Healthcare Improvement Scotland

ADP and Homeless Programme: Reducing Harm, Improving Care

Involving people with lived and living experience of alcohol, drug, and homeless services

September 2022

NHS SCOTLAND

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Background

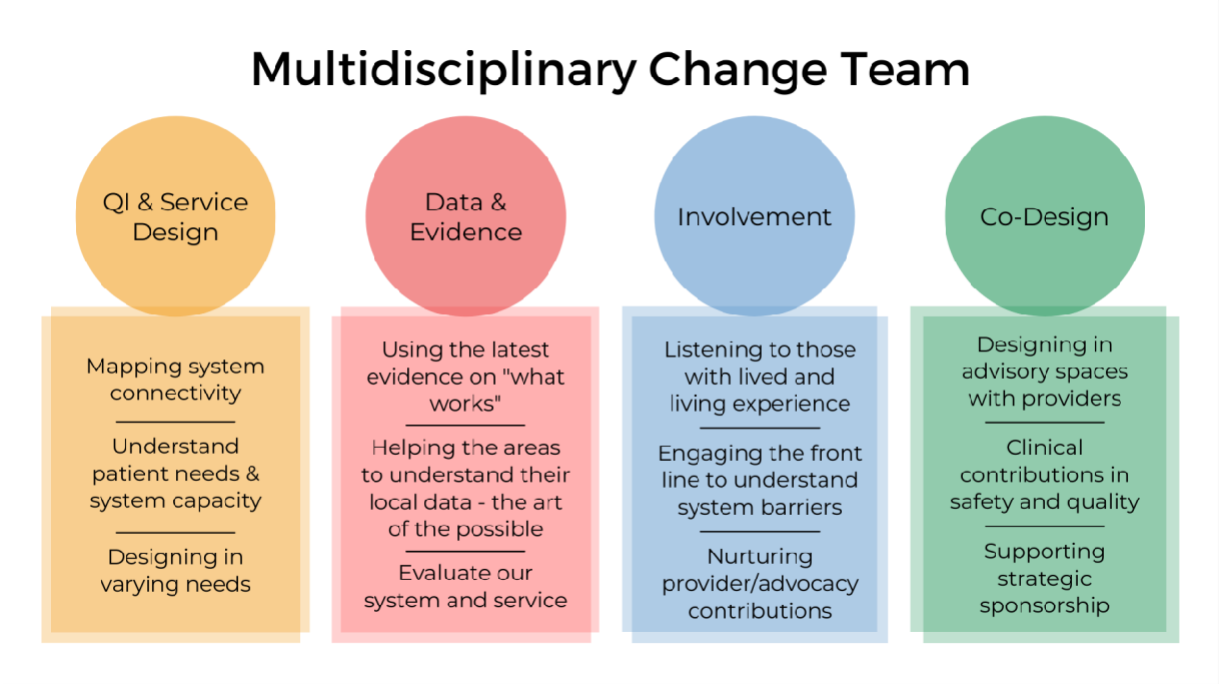
In 2021, Healthcare Improvement Scotland (HIS) was commissioned by Scottish Government and COSLA (Convention of Scottish Local Authorities) to deliver the ADP (Alcohol and Drugs Partnership) and Homeless Programme: Reducing Harm, Improving Care, to improve access, reduce harm and achieve better outcomes for people accessing alcohol, drug, and homeless services. To ensure a full understanding of the current system it was critical we sought the involvement and participation of people with lived experience as well as those who delivered services.

The value of people being able to share their experiences of services cannot be underestimated, it builds relationships with health and social care providers, to ensure that services are designed with patient outcomes in mind. Participation of people who use services in development is a key element of a Human Rights based approach, which requires that people are supported to be active citizens and that they are involved in decisions that affect their lives (www.gov.scot/publications/planning-people/).

People with lived and living experience have first-hand experience of a service or health need and they alongside their families and loved ones offer unique and helpful insights into how our system performs and how it feels to engage in it. This report will explore how we have embedded engagement into this programme of work and how the involvement of people with lived experience has shaped our current understanding of how people experiencing homelessness access drug and alcohol services.

Reducing Harm, Improving Care

Reducing Harm, Improving Care was designed as a multi-disciplinary redesign team bringing together a range of expertise in quality Improvement, service design, strategic planning, social research and analytical capacity. Working together we combined a variety of components to ensure the broadest understanding of the system of care. All our work was developed in conjunction with people who deliver services and those who use them to understand how we work in an integrated manner and how we design and deliver services that are accessible, and person centred.



Our approach

Why did we involve people?

The Charter of Patient Rights and Responsibilities states that people have the right to be involved in the development of the health and social care services they access as well as place responsibilities on health to ensure people are involved in decisions about their care. Learning from the personal experiences from people who access services makes services safer, more efficient and improves person centeredness and effectiveness, particularly when people who use services are involved in a meaningful way (https://www.hisengage.scot/informing-policy/research/improving-quality-through-participation/).

Alongside engaging with people who have lived and living experience, building relationships with communities, third sector organisations and representative bodies can help us reach groups of people or individuals who are under-represented in our engagement activities.
Engaging with organisations who facilitate and nurture engagement from people who use services or their families and loved ones increases the range of ways people can get involved in the design and delivery of health services whilst simultaneously creating safe spaces, peer support and incentives that encourage participation. The involvement of people with lived and living experience in the development of services enables service providers to understand needs, be more accountable, open, and transparent with people who access their services, therefore, building a more person centred, and trusted service.

Reducing Harm, Improving Care ensured that the views and experiences of people with lived and

living experience of using and accessing services across homelessness and alcohol and drug services were embedded throughout the programme to offer unique insights and help influence future improvements across health and social care. Our work ensured people with lived and living experience were recognised as an 'expert' within their own care and treatment and treated as an equal partner in our understanding of the system of care.

How we mobilised our engagement ambitions

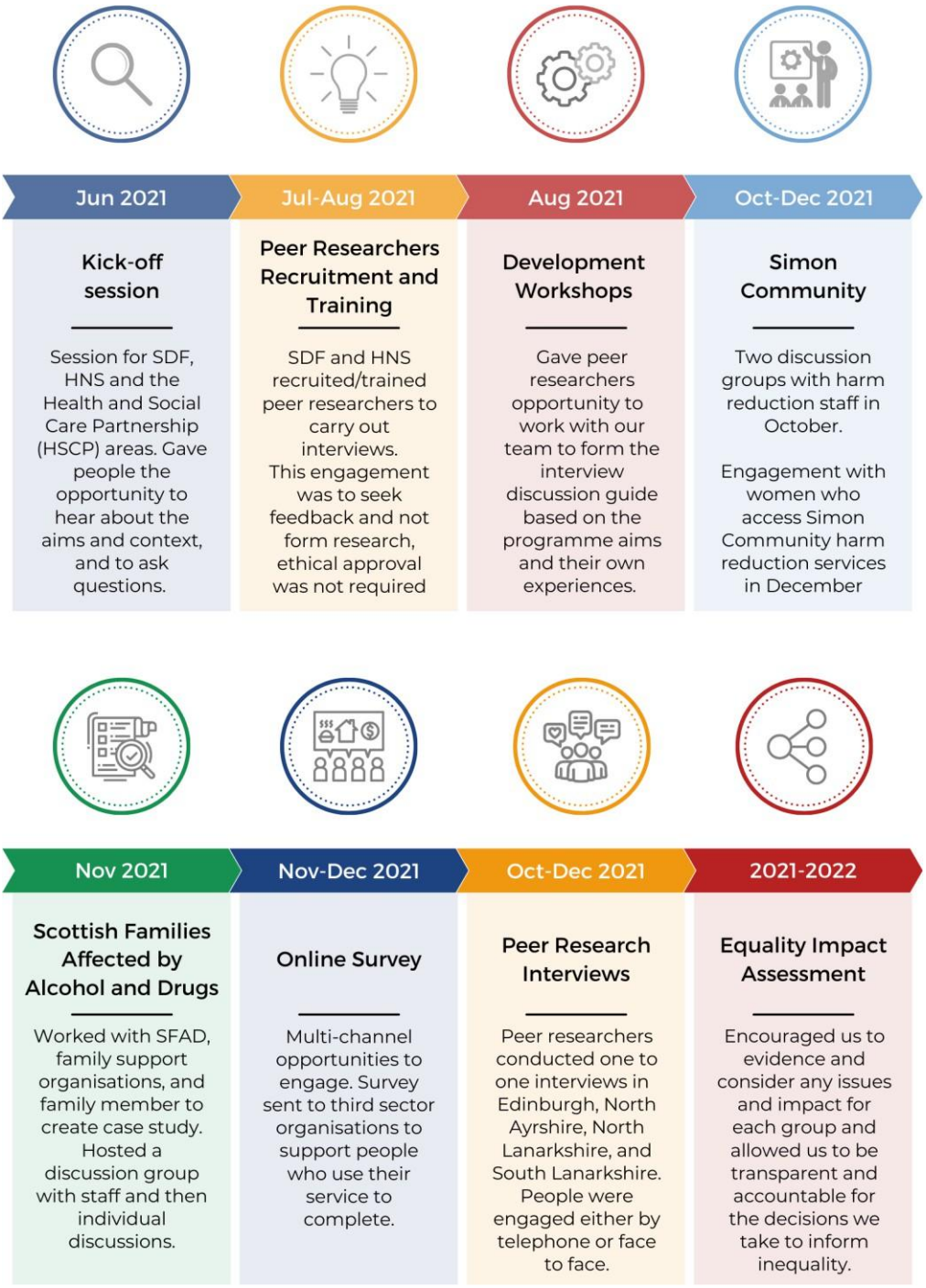
In 2021, Scottish Drugs Forum (SDF) and Homeless Network Scotland (HNS) were commissioned by the Scottish Government at the start of the ADP and Homeless Programme: Reducing Harm, Improving Care, to develop a network of peer researchers to reach people who have lived experience of alcohol, drugs, and/or homelessness. Peer researchers are people who have first-hand experience of alcohol, drug and homeless services and can act as a powerful resource to engage with a wide range of lived and living experience. Their contributions in supporting participation were critical to our success, feedback throughout evidenced the extent of the reassurance, support and comfort participants felt when engaging with someone who had 'been there, done that.' It was critical for us to ensure the safety and wellbeing of the peer researchers and those they engaged with, and utilising trusted providers felt like a great opportunity for us to learn to refine our engagement methods and approaches. Effective support mechanisms and an understanding of trauma became a key theme in this work and is reflected in our analysis.

Co-designing our Methodology

The public health control measures associated with COVID-19 were a key consideration in how we would be able to work with our peer partners as well as challenge our traditional engagement methods. The Reducing Harm, Improving Care team, together with SDF/HNS agreed to meet via MS Teams to build relationships and shape the engagement plan as a team, this continued to evolve through a dedicated MS Teams channel between meetings as required. It is important to acknowledge the role of the pandemic here in how we engaged internally and externally as a team, this offered greater levels of flexibility but of course there were times when we would have valued face-to-face meetings.

As part of developing the engagement work with our peer partners, we held a 'Kick off' session (23 June 2021) for SDF, HNS and the four Health and Social Care Partnership (HSCP) areas taking part in the programme. This gave people the opportunity to hear about the aims and context of the programme, as well as to ask questions.

We also held three individually co-designed development workshops during August 2021 with HNS, SDF, and our peer researchers:



- **Workshop 1: The role of a peer researcher.** This workshop focused on the role of the peer researchers, interview techniques and the key traits of effective peer research.
- **Workshop 2: Identifying the key themes to be explored in peer interviews.** Taking into consideration the experiences of peers and the aims of the RHIC programme, three key themes were identified: better outcomes, reducing harm, improving access
- **Workshop 3: Identifying key questions for interview discussion guide.** Based on the key themes identified, questions were developed to be used in the semi-structured interviews

The workshops gave peer researchers the opportunity to share their experiences, and work in partnership with our team to co-design an interview discussion guide that was informed by their expertise in experience. A copy of the discussion guide can be found in **Appendix 1**. A flash report summarising the workshops can be found here.

The development workshops explored the training needs of the peer researchers in carrying out interviews, and the support provided by SDF/HNS to do this safely. Peer researchers were offered incentives and financial assistance to support their time and contributions. A research proposal was developed by SDF which highlighted the research aims, methods used, recruitment of peer researchers per HSCP area, the analysis of the interviews and timescales. A copy of the research proposal can be found in **Appendix 2**.

Facilitating contributions

During our engagement we conducted 53 individual interviews with homeless people who were currently using or had experience of using drug and/or alcohol services. During October to December 2021, our peer researchers conducted these interviews in Edinburgh, North Ayrshire, North Lanarkshire, and South Lanarkshire. Due to ongoing COVID-19 restrictions at this time, people were engaged with either by telephone or face to face, with safeguards in place around social distancing.

Maximising their reach across existing networks, SDF and HNS were able to determine where they had a significant profile or reach to ensure an adequate sample size. These early discussions determined that SDF would focus on North and South Lanarkshire whilst HNS covered Edinburgh and North Ayrshire. All interviews were transcribed by an independent contractor, and then analysed by our Social Researcher and our Knowledge and Information Specialist to ensure rigor in our theming. To understand and make sense of these themes, all findings were sense checked by peer researchers and SDF/HNS staff who supported the interviews to ensure we represented views authentically and reduced the risk of misrepresentation.

Using a peer research approach helped us to gain valuable insights into people's experience of accessing alcohol, drug and homeless services. There were 9 key themes identified through the SDF and HNS peer led interviews, these were, improving access, coordinated care, person led services, health service use, mental health and trauma, safety, trust respect and no stigma, harm reduction, and services during COVID 19. A one-page peer research summary report can be viewed here and full analysis report here.

Ethical Considerations

In the design of our involvement activity, it was critical for us to ensure we understood and acted upon any ethical requirements and considerations. Our peer partners advised us to seek expert opinion on this issue and it was concluded that because this engagement was to seek feedback and not form research, ethical approval was not required. Whilst we did not require ethical approval for this work, in the interests of transparency we forwarded peer research documents such as consent records, participant information sheet and interview discussion guide to each of the participating NHS Board areas Clinical Care and Governance committees for information.

In planning our engagement activities, we completed our Equality Impact Assessment (EQIA). The EQIA enabled us to assess which of the protected characteristic groups the Reducing Harm, Improving Care work is relevant to, this encouraged us to evidence and consider any issues and impact for each group and allows us to be transparent and accountable for the decisions we take and to consider how this work can address inequality. This evidenced the need for us to ensure the inclusion of women who had experience of homelessness and using and/or alcohol, drug services and triggered further engagement with a third sector partner.
The EQIA can be found here.

Womens experiences

Our EQIA evidenced the need for us to intentionally seek out the contributions of women experiencing homelessness who require drug and/or alcohol services. We were able to work alongside Simon Community Scotland to understand the experiences of women and others who are currently accessing their services. Harm reduction staff engaged with us in digitally facilitated discussion groups and shared their insights and experiences of working with people who have experienced homelessness and who may have used alcohol and/or drug services.
This enabled us to understand the experiences of people who are currently accessing services such as the importance of staff being trauma informed and non-judgemental. Continuity of care is needed to understand complexities of individuals lives, when services do not work together, people fall through the gaps with people not receiving an intervention until they reach crisis point.

Building on these sessions, we were able to link in with the Women's Harm Reduction Coordinator to gain feedback from women who access Simon Community services. 10 women participated in discussions which were facilitated by the Women's Harm Reduction Coordinator, and we were able to provide funding to the Simon Community to give a £20 voucher incentive for each person taking part. Using this approach helped us to understand the insights and experiences that were important to woman participating in the discussion group. This included feeling safe, particularly when accessing services that are also used by men and being supported by staff who have an awareness of trauma and addiction as this helps women feel there is an

understanding of their situation which helps build positive, trusting relationships with staff (leading to better outcomes).

Families and Loved ones

As a programme, we felt it was important to understand the experience and insights of family members and carers of people who access alcohol, drug, and homeless services, because often, they are supporting loved ones to access the services they need. Scottish Families Affected by Alcohol and Drugs (SFAD) were able to offer us unique opportunities to understand this by engaging with a range of their services.

Firstly, we engaged with SFAD family support organisations from each HSCP area involved in the programme. A group discussion was held via MS Teams where we engaged with 5 staff members and a volunteer. This discussion was followed up with individual meetings with staff members to understand what the challenges, barriers and enablers were for people they support in helping a loved one's access to services**.**

Following on from this, we were given the opportunity to speak with a volunteer who has lived experience as a family member of someone who is accessing services. In our initial discussion, we were able to gain an understanding of her experience of supporting a loved one to access services, as well as insights into the difficulties experienced by family members to be involved in their loved one's care and treatment. This enabled us to have a follow-up discussion which provided further insight and detail which supported the development of a case study that can be used to demonstrate the experiences of family members and carers and the benefits of involving family members in decisions around how care and treatment can be provided for their loved ones. Both discussions took place via MS Teams with the family member, SFAD staff member (for support), Public Involvement Advisor and Knowledge and Skills Specialist. The case study can be found here.

Our approach to engaging with SFAD has helped us to understand issues experienced by family members when supporting a loved one to access alcohol, drug and homeless services. Family members do not feel listened to by service providers, with a whole family approach to service provision needed to remove barriers to accessing services. Family members are often coordinating care as well as helping loved ones navigate a complex system with support often being provided by third sector organisations and not the service providers.

The impact that this feedback has had on the development of the programme has been extraordinary, it has been vital in gaining insight and understanding of people's experiences of accessing the services they need, and the impact that this has on members of their family and the support that is needed, not just for the person accessing services, but for the family members helping them too.

Learning from our online survey

Embedding multi-channel opportunities for people to engage with us became a key priority, whilst digital working was the default during the pandemic, it allowed us to explore how digital methods can increase our reach making our activities accessible. An online survey was developed with questions based on the peer research interview questions. This allows us to quickly engage with wider partners and helped us address gaps in our reach.

Our online survey was sent to local voluntary and third sector organisations in the 4 HSCP areas involved in the programme, asking staff to support people who access their services to complete the survey. The online survey was also sent to members of the ADP and Homeless Programme Advisory group, HIS Community Engagement local engagement offices (in the 4 areas) and HSCP project teams involved in the programme for distribution.

To gain as much reach as possible, we also sent the online survey via Twitter to LGBTQI contacts and the Glasgow LGBTQI Substance Use Partnership (@LGBTQISubUse) who shared it via twitter and with their networks. The survey was further shared through the December 2021 edition of the Trans Community Newsletter. In addition to using Twitter and email, we also provided printable versions of the online survey in word format for people who wanted to write down their feedback instead of using an electronic device.

The number of completed online surveys was 18. Equalities monitoring information was gathered with the online survey to capture additional information about people who access alcohol, drug, and homeless services so we can identify gaps in our engagement.

Including an online survey in our engagement approach allowed us to understand the experiences of people who were not taking part in the one-to-one interviews. We gained insights into issues such as the impact of Covid-19 and the way services were being provided. People spoke of a need to have access to knowledge and information on all treatment options, as well as good communication and support from staff which would help reduce barriers. Support and interventions were often provided by family members when they were unable to access support from their GP and people still felt stigmatised by service providers.

A report of the complete findings from our engagement work detailed above can be found here.

What worked well?

Because we were not able to carry out face to face engagement, it was important to use different methods of engagement, to provide opportunities for people to become involved in a way that was inclusive and meaningful to them. We used virtual methods such as MS Teams, Google Meet, Google Jamboard, online survey, Twitter, and email, as well as working with key third sector organisations to support people to feedback in a safe and trusting environment.

When presenting information at workshops with the peer researchers, as well as providing any support information, we made sure this was presented in a format that was clear, accessible, and easy to read with information agreed with our partners at SDF/HNS.

Although we were working within short timeframes, we managed to build meaningful relationships with third sector organisations such as Scottish Families Affected by Alcohol and Drugs and the Simon Community Scotland, as well as local organisations in the HSCP areas we

were working in. Getting to know people through a virtual environment, developing trust and friendship through having a shared understanding and interest in the ADP and Homeless Programme, enabled us to work together which has led us to engage in opportunities that would not have been possible otherwise.

Being able to feed into the expertise and experience of SDF and HNS has been invaluable to the development of the programme. Because SDF and HNS are a trusted service by people who access alcohol, drugs and homeless services and have experience in involving people with lived and living experience in their research, we have been able to sense check our thoughts, ideas and feedback and seek their advice throughout the duration of the programme.

What were the challenges?

Capturing the views from a range of people with protected characteristics was a key ambition of our work. Our EQIA was developed and naturally evolved throughout the programme. This has highlighted gaps in our engagement, particularly in relation to speaking to people from black and minority ethnic communities. Although we reached people from the LGBTQI community digitally via social media, we were unable to speak to people directly through a discussion group or interview. We acknowledge that time demands and staff capacity in the programme was a challenge in capturing the experiences from a range of people with protected characteristics. We also reached out to particular groups, who were unable to take part in the engagement in the timeframes given, individuals and groups need achievable timescales to participate in a meaningful way, which is learning to take forward for future working.

A further challenge highlighted when carrying out the one-to-one interviews was a risk to peer researchers experiencing vicarious trauma due to the subject matter. To overcome this, we discussed the risk with SDF and HNS who gave assurances that peer researchers would be supported by a staff member in a 3-way telephone call/face to face discussion with the interviewee, and time to debrief after the interview was put in place. In addition to this, we also asked for assurances that consent was sought and that interviews were conducted in an ethical way.

Building relationships in a virtual environment and not being able to meet face to face with partners was a barrier in building rapport and getting to know each other. Because of the COVID-19 restrictions at that time, we were unable to carry out face to face engagement with third sector organisations and people with lived and living experience. An inclusive approach to involving people and building their experiences into the programme had to be thought about in a way that did not exclude people from telling us their experiences.

Conclusion

Overall, our approach to embedding involvement of people with lived and living experience (and their family members/carers) in the programme was achieved by using various methods of engagement. Applying different methods of engagement has helped people become involved in a way that was most comfortable and meaningful to them. It also provided further opportunities for people who were not directly involved in the programme to participate, although there were challenges such as timescales and lack of face-to-face contact due to COVID-19, the relationships that we built up with our third sector partners enabled us to engage with people with lived and living experience and provide them with the opportunity to feedback about services that are important to them.

Working in partnership with SDF and HNS, we gained understanding and insights through 53 one-to-one interviews with people who access alcohol, drug, and homeless services. Working with our peer research partners, we were able to gain insights and perspectives from peer researchers with lived experience as well as valuing their expertise of engaging with people with living experience. We have learned that people who are accessing services feel that it is important to engage with others who have had similar experiences to them, being able to build a trusting relationship and enabling meaningful feedback.

With the distribution of the online survey across the 4 HSCP areas, 18 people were able to provide their feedback and we made connections with local third sector organisations. The distribution of the survey enabled people who were not engaging with the services we were working with an alternative way to provide their feedback through local third sector organisations and social media. This helped to ensure that we reached as many people as possible and provided different methods of engagement so people could give their feedback to inform future improvements.

Through building our relationship with Simon Community Scotland, we were able to hear about the experiences and insights from Harm Reduction Staff who support people accessing services, as well as 10 women within their service having the opportunity to feedback their experiences. This meant that we were able to hear directly from people who were delivering services such as outreach street work and harm reduction, and the challenges, barriers, and enablers that third sector organisations faced, as well as hearing from people who currently access their services. Working with the Simon Community also allowed us to focus on engaging with women who are an identified group of people with protected characteristics from our EQIA. Hearing about the experiences of women who are accessing services led us to an understanding of the key challenges, barriers, and enablers for them including the importance of feeling safe, having support, trust and understanding of their experience from trauma informed staff members.

To understand the impact supporting people to access services has for family members, including children and the wider family through our work with SFAD, has been invaluable. Our work with SFAD has helped us to gain insight into the challenges and barriers families and carers face. SFAD brought us an understanding that family members need their health, wellbeing, and support to be considered alongside family members who are accessing services. Their involvement in the programme also highlighted that interventions are often facilitated by family members and not service providers. It has been invaluable to learn how family member involvement in helping a loved one to navigate a complex system is crucial in accessing the services they need, without this support, people often fall through the gaps of service provision. Involving family members in a loved one's care and treatment, working alongside service providers, can enable a more care coordinated approach, leading to better, more positive outcomes.

Although we used different engagement methods to collect people's views through one-to-one interviews, Google Jamboard, Google Meet, MS teams, Twitter, online survey, and email, underpinning all of this was the drive from all partners involved to work together to understand people's experiences of accessing alcohol, drug, and homeless services, the challenges, barriers, and enablers to accessing services that exist and understanding what a good service looks like for them.

The engagement and involvement of people with lived and living experience, alongside their family members and third sector organisations has provided the RHIC programme with key insights which can influence future improvements in the design and delivery of services. This would not have been possible if people were not provided with the opportunity to share their experiences with us. We need to continue to engage with people who have experience of using services, as well as family members and carers, in partnership with the service providers in an open and transparent way, to shape services that meet the needs of those accessing them. This creates trusting relationships which in turn can reduce risk, keep people safe and provide better outcomes.

Involving people with lived and living experience: A checklist for service redesign in alcohol, drug and homeless services

It is important that the involvement of people who access alcohol, drug and homeless services is central to how services design and deliver improved care and treatment for people. When designing and developing future services, alcohol, drug, and homeless services along with third sector support providers should consider the following recommendations to ensure that they are able to support people with lived and living experience to meaningfully engage, ensuring that services are person centred and meet the needs of those using them:

1. Develop an EQIA; this can support the system to identify gaps in their engagement as well as who to engage with, including targeted engagement of groups with protected characteristics. HSCP and NHS Board Equality and Diversity Leads may be able to support this

2. Engage with local HIS Community Engagement offices who can provide support and advice when engaging with people in NHS/HSCP service developments

3. Review and identify the key areas for your redesign within the Scottish Government Planning with People Guidance (2021) for involving people in HSCP, Local Authority and NHS Boards service developments

4. Work with local third sector support organisations to learn from their expertise and gain access to people who have lived and living experience. Ensure a range of engagement methods are available for people to have the opportunity to feedback in a way that is most comfortable and meaningful for them, reducing barriers to engagement and enabling people to become involved. Build relationships with third sector organisations, working with them as an equal partner in service improvements, as this leads to trusting relationships and a more person-centred approach

5. Work in partnership with third sector organisations to ensure support is available for people before and after the engagement, taking a trauma informed approach to reduce the risk of people experiencing vicarious trauma
6. Plan engagement activities to include working in partnership with third sector organisations and other delivery partners to coproduce data sharing agreements, participant consent forms and other ethical considerations including transcription and analysis of feedback

7. Ensure engagement has the appropriate reach, is proportionate and people with a diversity of experience are represented. People with lived and living experience, as well as their family members/carers should be provided with the opportunity to feedback about their experiences. People with lived experience can provide insight into their recovery journey including the challenges, barriers, and enablers they experienced. Those with living experience can provide insight into the systems and services they are currently accessing, with family members/carers sharing their own experiences as well as their loved ones'

8. Add value to an improvement programme by acknowledging the expertise of those who have lived and living experience as well as third sector support organisations. For example, sense check ideas and emerging thoughts with peer partners, enabling them to provide important insights and advice as the programme moves forward.

9. Engage with people with lived and living experience as well as their family members/carers/third sector organisations **at all stages** of a programme. They should be an equal partner alongside NHS Boards, HSCP and other delivery partners.

Acknowledgements

Thank you to SDF and HNS and the peer researchers who developed the interview discussion guide and carried out the one-one interviews and to everyone who agreed to participate.
Thank you, Simon Community Scotland staff and people who use their services, as well as Scottish Families Affected by Alcohol and Drugs, the family support organisations and the third sector organisations who supported the distribution and completion of the online survey.

We aimed to write this report using language that is non-judgement and non-stigmatising. However, we are aware that language tends to evolve rapidly and reflect social changes towards homelessness and substance use, we have used terms advised to us from our collaboration with third sector partners at that time.

Appendices

Appendix 1: Copy of interview schedule







Service User Interview
Peer Researcher
Questions

Remind the participant that the interview is being audio recorded but that they will be kept anonymous and non-identifiable. Questions in *italics* are prompts to be used as needed to gain more information.

Section 1 – Demographic information

- How would you describe your gender?
- What age are you?
- What area do you live in?

Section 2 – Improving access

- What services have you used?

Are these Addiction and/or Homelessness services? When did you use these? If you've used before and since Covid-19, how have the services changed? Has the change been good/bad? How long did you use them for?

- How did you find out about these services?

Did someone tell you about them? Were you referred by a worker? Did you self-refer?

- What motivated you to access these services when you did?
- Was it easy to access them when you needed/wanted them?

Were there any barriers to access? Did you need any support to attend? Did you get this support? What else might have helped?

- Did the services you used meet your needs?

How did they do this? Interventions? Assessments?

- When you accessed the services did they explain what would happen with your data/information and how this may help you?
- Do you feel Addiction and Homelessness services work together?

How do they do this? How could they do this more?

- What is the most accessible/best service you have used and why?
- What is the most challenging service you have used and why?

- Are there any other local support services you are aware of but have not used/mentioned so far?

Section 3 – Reducing Harm

- What does reducing harm in relation to substance use mean to you?

For example reduction/increase in substance use, prescribed MAT, Naloxone, BBV testing, Injecting Equipment Provision (IEP)

- What does reducing harm in relation to homelessness mean to you?

For example supported accommodation, Housing First, own tenancy?

- Have you experienced harm reduction efforts/interventions from services?

What were they? Were they effective for you? What else might have been helpful?

- Do the harms with substance use and homelessness impact each other?

Do services support with this? How could this be done better?

- How can housing allocations best be used to reduce harm?

Section 4 - Better (Person-Led) Services

- What does the phrase “person-led service” mean to you?

Would you say services you have accessed match up with this definition?

- How much of a say did you have in your treatment/care at these services?

Were you given choice in interventions (e.g. type of MAT, accommodation)? How was this choice explained/offered to you? Did you ever feel you didn’t have a choice? What did that feel like?

- How would you describe your experience with the service staff?

Did they involve you in your treatment plan, etc? Did you feel respected and listened to? Were they skilled in treatment provision you needed?

- How did the services communicate with you?

Was this good? How could it have been better?

- Would you be willing to share your information with all services that may be able to support you?

Appendix 2: SDF and HNS Research proposal document

Background

1,264 drug-related deaths were registered in Scotland in 2019, 6% (77) more than in 2018. In 2018, 53% of deaths among people experiencing homelessness were drug-related. During COVID-19, specialist services became less accessible and people, experiencing homelessness and drug and alcohol problems were particularly impacted. COVID-19 pandemic response has highlighted opportunities for innovation.

In partnership with Health Improvement Scotland (HIS), Scottish Drugs Forum (SDF) and HNS are proposing a to conduct a service evaluation of frontline services in order to improve the quality of care and health outcomes for people experiencing homelessness who require alcohol and drug services.

Research Aims

The overall aim of the evaluation is to:

- Understand the experiences of people who are affected by homelessness and who require drug and alcohol services

- Identify service user needs to inform development of an integrated model of care In order to meet these aims, the evaluation will seek to explore:
- The needs of people who are experiencing homelessness who access drug and alcohol services
- What is working well and what could be better – what does 'good' look like for people who access services?

Methods

A peer research model will be applied to the evaluation to help encourage a greater level of participation and a more open, honest and in-depth response. Peer research volunteers from HNS and SDF will be involved in all aspects of this evaluation from evaluation material design to data collection moving on to sense checking in the analysis then reporting.

Work will commence by holding 3 themed workshops in partnership with HIS, HNS and SDF and will involve bringing the peer research team together from SDF and HNS to meet with the social researchers from HIS and finalise the evaluation materials and plan for data collection.

Data collection with people who use services will then commence and a qualitative approach will

be applied. We will conduct semi structured interviews facilitated by peer researchers to gather information on the service experiences and needs of people who are experiencing homelessness and who access drug services. Interviews will be conducted via face to face, or by telephone or video call as appropriate in line with current COVID-19 guidance.

Staff from SDF and HNS will support the peer researchers to undertake interviews and give ethical oversight and support. For SDF, a user involvement development officer (UIDO) will be assigned to oversee the SDF peer researchers and assist them with the planning, recruitment and delivery of interviews. The UIDO will also be the key point of contact for the peers and lead SDF's contribution to the analysis and write of the findings.

Recruitment

HNS and SDF will aim to recruit approximately 25 service users for each HSCP area for the qualitative interviews. The interviews will be conducted by SDF in the following areas:

- North Lanarkshire
- South Lanarkshire

And by HIS in:

- Edinburgh city
- North Ayrshire

Recruitment will be conducted predominately by the peer researchers via peer networks, service contacts and snowball sampling but also by utilising service adverts and social media adverts as required to offer opportunity to people currently utilising or previously having used services. Participants will be offered a £20 shopping voucher to thank them for contributing.

Analysis

Interviews will be fully transcribed. An in-depth thematic analysis will be applied, this will be led by researchers at HIS and will be supported by SDF and HNS in regards to sense checking. Findings will be written up into a report including detailed qualitative findings from services user interviews and including feedback from workshops. This will be led by researchers at HIS and will be supported by SDF and HNS in regards to sense checking.

Timescales

Work will be commenced in June with the work aiming to complete by March 2022, some flexibility in the timescales would be advisable due to the challenges of data collection during COVID-19 and the late commencement of the project.

Budget

£20,000 in total has been awarded to both SDF and HNS. For

SDF this will cover:

- Peer researcher costs including travel, subsistence and/or phone allowance to conduct interview and engage in workshops.
- User involvement development officer 2 days per week until March 2022
- Senior officer/manager time to provide input to meetings, workshops and sense checking for analysis and write up

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