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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 REPORT

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.

Glossary of terms:

Abbreviation/Acronym	Meaning
AOD	Alcohol and other drugs
COVID-19	Coronavirus disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) that led to the global coronavirus pandemic
EC Victoria Partnership	Eliminate Hepatitis C Victoria Partnership which funded and supported the PATH project
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
IHN	Integrated Hepatitis C Nurse
NHMRC	National Health and Medical Research Council
NSP	Needle and Syringe Program
PAMS	Pharmacotherapy Advocacy Mediation Support, a state-wide telephone service run by Harm Reduction Victoria to support those on pharmacotherapy
PATH	Peers Assisting Treatment of Hepatitis C
Peer Specialists	Terminology used in PATH project for peer workers employed to deliver peer-led interventions within a clinical service who have a lived experience in injecting drug use and treatment for hepatitis C
PWID	People who inject drugs

We recognise that terminology around individuals involved in the harm reduction and the peer workforce space is varied and diverse. We respect and value individual and organisational preferences. For consistency with local and international literature, throughout this report we have referred to the peer workers involved in the PATH project as Peer Specialists and the individuals who they interacted with in this role as clients.

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1. 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.

2. Aims

PATH project aim: To develop a model where Peer Specialists, working with a PWID focused community organisation (Harm Reduction Victoria), are integrated into a clinical service (Access Health) to enhance access to hepatitis C care (including testing and treatment) for individuals at risk of hepatitis C.

Evaluation aims:

1. To determine the impact of the PATH project on people engaging with hepatitis C care at Access Health
2. To explore factors that influence and contribute to an effective Peer Specialist program around enhancing support and service access for individuals at risk of hepatitis C.

Findings from these evaluation aims will inform future peer-based programs of work. These will include a forthcoming project with secured funding from Gilead Sciences Inc. that will involve the same partner organisations as this project and will trial various mechanisms that peer specialists can use to engage with PWID around hepatitis C care.

3. PATH Project Design

3.1 Partners

Harm Reduction Victoria

Harm Reduction Victoria is the peak organization supporting people who use drugs in Victoria. They are a peer-based community organisation that aims to advance the health and wellbeing of people who use drugs by creating an environment in which individuals are empowered to realise their aspirations, meet their needs and participate fully in society.

For the PATH project, Harm Reduction Victoria recruited, trained and provided supervision and mentorship for two 0.6FTE Peer Specialists. The Peer Specialists were employed by Harm Reduction Victoria and based at Access Health service. Harm Reduction Victoria worked with Access Health and the Peer Specialists to identify opportunities for increased engagement with clients throughout the project.

Access Health Service

Access Health Service is a primary care service run by the Salvation Army. The health service unites providers as partners to deliver services specifically tailored to the needs of some populations most at risk of marginalisation from mainstream health services (see Appendix A for a program logic outlining partners, activities and desired outputs of the Access Health Alcohol and Other Drugs program). Throughout this report, these services are referred to as Access Health programs and initiatives. Access Health service has established expertise in working with population groups such as people at risk of insecure housing and homelessness, PWID, Aboriginal and Torres Strait Islander people and people who undertake street-based sex work. The Access Health programs and initiatives are located in the Port Philip local government area, an area with higher rates of homelessness and use of illicit drugs compared to the state average (1). Access Health has a dedicated Integrated Hepatitis C nurse (IHN) from Alfred Hospital who is generally on-site at Access Health once a week. The population that Access Health work with, along with the presence of the IHN, was thought to be a fitting setting to embed the Peer Specialists in the PATH project. Unfortunately, the IHN at Access Health left immediately prior to the Peer Specialists commencing their work from the service and was absent for the duration of the project.

Throughout the PATH project, the Peer Specialists were based at Access Health. As new staff they received orientation to the service and a flexible timetable of activities was created to embed and integrate the Peer Specialists into the service's programs and initiatives.

Burnet Institute

The Burnet Institute is committed to achieving better health for vulnerable communities in Australia and internationally by accelerating the translation of research, discovery and evidence into sustainable health solutions. One of Burnet Institute's research themes is concerned with addressing the impact of alcohol and other drug use through the application of research, treatment practice and community-

based harm reduction programs. Burnet Institute has a long history of collaborating and partnering with community organisations and primary health services.

For the PATH project, Burnet Institute had several different roles as the funder, the lead evaluator and coordinator, with Burnet Institute staff providing input from previous experience in the peer work area and expertise in evaluation. A part-time (0.2FTE) Burnet Institute staff member had a dedicated role in coordinating and managing the PATH project and was supported by an evaluation team.

3.2 Peer Specialist role

The aim of 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 repertoire and relationships with clients and potential clients to provide HCV education, increase engagement with clinical services and assist with clients' drug related health issues e.g. provision of naloxone referrals and/or accompaniment to support services. The Peer Specialists attended staff meetings at Harm Reduction Victoria and Access Health and became integrated with existing Access Health programs and initiatives.

Potential Peer Specialists were identified through existing partner's networks and approached for the role based on their professional and personal experience and expertise. Two experienced Harm Reduction practitioners were identified and recruited for the role. One individual who was recruited chose not to proceed, and another person was recruited as a replacement. This meant there was a staggered induction and start date for the two PATH Peer Specialists. Both individuals had experience in providing face-to-face, service- based, outreach and telephone support services in a variety of roles ranging from client liaison, advocacy and health promotion. At the time of recruitment, they had both previously completed a Certificate IV in Alcohol and Other Drugs and were also qualified to provide pre and post-test counselling for blood borne viruses.

The two Peer Specialists were employed through Harm Reduction Victoria each for three days per week. In general, they each spent approximately 2.5 days per week in and around Access Health building relationships and engaging with clients and potential clients. The remaining 0.5 day per week of their time was spent in administrative, data entry and supervision-related tasks.

Throughout the PATH project, the Peer Specialists received expanded education in hepatitis C, mental health first aid and management of aggression and other challenging behaviours training from the partner organisations, from Mental Health First Aid, Sacred Heart and Star Health. They were also trained by Burnet Institute staff in data collection required for the project.

3.3 Resourcing

A budget of AUD73,000 was provided for PATH by the EC Victoria Partnership, a Burnet Institute initiative funded by the NHMRC and Gilead Sciences Inc. The funds covered salary costs for the two 0.6FTE Peer Specialists. Funding also covered auxiliary costs including production and printing of health promotion resources, communications, and professional development. In addition to this dedicated

funding, substantial in-kind resources, predominantly salary costs, contributed to the PATH project; including at least 300 hours during the planning and design phase and at least 350 hours during implementation of unfunded time across all three organisations (Appendix B). There was a significant commitment of time in-kind made during the planning and design phase by collaborator Dr Graham Brown (La Trobe University) who provided his expertise on evaluation of peer-led programs using systems thinking.

3.4 Background

3.4.1 Scoping phase

Early stages of the project involved a scoping process by Burnet Institute staff to identify transferable elements of similar programs. In this process we reviewed programs that involved people with lived experience of specific conditions, attended at a local community of practice of peer workers and consulted with individuals and organizations that had established programs of peer workers (see Appendix C).

Local Australian influences informing the development of the PATH model were the shared and transferrable aspects of Living Positive Victoria's Peer Navigator Program and Hepatitis NSW programs, as well as those delivered by Queensland Injectors Health Network (QUIHN) and Peer Based Harm Reduction WA. These peer navigation programs had multiple models utilizing services of peer workers. Previous Harm Reduction Victoria programs also made a significant contribution to informing the development of the PATH model.

Learnings and recommendations identified during the scoping process informed the guiding principles of the PATH project (see Appendix D). The guiding principles were primarily drawn from the Canadian Peer Engagement and Evaluation team (2) and philosophical principles of "Nothing About Us Without Us"—Greater, Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical, and Human Rights Imperative movement (3). Guiding principles for the PATH project were:

- Peer programs should be driven by peers.
- Peer workers are experts who are distinctly different to other providers in the health care setting.
- Preparing the clinical service (service readiness) to work with peer workers is essential to the fullest use of their services.
- A combination intervention type might best address the multiple intersecting barriers to the continuum of hepatitis C care.

3.4.2 Planning and design phase

We utilised a collaborative approach with each partner organisations providing specialist expertise to the design process. The Burnet Institute brought research and evaluation expertise, Harm Reduction Victoria brought expertise around working with PWID, peer support and education, and Access Health brought clinical and community health expertise. Over approximately six months, we held interorganisational meetings every couple of weeks with input from each organisation strengthening the

research and project design. During the planning and design phase of the PATH project, various models were proposed and considered. Our plans evolved during this phase, particularly in relation to the ideal peer specialist candidate and the number and type of peer specialist roles required for the project.

Several considerations in the identification and recruitment of PATH Peer Specialists were agreed upon. Factors considered were:

- Employing someone who was active within the local community that the PATH project planned to operate within, had the potential to create instability within the project.
- There was a shared commitment to the PATH project having a low tolerance for activities that may potentially result in exploitation either directly, indirectly or unintentionally of staff.
- The project had a duty to protect peer specialists from harm or distress resulting from unnecessary scrutiny or other forms of attention particularly if they are considered part of a criminalized marketplace.

One of the designs we considered was having two PATH Peer Specialists with different focuses, a primary peer and a site peer, with distinct roles as described below.

- Primary Peer: Would provide health, harm reduction and service access information including written and verbal with a focus on hepatitis C, act as a linkage between the community and the health and clinical services at Access Health and be a trusted source of knowledge.
- Site Peer: They would have knowledge and insight into the local community that the Primary Peer may not have. This would mean they could act as a linkage between the community and the Primary Peer.

Our primary motivation for proposing peer specialists with distinctly different focuses was to expedite the introduction and acceptance of the primary peer to and by the local community through the site peer. This feature of the model was not realized primarily because of financial and time constraints of this pilot project. We also hypothesized that having two distinctly different roles for peer specialist may introduce hierarchy amongst peer staff, a model that would be opposed to the principles of peer work.

Another idea we considered for the PATH project was to have peer specialists based at the Access Health clinic site for the first half (three months) before transitioning into working from outside of the service for the latter half of the project. The rationale behind this idea was to establish the peer specialist model within the Access Health service and, once reach to clients solely within the service was saturated, then expand the reach to outside the service.

The time period that the PATH Peer Specialists were to work out of the Access Health service we set as six months. This was decided by budget constraints and our assessment of the appropriate time frame to examine the feasibility of embedding peer specialists into the service and demonstrate any impact on access to hepatitis C care. Not all ideas and concepts raised in the planning and design process were incorporated into the final implementation most frequently due to budget, time and resourcing constraints.

The final design, agreed on by all partners, involved newly recruited PATH Peer Specialists based at Access Health who concurrently performed clinic-based and outreach work, aligning with the natural workflow of Access Health's partnership services and programs and who would distribute equipment to promote safe injecting.

3.5 Implementation model

The two PATH Peer Specialists had their first orientation day together at Access Health on Monday 9th September before starting to engage with clients in the first week of October. The six month planned implementation ran across the Christmas and New Years period when the Peer Specialists took a two week break. The COVID-19 pandemic and ensuing public health restrictions, included social distancing measures, meant the Peer Specialists were withdrawn from Access Health two weeks early so the six month project had approximatly five months where the Peer Speclaitsts were engaging with clients.

The model implemented included discrete activities that aimed to provide opportunities for the Peer Specialists to intergrate into the health sevice, and to leverage the partners to promote the PATH project and reach new clients. Below we have categorised these these activities into: service readiness activities; clinic-based activities; health promotion initiatives and programs; branding activities; and administrative and management duties.

The Peer Specialist's timetable was structured to provide opportunities to work within and independently of existing programs (see Appendix E for example timetable) and to engage clients across the programs. This timetable was used as a guide with the Peer Specialist's activities being fluid and opportunistic.

Service readiness activities

Prior to embedding the PATH Peer Specialists within Access Health, the service's management inducted existing Access Health staff to work with and incorporate the Peer Specialists into the service. Access Health provided an orientation for the Peer Specialists, so they became familiar with all the various services and programs delivered at Access Health, and to support them to embed themselves within the service. The timetable of activities for PATH Peer Specialists included:

- Attending weekly Access Health staff meetings where the Peers Specialists provided updates on client engagements and promoted the project to internal staff and external workers coming into the service. In these meetings the Peer Specialists were informed of what the clinic's weekly priorities were and staff availability during the week.
- Attending existing programs for specific populations, for example Aboriginal and Torres Strait Islander rehabilitation support groups. Attendance in these programs strengthened relationships between the Peer Specialists and service staff and increased the visibility of the PATH project.
- Ongoing Training – training was provided in alignment with internal training at Access Health (e.g. a refresher naloxone training course for Overdose Awareness Week). Mental health issues were identified as prevalent among the clients and in response, the Peer Specialists undertook

Mental Health First Aid Training. The Peer Specialists also received training from other peer workers at Harm Reduction Victoria around conflict negotiation and developing skills around setting up boundaries with clients as a peer worker.

Clinic-based activities

Designated time was allowed for the Peer Specialists to engage with clients at the Access Health clinic. This involved frequenting the reception/waiting room and the drop-in space outside the entrance of the clinic. The Peer Specialists approached clients to build relationships and offer hepatitis C support. They also supported existing Access Health clients by working with service staff, notably:

- The duty social workers, who support all client facing work at Access Health.
- The generalist clinic nurses.
- The onsite GPs
- Planned to work with the IHN from Alfred Health, who was generally on-site once a week, however for the duration of the project's implementation phase, this role was vacant.

Health Promotion initiatives and programs

The PATH Peer Specialists aimed to work with Access Health's many partner 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. These partner organisations include Alfred Health, Prahran Psychology, Bolton Clark Homeless Persons Program, Star Health, Harm Reduction Victoria and Melbourne Sexual Health Clinic. Working with these partnership programs was designed to assist the Peer Specialists with integration into the clinical service and accelerate reach to specific populations of people who could benefit from the PATH services. The Peer Specialists were able to leverage existing relationships that Access Health had with key partners to promote and develop new points of access to clients. For example, the Access Health's First People's worker introduced the Peer Specialists to Aboriginal clients, and this facilitated a working relationship where the Peer Specialists became known in dedicated residential rehabilitation services for Aboriginal men (Galiamble Men's Recovery Centre) and women (Winja Ulupna). For a full list of partners and activities see Appendix A).

Over six months, the PATH Peer Specialists were successfully linked to the following seven programs that operated through Access Health or relevant services in the area. The interactions and frequency of attendance at each of these programs varied however, typically the Peer Specialists provided outreach education and opportunities to answer questions and promote hepatitis C services to community workers and potential clients. The seven programs were:

1. The food share and health outreach walk for Aboriginal and Torres Strait Islander sleeping rough in or hanging out in City of Port Phillip. Funded by Department of Health and Human Services Korin Korin Balit-Djak and run as a partnership between Access Health, Bolton Clarke Homeless Persons Program and City of Port Phillip, the initiative aims to build trust and thus health service engagement with and for Aboriginal and Torres Strait Islander community.
2. The weekly Wominjeka community barbeque for Aboriginal people at Victoria Gardens in St Kilda hosted by Star Health and where the local Aboriginal community meet, have a feed and a yarn.

3. Aboriginal and Torres Strait Islander support groups. The Peer Specialists worked with the First People's Worker that operated two abstinence-based support groups.
4. The Proactive Overdose Response Initiative offered by Star Health that aims to prevent overdose through information and Naloxone provision.
5. A rehabilitation support group for women, based at Access Health where the Peer Specialists joined various activities such as a visit to BreastScreen Victoria's mobile breast screening service.
6. Ourspace, a partnership between the Star Health AOD team and Access Health running weekly low-threshold AOD information and education session. During these open sessions, people come in and ask questions covering topics such as overdose education, detox referral, system navigation and harm reduction.
7. Access Health's Needle and Syringe Program (NSP) located next door to the health service. Although the PATH Peer Specialists carried equipment to promote safe injecting with them, due to the proximity of the NSP to Access Health, this equipment was not utilized.

The Peer Specialists also distributed PATH promotional materials (Figure 1) at the secondary NSP sites offered by Star Health, however their plans to attend these services were disrupted by the COVID-19 pandemic.

Branding activities

Events were held by the Peer Specialists to promote their role as a distinct component of Access Health service throughout the duration of the PATH project. These events increased the visibility of the Peer Specialists and provided opportunities to build connections with the clients. Events included:

- Fortnightly barbeques held in the courtyard of Access Health service – these enabled engagement with people near the health service in an informal setting.
- As a part of the Christmas party for clients at Access Health, the Peer Specialists made 'survival packs' which included a backpack with clothing, food and sanitary items that were given out to engage with at-risk clients.
- Additional one-off events were planned for early 2020 after the holiday period, the main one being a testing campaign with plans for the Peer Specialist's to follow up participants to return results and link them to treatment however, due to the COVID-19 pandemic this did not eventuate.

Branding material developed by Harm Reduction Victoria (Figure 1) was distributed by the Peer Specialists to various health and AOD services nearby Access Health. The aim of the materials was to familiarise potential clients with the program, explain the role of the peers, and promote events that the Peer Specialists were organising or attending.

A.

B.

C.

Figure 1: PATH project promotional material. **A.** Flyers that were left in the Access Health clinic waiting room and distributed by the Peer Specialists to potential clients and other services. **B.** Cards distributed by the Peer Specialists to potential clients, **C.** Flyers promoting barbeque events at Access Health

Administrative and management duties

The Peer Specialists had dedicated time within their working hours for administrative tasks including:

- Data entry of details regarding client interactions (Appendix F). These interaction forms used a REDCap platform which allowed the Peer Specialists to enter data on a tablet or mobile phone when out and about or at a computer when they were back in the office. The Peer Specialists also provided feedback on the use and content of the interaction forms to guide their refinement.
- The Peer Specialists also had the opportunity to add notes on general reflections on client interactions into the REDCap interaction form. This reflective element of their documentation provided feedback and allowed opportunities for potential additional support or training to be identified. An example was identification of mental health comorbidity in a large proportion of individuals that Peer Specialists interacted with leading to the prioritisation of mental health first aid training.

There were designated supervision activities for the Peer Specialists, and they were also offered formal and informal mechanisms of support typically available to employees of both Harm Reduction Victoria and Access Health. Harm Reduction Victoria provided formal employee supervision whilst Access Health provided on-site supervision. Meetings the Peer Specialists attended included:

- Staff meetings at Access Health, the Peer Specialists attended part of the weekly staff meeting to enable integration into the broader organisational culture and provide them with an opportunity to promote the PATH project. To avoid 'clinical colonisation' (or adopting characteristics of non-peer staff) they were intentionally not included in case management discussions at these meetings. This aimed to protect their unique relationship with the clients they engaged with as a peer.
- Staff meetings at Harm Reduction Victoria, where the Peer Specialists provided project updates. These meetings were the key point of contact between the Peer Specialists and Harm Reduction Victoria throughout the project.
- Ad hoc meetings with the 0.2FTE coordinator from the Burnet Institute who provided general support for the Peer Specialists, identified adaptations to the model as required and liaised between the partner organisations and all project staff.
- Two progress and data collection meetings occurred at the Burnet Institute during the implementation phase of the project. These meetings were attended by representatives from all partner organisations. These meetings were used to discuss successes and challenges of the model, as well as refine the evaluation data collection process. An interim report on data collected to date from the interaction form was also presented by the Burnet Institute.

4. Evaluation Methods

A program logic (Appendix G) was developed by Burnet Institute and reviewed by Harm Reduction Victoria (including Peer Specialists) and Access Health staff. The Burnet Institute took the role of evaluator with input from partners and stakeholders.

There were two main data sources for the evaluation:

1) Interviews with partner organisations:
    - Group interviews with the Peer Specialists (n=2), Harm Reduction Victoria (n=3) and Access Health service management staff (n=2) and social workers (n=3)
    - Individual interviews with Access Health service clinical staff (n=1) and First Peoples' worker (n=1).
2) Program monitoring data including meeting minutes from the planning and implementation phases of the PATH project, the mid-project review meeting, and the client interaction form (n=194) (Appendix F)

An evaluation tool used for another peer navigation program by Living Positive Victoria was adapted by Harm Reduction Victoria to create the first version of the PATH interaction form. This initial version was further revised by the Burnet Institute to capture additional relevant evaluation data and tested in the field. The refined version was then migrated to the secure web application REDCap. Further refinement of the interaction form occurred in collaboration with the partner organisations including the Peer Specialists as the project progressed. A few weeks following commencement of the Peer Specialists at Access Health, when 32 interactions had already been recorded, three extra questions were added. These were:

1. What other health issues did the client bring up?
2. Did you provide hep C education?
3. Did the person seem to have other priorities, other than hep C that they wanted to discuss with you?

On the 8 November 2019 when 126 interactions had already been recorded, a further two questions were added to the form:

1. Did the person mention where they are at with hep C?
2. Were any of the following hep C risk factors identified during the interaction?

Data was usually entered at the end of the day rather than immediately after an interaction thus relying on the Peer Specialist to correctly recall details of interactions that had taken place earlier. The Peer Specialists decided to record data this way to avoid making clients feel uncomfortable about data being collected about them immediately after a discussion which may deter future interactions. When using the interaction form, the Peer Specialists collected data on any substantial interaction between a Peer Specialist and a client, we defined this as interactions that went beyond a "hello". Three key sections were covered in the interaction form: 1. Who was the interaction with? 2. What happened? 3. How did being a peer influence things?

The data collected was from the perspective of the Peer Specialists rather than self-reported from the clients themselves which means that some data collected such as age, gender or identified hepatitis C

risk factors may not be completely accurate. A free text field at the end of the form was used by the Peer Specialist to reflect on the interaction. As the interaction used a REDCap platform, data could be entered on a tablet or mobile phone when the Peer Specialists were away from the clinic, or on a computer after an interaction had taken place.

All data entered into the interaction form was non-identifiable, so multiple interactions with the same clients were not linked, limiting our ability to assess "repeat" or return clients. Also, as we collected interactions rather than individuals, we cannot report the total number of individuals reached with this model, only the number of interactions.

Interviews occurred in May 2020, after the conclusion of the PATH project, and focused on the following topics:

- Planning and development of the program
- Challenges and enablers to implementation
- Lessons and suggestions for the future.

Three separate interview schedules (Appendix H, Appendix I & Appendix J) were used, tailored to the perspectives of each group; Peer Specialists, Harm Reduction Victoria and Access Health Service. Interviews were conducted by Burnet staff (J Gunn and F Djordjevic) and conducted via Zoom.

Interviews were either transcribed in verbatim or transcribed as notes. Interview notes/transcripts were then coded thematically by the interviewer before being written up, along with analysis from the interaction form data, as findings. Findings were reviewed by all partners and once finalised; we developed the recommendations.

This evaluation methodology was reviewed and approved by the Human Research Ethics Committee of Alfred Health (project 710/19).

We have presented the findings under the following sections:

Development and implementation of model

1. How was the model designed?
2. What were the expectations of the PATH model prior to implementation?
3. To what extent did the Peer Specialists integrate within Access Health clinic?
4. To what extent did the Peer Specialists interact with other services?

Impact of PATH on hepatitis C care at Access Health

5. How did the Peer Specialists engage with clients and potential clients?
6. Who did the Peer Specialists reach?
7. Did the PATH model increase hepatitis C testing and/or treatment uptake at Access Health clinic?
8. What, if any, was the added value to the clinical service, staff and clients provided by the Peer Specialists?

Factors that influence and contribute to an effective Peer Specialist program

9. What were the limitations and challenges encountered in the PATH project?
10. What would contribute to the effectiveness of future peer-led programs?

5. Evaluation Findings

5.1 Development and implementation of model

5.1.1 How was the model designed?

The co-design process involved in developing the PATH model was spoken positively about in interviews with management from Harm Reduction Victoria and Access Health. The interviewees reported they found the project planning stages collaborative, transparent and supportive. Those involved felt that the project had strengthened the relationship between organisations. Both Harm Reduction Victoria and Access Health agreed that thorough planning promoted confidence in implementing the intervention.

> *"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. We can at least say it wasn't poor or rushed planning that caused any issues. There were other things that we didn't foresee or were overly optimistic about, but the process was quite positive."* – Harm Reduction Victoria management

> *"This was one of my more positive experiences in terms of having three organisations coming together when there's nothing designed and then committing time and having open discussions and being frank and clear with one another. It was really supportive. In terms of co-design I thought it was really awesome and collaborative and forgiving of one another's deficits and troubleshooting."* - Access Health management

Although the co-design process of planning and developing the model was generally well regarded, there were frustrations around discontinuity of Burnet Institute staff with partners feeling that added unnecessary delays.

> *"We got quite a long way into it, and for whatever reason some staff started changing - people left. The models that we brought up, we ended up having to re-explain why we weren't doing x, y and z multiple times across multiple meetings and that really bogged us down in the middle. When you have too many meetings where we discussed why we were and weren't doing different things. That was a learning curve and there were some frustrations."* – Harm Reduction Victoria management

The importance of having the right people in the role of peer specialist was also considered important for implementation of PATH. The combination of personality, skill sets, and experience needed for the role was highlighted in the interviews.

> *"It's a lot to ask of someone basically to go in and do that role, we expected quite a lot of knowledge around hep C testing and treatment, some real amazing interpersonal skills both with peers, street people, people with mental health issues, and then being able to interact with nurses, clinicians, management as well – by themselves. To have all of that and apply it and still not get that many through testing and treatment – you need some really special people. There aren't loads of those kinds of people out there to be honest and that's one of*

the things that would limit scale-up as well is finding a trained workforce who is able to take on a role like that." – Harm Reduction Victoria management

"It's actually really hard to recruit for this sort of work. Frankly, I think that we were really fortunate with who we got working on the project in the end, but I do think it was luck rather than good management." – Harm Reduction Victoria management

"No one else could've done that position except for those two. When they came in it was just idle chatter and building relationships and trust which needs to happen first, especially in St Kilda." - First People's worker, Access Health

5.1.2. What were the expectations of the PATH model prior to implementation?

Throughout the co-design planning and design process there was a period of negotiation with the partners adapting and revising the original ideas and concepts they had for the PATH project.

"Burnet came to us and asked what we thought an ideal model would be. There were just some restrictions around funding and it being research, but I found [Burnet staff member] in the beginning open to ideas in general. I was talking about the idea of the perfect peer worker would basically be a drug runner who is on the ground and accesses and knows loads of people around the community. It's not like Pablo Escobar offering drugs treatment to people, it's usually their peers selling 5 or 6 small deals just so they can get something for themselves that day. That's not where it ended up but that's what we were talking about initially and then it became more formalized as [Burnet staff member] wrote up a few more models and I would share those with the team. There were a few months of general negotiation." - Harm Reduction Victoria management

When asked about expectations prior to commencing the implementation phase of the PATH project, stakeholders expressed varied expectations. There was some concern that much of the target population had already been engaged in hepatitis C education and care through previous interactions with Access Health and this would make it difficult for Peer Specialists to find individuals who would benefit from the PATH project. Whilst there was recognition that this may be challenging and that there would be other barriers, there was also excitement and enthusiasm for the project and, for Access Health, being able to benefit from a peer workforce.

"I was pretty sceptical too because I knew how hard it would be. And how there wouldn't be much slack at Access, I knew that they would've treated all the easy people to get onto it." - Harm Reduction Victoria management

"I had high hopes and liked the idea of the model. My only concern is that they'd come to this so late. In terms of the client group and the story of hep C, most of the regular clients of Access Health had been tested for hep C and engaged with the practice." - Access Health management

"I didn't really know what to expect – because it's a pilot I don't think anybody knew what to expect. The main thing that stood out for me was I thought that we would have more hep C engagement. I thought there would be a greater number of people seeking treatment and that we wouldn't be pushing it – I thought people would just do it I suppose. And then Access has already been very proactive so a lot of their clients had already been treated which meant there was less people showing interest than I thought there would be." - Peer Specialist, Harm Reduction Victoria

"I was really excited because our service had not had a peer workforce before…. I was pumped to have peers on site, whether it be hep C or not, to see whether it would have benefits to the service and the staff. The service tries to be multidisciplinary and peer workers has always been a gap." - Access Health Management

5.1.3 To what extent did the Peer Specialists integrate within Access Health clinic?

Overall, our data indicates that the Peer Specialists were well integrated into Access Health. Both Peer Specialists said they felt well supported and welcomed throughout their time at the service. Similarly, Access Health staff described the Peer Specialist's presence as a positive and constructive experience.

"Small gestures of inclusion have gone a really long way with me. Little things like when I first started at Access Health. [Access Health staff] had made a little 'Welcome [peer specialist]' sign for my desk. Just the fact that I felt really welcomed and had a place made for me there. It went a long way as to make me feel like part of a team." Peer Specialist, Harm Reduction Victoria

"I found it as being win-win. I felt comfortable talking with them [peer specialists] and about the patient group and specific patients and I think they felt comfortable talking to me. It was a very positive experience having them in the clinic and I thought there was mutual respect. I thought we worked collaboratively well, and I thought it enhanced the service. I'd love to have it across the board for managing other chronic health conditions, but obviously hep C is a beauty to work with." - General Practitioner, Access Health

5.1.4 To what extent did the Peer Specialists interact with other services?

The Peer Specialists interacted with a couple of other social services in the area, most notably the Sacred Heart Mission, who assist people experiencing homelessness. Interviewees noted that the connection with Sacred Heart Mission was underutilised and recognised that not all avenues identified in the planning stages came to fruition, partly due to limited time and staffing resources.

"Some days I would wander up the street to Sacred Heart. We have been inducted to Sacred Heart Mission, but we probably didn't utilise that as much as we should have. We probably should've spent more time at the courtyard up there. There's not a lot of cross over client-wise between the two services" - Peer Specialist, Harm Reduction Victoria

"It was a lot harder to leverage opportunities than it was to list them off in the planning stages. There were fewer organisations who could offer support/resources than we initially thought. An example would be that we were hoping to access people through the lunch at

Sacred Heart, but it was unrealistic for the peers to know all the services they offer and be able to make referrals." - Harm Reduction Victoria Management

5.2 Impact of PATH on hepatitis C care at Access Health clinic

5.2.1 How did the Peer Specialists engage with clients and potential clients?

The Peer Specialists utilised several approaches to promote their role, build awareness and relationships. These included being a consistent presence within the vicinity of Access Health, holding barbecues, attending support groups, street-based outreach, and producing promotional materials like t-shirts and flyers.

"They [peer specialists] were respectful to the elders, they were really helpful and made them feel welcome. All my groups take a harm minimization and AA approach, but they still came in and showed their respects. They also helped put on barbecues which was marvellous." - First People's worker, Access Health

"We had a couple of barbecues. I think the most popular one was the first one. People love a feed, but it wasn't ideal engagement for people to get tested" - Peer Specialist, Harm Reduction Victoria

"After a while [peer specialist] really started to own the space really well and people were coming in specifically to meet with [peer specialist]……..I just saw [their] confidence grow in terms of how to conduct [themselves] in that space and how to manage any issues that came up and communicate it back with Access Health. It grew quite wonderfully." – Social worker, Access Health

The Peer Specialists expressed a preference for working together as a team and noted the advantages including their varied background and skill sets and having both genders represented.

"I just felt more comfortable when we were working together. Somebody that I might not hit it off with, [peer specialist] might be able to, and vice-versa." - Peer Specialist, Harm Reduction Victoria

"There can also be that mistrust with women, and you can just see that they don't wanna be talking to a bloke. Having that availability there helped." - Peer Specialist, Harm Reduction Victoria

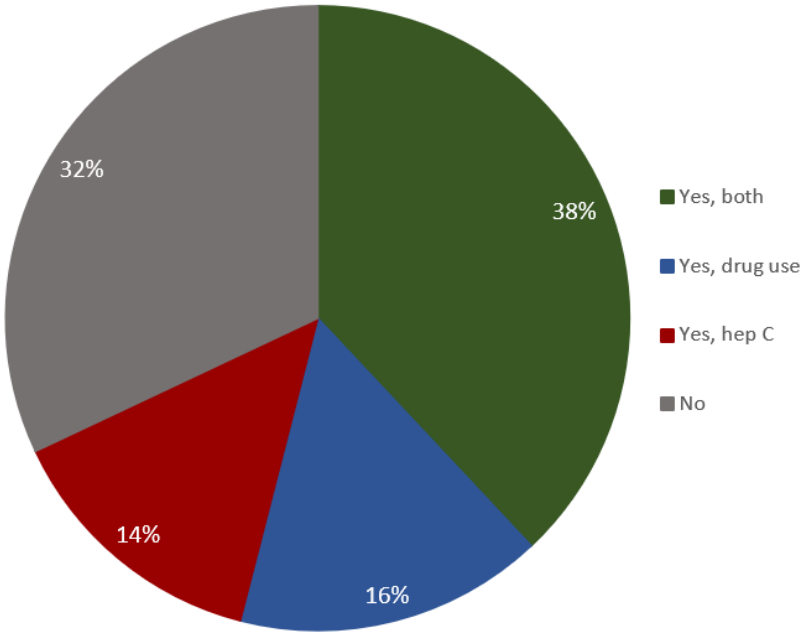
"Having them both there basically made their role a lot easier. And that's to be expected. Having support from someone else in the similar role is really helpful. Knowing that you're stuck in one conversation that you don't want to extract yourself from because of the rapport issues and that sort of stuff but that means they're not having a conversation with someone else – being able to make those trade-offs, there's less of that when there's two of you." - Harm Reduction Victoria management

Through the reflective element of the interaction forms the Peer Specialists completed after each interaction, we identified a high mental health comorbidity among clients. In response, the Peer Specialists completing mental health first aid training, strengthening their skills in identifying mental health issues and providing appropriate, relevant advice. The diverse and complex needs of clients identified through the interaction forms and discussed in meetings highlighted the importance of the Peer Specialists to be aware of local services in the area where they could refer clients when they felt this was appropriate as well as the importance of having regular debriefing sessions.

The value of the peer relationship was described as an important factor for engagement and enabling trust. Of the recorded interactions between the Peer Specialists and clients, there was a shared experience of; drug use (16%), hepatitis C (14%) or both (38%) (Figure 2). The Peer Specialists spoke about how shared experiences with clients helped them to more rapidly build a relationship where they felt the clients trusted them.

"Knowing people from the past helps a lot" - Peer Specialist, Harm Reduction Victoria

Figure 2: Proportion of recorded interactions that were identified as having shared experiences between the Peer Specialist and the client in relation to drug use, hepatitis C or both.



We found that the Peer Specialists valued being able to provide holistic support and they reflected that using their expertise and experience though involvement in PATH was empowering.

> *"I wanted to do something where I was giving something back, making a difference. I've had so many people helping me get to where I'm at today……. No matter how small it is, giving something back has been awesome. It's nice to feel good at the end of the day that you've done something."* - Peer Specialist, Harm Reduction Victoria

> *"It's also nice to have your life experience recognised as skills, as marketable skills."* - Peer Specialist, Harm Reduction Victoria

5.2.2. Who did the Peer Specialists reach?

> "*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. They're extremely grateful because somebody does have a friendly face, it's a big commodity in our community.*" - Peer Specialist, Harm Reduction Victoria

The two Peer Specialists each worked three days per week with approx. 2.5 days spent engaging with clients. The number of interactions varied week to week and dropped off over Christmas and New Year period, and during this period the Peer Specialists took a two-week break (Figure 3). A total of 194 total interactions were recorded.

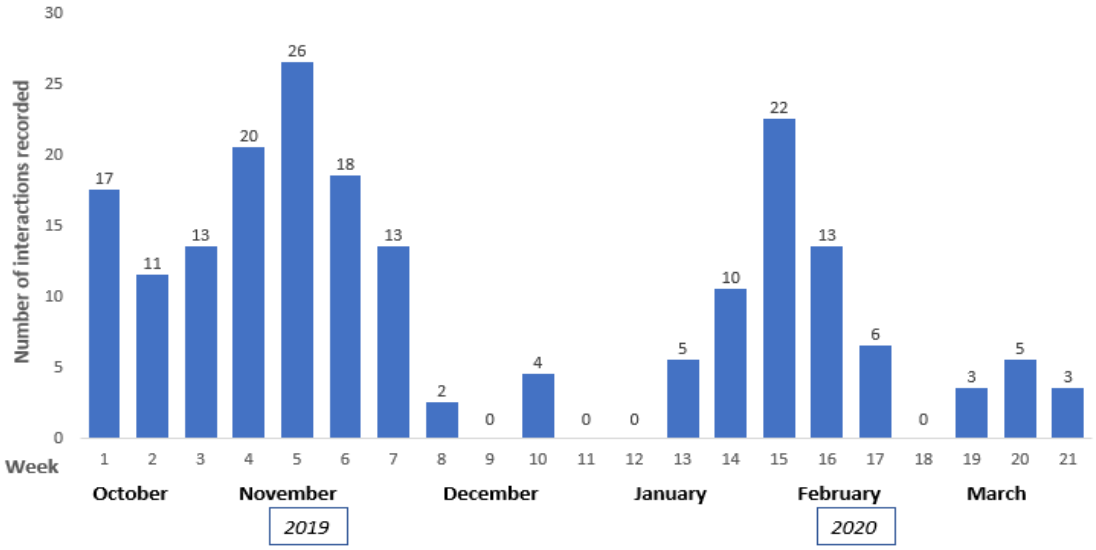


Figure 3: Interactions per week recorded by the two Peer Specialists throughout the duration of the PATH project. An encounter between a Peer Specialist and a client that went beyond a "hello" and was related to the PATH project was considered an 'interaction'.

Despite the relatively high number of interactions during the first four weeks of the PATH project (averaging approximately 2.5 interactions/day), the Peer Specialists indicated that there were challenges in gaining the trust required to engage with clients.

> "*People are not necessarily instantly trusting of someone that says they're a peer worker. There's a large degree of mistrust of institutions. To get past that, 'there's somebody with a lanyard so they're in a power position', 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

The Peer Specialists were asked to record on the interaction form their perceptions of the client's gender and age. This observational data suggests male clients were more commonly engaged with and an age group of between 30 and 50 years (Table 1). This demographic profile aligns with work completed in similar settings for example NSP surveys.

Table 1

Demographics	n (%)
What did the person's gender appear to be?	
Male	103 (53.1)
Female	64 (33.0)
Other	6 (3.1)
Not entered / Missing	21 (10.8)
What age do you think the person was?	
Less than 30	34 (17.5)
Between 30-50	101 (52.1)
Over 50	37 (19.1)
Not entered / Missing	22 (11.3)

Interactions usually took place as one-on-one conversations and the dynamics of the dialogue were most frequently led by the Peer Specialist (47%) with approximately one third (35%) felt to be equally led.

The majority (62%) of the recorded interactions were instigated by the Peer Specialist with approximately a quarter (26%) instigated by the client and eight percent referred to the Peer Specialist by a healthcare worker (Table 2). Nurse practitioners, social workers and management staff all referred clients to the Peer Specialists where they provided support, harm reduction and hepatitis C education.

With the Peer Specialists based out of Access Health, most of the peer-support interactions took place at Access Health clinic (62%) followed by on the street (22%) and in another service (13%) (Figure 4).

Table 2

Characteristics of the interaction	n (%)
Was the interaction with one person or a group?	
One person	171 (88.1)
A group	22 (11.3)
Not entered / Missing	1 (0.5%)
How long did the interaction take? (approximately)	
Less than 5 minutes	91 (46.9)
Between 5 minutes and 20 minutes	88 (45.4)
More than 20 minutes	12 (6.2)
Not entered / Missing	3 (1.5)
Who instigated the interaction?	
I did (Peer specialist)	121 (62.5)
Person interaction was with (client)	50 (25.8)
Health worker	16 (8.2)
Someone else	1 (0.5)
Not sure/don't remember	5 (2.6)
Not entered / Missing	1 (0.5)
Overall, who was leading the focus of the interaction?	
I (Peer specialist) was mostly leading it	92 (47.4)
The client/s mostly led it	19 (9.8)
Felt equally led	67 (34.5)
Don't know. It's hard to say	15 (7.7)
Not entered / Missing	1 (0.5)

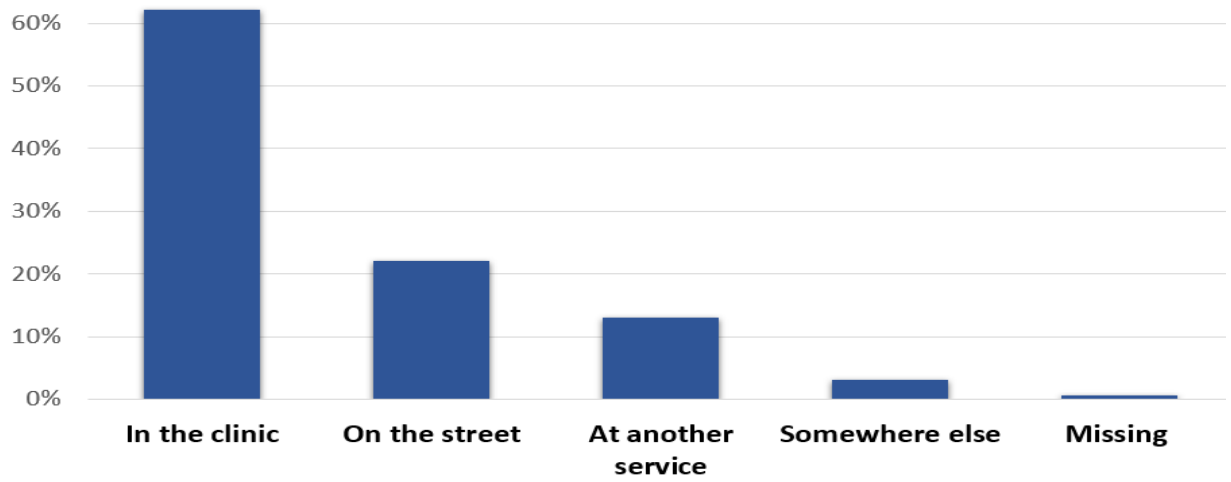


Figure 4: Locations of interactions by the two Peer Specialists throughout the duration of the PATH project.

We asked Peer Specialists to document hepatitis C-related characteristics of clients if it came up in conversation; however, data indicated that for almost half of the interactions, the client's hepatitis C status was not discussed (47%); so it was unclear at what stage along the care cascade most clients were at (Table 3). The data we did collect suggested eight (12%) of clients had a current hepatitis C infection however no data was collected on whether these individuals were receiving treatment. It is apparent that the population the Peer Specialists reached were key risk populations for hepatitis C with 71% identified as having frequent injecting drug use. Other hepatitis C risk factors that were identified during interactions included unstable housing/sleeping rough (43%) and mental health issues (28%) (Table 3). This data describes risk factors identified by the Peer Specialist rather than self-report by the clients so may not accurately reflect the population reached.

The Peer Specialists recorded what was covered in each of the interactions from the following options; hepatitis C, other health issues, building rapport and something else. Building rapport was most frequently selected across all locations and highest when the interaction occurred on the street (43% of interactions). Hepatitis C was also a frequent topic covered in interactions where it was recorded in 31% of interactions occurring at another health service, 28% of street-based interactions and 21% of interactions occurring at the Access Health clinic.

Table 3[2]

Hepatitis C-related characteristics	n (%)
Did the person mention where they are at with hep C?	n=68
Cured/treated	10 (14.7)
Currently diagnosed with hep C	8 (11.8)
Tested recently and not positive	5 (7.4)
Not tested recently	11 (16.2)
Never tested	2 (2.9)
Didn't say	32 (47.1)
Were any of the following hep C risk factors identified during the interaction?[3] *Multiple responses could be entered*	n=68
Frequent injecting drug use	48 (70.6)
Unstable housing/sleeping rough	29 (42.6)
History of incarceration	11 (16.2)
Mental health issues	19 (27.9)
None identified / No data entered [4]	10 (14.7)

5.2.3 Did the PATH model increase hepatitis C testing and/or treatment uptake at Access Health clinic?

The Peer Specialists recorded offering hepatitis C education to 47 of the clients (24% of total interactions recorded) and providing hepatitis C education to 38 of the clients (24% of interactions recorded for this question) (Table 4). The lower number of records for offering compared to providing hepatitis C education is most likely due to the question about provision of hepatitis C education being added to the data collection tool a few weeks later and therefore there are fewer total records for this question (158 compared to 194). Given there is very similar percentages of interactions for these actions, this is the likely explanation however, it may also be that some clients who were offered education declined it.

There were two instances where the Peer Specialists accompanied a client to a hepatitis C appointment and five instances when they referred a client into Access Health (Table 4). We also recorded instances

[2] Questions in Table 3 were added to the data collection tools on the 8 November 2019 after 126 records had already been documented. Percentages calculated using denominators of total number of interactions after this date (n=68).
[3] Data indicates risk factors identified by the Peer Specialists during the interaction rather than direct self-report from the client
[4] The data collection tools did not allow us to distinguish between whether there were no risk factors identified or no data was entered.

where the Peer Specialists thought that the clients had other priorities that wanted to discuss with them beyond hepatitis C. In almost half of the interactions (44%), there were other priorities beyond hepatitis C (Table 4). This is supported by data we collected describing the content covered in interactions, which commonly included housing services, mental health, substance use and material aid. Collectively this demonstrates the value of the Peer Specialists supporting clients in complex issues beyond hepatitis C.

Table 4

Actions resulting from interaction	n (%)
Did you provide hepatitis C education? [5]	n=158
Yes	38 (24.1)
No	114 (72.2)
Not entered / Missing	6 (3.8)
Did the person seem to have other priorities, other than hep C that they wanted to discuss with you? [4]	n=158
Yes	70 (44.3)
No	86 (54.4)
Not entered / Missing	2 (1.3)
Did you do something to actively engage the client in a hepatitis C clinical service? (select one only)	n=194
Yes, I accompanied the client to a hep C appointment	2 (1.0)
Yes, I referred the client into the clinic	5 (2.6)
Yes, I gave advice on where to go	31 (16.0)
No, but I referred them for another clinical service	27 (13.9)
No, I didn't engage the client in clinical services this time	81 (41.8)
No, but I offered hep C education	47 (24.2)
Not entered / Missing	1 (0.5)

[5] Added to the data collection tools a few weeks following the Peer Specialists commencement at Access Health when 36 records had already been documented. Percentages calculated using denominators of total number of interactions after this date (n=158).

In addition to the Peer Specialists recording when a client was accompanied or referred to the service, Access Health established a system where referrals were identified and recorded by the front desk staff. However, we found that this recording system was not fully implemented due to competing priorities of front desk staff, and no referrals were documented.

> *"The front desk here have 40 or 50 different data points to enter into for different activities and different projects can become convoluted. It's really hard, nothing's intuitive. Any sort of hep C engagement initiated by a peer was meant to get earmarked, and I think there's only two of those because it just fell through, despite us implementing that. I can't express how many data points there are to enter. It sort of fell by the wayside ...how busy our roles are. If we step into something like this, we need a coordination component attached."*- Access Health Management

Interviews with Access Health clinical staff further corroborated the Peer Specialist interaction data and indicated that there were instances of referrals made both from and to the Peer Specialists.

> *"There were formal discussions about patients in the weekly meeting, so sometimes they would bring up clients and so would we, and sometimes there would be a direct referral to [peer specialists] from those conversations. The feedback from [peer specialists] to me happened in my consultation room or within Access Health in corridor conversations. So there were formal and informal conversations."* - General Practitioner, Access Health

> *"I had good interactions with both of them and I felt that their interactions with the clients and what they brought for the clients was fabulous. We got a few people over the line and we got a few people educated in the community. I don't think new clients were brought in but [peer specialist] really engaged well with the clients and made them consider hep C treatment and other chronic health issues."* - General Practitioner, Access Health

5.2.4 What, if any, was the added value to the clinical service, staff and clients provided by the Peer Specialists?

A recurring theme identified throughout the evaluation interviews was the beneficial role of the Peer Specialists in providing holistic support to clients far beyond hepatitis C. As described in brief in the above section, the Peer Specialists supported clients in a range of complex issues beyond hepatitis C. These issues were most commonly around housing, mental health, domestic violence and substance use and the Peer Specialists linked clients into appropriate service and provided harm reduction education. Other less common topics included custody arrangements, law enforcement, vein health, overdose, pain management and oral health. By linking into appropriate services and supporting clients, the Peer Specialists played a valuable dual role in assisting both clients and health and social services.

Both Access Heath and Harm Reduction Victoria recognised and praised the breadth of support and expertise that the Peer Specialist provided throughout the project's implementation.

> *"I would say that the conversation, education and support that was provided in that time was fantastic. Especially making the connection between the clients and the service. There were multiple times where we called on [peer specialists] to have conversations out the front about things like safer using and naloxone. They were always available and ready to have those conversations and allowed them to become role models for clients in a way – through sharing their own stories."* – Social worker, Access Health

> *"Even if PATH hasn't had the testing and treatment outcomes, it's definitely had the outcome of peer programs in general – people's knowledge being raised, people's issues being dealt with or assisted being dealt with*" – Harm Reduction Victoria Management

> *"They noticed there were a lot of mental health issues among the people they were talking to. Some of the stuff they had to debrief with me about was pretty full on. Pretty heavy stuff for a peer worker to take on. I think they did it quite well."* - Harm Reduction Victoria Management

A noted benefit of the PATH project was a shift in the consciousness of health providers to use appropriate language with clients, which led to a perceived reduction of stigma in the service. This was particularly notable given the short time period that the project was running.

> *"There was one situation in a staff meeting where a doctor was bringing up a patient's experience in hospital and [peer specialist] pointed out that this person didn't get their hospital treatment due to stigmatisation. It led to the doctor making a complaint to the hospital. Having that person there put a face to stigma and injecting drug use and reminded us that we do need to speak up."* - Access Health management

> *"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. I think it would have positive impacts but it would take time "*- Access Health management

> *"Before [peer specialists] came on board we were having discussions about the power of words and language. So, to have someone sitting in meetings and has that background was really good because you were able to discuss 'what language are we using here' and 'how are we speaking' so it's a bit of check and balance in a way."* - Social worker, Access Health

In addition to the perceived reduction of stigma in the service, the presence of the Peer Specialist was reported to have a positive impact on the atmosphere of the service, including how clients were engaging with the service.

> *"Something that Access Heath fed back to us was that apparently on the day when a peer worker is there, there is a quite a different vibe in the service, waiting room and outside when [peer specialists] are there talking to people and giving people a place to offload.*

Just being a presence that was calming, was something we didn't set out to be the case, but definitely one of the advantages. They have an impact beyond what they're talking about with hep C." - Harm Reduction Victoria Management

[Peer specialist] was able to have really difficult conversations and never really shied away from them. [Peer specialist] always embraced them and what I really loved about their style was that they made the clients feel comfortable but also provided a great perspective with lots of different links or pathways. - Social worker, Access Health

5.3 Factors that influence and contribute to an effective Peer Specialist program

5.3.1 What were the limitations and challenges encountered in the PATH project?

Direct linkage between the Peer Specialists and clinical care

One of barriers we identified was a lack of direct linkage to clinical care primarily due to the departure of the specialised IHN prior to the Peer Specialists commencing their work interacting with clients at Access Health. The lack of direct linkage to phlebotomy services limited the Peer Specialist's ability to directly refer engaged clients into clinical care including immediate taking of bloods for testing when clients were interested.

"We lost three people that were ready to test right then and there and there was no one there to take bloods. Two doctors and a nurse were on, but the nurse doesn't take bloods and the doctors can't. If you take their bloods, they will come back for results out of curiosity. It sucks because we are there and there's no one to take bloods - especially if you take someone in and get to the counter and they say 'oh no we can't do bloods,' so you're going to have to ask them to come back" Peer Specialist, Harm Reduction Victoria

"I firmly believe that we need to have a nurse or essentially someone that can do tests and prescribe hep C treatment engaged with the program specifically, although that drives the cost up but a lot. Even if they weren't employed by us but at least attached to the clinic. The alternative to having a clinician attached to us would be a worker at Access Health whose entire job is this, who spends a number of hours per week breaking down the barriers and being there when someone needs a test and make that happen, because although when [peer specialists] told someone they needed a test and could get them in, it wasn't always that simple." - Harm Reduction Victoria management

An alternative link between the Peer Specialists and clinical services involved Access Health staff referring clients to the Peer Specialists to discuss hepatitis C and/or other support services identified as relevant to that client. With no funded roles at Access Health dedicated to the project, this linkage mechanism was not as utilised as anticipated in the planning of the project.

"I think because of all of the extraneous stuff it was a bit difficult to keep us in the forefront of their mind because they're dealing with wherever the client is at the time. So, if someone comes to book in to see a doctor for OST, I don't think the front desk lady's first thought is 'oh I wonder if this person wants to speak to a peer'. I think that was something that came afterwards." - Peer Specialist, Harm Reduction Victoria

Motivation for clients to engage with the PATH program

During the planning phase of the project, the idea of providing cash incentives for clients when the Peer Specialists were doing outreach work was discussed. We had proposed to call these incentives 'Sweet Deals'. With the majority of the interactions occurring at the Access Health clinic (Figure 4), and the service already providing some incentives to clients for other service initiatives, these weren't rolled out. We also wanted to explore what impact peer engagement strategies might have distinct from cash incentives. At the three-month mid-project progress meeting, the lack of incentives as a barrier to engaging with clients was again discussed and we decided to further expand the peer engagement strategies to include additional barbeque lunches, events, and business cards to see if these motivated clients to engage further with the Peer Specialists. A promotion video was also developed as a tool to promote the project and engage with clients (Figure 5).

Figure 5: Promotional video developed by Harm Reduction Victoria to promote the project and engage with clients.

In the evaluation interviews following the project completion, both the Peer Specialists reiterated that they felt a lack of financial incentives hindered their ability to keep clients engaged and to prioritise their health. One of the Peer Specialists suggested the idea of carrying petty cash to offer more tangible incentives to peers.

"One of the barriers for people being tested and treated for people with hepatitis C is a lack of incentives. Number one in capital letters. Big precedent set. But I do think there is an unsaid expectation in the community that if you are giving up your time for treatment etc, you expect an incentive. Biggest barrier of all." - Peer Specialist, Harm Reduction Victoria

"I was under the impression we would have incentives. Then for whatever reason we decided we wouldn't do cash incentives. As soon as that came about, counting the number of people treated was going to be really hard and wouldn't be the way to go. I think it was fine to not do incentives. That shows us something else - like what peers can do with conversations. Breaking through that final barrier is something that's hard without incentives and making it worth someone's while unfortunately." - Harm Reduction Victoria management

"It would help engagement by simply having $50 of petty cash on hand if there's people in the courtyard, if there's someone waiting to get tested. To have the ability to buy someone lunch or go for a coffee while you wait. Even a handful of Myki cards to have to get people to come back next week or a taxi voucher." - Peer Specialist, Harm Reduction Victoria

5.3.2 What would contribute to the effectiveness of future peer-led programs?

A client population in need of hepatitis C education and/or care.

We identified early in the implementation of the PATH project that many of the regular Access Health clients had either already received education, testing, or treatment for hepatitis C, likely due to the service already having a strong focus on engaging with PWID. At the three-month mid-project progress meeting, strategies to expand the reach of the Peer Specialists beyond the usual clients of Access Health were discussed and we decided that the Peer Specialists would focus on expanding into partner services and holding events to increase demand.

In the final evaluation interviews at the completion of the project, this challenge resurfaced with the suggestion for future programs to explore areas where services may have gaps in hepatitis C care and thus potential for an 'unreached' population. This would maximise the value of the project and likely lead to greater satisfaction for the peers and other project staff.

"Access Health is actually possibly too effective with accessing its clients, so a lot of the people we could have got some easy wins with – way more had already done testing and treatment than we expected. On top of that, the difficulties of getting people who had already been tested that they could get ongoing tests – people have this thing where I've already been treated or I'm already negative and that's that." - Harm Reduction Victoria management

"Access Health as a site sits perfectly for them but with the specific focus on hep C it's a bit difficult because we have a hep C specialist, we have hep C nurses, we regularly do recalls and get people into treatment and assertively follow them up. So there was a lot of let down with clients who they would engage and build rapport with and then find out that actually 'oh you have been tested, you have been treated?' – but then to be left looking at the statistics as what they got out of the project – that actually wasn't a true reflection of

how much engagement they did. It's just most of our population who come to Access are aware of the treatment because the doctors go on about it and testing for bloodborne viruses is in our intake form." – Social Worker, Access Health

Education around the role of the peer workforce

Service readiness activities undertaken prior to the project implementation included inducting existing Access Health staff as well as an orientation for the Peer Specialists. At the completion of the project, Access Health service staff indicated they felt the service readiness activities had not provided them with a good understanding of what the role of the Peer Specialists was, nor what they were aiming to achieve. They felt that having this more explicit prior to commencement of the project would have provided clarity for both the service staff and the Peer Specialist and enabled more rapid progress of the project.

"I've never worked with peers before so there were challenges with role clarity and how to navigate that, which was the same with some of my other colleagues. There could've been more work around what is a peer, what is their role, what are the expectations and we just had to navigate that ourselves, which is fine."- Social worker, Access Health

"For the first couple of weeks everyone was just wandering around aimlessly – like 'do we step in and ask you to do this or how assertive are you? You could sort of see there was this; Do we ask, do we not ask? What are you doing? We don't know' so everyone was looking forward to it and could see the merit to the program but not having that clear outline of the role and responsibilities and who to go to talk about that." - Social worker, Access Health

"It was sometimes a bit confusing for them [Access Health staff] because they didn't really know what we do." - Peer Specialist, Harm Reduction Victoria

Mentorship and supervision of the peer workforce and dedicated project coordination roles

Throughout the evaluation interviews we identified a need for increased supervision for the Peer Specialists including mentoring and support as well as increased project coordination. Staff at Access Health identified a gap in the oversight of the Peer Specialists and suggested that a coordination type role may have been useful in addition to mentoring/supervision. There were varying views and thoughts as to what type, and how much supervision and coordination would have been ideal for the PATH project. Examples were given where the peers were placed in difficult ethical situations where an additional worker to debrief with may have been useful, such as the peer specialists being asked to 'score' drugs or navigating engagement with substance abstinence support groups.

"*Essentially, the amount of supervision and support that the project needed was probably higher than we expected. Just like in an ideal world, Access might have a dedicated worker, in an ideal world, the peers would have some sort of peer leading type worker. I think that it requires way more supervision and support than we expected*." - Harm Reduction Victoria management

> *"This is the first time we've had people posted out at another service which was a learning curve for us just for practicality and supervision purposes."* - Harm Reduction Victoria management

> *"It would have been good to have someone a little more on-site supervising. Things happen with clients and Access staff might bring it up with the peers two or three days later it felt like a missed opportunity. So you wonder who's managing that – is it us or is it Harm Reduction Victoria. There probably should've been someone formally designated there from the start – which did happen but because they didn't have crossover days it didn't work out. If it was to get going, it would have [to have] a regular basis. To have discussions about any issues, good, bad or otherwise*."- Access Health Management

> *"It's been well acknowledged that we didn't have enough supervision. [Harm Reduction Victoria staff] had originally intended to have weekly catch ups. In reality we only caught up once a month."* - Peer Specialist, Harm Reduction Victoria

As peer workers are not currently a standard workforce within clinical services, there are no standardised professional development pathways. As described in section 5.2.1, tailored training based on the program and the client population that the Peer Specialists are working with was an important factor in enabling them to do their jobs well. Additional supervision, mentoring and coordination roles with the project could assist in the identification and facilitation of appropriate training and professional development opportunities.

5.4 Project and Evaluation Limitations

Limitations of the project included restricted funding and staff turnover. Limited funding meant only the Peer Specialists received salary support with the remainder of the roles completed through in-kind support. Role responsibilities that are tied to a salary are often prioritised over unfunded roles and we believe that dedicated funded roles for project coordination and supervision activities would have increased project efficiency. Staff turnover among some partner organisations was a challenge which created knowledge gaps and slowed the progress of the project. Having continuity of staff would alleviate this issue as would systematic and through handover processes. The PATH project was a partnership between three organisations all with different yet complementary focuses and areas of expertise. This had the benefits of bringing together various perspectives to create a robust model that utilised the relevant strengths of each organisation. Building relationships and defining the roles of the different partner organisations took some time. Continuing a collaborative process throughout implementation without the resources to coordinate regular meetings was also a challenge.

Australia recorded its first case of COVID-19 on 25 January 2020, the government introducing border restrictions from mid-February, and Australia moving into pandemic mode in late February. This was a period of great uncertainty around the susceptibility, incubation, duration, transmission, morbidity, and mortality of COVID-19 and coincided with the latter stages of the PATH project. This uncertainty and concern among the public and in health services staff, may have contributed to the lower number of

interactions recorded in the last month of PATH and led to an abrupt, earlier than anticipated end to the project.

There are several limitations to the PATH project evaluation. As noted elsewhere, the interaction data collected relied on observational and reflective data capture, rather than interviewed or client self-report which limited data completeness and utility. Missing data is included in this report. Interviews were conducted by Burnet Institute staff rather than evaluators from an independent, external organisation. Whilst using Burnet Institute staff limited evaluation costs, as the organisation funded and supported the project, the use of internal staff to conduct interviews may have influenced what interviewees disclosed. Interviews were not conducted with PATH clients and thus this evaluation does not capture the perspective for whom the project was designed to reach. The interviews were also all undertaken at the completion of the PATH project and therefore views were retrospective. The interviews were conducted in a time of great uncertainty with rapidly evolving COVID-19 restrictions and a sudden end to the PATH project which meant that the final planned engagement activities could not be completed, and for some there was no sense of closure to the project. This may have negatively biased interviewee's perceptions of the project.

6. Recommendations

Based on the findings from the PATH project evaluation, we recommend considering the following for future peer-led projects focused on improving access to hepatitis C care.

Planning and implementation of peer-led projects

- **Map local services and identify suitable settings for the integration of hepatitis C peers to maximise their impact.** The PATH project had excellent commitment from the partner organisations however, frustrations arose as many potential clients were already aware of their hepatitis C status due to the proactive hepatitis C program at Access Health. The PATH Peer Specialists reported that many times the clients had already been tested or treated for hepatitis C recently; limiting their ability to refer clients into hepatitis C care. Whilst they were able to assist the clients with other needs, such as referral to housing, domestic violence and mental health service, they felt they could have a greater impact if they had been able to target partner services where they could reach clients that were less likely to have already been engaged in hepatitis care. We recommend future projects design activities that address identified gaps in hepatitis C care among the project's target population. This will maximise value of the project and lead to greater satisfaction for the peers and other project staff.

- **Prioritise staffing resources for coordination and mentoring roles.** The PATH project did not fund a dedicated coordination role within Access Health. As the Peer Specialists were not familiar with Access Health's services and partnerships, this resulted in additional pressure on the Peer Specialists to themselves identify and seek out appropriate opportunities for interactions with clients. Provision of additional supervision and mentorship opportunities for the Peer Specialists was also identified in the PATH project evaluation as a potential mechanism to improve implementation. Coordination and mentoring roles were suggested as strategies to support building peer confidence and allow routine debriefing sessions to manage any distressing issues that arose in interactions with clients. We recommend that future projects fund a dedicated coordinator role at the service where the peers are based. Such a coordination role would ideally be in addition to a role focused on supervision and mentorship of the peers. If a project involves more than one service, we recommend a coordinator role at each service in addition to an overarching coordination role based at an organisation distinct from the services.

- **Provide service-wide education on the role of the peer workers prior to commencement of project**. The evaluation of the PATH project indicated that there was a lack of clarity among Access Health staff soon after the Peer Specialists arrived regarding their roles and how they fitted into clinic activities. Whilst this was resolved once the clinic staff and Peer Specialists spent time working together, an active education program could have accelerated this process and would likely have expedited their integration into Access Health. As peer workers are not currently a standard workforce within clinical services, we recommend that future 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.

Dedicated support and professional development opportunities for peer workers

- **Implement strategies to actively promote peer workers to increase visibility and engagement**. During the PATH project, the Peer Specialists found it took some time to build trust in the community and establish themselves as peers. Engagement strategies that assisted in this process included branding activities such as barbeques, T-shirts, business cards and flyers. These activities were valued by the Peer Specialists as they increased their visibility and helped them to build connections with clients. We recommend that peer engagement strategies are included in future projects to distinguish peer workers from clinical staff, increase the visibility of the peer-led program and build connections with the target population.

- **Directly link peer workers to dedicated clinical capacity**. During the PATH project, there were instances where clients had expressed interest in hepatitis C testing to the Peer Specialists, yet these clients were not able to have the required blood samples taken due to a lack of phlebotomy service available at that specific time. These examples highlight the importance of being able to act immediately when an opportunity arises. A clear limitation of the PATH model was the lack of an IHN role for the Peer Specialists to work with and refer clients to. We recommend that there is readily available clinical capacity to support peer workers so clients can more easily be linked into clinical care. Ideally an IHN 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.** During the PATH project, the Peer Specialists identified a key barrier to linking clients into hepatitis C testing and treatment was the lack of incentives on offer. The Peer Specialists felt that having incentives may have provided a greater attraction and resulted in more substantive interactions with clients. Harm Reduction Victoria identified that a precedent has been established such that PWID expect cash or voucher incentives for research initiatives related to hepatitis C. We recommend future projects trial the use of incentives. If the focus of the project is around building relationships between peers and clients and promoting hepatitis C education, we suggest a petty cash system to promote relationship building and ongoing interactions through activities such as the peer workers 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.

- **Provide professional development opportunities for peer workers as areas of need are identified**. It was recognised during the PATH project that the community the Peer Specialists were engaging with were diverse with complex needs and priorities. It was important for the PATH Peer Specialists to become familiar with the local services available so they could refer clients appropriately, for example to local mental health services or a nearby crisis centre. During the PATH project, we identified training needs in the areas of mental health first aid; however, the type of training needed for peer workers may vary in different settings and should be tailored to client populations and

needs. We recommend that peer workers for future projects are 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 target population, for example mental health, peer workers should be provided with additional training to increase competency and confidence in the identified field.

Evaluation

- **Create practical and sustainable ongoing monitoring systems.** In the PATH project, we intended to use triangulation to capture the number of clients referred from and to the Peer Specialists however, the system developed to capture client referrals from the Peer Specialists to Access Health did not function as intended due to busy nature of the health service front desk. In future projects, we recommend that once monitoring systems are developed and implemented, regular review and assessment of the data is undertaken 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.
- **Establish incremental/process measures of success that align with the overall project objectives.** In the PATH project, the Peer Specialists expressed disappointment at the low number of clients who were accessing hepatitis C testing and treatment after interacting with them. Whilst indicators around interactions and health promotion were included in the PATH project, there were challenges around how to capture the holistic nature of the work of the Peer Specialists. Some components such as hepatitis C education were quantitatively captured whilst others, such as lowering the distrust of the health service among clients were only touched on in the interviews during the evaluation. We suggest that evaluation frameworks recognise the complexities and multiple barriers that need to be overcome to improve pathways to hepatitis C care. We recommend developing incremental measures or process measures that are key to achieving the overall objectives and celebrating successes associated with these measures throughout the project.
- **Include perspectives of all stakeholders in the project, including the population it is designed to reach**. A limitation of the data collected in the PATH project was that the interaction data was limited to the Peer Specialist's observed or inferred responses rather than self-reported responses directly from the clients. No interviews or surveys were delivered to the client population. This meant that the perspectives or views of the clients were not captured in the PATH project. 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. We recommend that future projects 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.

7. Conclusion

Peers Assisting Treatment of Hepatitis C (PATH), a peer-based model, was co-designed and implemented as a partnership between three organisations with distinct yet complementary expertise: Harm Reduction Victoria, Access Health and the Burnet Institute. The model aimed to integrate Peer Specialists into a clinical service to enhance access to hepatitis C care for people at risk of or living with hepatitis C. The key elements of the PATH model included service readiness activities, clinic-based activities, health promotion activities, branding activities, administrative and management duties.

Working from the Access Health service over six months, the Peer Specialists built relationships and trust with existing and new clients. The Peer Specialists successfully engaged clients on a range of issues including hepatitis C. During the project implementation it was identified that the proactive hepatitis C program at Access Health meant most regular clients had already been linked into hepatitis C care; limiting the ability of the Peer Specialists to refer clients into care. However, the Peer Specialists were still able to frequently deliver hepatitis C education and provide tailored support beyond hepatitis C including referrals for housing, domestic violence and mental health. This holistic support provided by the Peer Specialists to the clients was recognised by Access Health staff as beneficial to the service. Another positive outcome for Access Health from the PATH project was a shift in the consciousness of health providers to use appropriate language with clients, which led to a perceived reduction of stigma in the service.

As peer workers are not currently a standard workforce within clinical services, service readiness activities that support the integration of peers into the service were identified as being particularly important. Key service readiness activities included education for service staff around the role and value of the peer workforce and dedicated coordination support for the peer-based program. For the peer workers, provision of regular and dedicated supervision and mentoring support as well as access to professional development including relevant training opportunities are crucial.

Efficiency within the PATH model could have been improved with pathways, strategies, and initiatives to promote engagement between the peer workers and the clients. We recommend the use of incentives to aid in engagement and/or linkage to hepatitis C care and to establish a direct link between the peer workers and clinical hepatitis C services to support opportunistic engagement of clients. Branding and peer engagement strategies such as dedicated events and promotional material were found to be important in building connections with the target population through raising the visibility of the peer-led program and the important work they do in engaging clients in hepatitis C care.

8. References

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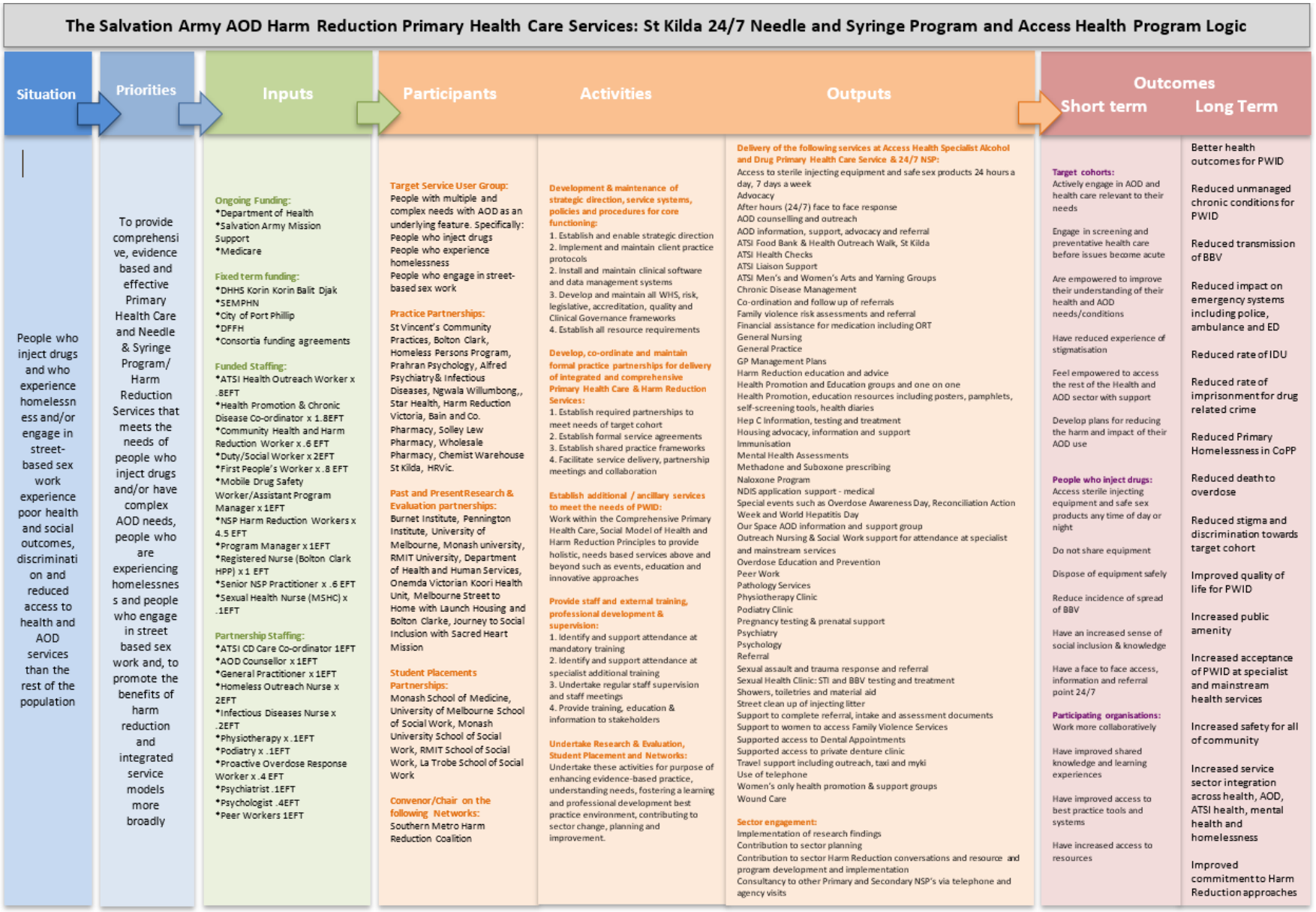
9. Appendices

A. Access Health Program Logic
B. Estimated in-kind resources
C. Summary of scoping activities for Peer Workforce
D. Peer Workforce Resources document
E. Example timetable for Peer Specialists at Access Health
F. PATH interaction form template
G. PATH program logic
H. Peer Specialists interview guide
I. Harm Reduction Victoria interview guide
J. Access Health Service interview guide

Appendix A: Access Health Program Logic



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Appendix B: Estimated in-kind resources

Estimated in-kind resources provided by all partners throughout the PATH (Peers Assisting Treatment of Hepatitis C) project planning and implementation phases.

Organisation	Staffing	Other
Harm Reduction Victoria	***Planning and design phase***	
	Three to four staff for input and contribution to planning and design.	Meetings – Four staff involved in meetings with a combined total of approx. 115 hours Internal training - Three staff for eight hours each (total 24 hours) External training – Two staff for eight hours each (total 16 hours)
	Implementation phase	
	Two management staff for supervision, management and oversight. One staff member at 0.05 FTE (1/4 day per week) and the other at 0.0025 FTE (1 hour per week)	Promotion costs: Flyers, catering, T-shirts, show bags Meetings – Two staff involved in meetings with Burnet Institute and/or Access Health for a combined total of approx. 120 hours over 20 weeks
Access Health Service	***Planning and design phase***	
	Two management staff for input and contribution to planning and design.	Meetings – Two staff involved in meetings with a combined total of approx. 60 hours
	Implementation phase	
	One management staff for oversight onsite at clinic	Resources: Desk space, computer access Shadow shifts with approx 4 staff (NSP, first peoples worker, duty social workers and nursing team) to assist with integration of peer specialists into clinic. Meetings – one to two staff involved in meetings with Burnet Institute and/or Harm Reduction Victoria for a combined total of approx. 80 hours over 20 weeks
Burnet Institute	***Planning and design phase***	
	Three to four staff for coordination, input and contribution to planning.	Meetings – Four staff involved in meetings with a combined total of approx. 115 hours
	Implementation phase	
	One 0.2 FTE (1 day per week) staff for dedicated coordination Approximately four to six 0.05 FTE (1/4 day per week) staff for coordination, oversight and evaluation	Resources: Two phones, RedCap set up and data management Meetings – Six staff involved at various times in meetings with Harm Reduction Victoria and/or Access Health for a combined total of approx. 160 hours over 20 weeks

Appendix C: Summary of scoping activities for Peer Workforce

Consulted	Peer worker Peer group Three community organizations
Literature	Reviewed other programs in literature to identify potentially portable components of peer programs. Programs included focused on other communicable diseases (HIV, HBV), target populations (defined by ethnicity, sexual orientation or other identifiable risk factor to a specific condition).
Other	Resources relating to inclusion of people who use drugs Resources directed at organizations undertaking peer work (mainly in mental health)

Learnings

- Ideally a Peer program is driven by peers.
- Service readiness / training is essential to promote:
  a) service factors essential integrating peer workers &
  b) an understanding of and mechanisms for the service to promote utilization of the role.
- Managing expectations of peer work should be integrated into all stages of a project.
- A combination intervention types might best address the multiple intersecting barriers to the continuum of care.
- Identifying the best method of describing the work of peers to stakeholders.

Guiding Principles of Peer Work

- Peer workers have an accomplished history of making a significant contribution to public health. This is acknowledged across different policy levels.
- Peer workers are experts who are distinctly different to other providers in the health care setting.
- Services readiness is essential to the maximum adoption and utilization of the role.
- Peer workers require professional support to undertake their work within services.
- Peer work should be integrated within services they support.

Consultations

i. Peer worker known to champion hepatitis C testing and treatment to clients accessing NSP service.
ii. Mental Health peer worker group trained in and practicing Intentional Peer Support (IPS)
iii. Community organizations whose interventions contribute to promoting access to hepatitis C care continuum.

Models of Peer Programs from Literature

- All models acknowledged health care access is affected by multiple characteristics of the individual, health care system and wider social context.
- All acknowledged the role of stigma as one deterrent to testing and sometimes commencing treatment.

- Some models also focused upon additional demographics contributing to further marginalization.
- Program interventions commonly addressed multiple barrier groups to facilitate access to care.

Characteristics of programs

- Patient empowerment was promoted through information provision and identification of & solutions to identified barriers to care.
- Programs acknowledged the broader context which contributes to the health & health care seeking of individuals.
- Program indicators varied from adaption of prevention activities, engagement and retention in care & use of clinical indicators.
- Programs were located in a variety of settings including community health services, clinical services and outside of services within the community.
- Programs generally used outreach with a dedicated contact person to provided information, navigation or referral to services.
- Program activities mostly focused on mutable factors through advocacy, health promotion, information and education, counselling and support and navigation. Many programs used tangible resources to accompany information and education.
- Program outcomes identified by clients included:
    - Normalization of their experiences with health care systems
    - Translation of medical concepts
    - Engagement / reengagement and retention in care
    - Motivation to seek care and treatment &
    - Enhanced experience within health services

Challenges experienced by Peer Workers

- Adjunct to core work (HCV care)
- Discordance between expectations and the work
- Service understanding & utilization of the role

Implications for EC peer project

- Expectations of workers should be appropriate to the setting
- Organizational preparedness
- Method of measurement of impact
- Integration and linkage with services

Appendix D: Peer Workforce Resources document

Peer Workforce Resources: CONTEXT

ARCSHS La Trobe University (2018). Hepatitis c treatment: peer insights in barriers and motivators to DAA treatment uptake.

Research project

The broadsheet aims to provide live feedback based upon the different experiences of people who use drugs with DAA treatment.

The first in the series identifies the importance of accurate messages around the experience of treatment and eligibility and cost to individuals.

Factors influential to treatment which have emerged from the first broadsheet include unstable housing, being asymptomatic, concerns about venipuncture, not being engaged in related services and the experiences of stigma and discrimination.

Peer Work Hub (2016). Employers guide to implementing a peer workforce. 1. A case for your organization

This document provides a brief overview of the rational for inclusion of peer workers in the field of mental health. It includes an outline of different roles and functions held by peer workers in mental health, the principles in which peer works practice in mental health, evidence of the benefits of peer workers in mental health and a brief discussion about training and career pathways for peer workers in mental health.
It outlines the policy context in which these peer workers work in Australia.

Peer Workforce Resources: BEST PRACTISE

The Peer Engagement and Evaluation Project (December 2017). *Peer engagement principles and best practices: a guide for BC health authorities and other providers (version 2)* Vancouver, BC: BC Centre for Disease Control. Written in partnership with peers and providers

PEEP is a participatory research project with people who use drugs which documents participant's experiences with engaging peers and other professionals.
The project identifies meaningful and active participation as essential to engagement and identifies barriers to maximizing engagement and strategies to overcome these.
This technical paper provides examples of engagement frameworks (p.19), the range of engagement that can be experienced by peer workers in decision making (p.22) and the barriers to peer engagement experienced by health authorities (p26).
Principles of best practice in peer engagement

The Peer Engagement and Evaluation Project (January 2018). *A brief overview of the peer engagement principles and best practices.*

This overview is a summary of PEEP research findings and includes a quick reference guide to the projects principles and practices for peer engagement and a checklist across the life of a peer project.
PEEP defines a peer as a person with lived experience of substance use who uses their experience to inform their professional work.

"Nothing about us without us". Greater, meaningful involvement of people who use illegal drugs: a public health, ethical and Human Rights Imperative. Canadian HIV/AIDS Legal Network, the International HIV/AIDS Alliance and the Open Society Institute. 2008

This report adapts the demand of people with disabilities for increased participation in decisions and actions which affect them to people who use drugs.
It provides rational for (and illustrates) the benefits of meaningful participation of people who use drugs in the identification of, planning for and responses to the potential harms they can be vulnerable to. It acknowledges all of the factors that determine the health of people who use drugs.
A pyramid of involvement (p.33) illustrates the difference between types of participation of people who use drugs have within activities that affect them and there is a quick reference checklist (p.43) to guide practical activities.

Canadian AIDS Society (June 2015). Peerology: a guide by and for people who use drugs on how to get involved.

This is a guide for individuals who want to increase their involvement in participatory activities written by and for people who use drugs. It also includes recommendations to assist organizations to increase inclusion of peers.

Peer Work Hub (2016). Employers guide to implementing a peer workforce.

The second part of the Peer Work Hub document is a practical guide to establishing a peer workforce. It has tools that can be used at all stages of program implementation including organizational factors, recruitment of peer workers, training & education and program evaluation.
It includes a practical guide to values and principles of peer work, organizational readiness and change management.

Western Australian Association for Mental Health (October 2014) Peer Work Strategic Framework.

The framework provides guidance for organizations to adapt a consistent approach to peer workers in the mental health and alcohol & other drug sectors. The framework provides an inclusive definition of a peer worker (p.15). The framework has a particular focus on components of the organization for which the peer workforce represents.
It includes examples of peer worker programs (WA).

Peer Workforce Resources: OTHER RESOURCES

SHARC - Peer Projects
Peer projects serves as a resource for activities and training for the workforce in the AOD treatment sector.

NSW Health (2016) Peer Worker information sheet

Information sheet which could be an example of a resource to promote organizational preparedness

International Association of Peer Supporters (April 2014) Recovery to practice participant workbook - v1.

Module 6: Peer support values and guidelines
This is part of a training module for peer workers in mental health. Module 6 could be used for boundaries training

Appendix E: Example timetable for Peer Specialists at Access Health

Example weekly timetable used as a guide

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Front desk IHN	Accompany PORI (Proactive Overdose Response Initiative) worker for out of clinic outreach	Front desk service based outreach Chill out space activities Data reporting Street based outreach	Access Health Staff training as relevant Peer Specialist onsite	Nil
PM	IHN ATSI group fortnightly Use of chill out space fortnightly	HRVic team meetings monthly (3 - 4pm)	Access Health staff team meetings Street based outreach HRVic health promotion activity events	Peer Specialist onsite	Clinic based outreach Hustle to Health

Appendix F: PATH interaction form template

Peer Specialist Interaction Form

Record ID _____

For each interaction with a peer that goes beyond "hello" or short interactions unrelated to your work.

This is to be filled out in a timely manner but not in front of peers. This is different to case notes, which we will develop separately.

Peer specialist initials _____

Date _____

Client details

Was the interaction with one person or a group?	◯ One person ◯ A group
How many people in the group? (approximately)	◯ Between 2 and 5 ◯ Between 6 and 10 ◯ More than 10
What did the person's gender appear to be?	◯ Male ◯ Female ◯ Other
What age do you think the person was?	◯ Less than 30 years old ◯ Between 30 and 50 years old ◯ Over 50 years old ◯ Don't know
Did the person mention where they are at with hep C?	◯ No ◯ Never tested ◯ Not tested recently ◯ Tested recently and not positive ◯ Currently diagnosed with hep C ◯ Cured/treated ◯ Naturally cleared hep C
Were any of the following hep C risk factors identified during the interaction?	☐ Frequent injecting drug use ☐ Unstable housing/sleeping rough ☐ History of incarceration ☐ Mental health issues
Have you spoken to this person before?	◯ Yes ◯ No ◯ Unsure

Did the person tell you they've made progress towards hepatitis C care since you last saw them?	◯ Yes, they have been tested ◯ Yes, they have started treatment ◯ Yes, they have done something else in the path to getting cure (eg had blood tests or a Fibroscan) ◯ No progress ◯ N/A - they didn't say anything
Did the person/people know about the peer specialist program before this session?	◯ Yes ◯ No ◯ Not sure

Interaction details

Where did the interaction take place?	◯ In the clinic ◯ On the street ◯ At another service ◯ Somewhere else
Where?	_____
Who instigated the interaction?	◯ I did (Peer specialist) ◯ Client/s ◯ Health worker ◯ Other clients ◯ Not sure/don't remember ◯ Someone else
Who else?	_____
How long did the interaction take? (approximately)	◯ Less than 5 minutes ◯ Between 5 minutes and 20 minutes ◯ More than 20 minutes
What was covered in the interaction? (select all that apply)	☐ Hep C ☐ Other health issues ☐ Building rapport ☐ Something else ☐ Substance use
What else?	_____
What other health issues did the client bring up?	☐ OST ☐ Mental health ☐ Vein health ☐ Oral health ☐ Pain management ☐ Didn't say ☐ Something else
If something else, what other health issue?	_____
Did you provide hep C education?	◯ Yes ◯ No

Did you do something to actively engage the client in a hepatitis C clinical service?	◯ Yes, I gave advice on where to go ◯ Yes, I accompanied the client to a hep C appointment ◯ No, but I referred them for another clinical service ◯ No, I didn't engage the client in clinical services this time ◯ No, but I offered hep C education ◯ Yes, I referred the client into the clinic
Were there any other actions arising from the interaction?	◯ Yes ◯ No ◯ No, but open to further contact
What other actions?	_____
Did the person seem to have other priorities, other than hep C that they wanted to discuss with you?	◯ Yes ◯ No
What other priorities?	☐ Other physical health conditions ☐ Other mental health conditions ☐ Unstable housing ☐ Money ☐ Work ☐ Family ☐ Substance use ☐ Didn't say ☐ Something else
What else?	_____
Reflections on the interaction	
Was there sharing of experiences about drug use or hep C?	◯ Yes - drug use ◯ Yes - hep C ◯ Yes - both drug use and hep C ◯ No
How open did the communication feel?	◯ Very open ◯ Somewhat open ◯ About neutral ◯ Fairly closed ◯ Very closed ◯ It's hard to say
Overall, who was leading the focus of the interaction?	◯ I was mostly leading it ◯ The client/s mostly led it ◯ Felt equally led ◯ Don't know. It's hard to say
Final comments	
Any other reflections on the interaction? E.g client risk factors, actions taken, or general comments	_____

Appendix G: PATH Program logic

PATH (Peers Assisting Treatment of Hepatitis C) Program Logic

Pilot Program aim: To develop a model where Peer Specialists, working with a PWID focused community organisation (Harm Reduction Victoria), are integrated into a clinical service (Access Health) to enhance access to HCV care (including testing & treatment) for individuals at risk of hepatitis C.

Evaluation aims: 1) To determine the impact of the PATH pilot on people engaging with hepatitis C care at Access Health. 2) To explore factors that influence and contribute to an effective Peer Specialist program around enhancing support and service access for individuals at risk of hepatitis C.

Situation/Problem

Approximately 65,000 people in Victoria are estimated to live with HCV* (2016).

In Victoria and Australia more broadly, PWID* are the population group who carry the greatest burden of HCV and are a population that experience multiple and complex barriers to care and treatment.

Australia is committed to eliminating HCV as a public health threat by 2030. To achieve this goal a diverse range of initiatives that will improve access and linkage to HCV care. Further evidence of the effectiveness of peer-led interventions in increasing access to HCV care for PWID in Australia is needed.

*HCV; Hepatitis C Virus
* PWID; people who inject drugs

Inputs

Over 12 months

Salaries
- Peer specialists (x2 @ 0.6FTE for 36 wks)
- HRVic* staff (in kind)
- Access Health clinic staff (in kind)
- Burnet staff (in kind)

Other Costs
- Tablets
- other resources incl HCV health promotion resources, travel costs est $2,500

Expertise and Knowledge including lived experience of HCV, peer-led interventions, harm reduction, effective interpersonal communication

*HRVic; Harm Reduction Victoria

Outputs

Actors

* **Peer Specialists (PS)** – employed and supervised through HRVic.
* **HRVic staff** - mentor & supervise PS on a day-to-day basis.
* **Access Health clinic staff** – work with PS to integrate peer-led interventions into routine practice.
* **Burnet staff** - evaluation support
* **Clients** who interact with PATH Peer Specialists

 # Peer specialists are individuals with lived experience who have been trained and certified to help their peers

Activities

* Train and mentor peer specialists (*HRVic*)
* Provide HCV focused peer education and support to clients attending Access Health (*PS, clients, Access Health clinic*)
* Provide street-based HCV education and NSP outreach. Engage clients in discussions (*PS, clients, Access Health clinic*)
* Refer patients from Access Health clinic who could benefit from peer support to PS (*Access Health clinic, PS*)
* Development of M&E data collection tools *(all actors except clients)*
* Regular collection of, and reflection on, M&E data *(all actors except clients)*

Outcomes

Short term (within timeframe of PATH)

* Model established where PS integrated into Access Health clinic, enabling access to HCV care (including testing & treatment) for clients
* Peer Specialists working on PATH developed further skills and more confident in roles as Peer professionals
* Increased accessibility for clients to seek and engage with HCV care at Access Health clinic
* Understanding of the client population reached by PS in PATH

Medium term (as a result of PATH)

* Increased HCV testing and treatment uptake rates amongst clients at Access Health clinic
* Peer Specialists identify and are seen as a valuable source of knowledge and part of health workforce
* Peer support for clients and increased referral into other health and social services
* Insights gained into best practices for an effective HCV peer workforce and to inform expansion of peer-led programs

Long term Outcomes

* Peer Specialists and peer principles are embedded into appropriate clinical services (supported by workplace culture) across Victoria
* Peer-led interventions established as a pathway for PWID to engage with HCV care across Australia
* Peer-led interventions contribute to HCV Australian elimination goals through increase in testing & treatment.
* Lower prevalence of HCV within Australian population

Assumptions

M&E level: 1) All clients who interact with PATH Peer Specialists and are consequently referred into health services, are appropriately flagged/recorded; 2) Peer Specialists collect complete data including recalling barriers & enablers; 3) Data collected by Peer Specialists (self-report & self-nominated), will be accurate or consistent enough to allow assessment of risk factors; 4) Providers are using electronic scripts; 5) accurate recording of activities & planning (including budget)

Other: 1) Additional peer support will be useful for PWID to increase HCV knowledge and motivate them to access HCV care ; 2) Support provided by the Peer Specialists will have direct measurable impact on HCV testing and treatment uptake in project setting; 3) The actors involved are cognizant enough to guide best-practices in HCV workforce and peer-led programs; 4) That peers and clinical staff value each other and want to work together; 5) That peers are aware of other services are available and are able to identify and appropriately refer PWID into those services

External Factors

- Continuity and buy-in from staff and stakeholders
- Policy and funding shifts

Appendix H: Peer Specialists interview guide

Focus Group Discussion guide for Peer Specialists

The focus group discussion will occur via phone or online format for the Peer Specialists employed by Harm Reduction Victoria it will focus on overall experience with the PATH project, relationships with clients and staff, reflections on peer-led models, and recommendations for future peer-led projects for hepatitis C. Attendees will be asked the following questions:

Experience working in the PATH project

- Tell me about your role day-to-day – what does a typical day look like for you?
- What made you choose to take up this role?
    - *What did you expect the role to be like?*
    - *How different was it from what you expected? How/why?*
- What do you think are some of the barriers for people being tested or treated for hepatitis C?
    - *Do you think as a peer specialist you enabled people to access care? If so, what barriers to care were overcome?*
    - *What barriers to accessing health care do you feel were really hard for you as peer specialists to help with?*
- How would you describe your relationship with clients?
    - *How do you think the peer relationship influences the impact of the program on clients?*
    - *What kind of activities helped you to build trust and rapport with clients?*
    - *Events? Smoking hang outs? Getting to know local surrounding services?*
- What kind of clients do you believe benefited the most from the PATH program?
    - *Why? How so?*
- Think about a memorable time when you engaged with a client. Would you be able to tell me about what kind of things they needed support with how you approached this?
- How would you describe your relationship with Access health?
    - *Did you feel that you were able to integrate into the service?*
    - *Did you feel the staff were able to refer/promote your service?*
    - *Who was your main contact point?*
    - *Was it easy to get in touch with them to organise or discuss issues?*
    - *Did you think clients recognised you as either part of Access health or a part of Harm Reduction Victoria? Did you think that mattered?*
- Did you feel like you were well supported and supervision from HRVic?
    - *Being based out of Access Health - did you feel that you got enough time to interact with HRVic staff and feel apart for their team?*
- How did you find documenting interaction and collecting evaluation data?
    - *Did you feel like you got enough support from Burnet to do this?*
    - *Did you find the data reports useful?*
    - *How would you change this?*

- What components of the program could be improved or changed?

Reflections on peer-led models of care

- What skills and training do you think is important for peer specialists to have?
  - *Is there additional training you would have liked to receive? If so, what and why do you think it would have been helpful?*
- Have you learnt or gained anything personally by being a peer specialist?
  - If yes: What have you learnt or gained?
- Is there any advice or lessons that you have learned which you think would help other organisations seeking to establish a peer-based hepatitis C service?

Final question

- Is there anything that we haven't covered that anyone would like to add?

Appendix I: Harm Reduction Victoria interview guide

Focus Group Discussion guide for staff at Harm Reduction Victoria

The focus group discussion will occur via phone or online format for staff involved in the peer program from Harm Reduction Victoria it will focus on perceived barriers to hepatitis C care, organisational resources required to support the program and perceived integration of the program into the organisations involved.

Attendees will be asked to discuss the following topics:

Involvement with the PATH Peer Specialist Program

- In what role were you involved with the PATH peer specialist program?
- Are you able to describe the activities and roles of Harm Reduction Victoria in establishing the PATH program?

Reflections on the PATH Peer Specialist program

- Thinking back to before the peer program began, what were your expectations of the program?
  - *What did you believe the role of the peer specialist to be?*
  - *Had you thought about how the peer program would be integrated into the health service?*
- What do you think are some of the barriers for people being tested or treated for hepatitis C?
  - *Do you think the peer specialist program enabled people to access care? If so, what barriers to care were overcome?*
  - *What barriers to accessing health care do you feel the peer specialist program was not able to assist people with?*
- What working relationship developed between the peer specialists and the service during the program?

  - How well do feel the peer specialists were able to integrate into the service?
  - How did Access Health assist the peer specialist program?
  - What was the response of the health staff to the peer program?
- What aspects do you think were successful about the peer-specialist program?

  - Did clients benefit from the program? If so, in what ways?
  - How did you or your staff refer/promote the program?
  - Did staff benefit from the program? If so, in what ways?
- What were some of the things you found challenging about being involved in the program?

  - Were there any components of the program that you don't feel fully comfortable with?

- Do you think additional training or resources would have been useful?
- And if so, what type of training would you have liked to receive?
- And if so, what part of the program would you resource better?

- Thinking back to how you thought the program would run before it started, how different was it at the end?
    - *How/why?*

Working in Partnerships

- Could you describe how you (HRVic) found working in partnership with Access Health and Burnet?
    - *Were there any benefits or disadvantages for HRVic to working in partnership with these partners on the program?*
- How did the preparation and implementation of the program meet the time and resource expectations you had of the program?
    - *What time and resource commitments were required of HRVic before the program started?*
    - *What time and resource commitments were required of HRVic during the program?*
    - *What training do you consider essential for peer specialist staff?*
- Did the peer specialist program positively or negatively impact upon HRVic as an organisation?
- How was the peer specialist program similar to or have cross over with other programs and activities at HRVic?
- How was the specialist program different to other projects and programs conducted by HRVic?
- Did the peer specialist program strengthen HRVic's networks with other services / organisations?
- Do you think there is a need to scale up this program or expand it?
- Is there any advice or lessons that you have learned that you think would help other organisations seeking to establish a peer-led hepatitis C service?
    - *What factors do you think would be important to consider? For example: clinical service suitability, training requirements, expectations, geographical location*
    - *Are there any key things you wish had been done differently now you look back on the program?*

Final question

- Is there anything that we haven't covered that anyone would like to add?

Appendix J: Access Health interview guide

Focus Group Discussion guide for Access Health staff

The focus group discussion will occur via phone or online format for staff involved in the peer program from Access Health it will focus on what their expectations of the program were, whether these were met and the identification of barriers and enablers that can be used to inform future work in this area.

Attendees will be asked to discuss the following topics:

Involvement with the PATH Peer Specialist Program

- Could you describe your role at Access Health and in what capacity you were involved in the PATH peer specialist program?

Reflections on the PATH Peer Specialist program

- Thinking back to before the peer program began, what were your expectations of the program?
  - *What did you believe the role of the peer specialist to be?*
  - *Had you thought about how the peer program would be integrated into the health service?*
- What working relationship developed between the peer specialists and the service during the program?
  - *Do you feel the peer specialists were well integrated into the service?*
  - *Were there any factors to consider when including the peer specialists in service activities?*
  - *What was the response of health staff to the peer program?*
- What do you think are the key barriers for Access health clients to initiate hepatitis C treatment?
  - *Do you think the peer specialist program enabled people to access care? If so, what barriers to care were overcome?*
  - *What barriers to accessing health care do you feel the peer specialist program was not able to assist people with?*
- What aspects do you think were successful about the peer-specialist program?
  - *Did clients benefit from the program? If so, in what ways?*
  - *How did you or your staff refer/promote the program?*
  - *Was the program successful in reaching clients who would have otherwise not been engaged about hepatitis C?*
  - *Do you think the peer program increased the number of people seeking testing and treatment for hepatitis C at Access Health?*

- *Did staff benefit from the program? If so, in what ways?*

- What were some of the things you found challenging about being involved in the program?
  - *How did Access Health find adding a peer-led service to the existing services?*
  - *Were there any components of the program that you don't feel fully comfortable with?*
  - *How did you find documenting referrals and collecting evaluation data?*
  - *Do you think additional training or resources would have been useful?*
  - *And if so, what type of training would you have liked to receive?*
  - *And if so, what part of the program would you resource better?*
  - *Thinking back to how you thought the program would run before it started, how different was it at the end? How/why?*

Working in Partnerships

- Could you describe how you (Access Health) found working in partnership with HRVic and Burnet?
  - *Were there any benefits or disadvantages for Access to working in partnership with these partners on those program?*

- How did the preparation and implementation of the program meet the time and resource expectations you had of the program?
  - *What time and resource commitments were required of HRVic before the program started?*
  - *What time and resource commitments were required of HRVic during the program?*
  - *How did you find the co-design development process?*
  - *What training do you consider essential for peer specialist staff?*

- Did the peer specialist program positively or negatively impact upon Access as an organisation?
- Do you think there is a need to scale up this program or expand it?
- Is there any advice or lessons that you have learned that you think would help other organisations seeking to establish a peer-led hepatitis C service?
  - *What factors do you think would be important to consider? For example: clinical service suitability, training requirements, expectations, geographical location*
  - *Are there any key things you wish had been done differently now you look back on the program?*

Final question

- Is there anything that we haven't covered that anyone would like to add?