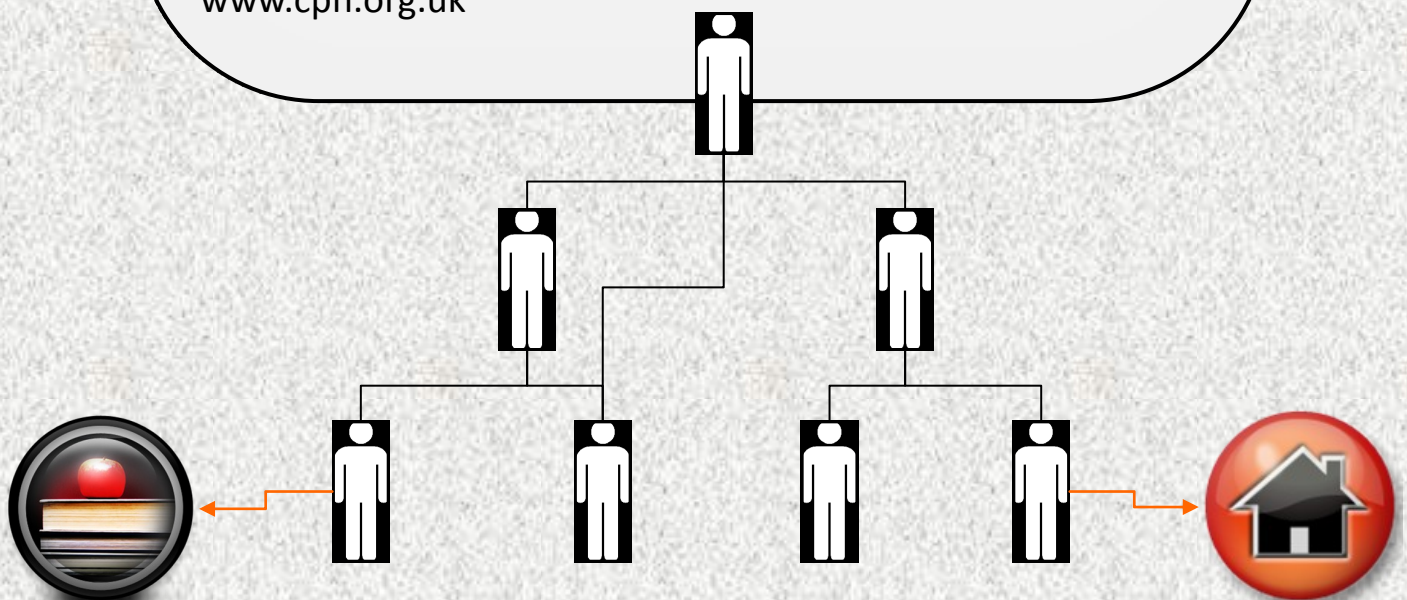




# Evaluation of Phase Two of the Liverpool Peer to Peer Project May 2009

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## 1.0 Introduction

It has been suggested that promoting health initiatives to socially marginalised groups demands creative approaches (Shiner, 1999), and peer led approaches are both innovative and creative in their philosophy and practice. Peer education in the field of substance use has been defined as; “sharing and providing information about drugs (and alcohol) to individuals or groups, occurring through messengers, who are similar to the target group in terms of characteristics such as age, gender, cultural background and experience, and has sufficient social standing or status within the group to exert influence” (McDonald, 2004).

It has been widely demonstrated that injecting drug users are initiated into injecting by their peers and the initial and lasting education messages they receive from their peers influences injecting practise throughout their drug using life (Hunt *et al.*, 1998). Evidence suggests that peer educators are considered a reliable and trustworthy source and that many individuals, especially in the case of substance users that have never accessed drug treatment, are thought to learn more effectively from within their own peer groups (HPA, 2005). The Peer to Peer (P2P) Project, at Lighthouse Project (LHP), was created with the primary aims of challenging misinformation, increasing safer drug using practice and encouraging the dissemination of harm reducing information among members of the substance using community by use of peer education. The additional aims of promoting personal development and improving confidence to become peer advocates were addressed via specific training sessions.

## 1.1 Background

In recent years, government strategies and policy making institutions have advised the development of non-traditional interventions among specific drug-using groups, in an attempt to address some of the harms associated with problematic drug use. In 1993, the Advisory Council on the Misuse of Drugs (ACMD) recommended peer-led interventions may be a useful technique when working with injecting drug users. In 2002, the update to the UK Drug Strategy highlighted the need for effective engagement and targeted action with ‘hard-to-reach’ drug using groups, such as homeless people and sex workers (Home Office, 2002). In 2004, the National Treatment Agency (NTA) recommended that commissioners account for and consider the provision of basic overdose prevention training to drug users and their friends and families in order to equip them with the necessary skills to make an appropriate response in a drug related emergency situation. The publication of Government White Papers research has drawn attention to the potential benefits of peer education as a method of drug prevention, mainly due to the credibility of peer advocates among their peers, in this case groups of young people (Orme & Starkey, 1999).

Research suggests that drug prevention interventions and harm reduction techniques can be delivered using peer led approaches in a number of examples. A project in Kent, London and Surrey in 1997, trained drug workers to deliver harm reduction interventions to injecting drug users, with the aim of changing the behaviour of injecting drug users when in the company of non-injecting drug users, who may be vulnerable to injecting and associated practices. The evaluation of this study demonstrated that the project had been effective in creating disapproval of injecting in front of non-injectors and substantially reduced the number of participants who injected in front of non-injectors (Hunt *et al.*, 1998). Peer education initiatives have been implemented in variety of settings in the UK. In Surrey, ‘Brown & White’ is a series of harm reduction peer-led workshops focusing on heroin and crack use with current drug users and injectors. An in-house

evaluation found that 89% of the participants reported a change in their drug using behaviour as a result of the workshops and, importantly, 89% reported passing on messages from the workshops to external peers (Whitfield, 2007).

The efficiencies of peer led initiatives have also been demonstrated among specific groups, such as the homeless. Research indicates that there is a link between social exclusion and substance use (Eaton et al., 2007; HPA, 2007) and evidence suggests that drug use is more prevalent among the homeless than those living in private households (Gill et al., 1996). Research also indicates that homeless people are also more likely to inject drugs (Gill et al., 1996; Klee, 1991) and that injecting is a high risk factor linked to homelessness (Kemp et al, 2006). Research by the charity Crisis (Fountain & Howes, 2002) reported that 80% of homeless people interviewed reported that they had begun using at least one new drug since becoming homeless. A feasibility study of introducing peer led approaches among Big Issue vendors reported that, while potential peer advocates would require training and support, peer education could be successfully incorporated into drug and alcohol work (Hunter & Power, 2002). However in some studies, there has been continued debate as to the attributes that makes a good peer educator (Shiner, 1999).

A further study examining the promotion of safer drug using practice in response to the spread of hepatitis C among intravenous drug users, found peer education to be a successful tool. The study demonstrated that, while medical systems may have the right information, it is not a trusted system and the greatest importance of peer education is the credibility that peers have among their social groups (Galindo *et al.*, 2007). Peer education is based on the rationale that the peers are from the similar societal group and the peer educators are considered trustworthy. P2P models have been demonstrated to be useful for various topics and a diversity of groups; effective peer-led approaches have been successfully demonstrated for sex education (Forrest *et al.*, 2002), HIV/AIDS awareness (Norton & Mutonyi, 2007), violence prevention (Wiist *et al.*, 1996), young people (Milburn, 1995) and substance users (Shaw et al., 2007). However, evidence demonstrating effectiveness in peer led approaches is limited and research has identified the need to develop a model of peer education that can identify effectiveness of peer education in the short, medium and long term (Parkin & McKeganey, 2000).

## **1.2 History of Peer to Peer**

Phase One of the P2P Project was originally developed by LHP in 2006, to deliver a programme of training to past and current drug users in Liverpool and Sefton, with the main aims of challenging misinformation, increasing knowledge of safe drug using practices and to oppose 'street doctor' mentality. LHP commissioned the Centre for Public Health (CPH) at Liverpool John Moores University to evaluate the project. The evaluation demonstrated that the project was successful in increasing participant's knowledge relating to drugs and associated harms and was successful in improving self-reported confidence of participants relating to passing on information or acting in drug-related emergency situations. The evaluation recommended that P2P should be strategically developed for a future programme and rolled out for a second phase (Shaw *et al.*, 2007).

In 2008, LHP received funding to facilitate Phase Two of P2P, consisting of two simultaneous programmes in Liverpool, which ran from September 2008 until May 2009. In response to evaluation recommendations, training delivery consisted of two parts; the first replicated the original P2P programme format of six weekly structured peer education sessions; while the second provided emphasis on personal development,

which aimed to build participant confidence and skill in becoming peer advocates. The personal development stage was delivered by LHP learning and development substance misuse trainers in conjunction with selected professionals.

### **1.3 Evaluating Peer to Peer**

The CPH at Liverpool John Moores University was commissioned by LHP to independently evaluate Phase One and commissioning was extended to evaluate Phase Two of the P2P Project. The evaluation combined quantitative and qualitative measures of data collection to gather evidence for the effectiveness of the P2P Programme, in terms of its impact on the participants involved and members of the substance using and wider community. Similar to the evaluation of the Phase One of P2P, the evaluation of Phase Two utilised data from participant Profile Sheets, a Big Quiz completed at the outset and programme end, Mini Quizzes to supplement data generated from the Big Quiz, qualitative data from Focus Group discussions and, unique to the second phase, additional Reflection sessions and Diary Sheets for participants to record examples of peer advocacy. The evaluation of the second phase was proposed to analyse the effects of the peer education sessions, as with the original phase, to analyse the effects of the personal development sessions and also to assess the mid-term effects of a substantially extended programme.

The evaluation was designed to record the following outcomes:

- Retention of participants for the programme duration
- The level of misinformation among participants relating to substance use, the consequential harms and available treatment options
- Changes and retention of participants' knowledge and awareness of high risk drug using behaviour and the potential associated harms
- Changes in participant confidence regarding passing on and disseminating information relating to substance use and the associated harms
- Examples of skill demonstrations or examples of peer advocates within substance using and wider communities
- Identification of effective training techniques and the potential barriers and limitations
- The impact of the P2P Programme on the participants personal lives, physical and mental health and emotional well being
- The impact of the P2P Programme on the participants professional aspirations and opportunities
- Examples of participant engagement with external parties, such as substance use services, support services or substance use professionals

## **2.0 Methodology**

### **2.1 The Peer to Peer Programme**

Two independent groups of 15 individuals attended six peer education training sessions, over a period of six weeks, and eight personal development training sessions, over a period of six months. The peer education training sessions covered topics relating to safer injecting, overdose prevention, blood borne viruses, health promotion and the availability of treatment services and options. The personal development training sessions covered topics relating to relapse prevention, mental health, complementary therapies, education training employment (ETE), a reflection session and two mentoring sessions. Additionally, LHP proposed further sessions relating to professional development, including a professional training certificate, for participants completing Phase Two of the P2P Project. However, the proposed duration and completion dates of the additional sessions were beyond the remit of the evaluation.

Sessions were facilitated by LHP staff and, where appropriate, a range of external professionals to cover each of the topics addressed during the peer education sessions. Professionals included representatives of the North West Ambulance service, mental health professionals, nursing professionals, drug education professionals and health and nutrition experts. Participants were administered with a range of materials such as introductory packs, presentation slides and treatment service availability and contact information. Participants were provided with £3 travel expenses and a £10 cash incentive, totalling £13 per participant, per session. Participants attended LHP in Fleet Street in Liverpool city centre for all training sessions, with the exception of the second groups' final personal development session, which was facilitated at LHP Bridle Road, Bootle.

### **2.2 The Evaluation Process**

A research team, two of four representatives from the CPH, attended the introductory sessions in order to introduce themselves and the evaluation to participants. Researchers also attended at various points of the programme to observe sessions and to lead Focus Group discussions. Issues including confidentiality, the right to withdraw and the evaluation methodology were outlined by the research team. Researchers were available to answer any questions or queries from participants, facilitators or LHP staff. LHP adapted and produced the quiz questionnaires from Phase One, which comprised the majority of the quantitative data. Participant Profile Sheets, Diary Sheets and Evaluation documentation, such as participant information sheets and consent forms, were produced by researchers and were administered during the introductory session and, in the case of the Diary Sheets, at the beginning of the second Focus Group discussion.

### **2.3 Evaluation Data**

- A client profile sheet was administered to participants at the outset to record information regarding drug use, drug taking behaviour, treatment history, alcohol use, employment status and knowledge of safer using practice.
- Knowledge was measured via a Big Quiz questionnaire administered at the introductory session and the penultimate personal development session. Data were recorded with the primary aim of describing changes in participant knowledge and awareness of the peer education sessions, and additionally of demonstrating changes in participant confidence, attitude and behaviour. The quiz

consisted of questions testing subject knowledge relating to the topics from the peer education sessions. Multiple choice questions, based on factual information, were accompanied by subjective questions, examining issues such as participant confidence or self perceptions. The Big Quiz provided baseline and programme end point participant profiles and scores, which could be utilised for within subject analysis.

- The Big Quiz was supplemented by Mini quizzes; which comprised the same questions as the Big Quiz but were edited to remove the irrelevant training session topics. This provided an intermediate data set between baseline and programme end and was useful in verifying trends. This data point was not graphically displayed since quizzes were completed directly after the session and were potentially misleading as to what knowledge participants would retain.
- A Confidence Quiz was administered after the peer education training sessions to record information regarding self perceptions, perceptions of the group, perceptions of the programme, self confidence, attitudes and behaviour. Data generated from the Confidence Quiz was useful in assessing personal development among participants.
- Participants were provided with Diary Sheets to track their experiences during the weeks between the personal development sessions. Participants were given a verbal explanation and written guidelines, about the type of information to record as an 'event' on the Diary Sheets. Explanations suggested recording such information as; opportunities for peer advocacy, changes in drug using status, changes in drug using behaviour, experiences of challenging environments or changes in confidence about being a peer advocate. The Diary Sheet recorded information about the nature of the 'event' by use of flow boxes and provided open text spaces for participants to express feelings or experiences regarding the 'event'.
- Qualitative information was collected to supplement quantitative data by use of multiple Focus Group discussions, which addressed a range of topics relating to all aspects of the programme. Focus Groups for each programme were conducted at the end of the peer education sessions, at the mid-point and at the end of the personal development sessions. At each Focus Group, the research team guided participants through a structured discussion examining issues including; feedback about the peer education sessions; feedback about the personal development sessions; how information was received; how information was reproduced; opportunities for peer advocacy; barriers to peer advocacy; persisting misinformation; changes in substance use; changes in using behaviour; opportunities for voluntary roles or employment; changes in physical and mental health; overall strengths and weaknesses of the programme; and significant life changes. Focus Group discussions were also useful for peers to discuss and help each other with some of the issues they did not fully understand.

## 2.4 Data Analysis

Hard copies of the Quizzes were sent to the CPH and were inputted and stored in secure SPSS files. Data sets requiring transfer were secured using password protection. Data were cleaned and validated and, for most analyses, reduced to a within subject group, who had completed the Big Quiz at the outset and at the end of the programme. Percentages given are valid percentages (of responding participants) and, in some cases, are reflective of the sub-sample, who completed the relevant sections for a particular topic or question. Focus Group discussions, or group interviews, did not employ any one method to generate information but were guided by participants. This interview process is commonly used (Kuehl & Newfield, 1991) and generates data that may be thematically analysed, where themes and patterns are identified and



separately considered (Aronson, 1994). Since Focus Groups were conducted at three stages for each group, themes, where relevant, have been considered in the context of the time stage in which they were recorded.

Statistical analyses were limited owing to the abundance of qualitative and subjective data. However, the McNemar change test was utilised to identify statistical significance among changes in correct participant scores between existing and learnt knowledge relating to the peer education sessions.

## **2.5 Ethics**

This research was ethically approved by Liverpool John Moores University Ethics Committee. Participants were provided with a participant information sheet, which was also verbally explained. Participants were given the opportunity to ask questions before giving informed written consent.

### 3.0 Results

#### 3.1 Session Attendance

Table 1 demonstrates participant attendance at the peer education (PE) and personal development (PD) sessions. As displayed, attendance gradually decreased throughout the duration of the programme but, as later discussed, non-attendees varied and many of the premature drop outs were for positive reasons.

**Table 1. Training Session Attendance: Both Groups & Groups Combined**

Session	Group 1 (N/15)	Group 2 (N/15)	Groups Combined (%)
PE 1. Introduction	15	11	86.6
PE 2. Safer Injecting	10	14	80.0
PE 3. Overdose Prevention	14	13	90.0
PE 4. Blood Bourne Viruses	13	9	76.6
PE 5. Heath Promotion	13	11	80.0
PE 6. Treatment Services	12	10	73.3
PD A. Reflection	10	10	66.6
PD B. Mentoring 1	9	9	60.0
PD C. Mentoring 2	10	9	63.3
PD D. Relapse Prevention	8	8	53.3
PD E. Mental Health	7	9	53.3
PD F. Complementary Therapies	3	7	33.3
PD G. Support Services	8	8	53.3

#### 3.2 Combined Group Profiles

Of 30 participants, 12 were female and 18 were male. The age range of participants was 29-54 and the mean age was 37.8 years. In terms of employment status, 95.7% were unemployed and 4.3% (one individual) was studying. In terms of accommodation status, 64.0% were in rented accommodation, 16.0% were in hostel accommodation, 4.0% had no fixed abode and 16.0% stated other (two of these individuals specified they were living with parents). Table 2 displays the drug using profile of the combined groups.

**Table 2. Drug Using Profile: Combined Groups**

Substance	Ever used (%)	Using at Baseline (%)
Heroin	86.4	15.8
Crack	95.7	25.0
Methadone	81.0	57.9
Amphetamines	87.0	57.9
Cocaine	100	13.6
Ecstasy	89.5	5.3
Cannabis	95.0	25.0

In terms of injecting behaviour, of the ten participants, who specified their usual route of use for heroin and/or crack, only one participant indicated their usual route was injecting at the outset. In terms of sharing, 37.5% stated they had ever shared needles, 41.2% stated they had ever shared syringes, 58.8% stated they had ever shared filters, 47.1% stated they had ever shared water and 61.1% stated they had ever shared spoons.

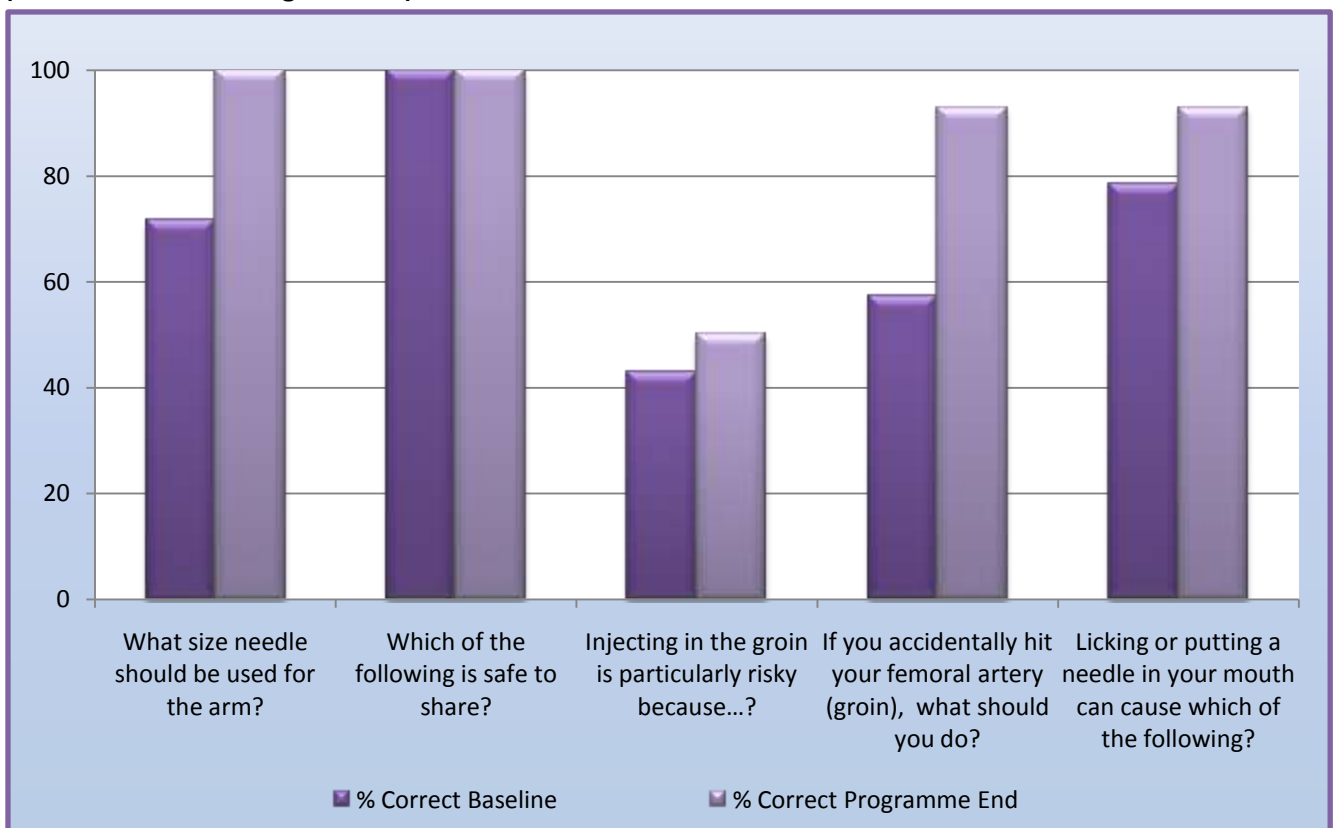
### 3.3 Big Quiz Data

See appendices for Big Quiz questions and answer options relating to each topic.

#### SAFER INJECTING

Graph 1 demonstrates the change in percentage of participant correct scores relating to safer injecting practices from baseline to project end. As displayed in most cases, substantial improvements were made for questions relating to safer injecting, except for the question relating to sharing injecting equipment, which was answered correctly by 100% of participants both at baseline and programme end. While a small improvement was made in the question relating to injecting in the groin, only 50.0% of participants answered this question correctly by programme end. No statistical significance was derived for these changes.

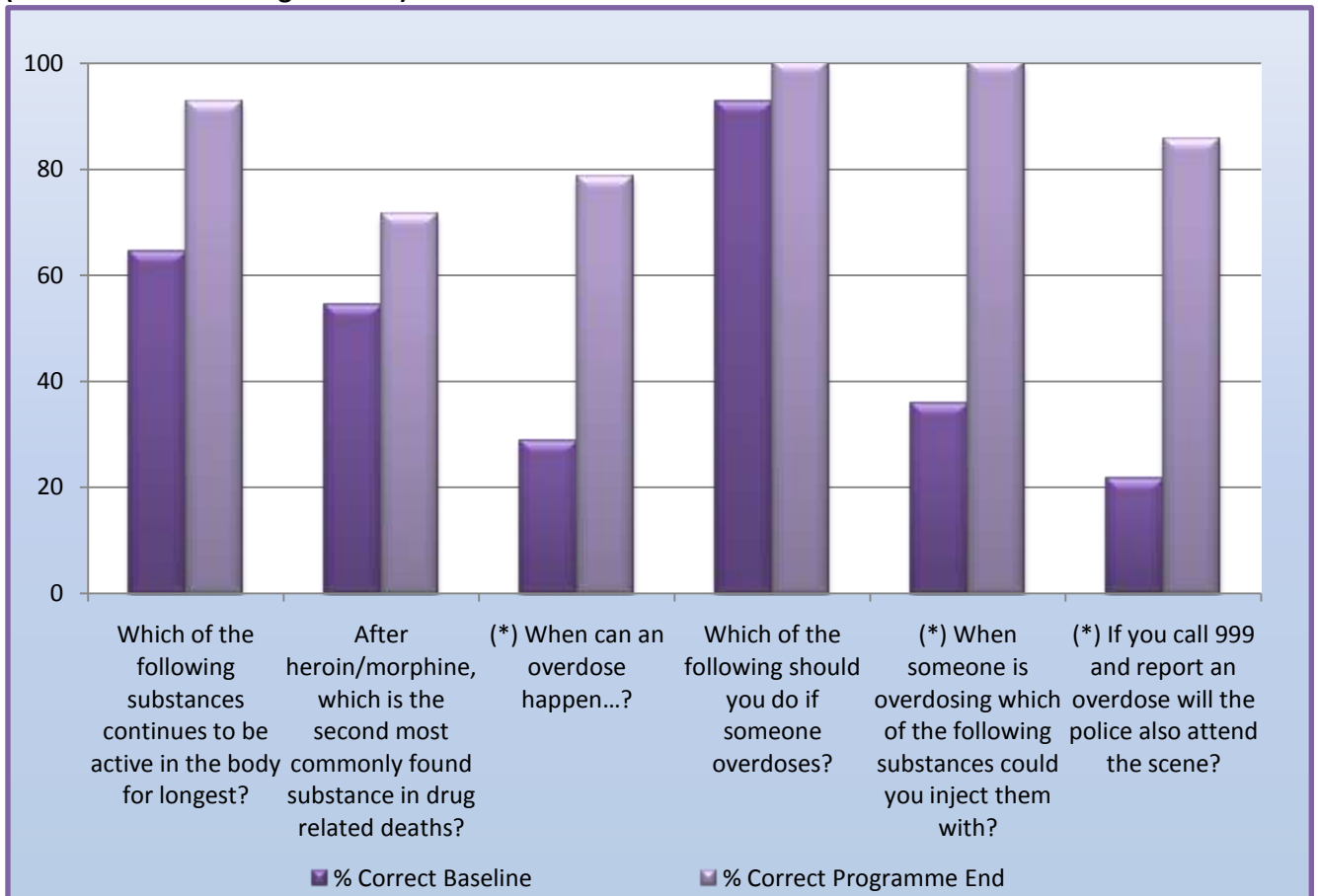
**Graph 1. Percentage of Correct Answers Relating to Safer Injecting at Baseline & Project End**  
 (\* denotes statistical significance)



## OVERDOSE PREVENTION

Graph 2 demonstrates the change in percentage of correct scores relating to overdose prevention from baseline to project end. As displayed often substantial improvements were made for questions relating to overdose prevention, which in three cases, were found to be statistically significant ( $p < 0.05$ ). Questions relating to overdose prevention were generally answered well by participants, with over 75.0% answering all questions correctly by programme end.

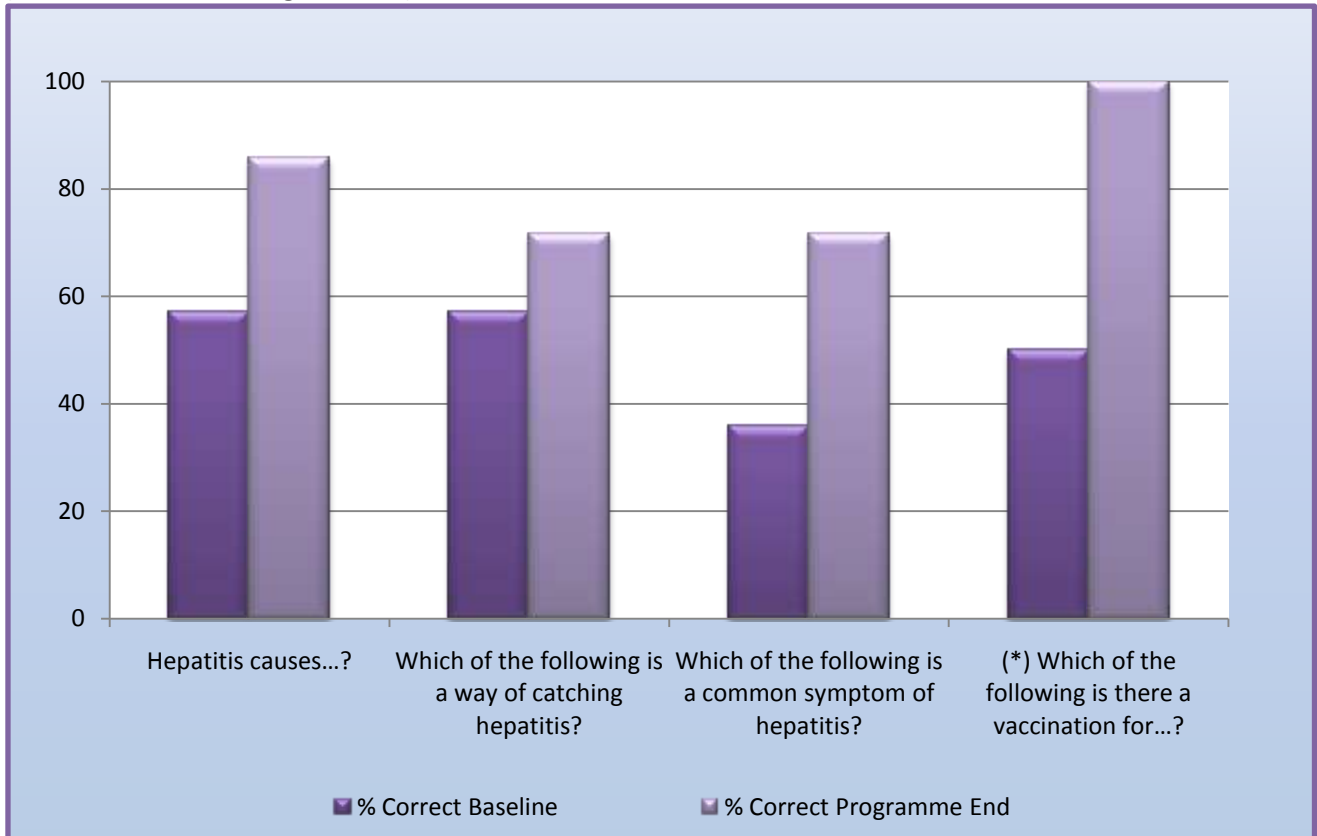
**Graph 2. Percentage of Correct Answers Relating to Overdose Prevention at Baseline & Project End (\* denotes statistical significance)**



## BLOOD BORNE VIRUSES

Graph 3 demonstrates the change in percentage of correct scores relating to Blood Borne Viruses (BBVs) from baseline to project end. As displayed, improvements were made for all questions relating to BBVs, which by project end were well answered by participants, with over 75.0% answering all questions correctly. Statistical significance was derived for the question relating to available vaccinations, where correct participant responses improved from 50% to 100% ( $p < 0.05$ ).

**Graph 3. Percentage of Correct Answers Relating to Blood Borne Viruses at Baseline & Project End (\* denotes statistical significance)**



## HEALTH PROMOTION

Graph 4 demonstrates the change in percentage of correct scores relating to health promotion from baseline to project end. As displayed, improvements were made for all questions relating to health promotion, which in one case, was found to be statistically significant ( $p < 0.05$ ). Questions relating to health promotion were answered well by participants in the most part, despite fewer respondents correctly answering the true or false question, relating to the transmission of sexually transmitted infections, at programme end when compared to outset. Statistical significance was not derived for changes in correct participant scores for questions relating to health promotion. The biggest percentage change was a decrease in correct scores of 25% for a true or false question relating to the transmission of sexually transmitted infections.

**Graph 4. Percentage of Correct Answers Relating to Health Promotion at Baseline & Project End (\* denotes statistical significance)**

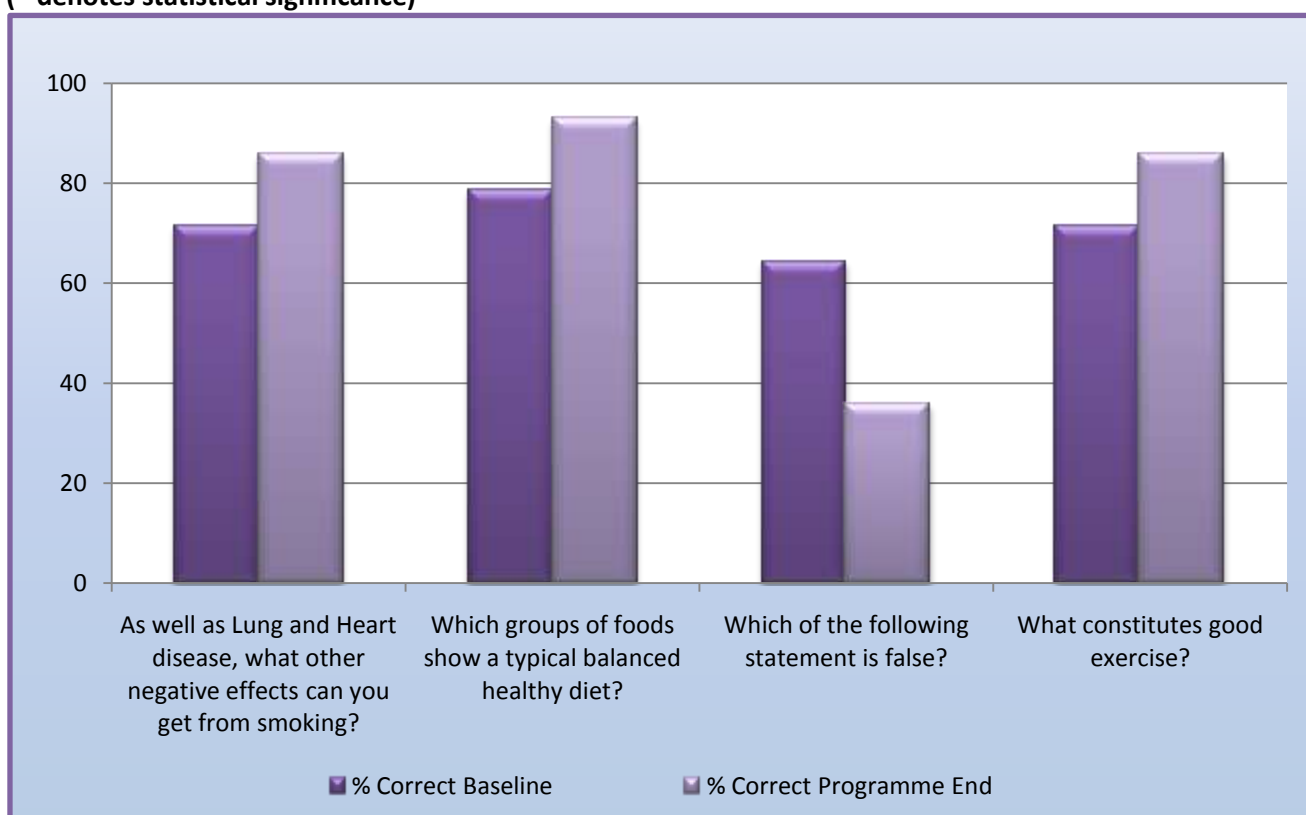


Table 3 demonstrates within subject confidence changes from baseline to project end as recorded by the Big Quiz. Cases have been collapsed from four options to two in each case, for example 'very unconfident' and 'very confident' have been included in 'unconfident' and 'confident' respectively. As displayed, all aspects demonstrated positive outcomes by programme end. Particularly positive were the 43.0% of participants who changed from feeling unconfident to feeling confident about giving harm reduction advice.

**Table 3. Big Quiz Within Subject Confidence Change from Baseline to Project End**

Topic & Question	Response	Start (%)	End (%)
<b>SAFER INJECTING</b>			
How confident do you feel about giving harm reduction and safer injecting information to an injector?	Confident	57.0	100
	Unconfident	43.0	0
<b>OVERDOSE PREVENTION</b>			
How confident do you feel about calling 999 if someone overdoses?	Confident	93.0	100
	Unconfident	7.0	0
How confident do you feel about your ability to put someone in the recovery position?	Confident	71.0	100
	Unconfident	29.0	0
<b>BBVs</b>			
How important is it to ensure that BBVs are not transmitted?	Important	100	100
	Unimportant	0	0
How comfortable do you feel about going to be tested for hepatitis C?	Comfortable	89.0	100
	Uncomfortable	21.0	0

### TREATMENT SERVICES

Finally, as part of the Big Quiz, participants were requested to indicate their knowledge of available treatment providers and access to services in Liverpool and Merseyside, both at the outset and programme end. Of participants, 28.6% at the outset were unclear about appropriate access routes to treatment; this proportion fell to 0% by programme end. By programme end, 100% of participants stated that they thought all service users should have an agreed care plan; 63.6% and 36.4% of these expressed that they thought care plan reviews should take place every three months and six months respectively. Finally by programme end, 63.6% and 85.7% of participants expressed that they thought complementary therapies ‘will support my drug treatment’ and ‘help me relax’ respectively.

### 3.4 Confidence Data

Table 4 displays the outcomes of various aspects of the Confidence Quiz, such as drug use, using behaviour, giving harm reduction advice and future goals and aspirations. As displayed, particularly positive outcomes were found for each question. In terms of drug use 71.4% of participants stated they were currently drug free and 28.6% stated that they were currently using less drugs than at the outset. In terms of injecting and using behaviour, 47.5% stated that they were less likely to inject, 90.9% of participants stated they felt more confident about safer injecting, 100% stated they do not share injecting equipment and 95.0% of participants stated they felt more confident about safer using. In terms of personal and professional development, 95.2% stated they felt positive about their future goals, 95.2% stated they felt very confident or confident about improving their lives, 85.7% of participants stated that they felt positive about future employment and 95.2% of participants agreed that the P2P programme had helped them feel respected and valued in the community. See appendices for Confidence Quiz questions and answer options.

**Table 4. Participant Confidence Quiz Results, Given as Combined Percentages (n=21)**

Question	Response	Groups Combined (%)
<b>How has your drug use changed since attending P2P?</b>	I'm still drug free	28.6
	I don't use drugs at all now	42.8
	I use less drugs	28.6
	I use the same amount of drugs	0
	I use more drugs	0
<b>Since attending P2P how do you feel about injecting drugs?</b>	I have never injected drugs	28.6
	I am less likely to inject	47.5
	I feel the same way about injecting	18.9
	I am more likely to inject	0
<b>Since attending P2P programme, how confident do you feel about safer injecting?</b>	I am more confident about safer injecting	90.9
	No change in my confidence about safer injecting	9.1
	I am less confident about safer injecting	0
<b>How do you feel about sharing injecting equipment since attending the P2P programme?</b>	I don't share works/equipment	100
	I share works/equipment less than before	0
	I share works/equipment the same than before	0
	I share works/equipment more than before	0
<b>Since attending P2P, how confident do you feel about giving correct information to other people about using drugs safely?</b>	I feel more confident about safer using	95.0
	I feel no change in my confidence about safer using	0
	I feel less confident about safer using	5.0
<b>How has the P2P programme made you feel about your future hopes/goals?</b>	I feel positive about my future hopes/goals	95.2
	I feel no different	0
	I feel negative about my future hopes/goals	4.8
<b>Since attending the P2P programme how confident do you feel about improving your life?</b>	Very confident	61.9
	Confident	33.3
	Don't know	4.8
	Unconfident	0
	Very unconfident	0
<b>How has the P2P programme made you feel about your future employment opportunities/income?</b>	I feel positive about future employment	85.7
	I feel no different	14.3
	I feel negative about future employment	0
<b>Do you agree with the following statement? "The P2P programme has helped me to feel respected and valued in my community"</b>	Strongly agree	42.9
	Agree	52.3
	Disagree	4.8
	Strongly disagree	0



## TRAINING MODULES & FACILITIES

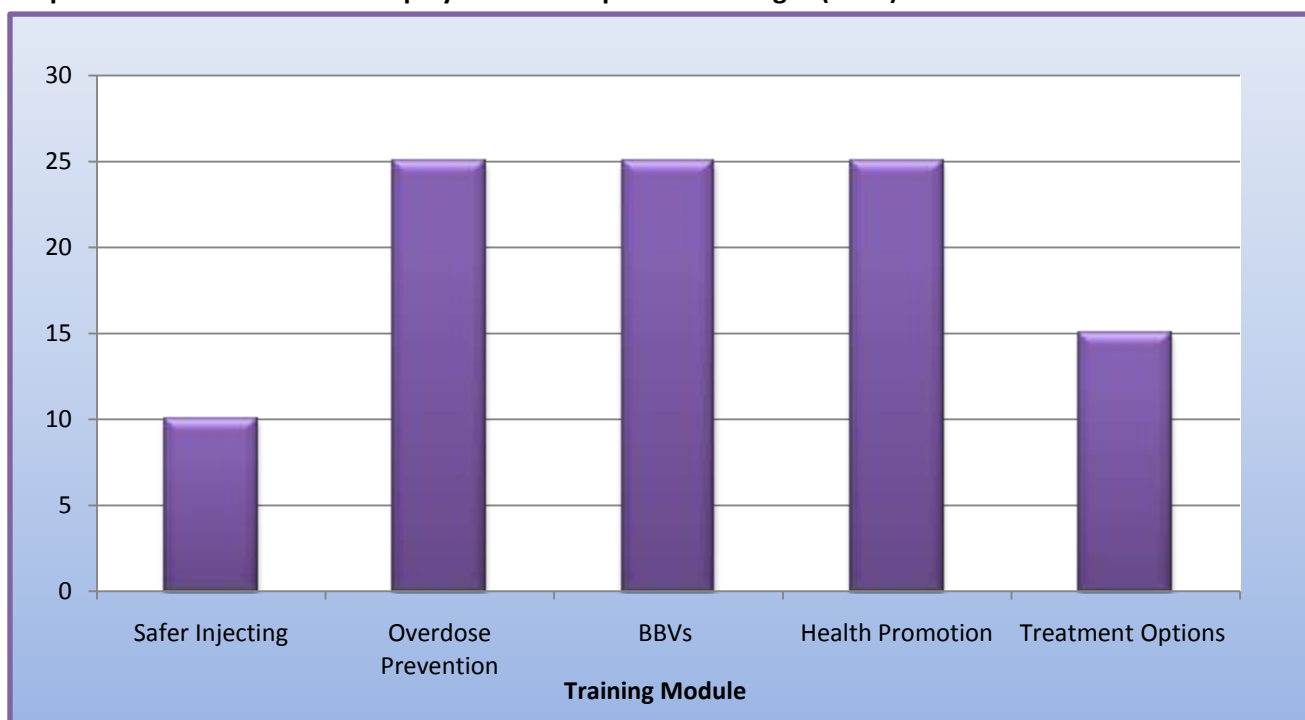
While 90.5% of participants stated they enjoyed all the sessions and found them useful, 9.5% indicated that some of the sessions were helpful but not all of them. Of participants, 100% stated that they thought the trainers made sessions easy and clear to understand, 88.9% stated the sessions lasted for the right amount of time, while 11.1% expressed that they thought the sessions were too short. Table 5 demonstrates participant confidence relating to aspects of the facilitation of the programme. As displayed, highly positive results were perceived and expressed in terms of LHP staff, food provisions, training room facilities and recommending the project to other people.

**Table 5. Participant confidence relating to the facilitation of P2P, given as combined percentages (n=21)**

Question	Response	Percent (%)
<b>Did you find the staff friendly, approachable and helpful?</b>	Yes	100
	No	0
<b>Did you enjoy the food?</b>	Yes	94.4
	No	5.6
<b>Did you like the training room?</b>	Yes	94.1
	No	5.9
<b>Would you recommend attending P2P programme to other people?</b>	Yes	100
	No	0

Graph 5 displays participant feedback relating to the specific peer education training sessions. As displayed, overdose prevention, BBVs and health promotion were the most positively received sessions, with each being preferred by 25.0% participants. However, a substantial proportion of clients stated that they enjoyed all sessions and that they were useful to them.

**Graph 5. Session Preferences Displayed as Participant Percentages (n=21)**



### 3.5 Focus Groups

To supplement the quantitative data, qualitative information was recorded at Focus Group discussions conducted at three time intervals of the P2P programme, the first at the endpoint of the peer education sessions, the second at the midpoint of the personal development sessions and the third at project end. Participant quotes from each group were combined and analysed thematically. The themes identified in this case were 'group dynamics', 'peer education sessions', 'social perceptions', 'peer advocacy in practice', 'personal development sessions', 'format & facilitation', 'barriers and problems', 'personal development in practice' and 'professional development in theory'. Where relevant, themes are considered and compared according to the stage of the project that data were recorded.

#### GROUP DYNAMICS

Some group members indicated they were previously aware of other participants before the P2P Project but generally there were few existing friendships between members of either group. Participants expressed that groups were relatively cohesive from the outset, despite an incident of an alleged theft of a personal possession in one of the groups' introductory session. Participants said in relation to the incident that despite the setback the group was responsible for itself and that kind of incident would not happen again. Group members indicated that the process of creating rules was beneficial and guided groups to be "comfortable and cohesive". Participants expressed that over time these rules become common sense, as groups became "on the same wavelength".

*"We wrote out rules and felt responsible...personally."*

Trust was identified as a key issue, with both groups expressing that it was fundamental to the groups' success. While participants expressed difficulty in "coming in from the street", many also expressed how trust was quickly formed and confidence among peers and between peers and agencies involved with training quickly developed.

*"We've all made friends and understand each other...trust is very important."*

Participants also stated that each group members' input was important and that the diversity in the group was "an education". Participants also stressed the importance of feeling relaxed among the group, stating that they were able "to get a lot more out of it". Participants expressed taking reward from being able to learn from one another and "bounce off each other". Group members also stated that issues were dealt with as they arose and that, while the group may "go off on a tangent" it would be brought back every few minutes. Participant perceptions of the group dynamics changed little over the duration of the project, however, perceptions of those who dropped out for unknown reasons varied between individuals. While some expressed that the unknown drop outs had "lacked determination and commitment" others expressed that they thought drop outs may have occurred for those using drugs more chaotically or problematically.

*"People were at different stages of drug use and non-use. So a month to one person, who was half way up the road (to recovery)...they can stick to the framework, but for other people a month is like years, for people just coming out of it (drug use)."*

## THE PEER EDUCATION SESSIONS

Generally the peer education sessions were particularly well received by all participants. Many expressed that previous knowledge had come from substance using communities and many aspects of that information were 'myths'.

*"The P2P programme opened my eyes to things I thought I knew."*

*"Sessions were interactive and not too regimented."*

The session relating to safer injecting was well received and the information was useful and positively reported by participants. However, some individuals found the imagery of injectors "off putting" and found the imagery to be uncomfortable; stating that if one was close to relapsing the imagery may have compounded cravings. Information relating to safer injecting practice was well received and generated a lot of interest among participants.

*"People are just injecting anywhere (on their bodies)."*

The session relating to overdose prevention was described to "dispel more myths than any other session" by participants. A general scepticism of police was observed among both groups, which did not dissipate throughout the programme. The issues about inviting police representatives to the project was considered but, when asked, group members indicated that police representation would not help "because it depends on what policemen you encounter on the street". Myths about police attending an emergency ambulance call also persisted despite information surrounding the issue being informatively addressed. One of the most positive outcomes from this session was the information relating to first aid, which participants were extremely enthusiastic about.

*"The bit about using a sleeve/porous alternative for clean mouth to mouth or through the nose, was really useful."*

In addition to misinformation, group members stated "there was a lot of ignorance", especially surrounding the issues of BBV transmissions. The BBV session generated a lot of interest among group members with some stating that they thought sessions relating to BBV transmission should have been longer and "more in depth", owing to the complexities of the issue. While many group members expressed surprise at some of the mechanisms of transmission, it was evident that some of the education messages were not reliably received, with some misinformation being observed at the early discussion forums. Much of this confusion related to the transmission of BBVs, for example some participants thought that hepatitis C could be spread through sweat or saliva. Despite a level of misunderstanding persisting, often these issues were discussed and corrected by the group until a level of understanding was shared among participants. Theoretical information was supplemented by practical information, such as where to gain access to BBV screening, which was also well received by participants. Generally the session relating to BBVs was described as very useful and the facilitation was positively reported, despite some participants expressing the session was "quite intense".

The session relating to health promotion was also generally well received although group members questioned aspects of the facilitation of this session. While the facilities or equipment provided, for example to test participant Body Mass Index (BMI) and heart rate, were well thought of, several group members expressed that the session was interrupted with individuals leaving the main group discussion to access equipment. Despite these issues surrounding the structure of the session, most participants were satisfied and relieved with the outcomes.

*"I was surprised at blood pressure and BMI information...pleasantly!"*

*"It opened my mind...it's not just what you eat it's mental and physical, not just about the physical."*

*"It was a relief that after all those years my heart (rate) and weight were still perfect."*

The session relating to treatment options and services was positively reported by group members. Despite little misinformation surrounding this topic many participants were previously unaware of the availability and options for accessing treatment services. Many individuals reported being impressed with the range of services; some expressed how far services had come in recent years. Participants also positively fed back about being made aware of treatment options that previously they had been unaware of, for example the availability of needles with buds in, which do not require filters.

*"I didn't know half these facilities were available...not just drug services but rehab all through drug services to aftercare."*

*"I thought the amount of information was brilliant. The A-Z leaflet with addresses and email addresses (of local services) was very good indeed."*

*"We've been given a booklet to look over, specifically about treatment, we know where to get info, who to contact, and which services are available."*

While participants did not negatively feedback about the session relating to complementary therapies, there was less positive feedback when compared to other sessions. While some individuals wanted further information, others stated that not all of the information was necessarily relevant for them. However most of those who were able to attend an acupuncture session stated that it was very helpful and that they enjoyed it.

*"We went to another lighthouse and had acupuncture, I found it very useful. I also went to complementary therapies elsewhere and have recommended it to a lot of people."*

When participants were invited to reflect and suggest improvements for the peer education sessions, most expressed there were few improvements to make. Of the suggested improvements, the most commonly recurring ideas were for the inclusion and representation of the social services in the peer education sessions. Other participants suggested they would have liked more information to do with sexual health and that they would like the session to be more individualised, however this suggestion was countered by other group members who suggested this project was about the group and not individuals.

## SOCIAL PERCEPTIONS

Of all the themes, the issues relating to social perceptions changed the most over the three time periods. At the outset participants described feelings of stigmatisation, marginalisation and being judged by wider society. Over the course of the programme these feelings appeared to dissipate as confidence was built and participants began feeling worthwhile members of society and contributors to their community. Participants expressed changes in confidence, brought about by interacting with external peers and organisations, such as community services, and becoming more comfortable with what qualities and skills group members had to offer the substance using and wider communities.

*"I didn't see myself as a bag head or a smack head...just a heroin addict."*

*"There is a lot of distrust between us and them (social services)."*

*"I feel like we have got something to offer and have changed the way we think."*

While the peer education modules were crucial in facilitating these successes, subject areas not covered or addressed by these modules continued to be perceived in a negative way. The main issue that persisted for the duration of the programme was the distrust of police and emergency services. Participants expressed that most of the time they thought they were "going to get nicked" if they called the police despite some group members expressing that because of the information given to them they would be more open and willing to trust emergency services in the future.

*"When I was using I would always have a warrant."*

*"Since when do you believe what a policeman says?"*

*"The police will just read policy and procedure if they come out here."*

Towards the end of the programme, in Focus Groups two and three, participant perceptions became more positive in terms of their role in society. In the most part, less emphasis was placed by group members on how society viewed them but instead participants made observations about societal problems and described possible solutions. Most of the identified problems related to social acceptability of certain drugs such as cocaine and alcohol, especially among young people, and where such drug use leads.

*"How acceptable is it in society now to do certain drugs like cocaine?"*

*"What (substances) come after drink?"*

## PEER ADVOCACY IN PRACTICE

The philosophy of the P2P programme depends on the reliable dissemination of learnt information throughout substance using communities. As with social perceptions a noticeable improvement was demonstrated among participants between the outset and programme end. Initially, not all participants

were confident about approaching particular issues with members of substance using communities but by the end of the programme virtually all participants had grown sufficiently confident to engage and actively seek interactions and conversation with others.

*"It's street knowledge isn't it, it's bullshit. It always goes through a few sets of hands...it's like Chinese whispers."*

*"I would be more comfortable with a leaflet to hand to distribute...wouldn't feel as comfortable just approaching someone who is injecting...I might know they are injecting but not how...would like just to give info on a piece of paper so (I could say) 'if you are injecting here's the info you need'."*

*"It (peer advocacy) brings up issues such as sitting in the same room as injectors for example. It's easier if users approach you...not easy to ask 'are you injecting?'."*

Participants expressed that, while some of them had previous awareness of how to adhere to safer using practices, the information detailing why such practice has been derived was interesting and useful when explaining such principles to others. Of all the topics, group members expressed that they were most comfortable talking to others about BBVs and safer injecting practices. One participant described how other residents in the YMCA would approach him to ask about different aspects of drug use, he described how over time hostel residents came to respect his knowledge and experiences with the P2P. One group member described how they had used the first aid knowledge and skills twice, and on one occasion had saved a neighbour from a potentially fatal overdose.

*"I have passed that information on to a lot of people. One individual was mainly a cocaine and alcohol user and he did not know that he could have contracted hepatitis in such a way – but now he has better awareness of it."*

*"I can't shut up about it, if I'm honest. People have been shocked."*

*"I get to do that a lot of the time anyway (the chance to pass on information) because of where I live (YMCA) so it's more or less a daily thing. I get young lads knocking on my door looking for advice and that."*

*"I have spoken about values with family and friends. I've not been angry with my family but I've been able to sit down and be patient and positive (with them)."*

*"A friend comes and sees me...he knows I'm on this course. I gave him some information about safer injecting and BBVs...I left him a pack and directed him to more information."*

*"I did advice someone who couldn't find a vein...so I gave him a 'UYB' leaflet...I think its just the same as a hit...I told him how to do it, he said he would try it."*

*"I convinced a mate in a psychiatric ward to go back on methadone to stop him trying to score. I explained how it got him into hospital to begin with. He got put back on 20mls (methadone). I felt real achievement and satisfaction."*

Over the course of the programme, group members also described an improvement in their ability to discern and tailor information depending on the audience and how messages were being received. Many participants commented that the P2P technique depends upon discerning among audiences, since not all individuals are “ready to listen” or accepting of the information. Participants also described how they had become more persistent when trying to educate others and being undeterred when faced with apathy or scepticism. While some participants described feeling happy and comfortable reducing harm throughout actively using communities, others described feeling uncomfortable spending time around users while trying to stabilise or abstain from using themselves.

*“Normally my confidence is through the floor, I wouldn’t say it was sky high but I’ve got more confidence than when I started. Mentoring helped me a lot. Being able to listen to people and what their needs are.”*

*“I’ll talk to anybody. We feel confident to. To a degree we judge people on how open minded they are. We don’t want to talk to a brick wall but to get through to people...it’s harder with some people than others.”*

*“It’s easy to say I know I know I know...you gauge a reaction then back off or press on.”*

*“People trust the Peer to Peer more than other organisations or people perceived to be in a position of authority.”*

*“It is all about trying to educate people at the end of the day.”*

## **PERSONAL DEVELOPMENT SESSIONS**

Like the peer education training sessions, the personal development sessions were generally well received by participants. Unlike the peer education sessions, the personal development sessions were not perceived specifically as particular topics but remembered and recounted as a platform of generalist principles. In particular, participants expressed the importance of learning to listen as key to this stage, as well as drawing inspiration from the mentoring sessions. Participants also described an unofficial support network that developed over this period, whereby bonds between group members and facilitators were strengthened and built upon. Group members agreed that the mentoring sessions were “brilliant” and “very thorough”. Individuals positively fed back about role playing, expressing it “was very good” and “helped to increase confidence”.

*“We didn’t really cover any one strategy but felt very positive at the time.”*

*“(the sessions were)...important in teaching us how to listen without putting our point across.”*

*“I never used to be able to sit down and listen to people and hear what they’re saying... (I have) learnt to be a lot less judgemental and have an open mind.”*

*“We had to write things under our name that was positive...it was good to say positive things about ourselves with others around.”*

The facilitation was also positively reported, with multiple individuals describing resulting productive personal outcomes, such as enrolment to study or improved access to employment. Most premature drop outs were not for unknown reasons but were often a result of positive personal or professional outcomes. Participants described how, of six unknown drop outs in one group, one individual gained employment, one went back to college and one individual left P2P to go to residential rehabilitation. The relapse prevention session was well received, despite participants commonly agreeing that relapse prevention strategies need to be individualistic.

*"Brilliant! I am actually on a concepts to counselling course as a result of those sessions."*

## **FORMAT & FACILITATION**

The format and facilitation was well received by all group members, however some facilitators were received more positively than others. Participants generally agreed that the facilitators from LHP were excellent. The guest speakers that covered BBVs and health promotion were also particularly well received. Participants generally stated that the sessions were comprised of useful subject material, that information was presented at a suitable level and sessions lasted a suitable amount of time. The £13 payment was considered "handy" by the group; although multiple group members indicated that they did not attend for the money and would be happy if they were only reimbursed for their travel expenses. Other group members expressed that the cash payment "was an incentive".

*"Talking about needles and injecting...needs a warning, it could tip you over the edge."*

The main barrier identified with the format of the programme was the gaps between the personal development sessions, which occasionally lasted four weeks. Participants stated that four weeks was too long to wait for the next session and if one were close to relapse, this could be a significant barrier.

*"(I've) missed it when it's not been here. (I've) missed coming once a fortnight... a month is too long."*

*"We don't have contact outside but when we come here we are like a team."*

Multiple participants also expressed that, despite being well supported during sessions, a regular contact point between sessions would have been useful. This was particularly a problem when the venue changed near the end of the programme from a city centre location to outside city centre location. Some participants explained that they felt they were not fully informed of the change of venue, participants also stated that, should the P2P continue to be facilitated from an out of city centre location, the programme would be more difficult to regularly access, especially during the early stages of the programme.

## **BARRIERS & PROBLEMS**

Despite the alleged theft that occurred during one of the groups' first session, there were extremely few problems or barriers identified by group members. One barrier described by participants was the problem of how being proximate to a substance using group or in a challenging environment, whilst on a journey of stabilisation or recovery, might increase the likelihood of relapse. For this reason some participants



described how these feelings of discomfort would reduce the longer an individual was stable or abstinent. This described discomfort was not expressed by all participants, with some group members explaining that from the outset of their recovery they were comfortable to present harm reduction messages from within the substance using community.

*"I would have to relapse first and I can't afford to put myself in that environment."*

Many participants also identified the stage of recovery as crucial to the success of the P2P Project as a whole. Group members expressed that those who had dropped out for unknown reasons were using drugs more chaotically, although this was not confirmed by the drug using profile sheet. While drug use cannot be considered a barrier since primarily the P2P is a treatment programme, the recruitment process and programme efficiency would benefit from considering and refining the recruitment criteria.

*"It's about reducing harm but that only applies if your taking is not chaotic."*

*"The psychological barriers are the biggest."*

One barrier identified at the outset of the programme was the feeling of stigmatisation of participants by wider community members. Despite not presenting a major barrier during the training sessions, participants described how they would not always feel comfortable initiating discussion in the "real world". Participants described how this barrier was overcome by increasing confidence during the programme and through the positive experiences of engaging other users and members of the public in various situations.

## **PERSONAL DEVELOPMENT IN PRACTICE**

At the outset of the programme many participants expressed or demonstrated aspects of self doubt or low self esteem. The changes in personal development were observable throughout the duration of the course and were vastly improved by programme end when compared to the outset.

*"I was walking round like a time bomb."*

*"You start thinking this is what you do to yourself... it's all self harm."*

*"The more addicted (you are) the more depressed you are...the thought of dying doesn't bother you."*

Many factors were identified as important in creating these improvements. The group created a platform of trust from which participants expressed they were able to learn or explore personal issues in a comfortable environment. Peers described how the education sessions created a level of understanding of issues surrounding drug use and safer practice which, in combination with stabilised use and increased interactions, led to substantial improvements in participant confidence. Increased confidence allowed participants to maximise the benefits from the P2P programme by interacting with peers, service representatives, health professionals or members of the general public.

*"I now know a lot more about addiction."*

*"It has been important in changing the way I think...challenging my thoughts."*

*"You can have loads of confidence and no self-esteem, and no self-esteem and no confidence; they need to go hand in hand together."*

As the programme progressed, an increasing number of participants expressed the desire to return and speak to a similar group in a future phase of P2P or a similar programme. While some participants expressed this interest from a personal development perspective, other group members described how such a contribution may be extremely important in helping others, since some substance users have difficulty accessing and maintaining treatment programmes, and input from those in a similar position can be of significant benefit.

Group members broadly commented on how their communication skills had been developed and how such a development had been a particularly positive outcome, not least because of the opportunities that arose to practice and demonstrate these skills. The clearest examples were the opportunities for participants to speak at various specialist local and national conferences, including the National Treatment Agency's (NTA) North West Harm Reduction Works Campaign launch in Liverpool and the National Drug Treatment Conference in London. Clients spoke extremely positively about the experiences and expressed the desire to continue feeding back to diverse audiences about their experiences.

*"The amount of people who have remarked upon the change in me...I haven't noticed it so much but they have."*

*"It's going to be the first time in life I've ever stood up in front of so many people to speak...but it's something I've got to do."*

*"(We have been) learning the difference between sympathy and empathy; if you give sympathy it's all about me but putting yourself in someone else's shoes, and having been in those shoes, it's nice to advise and say there is help out there."*

Group members described the therapeutic value of helping another and identified the personal improvements that occurred within them that enabled them to assume the position of a "helper". Group members spoke of the importance of health, knowledge, motivation, empathy, camaraderie, friendship, perseverance and confidence in being able to offer an individual, who has been affected by drug use, help and support. For those who completed the programme, achievements and progress in personal development were among the most positive outcomes.

*"I was aimless before I came here, now I have something to aim at."*

*"I would never have stopped drinking and taking drugs if I'd never come here and now I don't think twice about it."*

*"I have changed as a person...its put me on a path that would never have gone down or tried to go down...it's completely changed my life around."*

*"As it is now, I couldn't be happier."*

## **PROFESSIONAL DEVELOPMENT IN THEORY**

While an emphasis on professional development was not included in the proposal for Phase Two of P2P, its inclusion was driven and led by participant demand. Project facilitators felt the inclusion of an accredited certificate was important to give participants a formal achievement and, while such certification was welcomed by participants, most expressed that the P2P was "just the start" for them.

*"I'd like to carry on and get an accredited certificate."*

*"My mother used to say 'you can buy everything in life but you cannot buy experience' and my 30 odd years of drug use, and where drugs took me, enable me to be able to relate to people."*

*"I believe our experiences are our assets; that's why I would like to move towards employment in this field."*

*"I've got the ability and would no love to put myself in the situation to work with kids and draw on my experience to do so."*

*"I've never had an education and I want to be educated; it's the way the world works."*

At the mid-point of the programme group members were invited to discuss problems they perceived throughout the substance using and broader community. Participants expressed that it was only as their use became less chaotic were they able to consider the problems of other users and that the discussion forums were a good medium to encourage debate. Many participants expressed concern over the social acceptability of drinking and certain drug use, such as cannabis and powder cocaine. Group members questioned where this type of use leads and what the reasons were for perceived non-stigmatisation of these groups of users. Group members also expressed concern that drug users were becoming younger and that prevention was "always the best cure". In addition, a substantial number of participants expressed a desire to work with young people and help to prevent problematic or harmful drug use developing.

*"It's a massive problem among young people."*

*"Those experimenting with 'softer' drugs, sometimes naturally progress to harder drugs and more serious problems."*

*"There seems to be a social acceptance, especially in Liverpool, to take drugs when people go out."*

The majority of participants from each group, that attended the final discussion session, expressed a plan or interest in gaining voluntary positions or paid employment after the P2P programme. Many participants had started initiating these processes and, among those that had, all expressed feeling positive and

optimistic about reaching their final goals. Of those who had begun to initiate these processes; one individual had begun volunteering with young offenders; one individual had begun volunteering at the Independence Initiatives programme; one individual had begun volunteering at LHP and had organised a progress to work interview; one individual was waiting for a CRB check, which would facilitate qualification to become a hackney cab driver; one had begun a counselling course with the eventual aim of working with children coming out of care; and one individual had enrolled on a psychology course. Some participants described similar ambitions but expressed their immediate aims were to “stay clean” or gain stable accommodation.

*“I also passed my taxi knowledge test and I’m going to do that after Sharp. Driving a cab is probably the best outreach service in the city! That’s going to give me the freedom to pursue my real interest which will be the petals course/teacher training course so I can be a facilitator or a teacher in schools or another area.”*

*“I want to be able to volunteer and do dual diagnosis work but also other aspects of voluntary work. I will have to see what comes my way because I have mental health issues and I can’t work but I want to.”*

*“I would like to volunteer and work with both drugs and alcohol and help people in similar situations.”*

*“My main plan is to get into voluntary work very soon after February, and stick out 12 months, even two years, and after that hopefully paid employment.”*

*“I have done a different course...initiative recovery and I’m in two minds whether to go into drug work or social work with children. I have children myself to work around that but I want to pursue training.”*

## 4.0 Summary of Findings

The P2P project has been demonstrated to:

- Retain a viable percentage of participants for the duration of the programme.
- Induce reductions in drug use for participants, evidenced by the Confidence Quiz and Focus Group discussions.
- Encourage and facilitate moderations and improvements in safer using practice, evidenced by the Confidence Quiz and Focus Group discussions.
- Improve, in some cases significantly, participant knowledge relating to peer education topics, including drug use and the associated risks, as evidenced by the Big Quiz and Mini Quizzes.
- Facilitate the retention of knowledge throughout the duration of the programme among participants, as demonstrated by the Big Quiz.
- Create improvements in participant confidence relating to passing on information and skills to external members or associates of the substance using community, as evidenced by the Confidence Quiz, Big Quiz and Discussion Forums.
- Induce reductions in personal and community harm, evidenced by Focus Group discussions; including relapse prevention; administering first aid; calling the emergency services; aiding recovery and saving lives; reuniting families; and initiating outreach and providing service information.
- Facilitate and encourage information dissemination to “hard to reach” substance users or wider audiences, evidenced by Focus Groups and anecdotally.
- Create improvements in participant confidence relating to public speaking, evidenced by Focus Groups and local and national forums and conferences.
- Establish links for participants with wider public communities.
- Facilitate personal development among participants, evidenced by Big Quiz, Confidence Quiz and Focus Groups. Such improvements include improvements in knowledge, improvements in confidence, improved feelings of self worth and self respect and improved perceptions of participant contributions and roles within the community.
- Facilitate educational and professional development evidenced by Focus Groups. Such developments include a number of participants attending college, accessing alternate routes to becoming more qualified, seeking or gaining voluntary positions and seeking or gaining paid employment.

## 5.0 Discussion, Limitations & Recommendations

### THE PARTICIPANTS

Outcomes among participants who completed the programme were extremely positive and, among those participants who dropped out, few were due to unknown reasons. It was suggested by participants that those who did drop out for unknown reasons lacked commitment to the project and while, this may have been the case for some individuals, the nature and stage of an individuals' drug use was also described as a determining factor. While the format and facilitation was designed to be relaxed and informal, the quantity of information presented and the level of commitment required to complete a long term project may have presented a barrier to the more problematic or chaotic users. Refining the selection process may help produce stable groups comprised of individuals who are most likely to complete a challenging course of this nature.

The increase in confidence and improved awareness of safer drug using practice among participants was observable throughout the progression of the programme. The P2P Project has been demonstrated to be an effective mechanism for correcting misinformed 'street knowledge' and challenging the self perceptions and the perceived stigmatisation of participants by the wider public. This evaluation provides evidence that peer education can also be a useful reintegration tool for participants to gain access to education or employment opportunities. In multiple cases, participants expressed the desire to continue to work towards employment in the field of substance use and the P2P Project was described as instrumental in inspiring and facilitating these aspirations.

The Liverpool P2P Project has been demonstrated to moderate drug use, reduce harmful or risky substance using behaviour and, importantly, create a communication and support network for peer advocates, treatment providers and "hard to reach" substance users. One potential limitation described by participants was the level of comfort at operating among substance users when one's own use had only recently been moderated or stabilised. While some participants described feeling confident to operate in any environment, others stated that the P2P Project had made them want to remove themselves from these environments and communities. While participants experienced positive individual benefits and successfully disseminated information to individuals associated with the substance using community, their self removal from such communities may reduced derived community benefits and jeopardise the P2P philosophy.

In response to the described limitations the following recommendations are suggested:

- Define parameters for eligibility criteria to further reduce the drop-out rate.
- Apply these parameters to the selection and recruitment process; by administering a 'suitability' or 'appropriateness' questionnaire for potential participants.
- Consider report findings in defining eligibility criteria, for example by designing the questionnaire to identify level or nature of drug use.
- Identify the extent to which participant outcomes removed them from substance using communities. If necessary, address this limitation in future programmes by including preparatory techniques and mechanisms to prevent relapse should participants experience a challenging environment.

## THE PEER TO PEER PROJECT

The Peer to Peer project, in its second phase, retained good practices from the original phase but also introduced new areas of development. As with the initial phase, the project; created groups of suitable size, composition and, in most cases, appropriate levels of drug use; created and maintained trust and respect within each group; made use of a suitable location and facilities; utilised high quality facilitators and speakers; provided useful handouts and service information; provided reasonable expenses and incentives; provided good opportunities to practice newly developed skills, including public speaking; provided detailed information about local and national treatment services; and promoted specialist and alternative services and therapies. Newly developed aspects of the P2P Project were also well conducted, in particular; the address and emphasis on practical aspects of personal and professional development; the opportunities to meet for a group activity, for example to receive acupuncture; the opportunities to gain experience into wider substance use issues, for example as delegates at national conferences; and the potential to gain an accredited qualification by completing the proposed additional professional development sessions.

While design and delivery was well executed, several imitations to the programme were identified:

- Participant drop outs and withdrawals. Despite some drop outs occurring for positive reasons, combined groups consisted of 30 individuals and project efficiency could be compromised if a reasonable number left the programme prematurely.
- The occasional gaps of four weeks between the personal development sessions were identified as being potentially too long if a participant was close to relapse for example.
- The change of venue from the city centre was identified as a possible barrier for future sessions, or Phases of P2P Project.
- The problem of accurately disseminating and faithfully replicating information and skills to other individuals. While the evaluation demonstrates improvements and retention of participant knowledge, passing on and teaching this information may require additional skills.
- Identifying and demonstrating community benefits. While the unseen community benefits are not a barrier to the programme, demonstrating such benefits would be an important contribution to the philosophy and cost efficiency of the P2P Project.
- If such benefits cannot be demonstrated, relatively low numbers participating in a long and costly project may be considered a limitation to the continued funding of the P2P Project.

In response to the described limitations the following recommendations are suggested:

- Maintain sessions in a consistent and convenient location, in this case the city centre.
- Maintain a maximum gap between personal development sessions of three weeks.
- Maintain flexible and consistent staffing while accounting for specific group needs.
- Ensure available and consistent contact and support for participants.
- Include aspects of teaching and related interpersonal skills into sessions in future programmes.
- Design and implement a mechanism to empirically demonstrate community benefits.
- Analyse the costing of the project against the effectiveness and efficiency, incorporating an estimate of the derived benefits for substance using and wider communities.

## THE EVALUATION

While there were few barriers identified to the process of evaluating the P2P Project, there were some issues in the methodology that may have been improved. In particular data would have been more in depth if:

- Participant profile sheets had been fully completed by all participants to create a more detailed picture of the groups using patterns and history.
- Participant profile sheets had been repeated in creating within subject comparisons of drug and alcohol use and using behaviour.
- Questionnaire material had been further refined and developed. Some questions on the Big Quiz and Mini Quizzes may have been confusing for participants, for example one question about safe drinking limits offered multiple correct answers.
- Diary sheets had been more engaging for participants. If participants had successfully recorded examples of peer advocacy, generated data could have been utilised to quantitatively demonstrate benefits to the substance using or wider communities.

In response to these limitations the following recommendations are suggested:

- Ensure full completion of the initial participant Profile Sheet by explaining the importance and taking attention to ensure all participants completed all sections.
- Re-administering the Profile Sheet at the end of the programme to empirically demonstrate changes in drug use.
- Promote the use of Diary Sheets and allocate session time to record 'events' or examples of peer advocacy.
- Refine and re-design some of the phrasing or content of the quiz material to ensure all questions are clear for participants to understand.
- Develop a model to ascertain the effectiveness and efficiency of peer education, by offsetting the costs with quantified benefits for participants and the community, in the short, medium and long term.

In conclusion, the exceptionally positive outcomes for the participant group alone justify the continued funding and support of Peer to Peer initiatives such as this. This is especially true for the P2P Project since a treatment of this nature could be expected to become more cost effective as phases elapsed over time. As more participant groups complete the project, assuming a percentage of each group remains in substance using communities, the proportion of peer advocates operating in substance using and wider communities would be expected to consistently rise, yielding cumulative community benefits, not only in terms of reducing harm but also in aiding recovery.



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## **Appendix A**



Presented below are the Big Quiz questions. Mini Quizzes were derived from the same questions but included only questions relating to a given topic, e.g. 'Safer Injecting'.

 **Peer to Peer Quiz** 

# Peer to Peer Quiz





Name: \_\_\_\_\_


 **Safer Injecting** 


Please put a  in the box of the answer/statement you agree with.



1) When injecting in the arm what size of needle should be used?

a) Smallest Possible  

b) Largest Possible  


c) It does not matter  


d) Don't Know  


 **Safer Injecting** 


Please put a  in the box of the answer/statement you agree with.


2) Which of the following is safe to share?


a) Needle  


b) Barrel  



c) Water  

d) Spoon  

e) Swabs  

f) None  

g) Don't Know  

 **Safer Injecting** 

Please put a  in the box of the answer/statement you agree with.

3) Injecting in the groin is particularly risky because.....


a) The vein is deep and not visible



b) The vein is close to a nerve and major artery

c) The groin area can be prone to infection

d) All of these reasons

e) Don't Know



 **Safer Injecting** 

Please put a  in the box of the answer/statement you agree with.

4) If you accidentally hit your femoral artery (groin), you can lose a lot of blood very quickly.

If you do hit this artery what should you do?


a) Continue to inject to deaden pain and stop bleeding



b) Tie shoe lace tightly around leg

c) Remove needle and lay in a bath of cold water

d) Remove needle & lay flat on the ground applying pressure for 10 mins

e) Don't Know



 **Safer Injecting** 

Please put a  in the box of the answer/statement you agree with.


5) Licking or putting a needle in your mouth can cause which of the following?

a) Bacterial infections

b) HIV

c) Overdose

d) Don't Know





**PHPP** **Peer to Peer Project**


## Safer Injecting


Please put a  in the box of the answer/statement you agree with.

6) How confident do you feel about giving harm reduction and safer injecting information to an injector?

a) Very Confident  

b) Confident  

c) Unconfident  


d) Very unconfident  


**PHPP** **Peer to Peer Project**


## Overdose Prevention


Please put a  in the box of the answer/statement you agree with.


1) Which of these substances continues to be active in the body for the longest?

a) Cocaine  

b) Heroin  

c) Amphetamines  

d) Benzodiazepines  


d) Don't Know  


**PHPP** **Peer to Peer Project**


## Overdose Prevention


Please put a  in the box of the answer/statement you agree with.


2) After heroin/morphine, which is the second most commonly found substance in drug related deaths?

a) Cocaine  

b) Alcohol  

c) Methadone  

d) None  

e) Don't Know  

**PHPP** **Peer to Peer Project**

## Overdose Prevention

Please put a  in the box of the answer/statement you agree with.

3) When can an overdose happen.....

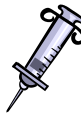
a) Immediately following injection

b) Several hours after injection

c) Both immediately and several hours after injection

d) Neither immediately or several hours after injection

e) Don't know





**PHPP** **Peer to Peer Project**


## Overdose Prevention


Please put a  in the box of the answer/statement you agree with.

4) Which of the following should you do if someone overdoses?

a) Put them in a cold bath  

b) Call 999  

c) Walk them around  

d) Don't know  

**PHPP** **Peer to Peer Project**

## Overdose Prevention

Please put a  in the box of the answer/statement you agree with.

5) When someone is overdosing which of the following substances could you inject them with?


a) Salt water

b) Cocaine

c) Water

d) None of the above

e) Don't Know



**Overdose Prevention**

Please put a  in the box of the answer/statement you agree with.


6) If you call 999 and report an overdose will the police also attend the scene?

a) Yes

b) No

c) Only in certain circumstances

d) Don't Know



**Overdose Prevention**

Please put a  in the box of the answer/statement you agree with.

7) How confident do you feel about calling 999 if someone overdoses?

a) Very Confident

b) Confident

c) Unconfident

d) Very unconfident

**Overdose Prevention**

Please put a  in the box of the answer/statement you agree with.


8) How confident do you feel about your ability to put someone in the recovery position?

a) Very confident

b) Confident

c) Unconfident

d) Very unconfident



**Blood Borne Viruses**

Please put a  in the box of the answer/statement you agree with.

1) Hepatitis causes.....

a) Inflammation of the Liver

b) Inflammation of the kidneys

c) Inflammation of the bowels

d) All of the above

e) Don't Know

**Blood Borne Viruses**

Please put a  in the box of the answer/statement you agree with.

2) Which of the following is a way of catching hepatitis?

a) Contact with blood from an infected person

b) Unprotected sex

c) Sharing toothbrushes and razors with an infected person

d) None of the above

e) All of the above

f) Don't Know

**Blood Borne Viruses**

Please put a  in the box of the answer/statement you agree with.

3) Which of the following is a common symptom of hepatitis?

a) Flu Like symptoms

b) Loss of appetite

c) Lack of energy

d) All of the above


e) Don't Know

**Blood Borne Viruses**

Please put a  in the box of the answer/statement you agree with.

4) Which of the following is there a vaccination for.....

- a) Hepatitis B
- b) Hepatitis C
- c) HIV
- d) All of the above
- e) None of the above
- f) Don't know




**Blood Borne Viruses**

Please put a  in the box of the answer/statement you agree with.

5) How important do you feel it is to ensure that BBV are not transmitted?





- a) Very important
- b) Important
- c) Unimportant
- d) Very unimportant
- e) Don't know



**Blood Borne Viruses**

Please put a  in the box of the answer/statement you agree with.

6) How comfortable do you feel about being tested for Hepatitis C?


- a) Very Comfortable  
- b) Comfortable  
- c) Uncomfortable  
- d) Very uncomfortable  

**Health Promotion**

Please put a  in the box of the answer/statement you agree with.

1) As well as Lung and Heart disease, what other negative effects can you get from smoking?

- a) Stroke
- b) Mouth cancer
- c) Bladder cancer
- d) Cervical cancer
- e) Facial wrinkles
- g) Stomach cancer
- h) Low energy levels
- i) High blood pressure
- j) None of the above
- k) All of the above




**Health Promotion**

Please put a  in the box of the answer/statement you agree with.

2) Which of the following is the safe weekly alcohol unit limit for men and women:

- a) Men 21 units - Women 14 units
- b) Men 14 Units – Women 7 units
- c) Men 0 units – Women 0 units
- d) Men 14 units – Women 14 units



**Health Promotion**

Please put a  in the box of the answer/statement you agree with.

3) Which group of foods shows a typical balanced healthy diet?

- a)  
- b)  
- c)  




**Health Promotion**

Please put a  in the box of the answer/statement you agree with.

4) Which of the following statements is FALSE:

- a) Gonorrhoea can be passed on through oral sex
- b) Chlamydia can lead to infertility if left untreated
- c) Hepatitis is not passed on by sharing contaminated needles
- d) HIV can be passed on by having vaginal, anal or oral sex without a condom with someone who has HIV
- e) One million people are infected with STI's around the world every day of the year




**Health Promotion**

Please put a  in the box of the answer/statement you agree with.

5) What is best to give you a balanced form of healthy exercise?

- a) A hard workout at the gym, once a week
- b) Playing computer games every night
- c) A long brisk walk, at least 5 times a week
- d) A short slow walk, twice a week
- e) Jogging at the weekend
- f) An occasional swim



**Treatment Services / Options**

Please put a  in the box of the answer/statement you agree with.

1) Can you potentially access drug treatment via ALL the following?

- ❖ Your GP
- ❖ A Pharmacy
- ❖ An NHS Walk in Centre
- ❖ Drug Help Lines
- ❖ Drop in Centres
- ❖ Citizen Advice Bureau
- ❖ Hospitals
- ❖ Criminal Justice System

a) Yes  **b) No**  **c) Don't Know**

**Treatment Services / Options**

Please put a  in the box of the answer/statement you agree with.

2) How would you access / engage in specific drug treatment services in Liverpool shown below.

	Self Referral	Agency Referral
Mersey Care - DDU	<input type="checkbox"/>	<input type="checkbox"/>
Lighthouse Project	<input type="checkbox"/>	<input type="checkbox"/>
GP – Shared Care	<input type="checkbox"/>	<input type="checkbox"/>
The Gateway	<input type="checkbox"/>	<input type="checkbox"/>
The Kevin White Unit	<input type="checkbox"/>	<input type="checkbox"/>
Rehabilitation	<input type="checkbox"/>	<input type="checkbox"/>

**Treatment Services / Options**

Please put a  in the box of the answer/statement you agree with.

3) What treatment options are available in Liverpool?



- a) Inpatient Detox
- b) Counselling
- c) Methadone Prescribing
- d) Community Detox
- e) Residential Rehab
- f) Naltraxone Implant
- g) Subutex Detox
- h) Alcohol Detox
- g) Stimulant services
- h) Ultra Rapid Detox (hospital)
- i) Subutex maintenance
- j) Methadone Detox
- k) Amphetamine substitute prescribing
- l) Structured day programmes
- m) Dual Diagnosis (Mental Health)
- n) None of the above
- o) All of the above

**Treatment Services / Options**

Please put a  in the box of the answer/statement you agree with.

3) What Health Promotion Interventions can you access in Liverpool?




- a) General health screening
- b) Safer Injecting advice
- c) Syringe exchange
- d) HIV screening
- e) Tetanus vaccination
- f) Dietary advice
- g) Housing advice
- h) Outreach support
- g) Stimulant services
- h) Steroid services
- i) Training & Employment advice
- j) Money management / benefits advice
- k) Mobile syringe service
- l) Wound care / management
- m) Hepatitis B & C screening
- n) None of the above
- o) All of the above

 **Treatment Services / Options** 

Please put a  in the box of the answer/statement you agree with.



**5) Should all service users in treatment have an agreed Care Plan?**

**a) Yes**  **b) No**  **c) Don't Know**

and... A Care Plan should be reviewed every:




**d) 1 month**  **e) 3 months**  **f) 6 months**

 **Treatment Services / Options** 




Please put a  in the box of the answer/statement you agree with.

**6) Complementary Therapies such as – EST (Electro Stimulation Therapy), Auricular (ear) Acupuncture, Indian Head Massage and Body Massage are available in Liverpool and.....**

**a) Can improve my sleep pattern**  **b) Will support my drug treatment**  **c) Will cause me stress and anxiety**

**d) Will always be painful and uncomfortable**  **e) Will cure illness**  **f) Can help me relax**

## **Appendix B**

Presented below are the Confidence Quiz questions.

## PEER2PEER QUESTIONNAIRE

Please complete this form and let us know what you thought about the P2P programme

**How has your drug use changed since attending the P2P programme?**

- I use *less* drugs
- I use *more* drugs
- I use the *same* amount of drugs
- I *don't* use drugs at all now
- I'm *still* drug free



**Since attending the P2P programme how do you feel about injecting drugs?**

- I am *less* likely to inject drugs
- I am *more* likely to inject drugs
- I feel the *same* way about Injecting drugs
- I have *never* injected drugs

*For injecting drug users only:*

**Since attending the P2P Programme how confident do you feel about safely injecting drugs?**

- I am *less* confident about the safe way to inject drugs
- I am *more* confident about the safe way to inject drugs
- No change* in my confidence to inject drugs safely



*For injecting drug users only:*

**How do you feel about sharing injecting equipment since attending the P2P programme?**

- I share works/equipment *less* than before
- I share works/equipment *more* than before
- I share works/equipment the *same* as before
- I *don't* share works/equipment

**Since attending the P2P programme how confident do you feel about giving correct information to other people about using drugs safely?**

- I feel *more* confident to help other people use drugs safely
- I feel *less* confident to help other people use drugs safely
- I feel *no change* in my confidence to help other people use drugs safely

**How has the P2P programme made you feel about your future hopes/goals?**

- I feel *positive* about my future hopes/goals
- I feel *negative* about my future hopes/goals
- I feel *no different*



Since attending the P2P programme how confident do you feel about improving your life?

- Very confident*
- Confident*
- Unconfident*
- Very unconfident*
- Don't know*



How has the P2P programme made you feel about your future employment opportunities/ income?

- I feel **positive** about future employment*
- I feel **negative** about future employment*
- I feel **no different***

Do you agree with the following statement?

*“The P2P Programme has helped me to feel respected and valued in my community”*

- Strongly Agree*
- Agree*
- Disagree*
- Strongly Disagree*



Did you enjoy the P2P sessions and were they helpful to you?

- Yes I enjoyed all the sessions and found them very helpful*
- Some of the sessions were enjoyable and helpful, but not all of them*
- No I didn't enjoy any of the sessions*

Which was your favourite session?

- Session 1 - Introduction**
- Session 2 - Safer Injecting**
- Session 3 – Overdose Prevention**
- Session 4 – Blood Borne Viruses**
- Session 5 – Health Promotion**
- Session 6- Treatment Options**



Do you feel confident and happy about passing on the knowledge you have gained to fellow peers?

- Yes**
- No**

**Would you recommend attending the P2P programme to other people?**

- Yes
- No



**Were the sessions set at the right level for you?**

- The trainers made the sessions clear and easy to understand.
- I felt the sessions were too simple and I understood more than the trainers thought I would.
- Some of the information was unclear and too difficult to understand.

**Did the sessions last for the right amount of time?**

- Yes, just right!
- Too long
- Too short



**Did you find the staff friendly, approachable and helpful?**

- Yes
- No

**Did you enjoy the food?**

- Yes
- No



**Did you like the training room?**

- Yes
- No



**Is there anything else you would like to say about the P2P programme?**

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**THANK YOU FOR TAKING PART IN THE PEER2PEER PROGRAMME  
WE HOPE YOU ENJOYED THE EXPERIENCE.**