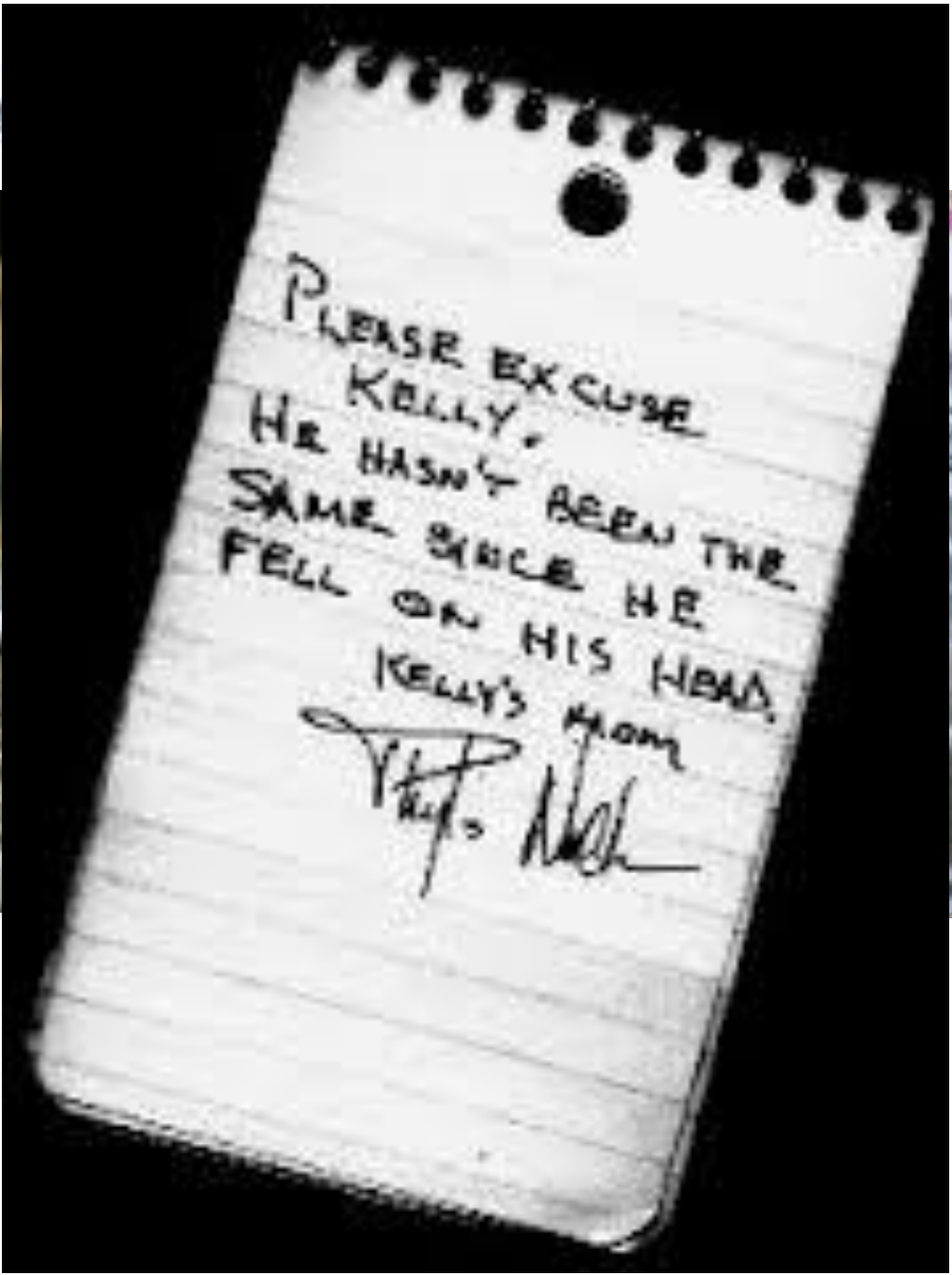


Hepatitis C peer support:

Transforming lives
Transforming services

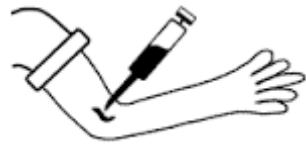
Drug treatment





Hep C

- For most users in 90s it was a one-way ticket
- Later, improving treatments still denied current users



- Still feeling impact of this today and is still true in many places
- Experience of stigma / discrimination impacts further on treatment uptake – remember discrimination is perceived not always intended



Peer Education / Peer Support

A structure that acknowledges expertise of those living with OST



A structure that acknowledges expertise of those living with hep C

Someone you can tell the truth to without negative consequence

Peer Support Models Review

- Review written 2013 :Me / Nicky Bath
- Reviewed peer support *in literature* – i.e. evaluated and reported in journals etc.
- There are a number of other examples of peer support



Peer Support Models Review

- Two key approaches:
 - Peer Driven from outside services (Community generated)
 - Peer Driven from within services (Service generated)
- These are roughly divided into Australia and North America



“Service Generated” Models

- 3 Sites in literature: Vancouver; Oakland, New York
- All sites offer OST / MATOD / OAT 😊
 - Only one primarily OST clinic
- Trad biopsychosocial substance use reduction treatments generally offered eg:
 - Self-help groups
 - Peer interventions
 - Therapeutic communities
- These elements “instinctively incorporated*”

*Sylvestre et al 2007

“Service Generated” Models

- Self-help group co-facilitation (peers + service workers)
- Large numbers need to be engaged – groups most efficient
- Telling stories to group central – self-transformation highly common*
- Socratic approach (Q & A)
- Peers recruited clients for treatment
- Medical treatment, including HCV assessment, often concurrently
- All sites include training and support

*Grebely J, Knight E, Genoway KA, et al 2010; Sylvestre et al 2007; Galindo et al 2007

Service Generated Outcomes

- High numbers assessed and high proportion treated
- Other aspects of attendee's lives improved including nutrition and general health
- Potential for self-transformation highlighted – this included positive role-modelling and self care

“Community Generated” Models

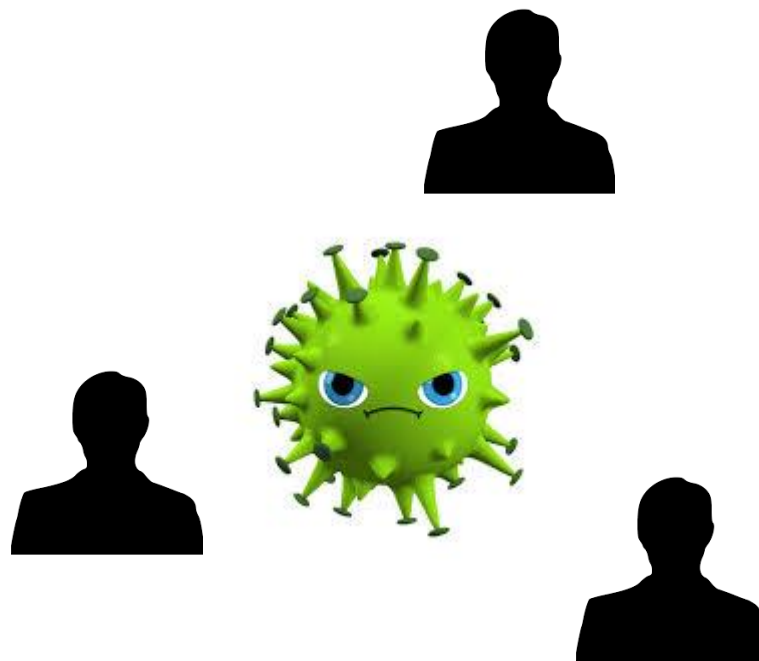
- 2 Studies; 3 sites: All OST provider sites
- 2 x public, free clinics (Regional centre, NSW; Melbourne)
- 1 x private, cost recovery clinic (Central Sydney)

A break to talk about peerness

Expresses itself in a multitude of ways – around a medication:



Around a virus



Around illicit drug use



Around all these things



“Community Generated” models

Models:

1. A full time peer support worker embedded at OST clinic (methadone peer but prescribed and dosed **elsewhere**) as part of workforce
2. Two mutually supporting peer support workers **who were also clients of the site clinic**. Operated (initially) more independently from the clinic staff (ie in partnership with external hep C nurse)

Community Generated Components

1. Embedded worker engaged **one to one with peers** at all levels and stages of assessment and treatment in partnership with clinic staff.

2. Other key model was less integrated and as a private business, the clinic did not have the same health resources on site. i.e. more barrier and less integrated workers

ALL peer support workers recruited, trained and supported primarily by NUAA – a drug user organisation, external to the service providers

Outcomes

- High degree of trust between peer support workers and clients of clinic
- Fears of treatment eased
- Treatment participation increased
- As with other models peer transformations occurred
- Notably, service transformation highlighted

Service Transformation

“I think this place has improved out of sight as far as the feeling, the vibe of the place”

- client

“the atmosphere changes [when the PSWs are present]... everyone’s in a good mood.”

-staff

Models a product of structure

- Nth American models developed within services with a harm reduction context which already have a component of group support.
- Australian models developed within stricter specialisation and in case of private clinics, with split motivations.
 - Profit motive well known by clients of the private clinics
- In Australian context Hep C treatment initially needed to be pushed externally, and peer support in particular advocated for by peer organisations *because it was not part of practice*

Self and Service transformations

- While Australian models provided both service and peer transformation, our services seem to need the transformation....
- Because peers set the parameters of the community generated models, service change was pursued.
- Would this be as likely in a service generated model? Possibly- there are examples now, but the community paved the way

The take home?

- Peer support viable in OST settings but applicable broadly across AoD
- If you are an AoD clinician engaged in HCV treatment don't assume that just because you don't discriminate, your patient doesn't feel stigmatised
- Empower affected community to set parameters
- Be prepared for change that may be uncomfortable or unintended
- Be prepared for change that will be fun

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