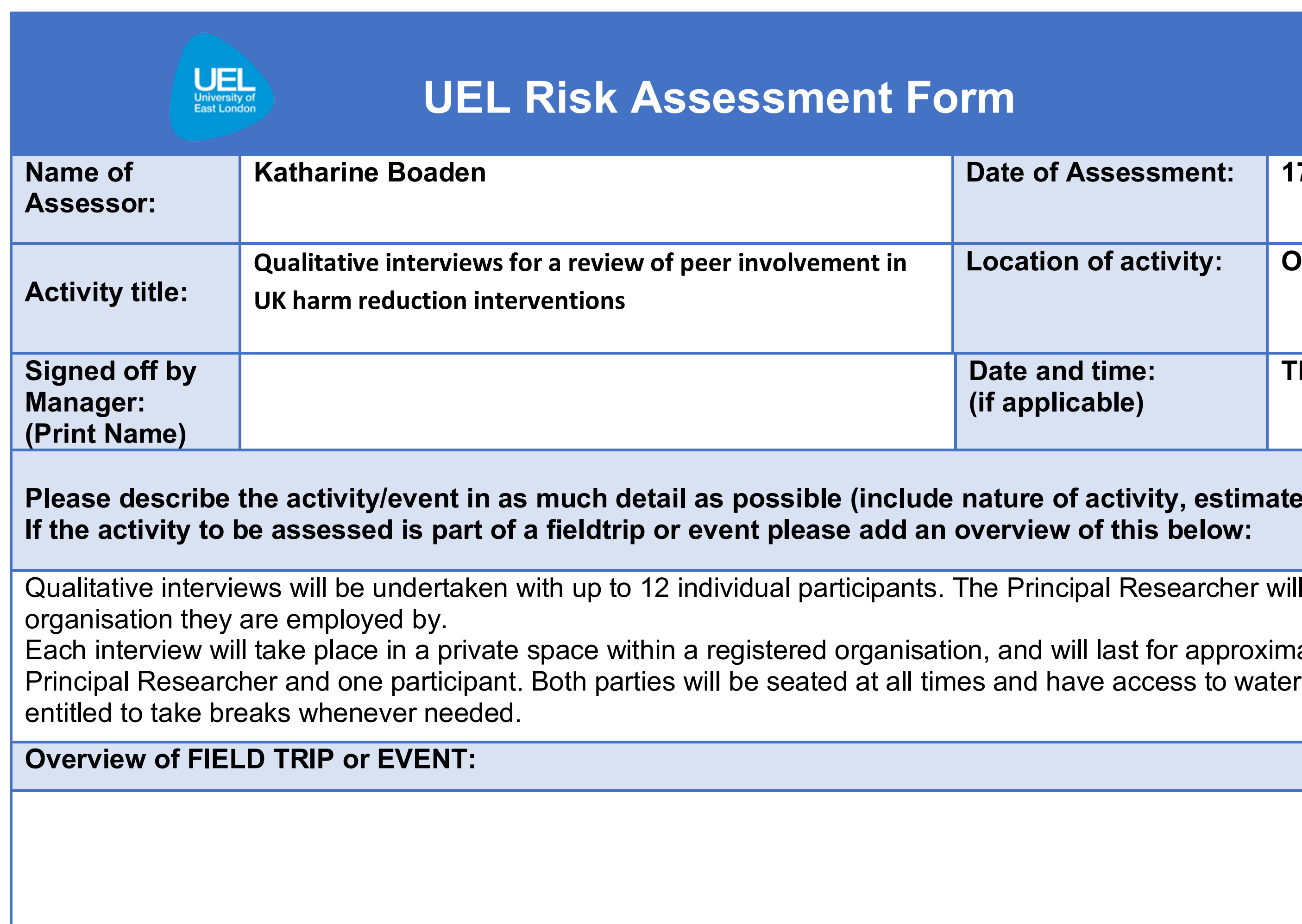
Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology,
University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking part in my study

Appendix D: General Risk Assessment Form template

Guidance: A comprehensive guide to risk assessments and health and safety in general can be found in *UEL's health and safety handbook*. A comprehensive guide to risk assessment is also available on the *Health & Safety Executive's website*. An example risk assessment (for a wellbeing conference/event) is presented below, please replace text in RED with your own/study specific information. This form should consider both physical and/ or psychological risks and how these can be minimised.

DO NOT LEAVE ANY RED TEXT IN THE FINAL VERSION OF YOUR RISK ASSESSMENT FORM



UEL Risk Assessment Form			
Name of Assessor:	**Katharine Boaden**	**Date of Assessment:**	**17**
Activity title:	**Qualitative interviews for a review of peer involvement in UK harm reduction interventions**	**Location of activity:**	**O**
Signed off by Manager: (Print Name)		**Date and time: (if applicable)**	**Th**
Please describe the activity/event in as much detail as possible (include nature of activity, estimate **If the activity to be assessed is part of a fieldtrip or event please add an overview of this below:**			
Qualitative interviews will be undertaken with up to 12 individual participants. The Principal Researcher will organisation they are employed by. Each interview will take place in a private space within a registered organisation, and will last for approxima Principal Researcher and one participant. Both parties will be seated at all times and have access to water entitled to take breaks whenever needed.			
Overview of FIELD TRIP or EVENT:			

Guide to risk ratings:

a) Likelihood of Risk	b) Hazard Severity	c) Risk Rating (a
1 = Low (Unlikely)	1 = Slight (Minor / less than 3 days off work)	1-2 = Minor (No f
2 = Moderate (Quite likely)	2= Serious (Over 3 days off work)	3-4 = Medium (Ma
3 = High (Very likely or certain)	3 = Major (Over 7 days off work, specified injury or death)	6/9 = High (Furthe

Hazards attached to the activity

Hazards identified	Who is at risk?	Existing Controls	Likelihood	Severity	R Ri (Li S
Participants experience emotional distress as a result of participating in interviews.	Participants	Participants will be informed about the nature of the study before being interviewed and will be given the opportunity to withdraw at any time before or during the interview. Participants will be debriefed following the interviews to check on their emotional well-being. They will be signposted to support if needed, including the organisations they work with and external organisations. All interviews will be held in the organisations that the participants work in, so that they have access to support from colleagues if needed.	1	2	2
Principal Researcher experiences emotional distress as a result of conducting interviews.	Principal Researcher	PR will have regular meeting with DoS to discuss any issues arising.	1	2	2

Principal Researcher or participants come to physical harm during the interviews.	Principal Researcher Participants	Travel to each interview location will be by public transport during the daytime. Interviews will be conducted during the daytime in the offices of a registered organisation. Organisational health and safety policies will be reviewed prior to the interviews being conducted. The PR will provide the DoS with a schedule of interviews including dates, times, locations and contact details. The PR will check-in with the DoS prior to and following each interview. The PR will have a mobile phone which can be used to contact 999 in the event of an emergency.	1	2	2

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in blue | **Student:** Please complete/read sections in orange

Details	
Reviewer:	**Elizabeth Wilson**
Supervisor:	**Lorna Farquharson**
Student:	**Katharine Boaden**
Course:	**Prof Doc Clinical Psychology**
Title of proposed study:	Please type title of proposed study

Checklist
(Optional)

	YES	NO	N/A
Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	☐	☐	☐
Detailed account of participants, including inclusion and exclusion criteria	☐	☐	☐
Concerns regarding participants/target sample	☐	☐	☐
Detailed account of recruitment strategy	☐	☐	☐
Concerns regarding recruitment strategy	☐	☐	☐
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	☐	☐	☐
Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	☐	☐	☐
Clear and detailed outline of data collection	☐	☐	☐
Data collection appropriate for target sample	☐	☐	☐

If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	☐	☐	☐
If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	☐	☐	☐
Concerns regarding data storage (e.g., location, type of data, etc.)	☐	☐	☐
Concerns regarding data sharing (e.g., who will have access and how)	☐	☐	☐
Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	☐	☐	☐
If required, General Risk Assessment form attached	☐	☐	☐
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
If required, Country-Specific Risk Assessment form attached	☐	☐	☐
If required, a DBS or equivalent certificate number/information provided	☐	☐	☐
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	☐	☐	☐
All relevant information included in the participant information sheet (PIS)	☐	☐	☐
Information in the PIS is study specific	☐	☐	☐
Language used in the PIS is appropriate for the target audience	☐	☐	☐
All issues specific to the study are covered in the consent form	☐	☐	☐
Language used in the consent form is appropriate for the target audience	☐	☐	☐
All necessary information included in the participant debrief sheet	☐	☐	☐
Language used in the debrief sheet is appropriate for the target audience	☐	☐	☐
Study advertisement included	☐	☐	☐
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	☐	☐	☐

Decision options	
APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **before** the research commences. Students are to do this by filling in the confirmation box at the end of this form once all amendments have been attended to and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records. **Minor amendments guidance:** typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.

NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	In this circumstance, a revised ethics application **must** be submitted and approved **before** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study

Please indicate the decision:	Please select your decision

Minor amendments

Please clearly detail the amendments the student is required to make

The following extract needs further explanation. Given you are anonymising, can more care not be taken to ensure that by changing details no participant will be identified, certainly not by service users who are not bound by confidentiality, like staff.

Care will be taken to ensure that, as far as possible, data published in the report will not contain information that may allow a participant to be identified. As such, details of age, gender, or other potentially identifying factors will be removed. Participants will be informed beforehand that the final research may contain direct quotes of what they have said and will be shared with harm reduction organisations and it is possible they may be identifiable by readers (both staff and service users)

Major amendments

Please clearly detail the amendments the student is required to make

Assessment of risk to researcher

	YES	NO
	☐	☐

Has an adequate risk assessment been offered in the application form?	If no, please request resubmission with an **adequate risk assessment.**	
If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:		
HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	☐
MEDIUM	Approve but include appropriate recommendations in the below box.	☐
LOW	Approve and if necessary, include any recommendations in the below box.	☐
Reviewer recommendations in relation to risk (if any):	Please insert any recommendations	

Reviewer's signature	
Reviewer: (Typed name to act as signature)	**Elizabeth Wilson on 3/8/22**
Date:	Click or tap to enter a date
This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Ethics Committee	

RESEARCHER PLEASE NOTE

For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.

Confirmation of minor amendments (Student to complete)	
I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data	
Student name: (Typed name to act as signature)	**Katharine Boaden**
Student number:	**U2075198**
Date:	**11/08/2022**
Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required	

Appendix E: Interview Schedule

People delivering peer intervention

Q1. I'd like to ask you a little bit about yourself. How old are you? What is your gender? What is your ethnicity?

Q1. What do you do for XX organisation? What sort of people do you support? Where do you work? What do you do? How many hours do you work? Do you get paid? Did you get any training? Do you have a manager/supervisor?

Q2. How did you get involved with XX organisation and why did you decide to do so?

Q3. What is it about being involved in peer work that you like/dislike?

Q4. How do you think peer work for people who use drugs is helpful/unhelpful? How do people respond when you work with them? Is there anything about being a peer that makes your work easier/more difficult?

Q6. Have you noticed anything different in your life since you started peer work (positive or negative)? Have there been any changes to your well-being, mental health?

Q7. Is there anything else you would like to add?

Appendix E: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Understanding the role of peer involvement in UK harm reduction interventions
Contact person: Katharine Boaden
Email: u2075198@uel.ac.uk

You are being invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information which outlines what your participation would involve. Feel free to talk with others about the study (e.g., friends, family, colleagues, etc.) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

Who am I?

My name is Katharine Boaden. I am a postgraduate student in the School of Psychology at the University of East London (UEL) and am studying for a Doctorate in Clinical Psychology. As part of my studies, I am conducting the research that you are being invited to participate in.

What is the purpose of the research?

I am conducting research into harm reduction interventions delivered by peers. My research will look at how people who use drugs are involved in peer interventions and experiences of delivering them.

Why have I been invited to take part?

To address the study aims, I am inviting people who use drugs and are involved in the delivery of harm reduction services to take part in my research. If you are a person who uses drugs who is involved in the provision of peer-delivered harm reduction services then you are eligible to take part in the study.

It is entirely up to you whether you take part or not, participation is voluntary.

What will I be asked to do if I agree to take part?
If you agree to take part, you will be asked to participate in an interview.

- During the interview I will ask you questions about the services you are involved in, how you came to be involved, ask you to think about what you like and dislike about your work and what you think has changed in your life as a result of doing peer work.
- The interview will last approximately one hour.
- You will be interviewed in a private and confidential space at the organisation that you work in.
- I will record the interviews using voice-recording equipment.
- If there are any questions that you do not feel comfortable answering then you will not be required to do so. The interview will be held at a time that feels comfortable for you so that you can access your support networks as easily as possible.

Can I change my mind?
Yes, you can change your mind at any time and withdraw without explanation, disadvantage or consequence. If you would like to withdraw from the interview you can do so at any time before or during the interview. If you withdraw, your data will not be used as part of the research.

Separately, you can also request to withdraw your data from being used even after you have taken part in the study, provided that this request is made within 3 weeks of the interview (after which point the data analysis will begin, and withdrawal will not be possible).

Are there any disadvantages to taking part?

- I will be asking you questions about your involvement in harm reduction work and there is a possibility that our discussion may require you to think about difficult or challenging experiences, which may cause some distress.
- I will provide details of organisations that you might wish to contact for further support.

How will the information I provide be kept secure and confidential?

- Participants will not be identified by the data collected, on any material resulting from the data collected, or in any write-up of the research. Your interview will be audio-recorded and when it is written up, you will be assigned a pseudonym so that your personal details will not appear in any reports.

- Contact details will be stored in a secure, password protected, digital folder until the study has been completed, and then they will be deleted.
- All data will be stored in a secure, password protected folder on the University computer system. Any transfer of data will be done over secure University email.
- Once the study has been completed, all raw data (such as contact details will be deleted. Interview transcripts will not include any personal details.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the 'public task' condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as 'special category data' in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Registry of Open Access Repositories (ROAR). Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles and conference presentations. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally as any personally identifying information will be changed.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by Dr Lorna Farquharson for a maximum of 3 years, following which all data will be deleted.

Who has reviewed the research?

My research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me:

Katharine Boaden
Email: u2075198@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Lorna Farquharson, School of Psychology, University of East London, Water Lane, London E15 4LZ.
Email: l.farquharson@uel.ac.uk

or

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking the time to read this information sheet

Appendix F: Participant Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Understanding the role of peer involvement in UK harm reduction interventions
Contact person: Katharine Boaden
Email: u2075198@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet dated 17/07/2022 (version 1) for the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	
I understand that if I withdraw during the study, my data will not be used.	
I understand that I have 3 weeks from the date of the interview to withdraw my data from the study.	
I understand that the interview will be recorded using voice-recording equipment.	
I understand that my personal information and data, including audio from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	
I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I agree to take part in the above study.	

Participant's Name (BLOCK CAPITALS)

……

Participant's Signature

……

Researcher's Name (BLOCK CAPITALS)

……

Researcher's Signature

……

Date

……

Appendix G: Hand-Coded Interview Transcript

your own lived experience (P7: yeah) what are th… what do you think's helpful about that or perhaps sometimes not helpful I don't know

P7: Er when we're going out on the streets and we're doing this I a I think it's invalid erm 'cause we can reach people that m-members of staff (Int: yeah) wouldn't reach and if they did reach them the way the reaction would be between them or us is totally different (Int: yeah) generally we know these people (Int: yeah) and we can talk to them on a level they know we use as well (Int: yeah) and so they know we're not there you know we're there f-for good basically (Int: yeah) yeah it's it's its more the fact we can talk to people on a level

Value of lived experience.

Int: On a level yeah

P7: Yeah

Int: And do you think there's any bad sides to being like a peer or s- you know

P7: Erm (pause) yeah I I the bad side is I think you've always you're always going to get the one or two I've I've said before you're always going to get the one or two that's the bad side (Int: yeah) but on the whole so far it's been really positive

Emotional toll.

Downsides of peer work.

Int: Yeah yeah sounds it (P7: yeah) sounds it and do you know what are there any like plans for the future you know what what's next do you just continue with the Naloxone are you going to do other stuff or

P7: Erm I'm not sure at the moment erm I know erm I think we're doing this for eighteen months

Int: Okay okay great

P7: Erm after that I am we're not a hundred per cent sure at the moment

Fragility.

Int: Yeah you've still got a way to go haven't you,(P7: yeah) you know you've still got a lot of time to (P7: Yes yeah) to work all that out.

P7: Yeah I'm personally I'd like to try and carry on I'd like to try try and do something after

Hope/motivation for future

Int: Yeah (P7: yeah) yeah so there's that motivation to sort of do keep (P7: yeah) this going as it were (P7: keep something yeah) or something going (P7: yeah) yeah yeah yeah definitely and anything else you think its good for me to to know about about it

P7: I'm trying to think erm not off the top of my head no

Int: And thinking about what you were saying it's really interesting isn't it about like erm yeah just the positives I guess I was thinking about what you were saying about feeling erm like you've got something to do erm (P7: yeah) yeah all that side of it like

P7: (Indistinct words) one of the positives I mean I I suffer from depression as well (Int: uhuh) and a positive personal positive is is that's been really okay like since I've started this it's given me a personal boost (Int: yeah) and it's made me feel good about myself again

Mental health

change in feeling a boost.

Int: Do you have a sense of why that is or is it just a feeling

P7: I I it's it's it's a feeling but I think I think it's just a feeling (Int: yeah) to be honest yeah yeah I think it's knowing that you know years and years of using I'm actually got a bit of

Value of lived experience.

7

involved (Int: mmm) um there's three of us that have come virtually every week now and we've done we've become with the co-ordinator um er from [HARM REDUCTION ORGANISATION] and we've become a real tight-knit team (Int: mmm) and um we actually look forward to it each week we actually get paid erm cash which erm is brilliant because it doesn't we're not undervalued (Int: mmm) er were actually treated (pause) not necessarily like a full time employee but we're treated with respect um that we're prepared to give up some of our time to help others let's say.

Social connection

Payment.

Change in relationship with staff.

Int: Umm so actually getting that payment it feels like the work is valued from (P8: Absolutely) what you're saying.
P8: Absolutely and that um er makes (short pause) it doesn't necessarily make us turn up each week but it is an incentive to when we do turn up to erm erm (short pause) it's an incentive to be useful or erm (Int: Uhuh uhuh) err productive (Int: yeah) you know so erm I think if we weren't paid we wouldn't we wouldn't feel the incentive to either go into town and speak to people or erm provide our opinion there was erm when we did the CPR training we did that on one afternoon and we the three of us er the peers were there with ten people who worked with the service and they would they were while they were describing or the people running the actual workshop were describing the CPR process erm I'd done it years ago when I got involved in we did overdose workshops (Int: mmm) and a Hepatitis C workshops many years ago and what they have agreed to do this time is a harm reduction workshop so the plan is erm in the spring or in you know in the next few weeks to organise a harm reduction workshop where we will pay service users err might be a fiver but hopefully ten pounds to come and sit for a couple of hours erm and the peers will provide the harm reduction training with a member or (Int: mmm) of [HARM REDUCTION ORGANISATION] erm to the service users erm and they will get paid for coming and (Int: mmm) hopefully learning

Payment.

Peer work as a vocation.

Planning for the future.

Int: And what what harm reduction stuff is that going to be about sort of safe injecting (P8: So yeah) or is it gonna be all sorts?

P8: So it's erm it's all sorts it's safer injecting it's encouraging people to consider smoking instead of injecting (Int: ahah) I've never injected I've only ever smoked (Int: ahah) erm errr so I'm a big believer that you know smoking is less harmful than injecting (Int: mmm mmm) erm there's er also er er harm reduction in terms of encouraging people not to share (Int: yeah) equipment erm and there might be other things like there would be a bit of information about bloodborne viruses (Int: yeah) erm information about erm trying to encourage people not to mix so if they are going to do some heroin trying to encourage them not to do erm benzodiazepines (Int: ahah) or whatever I think if I've got that right erm erm or alcohol as well (Int: yeah) because those are there's some **poly** use is the big risk for overdose (Int: yeah) so there's a variety of things that we would erm include in the workshop erm and erm I the when I suggested it erm Christmas time erm they said they would consider it and then they agreed a couple a few week a coup- a few weeks ago that it would be something that they would do erm you know in the next erm you know couple of months two or three months.

Plans for the future.

Inputs taken on board.

Ownership

Int: So your suggestions are really being taken on board

4

47 Int: Oh fantastic oh so you give it to like the staff and whatnot there?
48
49 P3: Yeah the staff and (unclear)
50
51 Int: Oh that's a great idea yeah (P3: yeah) and so when did you get involved then
52 with [HARM REDUCTION ORGANISATION] or with doing this actual peer work?
53
54 P3: With [PEER WORK TEAM] (overlapping) (Int: (overlapping) and [PEER WORK
55 TEAM]?) I got involved about three month ago (Int: okay) and err I've been told by
56 some of the other members that we we go out in the community err clean some of
57 the erm sites up where the where the drug users have err left litter (Int: yeah) and
58 needles pots pans and things like that (Int: yeah) erm for cooking up and they clean
59 them up and talk to erm drug users and service users (Int: yeah) err see what what's
60 going on on the streets see how we can help (Int: yep) things like that.
61
62 Int: Yeah amazing and what was it what sort of did they ask you or what attracted
63 you to sort of getting involved would you say?
64
65 P3: Umm one one of the um one of the lads that are on the group err he was talking
66 one day and I I was like ah just jokingly (indistinct) how do I get on one of th. ah on a
67 group like that and like a couple of days later I think it's [NAME S] erm pulled me to
68 one side and he was like I've heard that you're you're interested in some groups and
69 that and err there's a space on [PEER WORK] group if you if you want to take the
70 opportunity and I was like yeah course.
71
72 Int: Oh that's brilliant yeah.
73
74 P3: That's how it come about.
75
76 Int: Oh excellent oh god so just good job you said that to someone and then they
77 they obviously let them know here and obviously you've mentioned a bit about the
78 sort of work you do do you have like a set amount of hours do you get paid how does
79 it work?
80
81 P3: Like I say the last couple of month because of Covid and staff shortages and
82 things like that erm we we've only been on meet once a month but erm I've been to
83 one meeting with like Council officers other other agencies erm how to make
84 services better things like that erm and we got twenty-five pounds for that for our
85 time (Int: uhuh) erm but we 'cause of Covid and things like that erm and there was a
86 lady left left the group erm we've not really been able to do what we what we could
87 do.
88
89 Int: Um um so do you get twenty-five pounds each time you sort of do like a meeting
90 or a.....
91
92 P3: Yeah up until like from when I started up until now yeah

Different aspects of role

Lack of formal interview process.

feeling the need for stay involvement and how simple this is.

Different aspects of role

Payment.

Payment.

Appendix H: Organisation of Coded Data

NVIVO
Thesis.nvpx

IMPORT
Data

ORGANIZE
Coding
Codes
Cases
Cases
Case Classifications
Notes
Memos
Annotations
Memo Links
Sets

EXPLORE
Queries
Query Criteria
Query Results
Coding Matrices
Visualizations

Home | Edit | Import | Create | Explore | Share | Modules | Log In | Search

Clipboard | Item | Organize | Visualize | Code | Autocode | Uncode | Code In Vivo | Spread Coding | Case Classification | File Classification | Workspace

Name	Files	References	Created on	Created...	Modified on	Modified by	Color
Changes in relationships	1	5	27 Mar 2023 at 23:...	KB	27 Mar 2023 at 23:...	KB	
Exceeding Expectations	1	1	27 Mar 2023 at 23:...	KB	27 Mar 2023 at 23:...	KB	
FACTUAL INFO	0	0	16 Feb 2023 at 22:...	KB	16 Feb 2023 at 23:13	KB	
Feeling left behind	1	1	14 Feb 2023 at 15:...	KB	14 Feb 2023 at 15:...	KB	
Helping Others	2	4	27 Mar 2023 at 22:...	KB	28 Mar 2023 at 17:...	KB	
Hope for the future	2	11	27 Mar 2023 at 23:...	KB	28 Mar 2023 at 17:...	KB	
HOW IT WORKS	0	0	16 Feb 2023 at 23:12	KB	16 Feb 2023 at 23:13	KB	
Independence	1	1	27 Mar 2023 at 22:...	KB	27 Mar 2023 at 22:...	KB	
Keeping Occupied	1	1	27 Mar 2023 at 23:...	KB	27 Mar 2023 at 23:...	KB	
Negatives of peer work	2	4	27 Mar 2023 at 23:...	KB	28 Mar 2023 at 17:...	KB	
Payment	5	31	14 Feb 2023 at 15:...	KB	28 Mar 2023 at 17:...	KB	
PERSONAL IMPACT	0	0	16 Feb 2023 at 22:...	KB	16 Feb 2023 at 23:13	KB	
Previous experience	1	1	28 Mar 2023 at 10:...	KB	28 Mar 2023 at 10:...	KB	
UNIQUE SKILLSET	0	0	16 Feb 2023 at 22:...	KB	16 Feb 2023 at 22:...	KB	
Us and them	1	2	28 Mar 2023 at 17:...	KB	28 Mar 2023 at 17:...	KB	
Value of peer work	1	1	16 Feb 2023 at 22:...	KB	16 Feb 2023 at 22:...	KB	

0 item selected

Appendix I: Thematic Map