Burnet Institute
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Harm Reduction Victoria

The Salvation Army Access Health and St Kilda 24/7 Needle and Syringe Program

PEERS ASSISTING TREATMENT OF HEPATITIS C (PATH) PROJECT AND EVALUATION

EXECUTIVE SUMMARY

2021

"As a mediator between clients and clinical services I think we offered a comfort factor. If you're doing it hard, we can make it a bit easier for you. People have thanked us just for sitting down and checking in with them." - Peer Specialist, Harm Reduction Victoria

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This project was conducted on the lands of the Wurundjeri and the Boon Wurrung peoples of the Kulin Nations, whose sovereignty was never ceded. We acknowledge their elders past, present and emerging, and express our humble gratitude for living and working on these lands

Executive Summary

Background

Most countries are unlikely to meet the World Health Organization 2030 hepatitis C elimination targets despite hepatitis C elimination being highly cost-effective and cost-saving. In Australia, following the introduction in March 2016 of near-universal access to direct-acting antivirals (DAAs), hepatitis C treatment uptake was rapid however, there has since been a steady decline in treatment numbers, threatening progress towards elimination targets. People who inject drugs (PWID) are the key risk population for hepatitis C in Australia and face many barriers to testing and treatment, including stigma and discrimination, difficult venous access and competing priorities.

Peer support models are increasingly being utilised in the health sector as a mechanism to facilitate engagement among marginalised or 'hard-to-reach' groups. Peer workers are individuals who have lived or living experience with a specific illness or lifestyle experience, and support others experiencing similar challenges. Peer support has been associated with improved engagement in hepatitis C services and retention in care as well as increased hepatitis C knowledge among PWID. Innovative peer support models provide a pathway to engage individuals who are less connected to health services and support PWID to prioritise treatment while reducing stigma and discrimination.

This report describes and evaluates a pilot project that sought to understand the feasibility of establishing peer-led interventions to improve engagement in hepatitis C care among PWID in Melbourne. Peer Specialists were employed by a PWID-focused community and integrated into a clinical service to enhance access to hepatitis C care (including testing and treatment) for people at risk of, or living with, hepatitis C. We use the term Peer Specialists to describe peer support workers with lived experience of hepatitis C and injecting drug use. Learnings from this pilot will inform future peer-led interventions in similar settings.

> *"You still need to break down a barrier to let them know you're part of their community. People sense it if you're on the same page. Most of the time it was fairly easy. They haven't seen peers in action a lot. Someone who's a staff member who's active in the drug user community, it's a bit foreign to them"* -- Peer Specialist, Harm Reduction Victoria

'Peers Assisting Treatment of Hepatitis C' project model

The project, called PATH: Peers Assisting Treatment of Hepatitis C (hereafter referred to as the PATH project), was developed as a partnership between three organisations; Harm Reduction Victoria, The Salvation Army's Access Health Program and the Burnet Institute. The PATH project model was developed through a co-design process and implemented at the site of the clinical service partner, Access Health, by two Peer Specialists employed by Harm Reduction Victoria. Burnet Institute evaluated the project and provided funding for the Peer Specialists. PATH Peer Specialists commenced working out

of Access Health service in October 2019 with a planned implementation phase of six months which was cut slightly short due to the COVID-19 pandemic.

The Peer Specialist role was to make accessing hepatitis C care in a primary health setting as simple as possible for potential clients. Peer Specialists responsibilities included building trust, rapport and relationships with clients and potential clients to provide hepatitis C education, increase engagement with clinical services and assist with clients' drug related health issues, for example provision of naloxone referrals and/or accompaniment to support services.

PATH project activities were designed to provide opportunities for the Peer Specialists to integrate into Access Health services and to leverage outreach activities with Access Health partners. The schedule of activities for the Peer Specialists was fluid to better allow for opportunistic interactions with clients. Activities included:

Service readiness activities – designed to support the integration of the Peer Specialists into Access Health and facilitate potential avenues for the Peer Specialists to interact and build relationships with existing and new clients. Activities included an induction into Access Health services, ongoing training and attendance at relevant meetings. Training opportunities aligned with Access Health internal training in addition to mental health first aid training which was provided in response to an identified need. The Peer Specialists attended weekly Access Health staff meetings where they were informed of the clinic's weekly priorities, service updates, information sharing and staff availability.

Clinic-based activities – designed to facilitate engagement between the Peer Specialists and Access Health clients at the clinic. The Peer Specialists worked with Access Health staff including duty social workers, generalist clinic nurses and general practitioners to support existing clients of the service. A key element of the clinic-based activities was the relationship between the Peer Specialists and the Alfred Health Integrated Hepatitis Nurse (IHN) who worked at Access Health. Unfortunately, the IHN left Alfred Health immediately prior to the commencement of the Peer Specialists at the service, which meant there was no IHN at Access Health for the duration of the pilot and that this component of the model was not fully realised.

Health Promotion activities – designed to link the Peer Specialists into existing partnerships between Access Health and outreach services. Access Health works in partnership with many organisations that deliver programs and services for PWID, people who experience homelessness and people who engage in street-based sex work in the local areas including Alfred Health, Prahran Psychology, Bolton Clark Homeless Persons Program, Star Health, Harm Reduction Victoria, and Melbourne Sexual Health Clinic. The Peer Specialists leveraged these existing relationships, attending a number of these programs and services to accelerate their reach to specific populations of people who could benefit from the PATH project.

Branding activities – designed to promote the Peer Specialists and their role. Activities sought to increase the Peer Specialists visibility and included hosting barbeques at Access Health, wearing branded PATH t-shirts and handing out PATH flyers and business cards.

Evaluation Overview

The PATH project evaluation assessed the model established and explored the:

- Impact of the PATH project on the engagement of clients with hepatitis C care and,
- Factors that influence and contribute to an effective Peer Specialist program around enhancing support and service access for individuals at risk of hepatitis C.

The main data sources that were used for the evaluation were:

1) Project monitoring data. This included meeting minutes from the planning and implementation phases of the PATH project, and the client interaction form. The interaction form (n=194) was completed by the Peer Specialists after each interaction with a client and included data on perceived characteristics of the client, location, and content of the interaction.

2) Interviews with partner organisations. This included four group interviews with the Peer Specialists, Harm Reduction Victoria and Access Health service management staff and Access Health social workers as well as two individual interviews with an Access Health clinical staff member and an Access Health First Peoples' worker. The interviews were conducted at the completion of the project and focused on; a) planning and development of the program, b) challenges and enablers to implementation, and c) lessons and suggestions for the future.

Key Findings

Development and implementation of the model

The co-design process was highly regarded by all partner organisations. The project planning stages were described as collaborative, transparent, and supportive. The co-design process fostered a shared understanding of, and commitment to, the project, and strengthened relationships between partner organisations.

> *"I would say a real success that came out of this project is that it was a proper process of co-design, and that's why it took so long. And I think it should be held up as an ideal that is really useful for us." – Harm Reduction Victoria management*

Service readiness activities were important in facilitating the integration of the Peer Specialists within Access Health. It took time for Access Health staff and the Peer Specialists to gain an understanding of each other's responsibilities and how they could all contribute to the PATH project. In the absence of a dedicated project coordination role within Access Health, the service readiness activities assisted the Peer Specialists in identifying and seeking out appropriate opportunities for interactions with clients. Having a range of activities and locations where the Peer Specialists could engage with clients expanded their reach. Almost two-thirds (62%) of the 194 interactions recorded by the Peer Specialists took place at the clinic with the remaining occurring on the street or at another service. A thorough co-design process, strong support, relationships and commitment from all partners, and the employment of individuals with the right mix of skill sets and experience for the role of Peer

Specialists, were deemed to be key elements in the success of establishing the model. Integration into Access Health was critical for the Peer Specialists to facilitate engagement with clients.

Impact of PATH on hepatitis C care at Access Health

The Peer Specialists had a positive impact on the Access Health workforce particularly around the awareness of appropriate language used by clinic staff with clients. This resulted in a self-reported perceived reduction of stigma in the service. There was appreciation among Access Health service staff of how Peer Specialists were able to engage with diverse clients to start a conversation, providing education and support.

> *"I think it's really valuable to have peers talking in this space because hep C space has always been a very medical model. Decentralising it away from that medical model is hugely valuable."- Access Health management*

The absence of the IHN at Access Health meant that the clinical linkage between the Peer Specialists and the service was not as strong as was intended during the planning and design stages. The Peer Specialists were able to engage and build strong relationships with a broad range of clients; at least one risk factor for hepatitis C was identified by Peer Specialists in the majority of interactions[1] including; frequent injecting drug use (71%), unstable housing or sleeping rough (43%), mental health issues (28%) and a history of incarceration (16%). During the six months of the pilot project, the Peer Specialists recorded; delivering hepatitis C education to 38 clients (24% of interactions), five instances where they referred a client into Access Health for testing and two instances where they accompanied a client to a hepatitis C appointment. Although there was a high number of interactions, the Peer Specialists felt it was difficult to encourage clients to attend an appointment without the direct link to the IHN or the ability to offer incentives to help prioritise hepatitis C testing or treatment.

The Peer Specialists role was holistic and diverse. They were not limited to a hepatitis C educator, rather they played a triage and connector role, often providing clients with advice about, or referrals to other services (ie. domestic violence, housing) and general health information. When clients were interested, the Peer Specialists provided hepatitis C education, referred them to Access Health, or accompanied them to an appointment.

Factors that influence and contribute to an effective Peer Specialist program

The partnership model of Access Health, where providers are united to deliver services specifically tailored to the needs of populations most at risk of marginalisation from mainstream health services including PWID, was an ideal setting for the PATH project. However, frustrations arose as many potential clients reported already being aware of their hepatitis C status due to the proactive hepatitis C program at Access Health. The PATH Peer Specialists reported that many times clients had already been tested or treated for hepatitis C recently; limiting their ability to refer clients into hepatitis C care. As a result, the Peer Specialists needed to build strategies to engage the clients around the value of regular testing for

[1] The data available on the risk factors and hepatitis C status was entered only if this information came up naturally in the interaction between the client and peer specialists. Data collection fields were added throughout the project's implementation. The denominator used in analysis was the total number of interactions for each specific field.

which there was less motivation from the client's perspective. Therefore, while there was limited scope for the PATH Peer Specialists to drive new referrals into Hepatitis C care at Access Health; they demonstrated an additional value add beyond hepatitis C, including supporting the client population in a vast array of issues related to mental health, domestic violence, housing and harm reduction. This highlighted the balance between finding a setting where there is a client population that will benefit from peer workers promoting hepatitis C care, such as in outreach settings or through other social services including homeless shelters and crisis accommodation and ensuring that peer workers have a broad enough scope of work to ensure their utility and effectiveness in any setting.

Recommendations

When planning for peer-led projects focused on improving access to hepatitis C care, we recommend:

- **Mapping the local services to identify suitable settings for the integration of hepatitis C peers.** Designing project activities that address any identified gaps in hepatitis C care among the target population will maximise value of the project and lead to greater satisfaction for the peers and other project staff.
- **Prioritising staffing resources for coordination and mentoring roles**. Fund a dedicated coordinator role at the service where the peers are based. Such a coordination role ideally would be in addition to a role focused on supervision and mentorship of the peer workers. If a project involves more than one service, we recommend a coordinator role/contact person at each service in addition to an overarching coordination role based at a lead organisation.
- **Providing service-wide education on the role of the peer workers prior to commencement of project.** As peer workers are not currently a standard workforce within clinical services, we recommend that projects provide education to service staff prior to the arrival of the peer workers focused on the role and value of peer workers and how service staff can support them.

We recommend establishing pathways, strategies, and initiatives to promote engagement between the peer workers and the clients and encourage linkage to clinical hepatitis C care. These include:

- **Implementing strategies to actively promote peer workers and increase visibility.** The inclusion of branding and peer engagement activities will distinguish peer workers from clinical staff, increase the visibility of the peer-led program and build connections with the community.
- **Directly link peer workers to dedicated clinical capacity**. Ensure that there is readily available clinical capacity to support peer workers and enable clients to easily be linked into clinical care. Ideally a dedicated hepatitis nurse would work in partnership with peer workers focusing on activities where they are likely to interact with clients at risk of hepatitis C. Peer workers could also receive training in phlebotomy which would expedite hepatitis C testing for clients as well as boost clinical capacity at the health service.
- **Provision of incentives that the peer workers can use in their engagement with clients and to encourage linkage to care.** If the focus of the project is around building relationships between peers and clients and promoting hepatitis C peer-education, we suggest a petty cash system that would allow peer workers to offer gestures that promote relationship building and ongoing interactions with clients such as buying clients a coffee to chat over. If the focus of the project is

around increasing hepatitis C testing or treatment, we suggest in addition to a petty cash system, a structured incentive system linked to testing, treatment or attending appointments with a nurse or general practitioner aimed to help to prioritise hepatitis C care among clients.

- **Providing professional development opportunities for peer workers as areas of need are identified**. Peer workers should be linked in with the services available in the local area to build appropriate referral mechanisms. When there is a high prevalence of a particular issue within the community, for example mental health, peer workers should be provided with additional training to increase competency and confidence in this field. Capacity and time should be factored into projects to enable professional development of peer workers.

For organisations that plan to evaluate their peer-led project, we recommend:

- **Creating practical and sustainable ongoing monitoring systems.** Once monitoring systems are developed and implemented in a project, undertake a mid-project or regular review and assessment of the data to ensure that the intended data is being captured within the system. This will allow for early identification of any issues with the system and provide an opportunity to rectify this before the final evaluation.
- **Establishing incremental/process measures of success that align with the overall project objectives.** Evaluation frameworks should recognise the complexities and multiple barriers that need to be overcome to improve pathways to hepatitis C care. We recommend developing incremental or process measures that are key to achieving the overall objectives and celebrating successes associated with these measures throughout the project.
- **Including the perspectives of all stakeholders in the project, including the population it is designed to reach**. Projects should collect identifiable data on individuals, rather than just interactions, and ask clients specific questions rather than relying on observed or inferred data. If peer workers or the target population, consider requesting identifiable data a barrier to engagement, then formal surveys or interviews with the client population is recommended. Collecting information on what clients like, dislike or find useful when interacting with a peer worker would allow future iterations of the intervention to be tailored to the specific population.