

EVALUATION OF THE SOUTH WEST HEPATITIS C PARTNERSHIP PILOT

FINAL EVALUATION REPORT

March 2017



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1. Executive Summary

1.1 Context

Addaction (a national substance misuse treatment provider) and The Hepatitis C Trust (the national UK charity for hepatitis C) formed a partnership in 2014 through which the two organisations sought to work together to better support more people with a history of injecting drug use who are engaged with Addaction services into hepatitis C treatment.

Both organisations were motivated by a vision that the elimination of hepatitis C (HCV) is a realistic prospect with the advent of new treatment if the right package of support is provided to those at most risk. In particular the partnership aimed to support more people with a history of injecting drug use engaged with Addaction services into treatment. The organisations recognized that, by working together, they could make significant in-road on tackling levels of HCV – Addaction recognizing that they work with a client group that is particularly vulnerable and The Hepatitis C Trust recognizing that they could achieve their mission by collaborating closely with a substance misuse provider.

In order to address the joint vision it was decided that the partnership should develop a pilot to test three key interventions. These interventions were:

- **Peer education workshops:** in which a peer educator with lived experience of HCV delivers workshops based on key messages about HCV prevention, diagnosis, care and treatment to people attending drug services, rehabs, detoxes and day programmes
- **Buddy scheme:** in which those seeking or accessing HCV treatment are provided with support by a “buddy” with experience of HCV and/or substance misuse. Unlike the peer educators, buddies did not necessarily have lived experience of HCV.
- **Workforce development:** training to a range of Addaction staff (including clinical and non-clinical, paid and volunteers) about HCV and other Blood Borne Viruses

The partnership and the resultant pilot activity was supported by a third key partner, the biopharmaceutical company Abbvie who provided funding and support.

The various elements of the pilot, as noted above, were piloted in the South West of England. The South West was chosen for a number of reasons.

1.2 Methodology

The evaluation adopted both qualitative and quantitative elements in order to develop an in-depth picture of the impact of the pilot.

Quantitative research

Data for the peer education workshop element of the pilot consisted of records of activity (numbers of workshops and numbers of participants engaged in sessions across the country between September 2015 and September 2016 (inclusive)). Responses to feedback questionnaires completed by participants at each peer education workshop were analysed to ascertain the demographic characteristics of those the workshop are reaching and the impact of the workshops on knowledge and understanding of HCV.

Data for the buddy scheme consisted of analysis of the buddy log kept by The Hepatitis C Trust to record the activity of the buddies available.

For the workforce development, questionnaires completed by training participants were used to evaluate staff members' confidence in their own knowledge and ability to use this knowledge to advise and support their clients, before and after the training sessions.

Qualitative research

CPI undertook one-to-one follow-up interviews with a number of service users who had attended a peer education workshop during 2016. These interviews were conducted by telephone.

A stakeholder workshop was delivered at the end of the evaluation (March 2017) at which the findings were presented along with conclusions and recommendations. Attendees were able to co-produce additional recommendations. These have been highlighted in the relevant sections.

1.3 Peer education workshops

806 people attended over 112 HCV workshops that were delivered by peer educators. The initial conclusion to be drawn is that peer educators are an efficient and effective mechanism through which to provide important information to large volumes of people. The sheer volume of people engaged over the course of the pilot is to be applauded, particularly given that this is a "hard to reach" group of people who can be difficult to engage with.

Peer education is however evidently not just effective in terms of effective reach. The results would appear to demonstrate that the outcomes of the workshop are very good with 70% of

those trained indicating that their knowledge had increased A Lot or Massively as a result of the workshop. Knowledge of the five key messages was high with an average of 89% of respondents answering the five questions correctly. It can therefore be concluded that the peer educators have proven to be an effective means through which to communicate a small number of core (but vital) messages about HCV to a high-risk group of clients.

The longitudinal qualitative aspect of the evaluation indicates that longer-term retention of the information provided in the peer education workshop is good with near universal recall among those interviewed of key messages in relation to: transmission routes, the role of blood to blood contact and the availability of new treatment. Some of those interviewed indicated that they had gone on to get tested as a direct result of the workshop and some were planning to do so. Of no little note, a number of those interviewed indicated that they had shared key messages about HCV with their partners, friends and peers. This would tend to indicate that the peer to peer education is embedding accurate information about HCV within the drug using community, the messages which are then being transmitted through the community. This is a very welcome finding.

While the results of the peer education workshops are on the whole very positive, some attention should be given to the profile of attendees. The results indicate large numbers of attendees who have not injected (whereas those who have injected are the most high risk group) and numbers of clients in alcohol treatment (a lower risk group). It may therefore be beneficial to consider greater levels of targeting in relation to who workshops are delivered to so as to ensure that the most vulnerable engage and receive the important messages conveyed by the peer educators. However feedback from Addaction's service users suggests that with many people using multiple substances over their lifetime, providing HCV information to those people who may not have injected is important as they may inject at a later point.

It is worth noting that those interviewed emphasised the positive quality of the peer educators. The findings demonstrate the importance of using peers to deliver the workshops and particularly the fact that they have lived experience of HCV. This is possibly instrumental in achieving the results that are set out.

Whilst the introduction of "Talk and Test" (i.e. provision of testing immediately following workshops) was a later innovation the results would tend to indicate that this is leading to an

increase in levels of testing among the target group and therefore consideration should be given to making this part of the standard delivery of the training.

Recommendations

1. The peer education workshop strand should be rolled out across all Addaction areas to enable all Addaction clients to benefit from key and important messages about HCV.
2. Where possible workshops should be targeted at higher risk groups – particularly injecting drug users or those who have had some history of taking drugs intravenously.
3. In addition to heroin users it may be worth seeking to engage other types of injecting drug users – for instance those who use image/performance enhancing drugs. This recommendation was generated by attendees at the stakeholder workshop (and also by a peer education workshop attendee interviewed as part of the evaluation).
4. Should recommendation 1 be approved, additional peer educators should be recruited and trained to ensure that there is sufficient capacity to manage the increased demand.
5. A quality control programme should be introduced for peer educators to ensure that they are clear about the key messages that need to be delivered and are delivering these effectively to audiences. This could take the form of staff from The Hepatitis C Trust observing peer educators at regular intervals (perhaps six monthly) and regular ‘top-up’ training to ensure that peer educators are delivering the right message, whilst also providing an opportunity to share up-to-date information on HCV treatment and developments. ‘top up’ training should be provided annually. The quality control element should be overseen by The Hepatitis C Trust.
6. A peer educator professional development package should be put in place to enable peer educators to learn from one another, share good practice and develop their training skills. This should be tied into the ‘top up’ training (described at recommendation 5 above).
7. To the extent that it is possible, Talk and Test should be rolled out as standard across all peer education workshops ensuring that testing is available directly after all workshops. If universal testing is not viable, then Talk and Test should be targeted at those venues and groups where there are likely to be injecting drug users or those with a history of injecting drug use following the segmentation of workshop clients (see recommendation above on better targeting).

1.4 Buddy scheme

Over the two years of the pilot a total of 46 volunteers received a day of HCV training and an additional day of training on how to be a buddy – i.e. how to provide peer support. Training was provided by The Hepatitis C Trust with day to day support for buddies provided by Addaction. Buddy work was limited to Cornwall.

There is insufficient data to draw any firm conclusions regarding the buddy scheme and its effectiveness as a method of support.

Recommendations

8. The buddy scheme concept should be re-tested in another area covered by Addaction to determine whether the concept proves more effective when located in another region.
9. If the buddy scheme is re-tested robust data should be collected about the activities that take place under the scheme to enable a determination to be made as to the effectiveness of the concept.
10. Currently large numbers of volunteers have been trained as buddies but are inactive. Consideration should be given to developing a smaller cohort of buddies who are more likely to be engaged and active. One mechanism may be to select buddies on the basis of lived HCV experience.

1.5 Workforce development

Over the course of the pilot in the region of 205 members of Addaction staff and volunteers have been trained about both HCV and other BBVs. The data from the surveys clearly indicates a positive impact of this training – 90% of attendees reported increased knowledge of BBVs, a third of attendees were Very Confident in their knowledge of HCV. Similar levels of positive reporting were identified across all other variables. The pilot has therefore had an appreciable impact among Addaction staff about BBVs and how to support their clients.

Recommendations

11. The questionnaire used in the workforce survey to test the impact on attendees should be amended to allow for a direct comparison to be made on individual's knowledge before and after training. This would allow “distance travelled” to be measured per attendee. The most straightforward approach would be for the before and after questions to be on either side of a single sheet of paper. This recommendation was generated by attendees at the stakeholder workshop.

12. BBV/HCV training in its current format should be rolled out to Addaction staff and volunteers as standard practice to ensure that the entire workforce has high levels of awareness and can therefore better support their clients.
13. Consideration should be given to short “top-up”/refresher training sessions to make sure that staff who have been trained retain knowledge of key concepts and ideas.
14. Addaction staff and volunteers should be given the opportunity to attend peer education workshops which may prove to be beneficial to them in terms of their learning and development. This recommendation was generated by attendees at the stakeholder workshop.

2. Context

2.1 The Pilot

Addaction (a national substance misuse treatment provider) and The Hepatitis C Trust (the national UK charity for hepatitis C) formed a partnership in 2014 through which the two organisations sought to work together to better support more people with a history of injecting drug use who are engaged with Addaction services into hepatitis C treatment.

The partnership was predicated upon the shared understanding of a number of key issues:

- That drug users are at particularly high risk of infection from hepatitis C (hereafter HCV)
- That drug users find it difficult to engage in testing for HCV and onward treatment where needed

Both organisations were motivated by a vision that the elimination of HCV is a realistic prospect with the advent of new treatment if the right package of support is provided to those at most risk. In particular the partnership aimed to support more people with a history of injecting drug use engaged with Addaction services into treatment. The organisations recognized that, by working together, they could make significant in-road on tackling levels of HCV – Addaction recognizing that they work with a client group that is particularly vulnerable and The Hepatitis C Trust recognizing that they could achieve their mission by collaborating closely with a substance misuse provider.

In order to address the joint vision it was decided that the partnership should develop a pilot to test three key interventions. These interventions were:

- **Peer education workshops:** in which a peer educator with lived experience of HCV delivers workshops based on key messages about HCV prevention, diagnosis, care and treatment to people attending drug services, rehabs, detoxes and day programmes
- **Buddy scheme:** in which those seeking or accessing HCV treatment are provided with support by a “buddy” with experience of HCV and/or substance misuse. Unlike the peer educators, buddies did not necessarily have lived experience of HCV.
- **Workforce development:** training to a range of Addaction staff (including clinical and non-clinical, paid and volunteers) about HCV and other Blood Borne Viruses

In addition to the activities above, a fibroscan technician was recruited during the course of the programme (June 2016) and operated in Cornwall (i.e. not across the entire programme area).

The partnership and the resultant pilot activity was supported by a third key partner, the biopharmaceutical company Abbvie who provided funding and support.

Addaction and The Hepatitis C Trust had applied to a number of pharmaceutical companies to fund the pilot work outlined above. A submission to Abbvie indicated that they were eager to be involved and to fund the activity that was to take place. Abbvie requested that the pilot may be more suited to a single defined region to better determine the impact of the work taking place.

The elements of the pilot were initially tested in the South West to test the impact and effectiveness of the three interventions. It was intended that, dependent on the success of the pilot in the South West, that the various elements could potentially be rolled out across all areas of the country as an ongoing programme within Addaction's core service delivery

2.2 Hepatitis C treatment landscape

Prior to the roll-out of the pilot, testing and treatment numbers for drug users were low nationally (that is, not just an issue in the South West of England). This is often attributed to poor linkage to care, sporadic testing policy and very little partnership working between third sector substance misuse providers and the NHS. In addition to this, tough HCV treatment regimes that were commonly perceived by drug users as difficult to tolerate or deemed as not suitable for them made led to lower numbers of this cohort engaging in secondary care.

In addition to perceived barriers to engaging (as described above) the pilot also coincided with the introduction of new treatments - Direct Acting Anti-Virals (DAA's). This could have had a detrimental effect on the pilot given that there was very slow implementation of these new treatments by the NHS leading to many potential patients choosing to wait, and in some cases, hospitals not providing any treatment until they could provide the new drugs. This could have affected the number of clients engaging with any form of buddy support.

2.3 Implementation of pilot

The various elements of the pilot, as noted above, were piloted in the South West of England. The South West was chosen for a number of reasons. The primary reason for the choice of

location is that Addaction provide all substance misuse services in the area (as the sole provider of substance misuse services in Cornwall and the lead provider in Devon) meaning that it was easier to co-ordinate and deliver the pilot in an area with a single substance misuse lead. This also aligned with Abbvie's requirements to deliver the pilot across a single region (see above).

Additionally, in 2012, Addaction employed a dedicated nurse with a specific responsibility for covering Blood Borne Viruses (hereafter BBVs) in Cornwall, meaning that there was a pre-existing BBV infrastructure. Whilst not essential to the delivery of the pilot, it was deemed that the BBV nurse added value to delivering the pilot in the Cornwall area. The BBV nurse has an honorary prescribing contract with a local hospital and so is able to test, diagnose and treat in the community – an offer that is considered to be unique. The work of the nurse has been further supported by the employment of a fibroscan technician (funded by Abbvie) to work through the back-log of 80 service users waiting for staging in the community, meaning that it is becoming possible to put more people through to treatment.

The pilot also builds on the Hepatitis C Trust's existing peer education programme which has been running since August 2010 providing key messages about HCV prevention, diagnosis, treatment and care to those at most risk of infection. This however was a single paid post. The Hepatitis C Trust therefore wanted to explore the possibility of using existing networks of volunteers within substance misuse services to expand the delivery of this intervention. Within the volunteers some distinction was drawn – only those with lived experience of HCV could be peer educators (as the workshops very much hinge around their personal story) whereas this was not a requirement for buddies. The range of Addaction volunteers made it feasible to test this concept in the South West (albeit noting that all Addaction sites have a range of volunteers and this is not something particular to the area).

In addition to this, the buddy element was in turn inspired and informed by pioneering work in Motherwell (the Positive Support project) that used a "buddy scheme" (using paid workers) to promote engagement with HCV treatment. It was the intention of the South West pilot to draw on the lessons of this project, and specifically to explore the use of the volunteers, and further determine the efficacy and impact of using peers to provide support and help. Finally, the pilot sought to explore the impact of using those with lived experience of drug use and HCV to provide information and advice to other drug users to determine whether a peer-led approach proved to be more effective.

Following initial roll-out of the pilot in the South West, in 2016 elements of the project were delivered in additional areas where Addaction had a treatment presence. Specifically, peer to peer education was delivered in Lincolnshire, St Helens and Liverpool. Given this, this evaluation report also encompasses work carried out in these areas as well as in the South West.

2.4 Interim evaluation findings

The work of the initial phase of the pilot was evaluated between October 2014 and April 2015 (also by CPI). The evaluation reached a number of conclusions which are set out below.

Peer education workshops

There was widespread consensus that the peer workshop element of the pilot was an effective mechanism through which to engage with service users and improve their awareness around a number of key issues relating to HCV. The data from evaluation forms completed by attendees substantiated this assessment and demonstrated that those who attend workshops leave with improved awareness regarding HCV, are better able to manage risks associated with transmission and know how to seek testing and treatment if required.

The report noted that there were some concerns about the consistency across the trainers - specifically variations in their ability to cogently and concisely deliver the five key messages. The evaluation concluded that "Should issues with quality and standardisation be addressed, it would appear that peer to peer education is an excellent mechanism for communicating with clients and that should be rolled out at scale".

Buddy scheme

With regard to the buddy component, the first evaluation report concluded that there was a clear consensus among professional stakeholders and buddies themselves that the buddying scheme was a good concept that should improve engagement of substance misuse clients with HCV treatment. The data at the point of writing however did not substantiate this hypothesis and it was noted that the efficacy of the concept had not been demonstrated.

Workforce development

In relation to the workforce development aspect, the first evaluation report concluded that the results of the workforce training were positive with consistent majorities of staff indicating that

the training increased their awareness and confidence. Following the training over half of training recipients indicated that they were confident to provide support and advice to their clients about HCV, meaning that more drug users in the region should receive support and timely advice about BBVs from the professionals that they come into contact with.

3. Methodology

The evaluation adopted both qualitative and quantitative elements in order to develop an in-depth picture of the impact of the pilot.

3.1 Quantitative research

Quantitative data was analysed to enable evaluation of the scope of the pilot and its effectiveness.

Data for the peer education workshop element of the pilot consisted of records of activity (numbers of workshops and numbers of participants engaged in sessions across the country between September 2015 and September 2016 inclusive).

Responses to feedback questionnaires completed by participants at each peer education workshop were analysed to ascertain the demographic characteristics of those the workshop are reaching and the impact of the workshops on knowledge and understanding of HCV. Completion of these questionnaires was optional (insofar as attendance at peer education workshops was not conditional on completion of a questionnaire), and while for some areas the questionnaire data was input by a member of staff from The Hepatitis C Trust, in others data entry was reliant upon the individual peer to peer education volunteers (i.e. those delivering the training). The peer educators were given clear instructions and guidance as to why data needed to be collected, how it should be collected and the importance of the data. Data was collected the end of each session to maximise return rates.

The data on numbers of workshops and participants was provided by peer educators via completion of a 'Peer Educator Statistics Sheet'.

Data for the buddying scheme was limited due to difficulties in accessing NHS data on numbers presenting for treatment and associated appointment attendance. The aim of the buddying scheme was to improve engagement with the NHS and to support clients to attend NHS appointments. The lack of data with regard to appointments attended therefore impacted on the ability to judge whether this element of the buddy scheme had proven to be successful. Thus data consisted mainly of the buddying log kept by The Hepatitis C Trust to record the activity of the buddies available.

For the workforce development, questionnaires completed by training participants were used to evaluate staff members' confidence in their own knowledge and ability to use this knowledge to advise and support their clients, before and after the training sessions.

3.2 Qualitative research

CPI undertook one-to-one follow-up interviews with a number of service users who had attended a peer education workshop during 2016. These interviews were conducted by telephone and interviewees were offered a £5 voucher as a 'thank you' for participating (this was offered and provided by The Hepatitis C Trust).

A total of 34 participants were interviewed during this round of the evaluation. In addition, five re-interviews were carried out with participants who had attended the training between November 2015 and May 2016, and had previously been interviewed in May-June 2016. These re-interviews aimed to establish whether participants' recall of the key messages and the session itself had been maintained 4-five months later and therefore to identify the longitudinal impact of the pilot – that is, whether behaviour changes were retained over a longer time frame.

3.3 Stakeholder workshop

In March 2017 a stakeholder workshop was held bringing together ten people from Addaction and The Hepatitis Trust (both staff and volunteers). The workshop was used as an opportunity to present the key findings of the evaluation and to explore the conclusions and recommendations. A number of recommendations were developed at the event which were subsequently incorporated into the final report.

3.4 Reporting

A report on the initial phase of the pilot (including peer education workshops, a buddying scheme and workforce development all piloted in the South West region) was produced in December 2015 the key messages from which are set out in Section 2 of this report (above).

This report takes a more complete view of the pilot following its expansion to other areas of the country and covers a 13-month period of activity from September 2015 to September 2016.

4. Quantitative Analysis

Quantitative data was analysed to enable evaluation of the scope of the pilot and its effectiveness - particularly in terms of raising awareness of HCV among Addaction clients.

4.1 Peer Education Workshops

As noted at section 2.4, the interim evaluation report noted that the peer education workshops were an effective mechanism to engage with service users. The report noted some concerns about the consistency of trainers. As a result of this finding the competency of peer educators is assessed six months after their initial training to ensure that they are delivering the right messages and that their work is of an effective standard.

4.1.1 Data Collection

Data for the peer to peer element of the pilot consisted of records of workshop activity (numbers of workshops and numbers of participants engaged across the country between September 2015 and September 2016 (inclusive), which was gathered by the peer educators themselves at each workshop. This was augmented by responses to peer feedback questionnaires completed by participants (on a voluntary basis), which gave information on the demographic characteristics of those attending the workshop, as well as an evaluation of the session and a self-reported assessment of improvement in participants' knowledge and understanding of the key messages following the workshop.

4.1.2 Peer to peer Workshop Activity

Between September 2015 and September 2016, a total of 112 peer to peer education workshops were held, attended by a total of 806 participants. Workshops were held at a variety of venues including:

- Substance misuse day programmes
- Rehabilitation units
- Hostels, and
- Homeless shelters

This equates to 62 attendees on average per month. The table below shows the number of participants accessing peer to peer workshops in each area during the year (note that in some areas workshops were only running for part of the year).

Cornwall had the highest number of peer education workshops carried out, followed by North Somerset¹ – note these are the areas where the pilot has run for the longest period of time.

Data was not available to determine whether some participants attended more than one workshop as the names of participants were not required on feedback forms.

Figure 1: Workshops and Participants

Area	Workshops running since	Number of Workshops Completed	Total Attendees	Average per workshop
Bournemouth	04/03/2016	10	56	6
Cornwall	09/08/2014	44	334	8
Devon	22/09/2015	10	64	6
Lincolnshire	25/11/2015	2	21	11
Liverpool	30/10/2015	8	54	7
St Helens	22/10/2015	9	65	7
North Somerset	28/8/2014	29	212	7
Total		112	806	7

Data entry was somewhat incomplete for St. Helens and Liverpool, both in terms of the number of workshops completed, number of attendees, and numbers tested on the day. Thus the numbers shown above may be an under-estimate for these areas.

With regards to those areas outside of the South West (where numbers are lower due to them being new projects) it was noted that significant efforts were expended on getting peer to peer work off the ground with good buy-in from Addaction staff and volunteers.

Some problems were experienced in Liverpool. Specifically, it was thought that a requirement for recruitment was that an individual must have completed the new DAA treatment in order to be a peer. Peers needed only to have had lived experience of HCV regardless of treatment

¹ Also referred to as "Weston" in the report for brevity.

² Note – drug treatment services are commissioned across local authority areas some of which are therefore county-wide whereas others are focused on specific towns and cities. The geographic nature of how services are commissioned is therefore reflected in the areas across which substance misuse services are delivered.

³ Data relates to the period covered by this evaluation.

experience. In St Helens it was noted that the peer educator found paid employment meaning that initial gains that were made could not be built upon as rapidly as had been hoped. In Lincolnshire, the first peer educator moved into paid employment. A second peer educator was trained but the work was interrupted by the re-commissioning of the substance misuse service. This demonstrates that local initiatives can be disrupted by changes in commissioning and the periodic re-commissioning of treatment services.

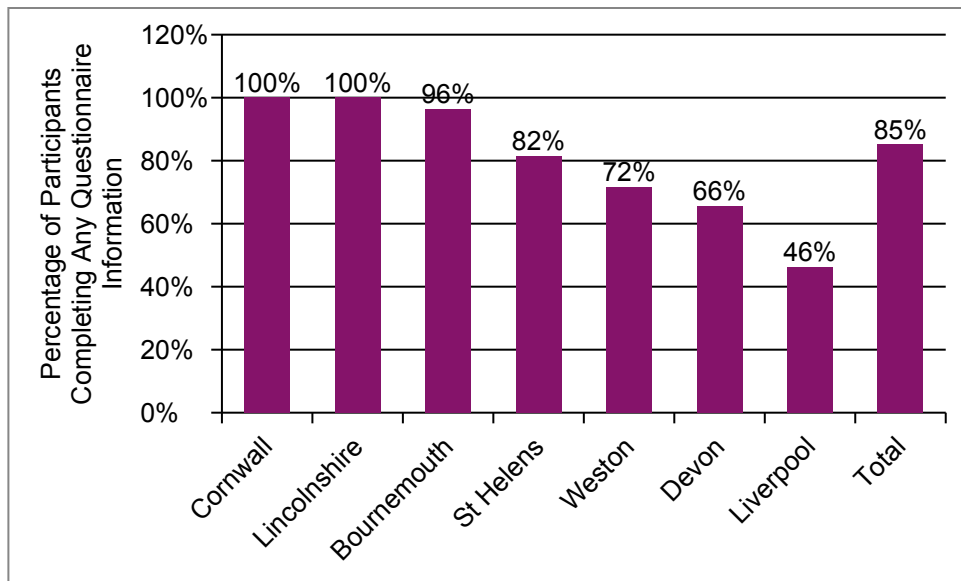
A majority of the workshops (82% overall) were held at venues able to provide on-site dry blood spot testing for Hepatitis C following the workshop (but not necessarily immediately at the end of the workshop), if any of the participants wished to be tested. However, recording of the numbers tested at each of these workshops was not required as part of the peer educator statistics sheet and as such was extremely inconsistent. Given this, data regarding tests cannot be said with certainty to be 100% accurate. Anecdotal feedback provided by peer educators indicated that a higher number of clients than indicated above were tested immediately following a workshop (where this facility was available) as they observed training participants engaging after their workshops. The subsequent roll-out of a “Talk and Test” initiative is discussed later in this report (see section 4.1.6).

Where session length was recorded, this was between 30 and 90 minutes. No data was provided to explain this degree of variance.

4.1.3 Profile of attendees

Data to describe the profile of attendees and the learning impact of the workshops was taken from questionnaires completed by participants following each workshop. Completion of these questionnaires was optional, and while for some areas the questionnaire data was input by The Hepatitis C Trust staff, in others data entry was reliant upon individual peer educator volunteers. These factors combined meant that questionnaire data was not available for all participants. Overall, 81% (n=656) of all known participants completed the section of the questionnaire on age, gender and injecting history, while 84% (n=677) completion the workshop evaluation section, and 84% (n=681) completed the section on understanding of the key points. Figure 2 below shows the proportion of attendees in each area who completed any part of the post-workshop questionnaire. There was no consistency with regards to which parts of the questionnaire were completed and which were omitted.

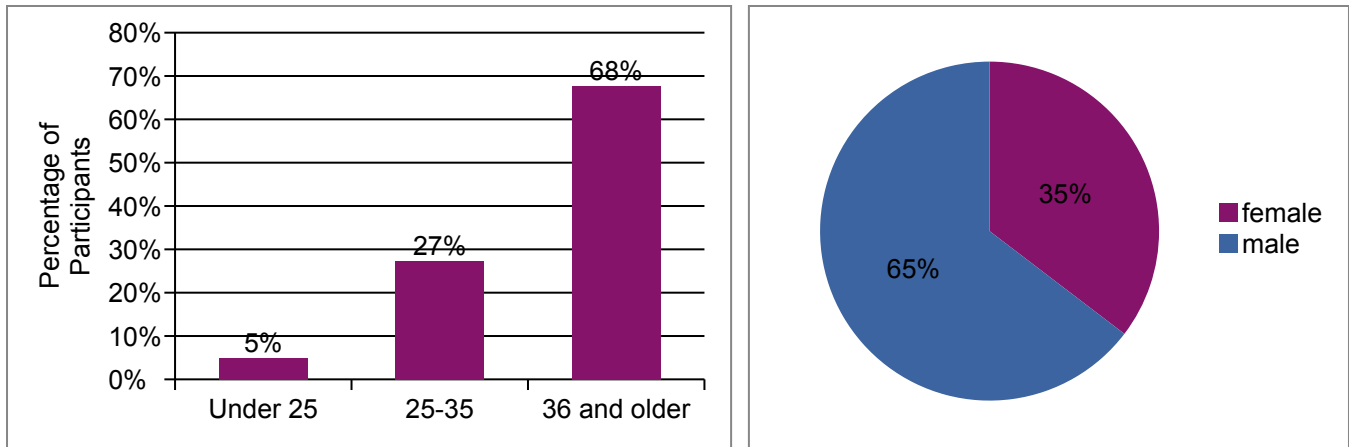
Figure 2: Questionnaire Completion (Any) by Area



The following charts show the demographic characteristics of the participants for whom this information was available (81% or 656 of the total 806 attendees). The majority of attendees were male and aged over 35. It may be that older individuals are more likely to be in contact with services that could invite them to a peer to peer session – noting that it is recognised that drug users in contact with substance misuse services tend to be older (particularly for the use of substances that are commonly injected, such as heroin and crack cocaine⁴). Data was not available to indicate whether the gender profile was skewed due to the nature of venues where workshops were delivered – i.e. whether any took place in male-only environments.

Figure 3: Age and Gender of Participants

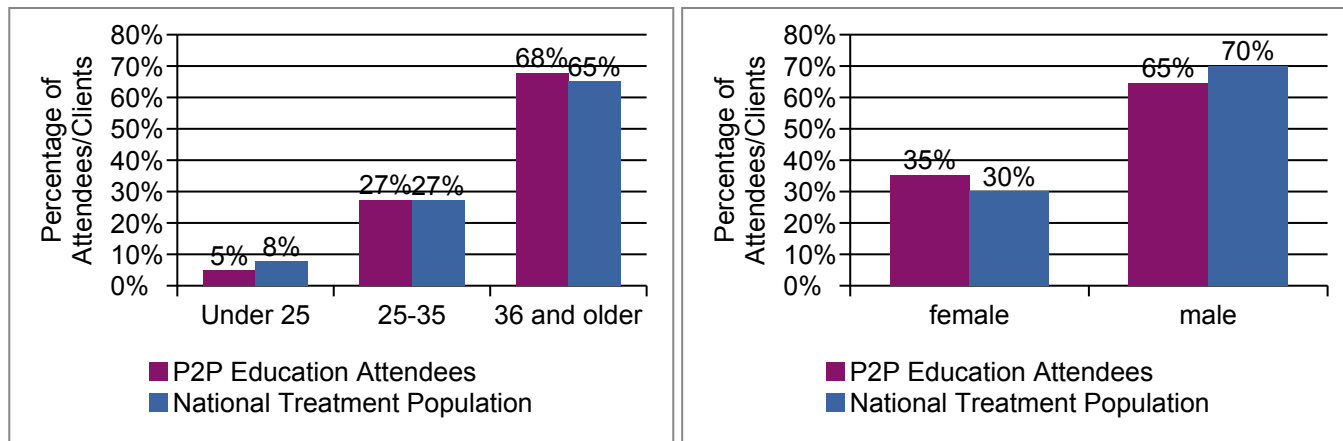
⁴ National Treatment Agency (2014) Adult Drug Statistics from the National Drug Treatment Monitoring System 2013-14 (supporting data table 2.5.1) available from <http://www.nta.nhs.uk/statistics.aspx>



The age profile of those attending the peer education workshops is very closely aligned to that of people in drug treatment nationally. This is in contrast to the situation at the time of the pilot report, when those attending the education workshops were somewhat older than the in-treatment population nationally (this may have been a feature of the attendees in the South West). Women make up a slightly higher proportion of those attending the workshops compared with those in substance misuse treatment. See Figure 4 below.

Figure 4: Age and Gender of Attendees Compared with National Treatment Profile⁵

⁵ In-Treatment Profile based on 2014/15 data on all those in treatment in England for all substances <http://www.nta.nhs.uk/statistics.aspx>

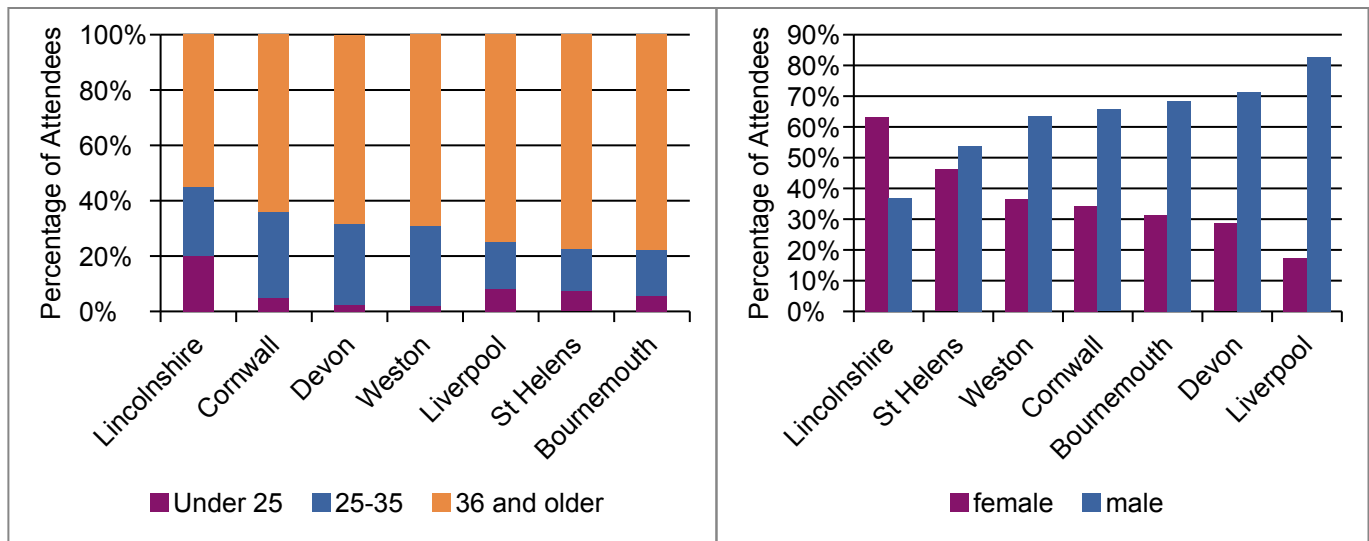


The slight over-representation of women among the peer education workshop recipients is interesting, since evidence suggests that female injecting drug users are more likely than men to share injecting equipment (and be last to receive shared equipment)⁶.

There was also some variation in age and gender of attendees by area. Bournemouth had the oldest attendee population, while Lincolnshire and Cornwall had the youngest. Lincolnshire also had the highest proportion of female attendees. Lincolnshire had the smallest number of attendees of any area (n=21) so care should be taken in generalising from these results. Liverpool had the highest proportion of male attendees.

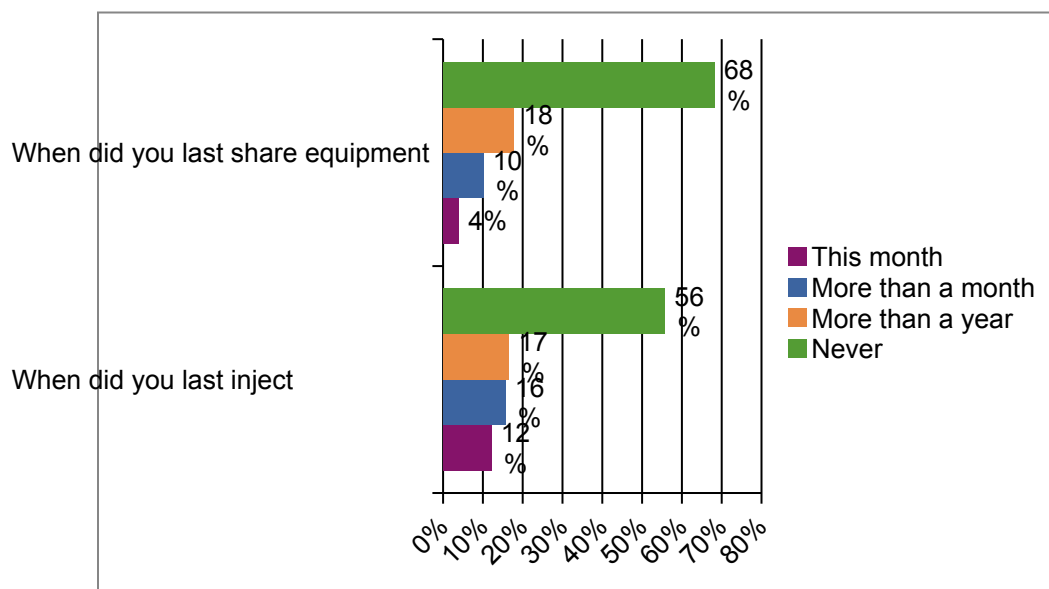
Figure 5 – Age and Gender by Area

⁶ http://www.healthpolicyproject.com/pubs/38_HPPWIDModelBriefWomensIssues.pdf; www.whatworksforwomen.org/chapters/7/sections/11



Information regarding injecting drug use and sharing of equipment was also requested in the questionnaire administered to attendees. The data is set out in Figure 6 below.

Figure 6: Injecting and Sharing Equipment⁷



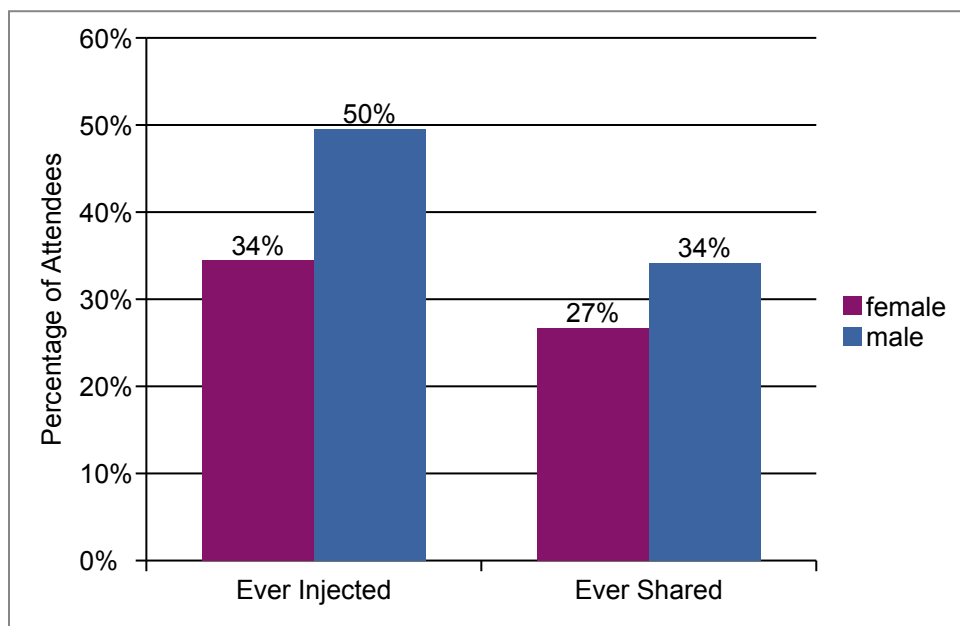
The results are striking in that a large majority of respondents indicated never having shared equipment and having never injected. It is likely therefore that wider messages around safe

⁷ Note that the data for those who indicated when they last share are derived from the 45% of those who said that they had injected at some point.

injecting practice (and avoiding injecting) are having some impact on drug users. Note however that data on injecting are self reported and it is possible that there is some possibility of bias as attendees chose not to give a true reflection of their injecting history (for instance not wishing to share this information due to a perceived stigma). Even for recent injectors, recent sharing was not common. The results should however be read with a degree of caution – it is not possible to determine whether those who attend the workshops are a representative sample of drug users, or whether people who do not inject are more likely to attend.

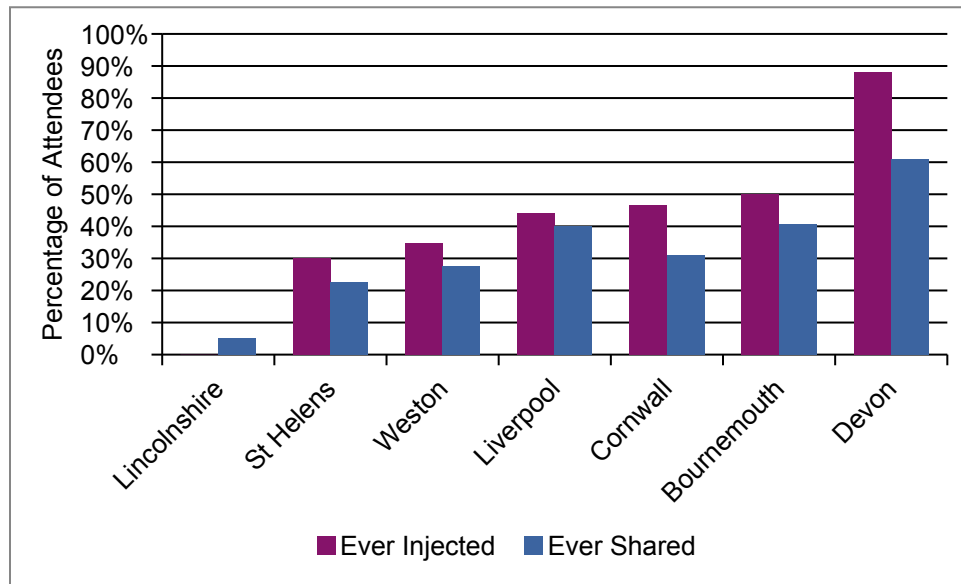
Male attendees were more likely to have ever injected and to have recently injected: 65% of female attendees had never injected, compared to 50% of male attendees; and 14% of male attendees reported injecting in the last month compared to 8% of female attendees. Seventy-two percent of female attendees had never shared, compared to 65% of male attendees.

Figure 7: Injecting and Sharing by Gender



Despite the proportions being relatively low, it is concerning that 4% (n=27) of attendees over the course of the year reported sharing equipment recently (in the last month prior to being asked), and 10% (n=68) in the last year. There was some variation in self-reported injecting and equipment sharing by area, with participants in Devon most likely to report ever having injected or shared equipment, as shown in Figure 8 below.

Figure 8: Injecting and Sharing by Area

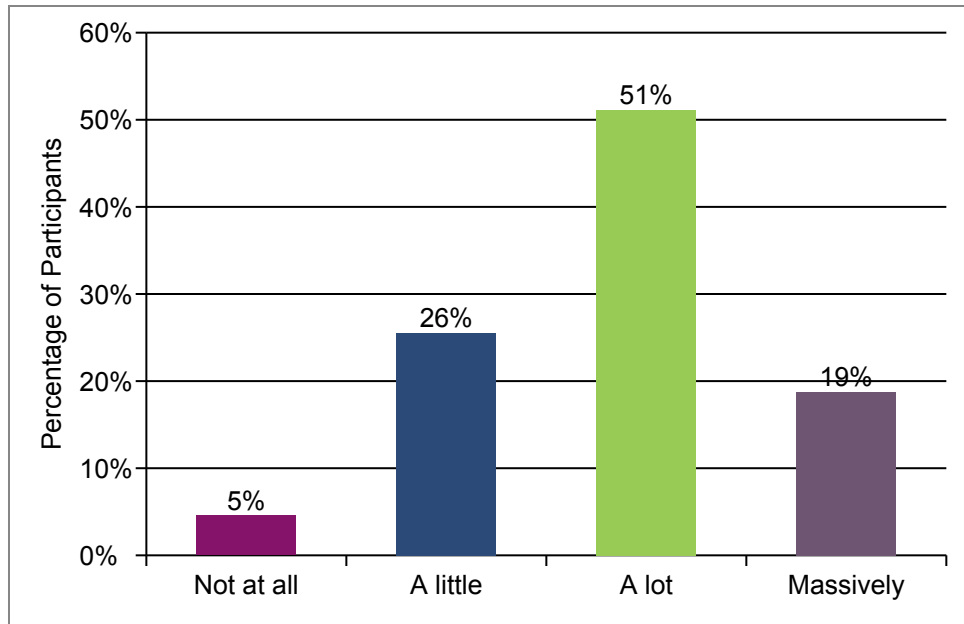


It is worth noting that Liverpool and Lincolnshire were part of the HepCATT study during the period for which data was collected. HepCATT is a large-scale evaluation to determine the effectiveness of interventions designed to increase diagnosis and treatment of patients with HCV. It is not possible to determine the impact of HepCATT work on the work of the pilot.

4.1.4 Impact of peer education workshops

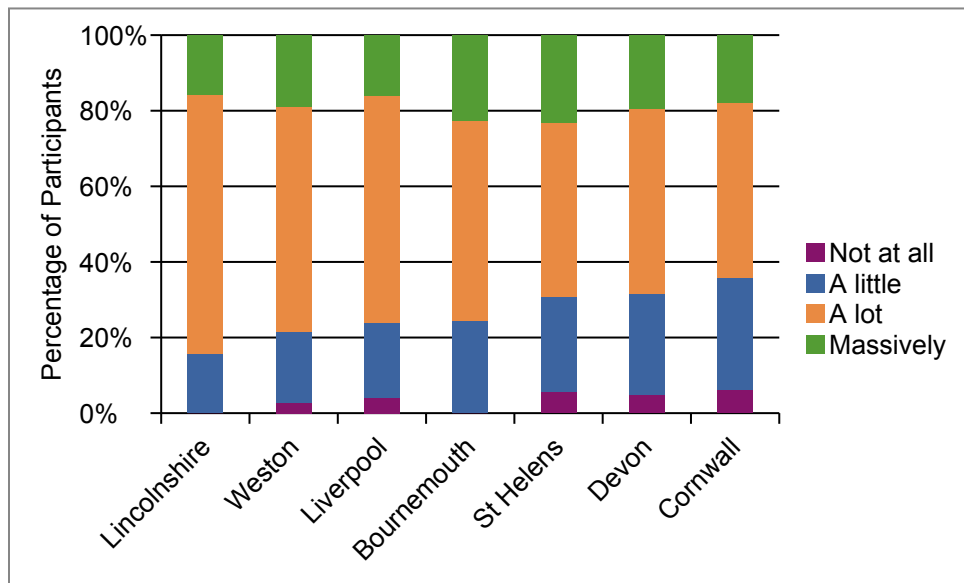
Participants were asked to rate the statement 'The session increased my knowledge of HCV' from 'Not at all – nothing new' to 'Massively'. The results for the 677 participants for whom this data was available are illustrated in Figure 9 below. Overall, attendees' perception of the increase in their knowledge was positive, with 70% (n=473) reporting their knowledge had increased 'A lot' or 'Massively'. Twenty-six percent (n=173) reported the workshop had only increased their knowledge 'A little' and 5% (n=31) reported no increase in their knowledge.

Figure 9: Self-Reported Increase in Knowledge of HCV



The self-reported increase in knowledge was further analysed in relation to geographical area; this is illustrated in Figure 10 below.

Figure 10: Improvement in HCV Knowledge by Area

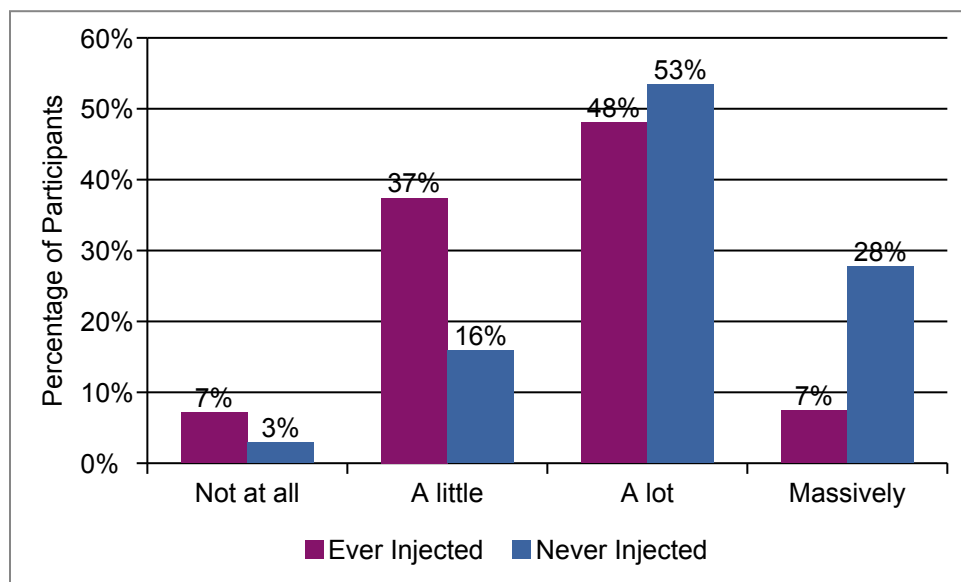


Attendees in Lincolnshire and North Somerset were most likely to report feeling that the peer education workshops had improved their knowledge of HCV ‘A lot’ or ‘Massively’. Bournemouth

had the highest proportion reporting a 'Massive' improvement. Those in Devon and Cornwall were the most likely to say the workshop had not improved their knowledge albeit that the majority of attendees reported an increase in their knowledge. Data was not available to explain the variance seen between the different areas.

When the participants' perceptions of the usefulness of the workshops was considered in relation to their injecting history, it seemed that those who reported having never injected or shared equipment found the workshops more informative than those who had previously injected or shared. Twenty-eight percent of those who had never injected and 24% of those who had never shared reported a 'Massive' improvement in their knowledge of HCV, compared to 7% of those with an injecting history and 8% of those with a history of sharing. Thus, those with a history of injecting drug use felt they learned less new information from the workshops than others. This may be because those with injecting histories are likely to have previously been targeted with information about blood borne viruses. It also indicates that those with prior knowledge of HCV might benefit from a greater focus on information they may not have previously encountered, such as recent developments in treatment, or details of the different genotypes.

Figure 11: Improvement in HCV Knowledge by Injecting History



However although previous and recent injectors overall reported less of an impact from the peer education workshops than those who had never injected, most did report some benefits, with

only 7% (n=20) feeling their knowledge had not been improved at all. Similarly, only 6% (n=17) of those with a history of sharing equipment reported no improvement from the workshop, with the rest reporting at least 'A little' improvement.

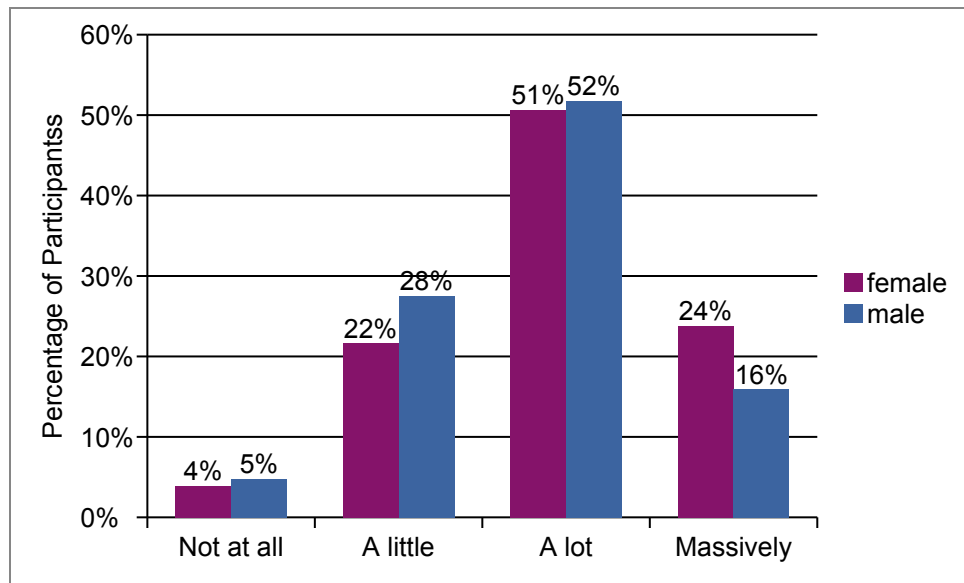
Comments from participants indicated that even those who had not learnt anything new had appreciated the workshop:

"It was good to recap what knowledge I knew previously."

"I have sat through several Hep C Trust groups so I am well updated. The group was very well delivered & information was clear."

The results were also analysed by gender. As illustrated in Figure 12 below, female attendees were somewhat more likely than males to report a positive impact from the peer education workshops. This may be due to a difference in how receptive attendees were to health messages; it is also likely due to differences in injecting history, since female attendees were considerably less likely to have ever injected (73% had never injected, compared to 51% of male attendees) and it seems that the workshop was found to be more informative by those with no injecting history, possibly indicating that those with an injecting history had previously received some form of targeted harm reduction intervention.

Figure 12: Improvement in HCV Awareness by Gender



4.1.5 Comprehension of Key Messages

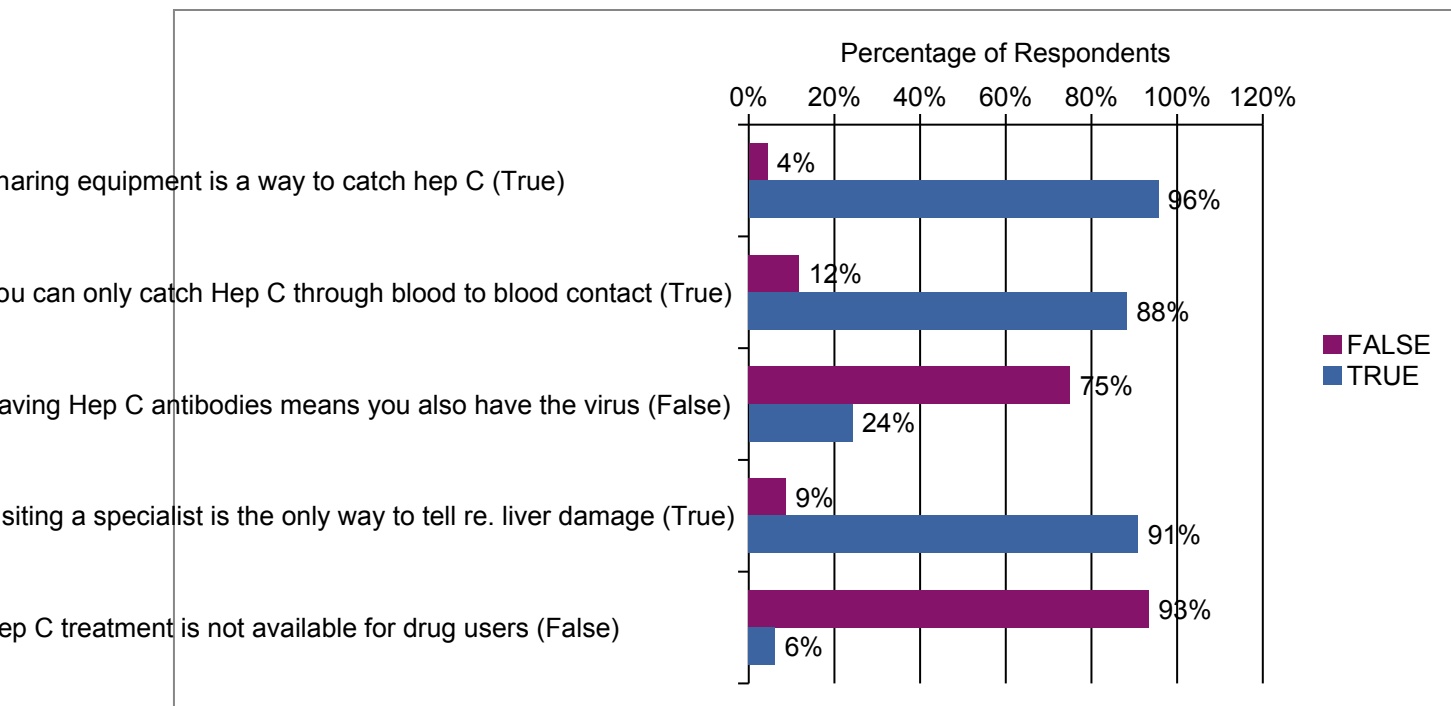
Out of the total 806 attendees, 681 completed a five-question 'quiz' to assess the impact of the peer education workshops on their understanding of key issues regarding HCV. They were asked to rate the following five statements as 'True' or 'False':

1. Sharing equipment (including spoons, filters, water, swabs or tourniquets) when injecting drugs is a way to catch Hepatitis C (True)
2. You can only catch Hepatitis C through blood to blood contact (True)
3. Having Hepatitis C antibodies means you also have the virus (False)
4. Visiting a specialist is the only way to see how much liver damage you have (True)
5. Hepatitis C treatment is not available for drug users (False)

The results are set out in Figure 13 below. On average, 89% of responses were correct.

Figure 13: Responses to HCV 'Quiz'⁸

⁸ Note the percentages do not sum to 100% because some attendees, while completing some/most of the 'quiz', left one or more questions blank.

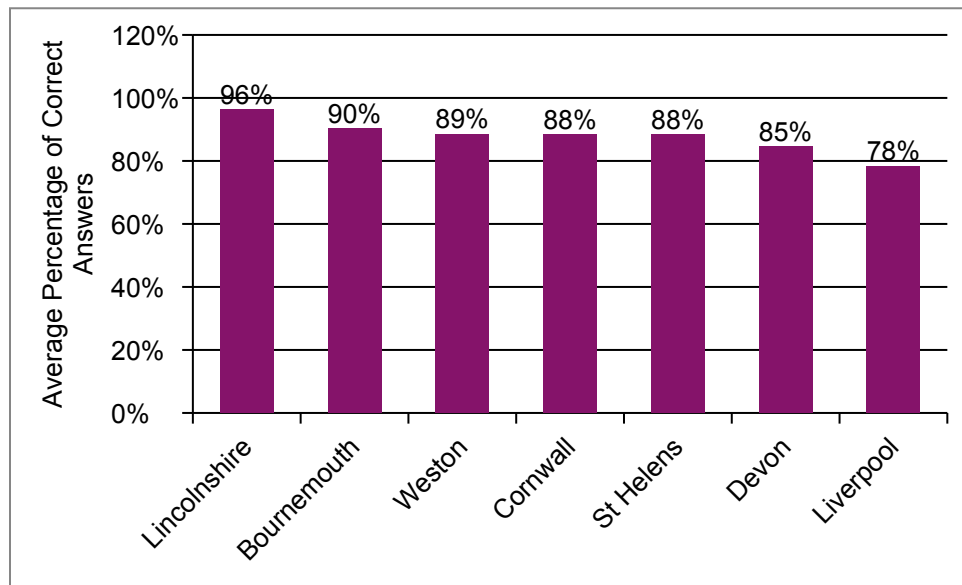


As shown in Figure 13, participants generally had a good understanding of the transmission of HCV (possibly also reflecting prior exposure to harm reduction messages), were aware that treatment was available to drug users, and had generally absorbed the messages that visiting a specialist is the only way to assess damage to the liver, and that treatment is available for drug users.

However, 12% of attendees were not clear about methods of transmission, and there was also a lack of clarity about whether having HCV antibodies meant having the active virus. While the question regarding antibodies would mainly be important to those receiving test results, methods of transmission of the virus is relevant to all participants, and the confusion over this is somewhat concerning. These points may need greater focus and clarity in the workshops

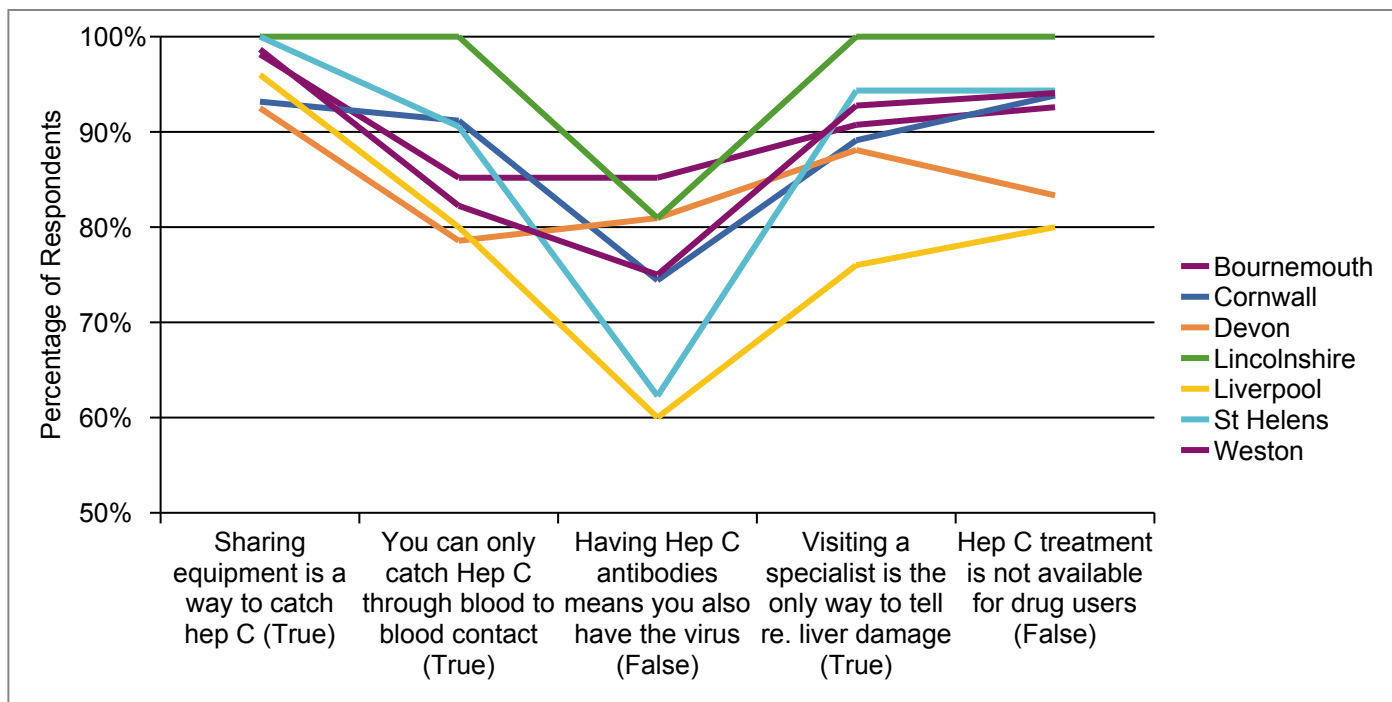
Results were considered by area. This indicated that there was some variation by area in terms of understanding following the workshops, with Lincolnshire and Bournemouth attendees most likely to answer questions accurately, and attendees in Liverpool least likely to do so. Data was not available on which trainers delivered which session so it was not possible to disaggregate the data to determine the relative effectiveness of different peer educators.

Figure 14: Average Percentage of 'Quiz' Questions Answered Correctly



More detail regarding correct 'quiz' responses by area is shown in Figure 15 below.

Figure 15: Correct Responses to 'Quiz' by Area



Despite some variation between areas, no area had less than 60% of attendees leaving the workshops with a full understanding of all five key messages.

4.1.6 Talk and Test

An innovation that was introduced during the final year of the pilot (in Devon) was the introduction of on site availability of HCV testing immediately following the delivery of the workshop – so called ‘Talk and Test’. This was done in recognition of the fact that testing numbers continued to be low across the county. Feedback from previous workshops and from the peer educators indicated that people were willing to be tested if the test was available at the close of the workshop they attended.

Data was provided regarding the number of dry blood spot tests recorded at each workshop location during the month prior and the month following the peer education workshops. From this the data was analysed to see whether there was any increase in levels of testing post-training.

For most locations an increase in testing was evident, as can be seen in Figure 16 below.

Figure 16: Pre- and Post-Session Testing Figures

Delivery Date	Service (Session Location)	Testing on the Day Available	Number of Tests in Previous Month	Number attending session	Test complete on day (where available)	% attendees completing a test on day	Number of Tests in Following Month (Including testing on the day)	Increase / Decrease in Number of Tests
22/09/2015	Tiverton	No	1	NA	NA	NA	3	2
26/10/2015	Newton Abbot	No	1	NA	NA	NA	4	3
24/11/2015	Tiverton	No	1	NA	NA	NA	19	18
30/11/2015	Tiverton	Yes	3	16	10	62.5	19	16
05/05/2016	Honiton	Yes	5	3	3	100	5	0
05/07/2016	Tiverton	No	2	NA	NA	NA	2	0
28/07/2016	Exeter	Yes	2	5	4	80	6	4
08/08/2016	Newton Abbot	No	7	NA	NA	NA	2	-5
21/09/2016	Barnstaple	Yes	5	8	5	62.5	5	0

Note that Talk and Test sessions were available in Devon on four occasions.

Overall there were 27 recorded tests across all locations in the preceding time (an average of 3 per location), and 65 tests in the weeks immediately following delivery of a peer education workshop (an average of 7 per location). This indicates an average increase in testing of 141%. Note that there was a testing day in Newton Abbot on 28th July (World Hepatitis Day) which may explain the apparent anomaly in results for this area.

The data further indicates a particular spike in take-up where testing was available at the end of the workshop with a significant proportion of the monthly total (for the month following) having been tested at the end of the workshop.

Figure 17: Availability of Testing on the Day of Workshop

Testing on the Day Available	Average Number of Tests in Previous Month	Average Number of Tests in Following Month (Including testing on the day)	Increase / Decrease in Number of Tests
No	2.4	6.0	+150%
Yes	3.8	8.8	+133%
Total	3.0	7.2	+144%

4.1.7 Fibroscan data

Some data was provided relating to fibroscans that were carried out over the course of the pilot. A fibroscan is a scan, similar to ultrasound that is used to measure the elasticity of the liver and thus determining any damage that may have occurred (a stiff liver being a sign of damage). It is necessary to undertake a fibroscan before any decision to treat can be made.

A fibroscan technician was recruited in June 2016 and, from July 2016 onwards, spent two days a week in the community scanning Addaction clients. From July to the end of November 2016, 42 clients have had a fibroscan within Addaction services, which has significantly impacted on the waiting list of 80 patients awaiting a scan.

A snapshot of the fibroscan data was provided. This sets out the number of outreach sessions conducted by the fibroscan technician up until August 2016. The results are set out at Figure 18.

Figure 18: Fibroscan outreach testing (July to August 2016)

Outreach area	Number of visits to area	Total number scanned	Did not attend (%)
Liskeard	1	6	0
Bodmin	1	5	0
Mulion	1	1	0
Penzance	1	4	50
Boswyns ⁹	2	1	0
St Austell	1	2	0
Truro	2	2	1
Newquay	2	2	66
Redruth	2	3	0
Total	13	26	

As indicated above, the fibroscan technician was able to scan 26 Addaction clients over 13 outreach sessions across Cornwall. The data represents early data and the DNAs were picked up in other outreach areas (such as home visits, GP surgeries and pharmacies). The current DNA rate (across the full 42 clients) was a much lower 14%.

4.2 Buddying Scheme

⁹ Residential rehabilitation unit

4.2.1 Buddy training

Over the two years of the pilot a total of 46 volunteers received a day of HCV training and an additional day of training on how to be a buddy – i.e. how to provide peer support. Training was provided by The Hepatitis C Trust with day to day support for buddies provided by Addaction. All volunteers were asked whether they interested in becoming a buddy and the BBV nurse also asked all clients whether they were interested in pursuing this opportunity following their treatment. As a result, recruitment for buddies was different than for peer educators, the latter of whom were recruited on the basis of lived experience of HCV which was not the case for buddies.

Buddy work was limited to Cornwall. The intention had been to test the buddy concept in a limited geographic area and then scale up activity over the course of the programme. The buddy scheme was not however scaled up as data from the interim evaluation (see section 2.4 earlier in this report) noted that there was little or no evidence to demonstrate the impact of this component. It was therefore decided to continue buddy work only in Cornwall.

4.2.2 Data Collection

Data from the Buddying Scheme log, an online tool used by The Hepatitis C Trust to log activity related to the buddy scheme, was used to analyse activity over the course of the evaluation period (September 2015 to September 2016).

The Buddying Scheme log provided some basic information on buddying activity between September 2015 and September 2016. During this period there are records of one buddy (plus one contact from an Addaction staff member and one from an Addaction driver providing transport to a hospital appointment) providing support to nine different clients. While the data provided indicates activity for one buddy this appears to be an issue more to do with the recording of activity than actual numbers delivering support work. It would appear that more buddy work was taking place but that the exact nature and volume of this work has not been captured.

Five of the clients were seen once; two were seen twice; one had three buddy contacts and one had 16 contacts, with log notes indicating this contact extended from testing, with support to attend mutual aid meetings and 8 hospital appointments.

The log also provided some information on the number and type of buddy contacts during the evaluation period. This is presented in Figure 16 below.

Figure 16: Buddy Contacts (September 2015 – September 2016)

	Number of Contacts	Percentage of Contacts
Total Contacts	28	
One to one buddy contact	14	50%
Accompanying to scan	2	7%
Other Hospital	12	43%

The one-to-one buddy contacts tended to have additional information recorded, which showed that these contacts covered a variety of activity – from supporting a client to be tested for HCV at Addaction, to attending an AA or NA support group meeting with a client, or meeting for a coffee or lunch and a conversation to encourage a client to follow up a fibroscan appointment.

The recorded length of buddy contacts ranged from 2 hours up to 8 hours, with the average recorded time at just under 6 hours (only 7 of the 28 buddy contacts had length of time recorded).

The component of the evaluation addressing the buddy scheme focused on an analysis of the buddy scheme log. It is therefore not possible to comment in relation to whether the numbers set out above are due to a lack of demand for the buddy scheme, the lack of willingness among intended recipients to engage with buddies, or whether intended recipients were not aware of the scheme. Further analysis is required to determine why the large numbers of volunteers engaged did not translate into higher levels of take-up of the buddy scheme.

4.3 Workforce Development

Training to Addaction staff and volunteers on HCV and wider issues in relation to BBVs were provided by staff from The Hepatitis C Trust as part of the programme. The training must be contextualised in view of the fact that the training sits within the wider context of the wider

learning and development strategy of Addaction which includes BBV work, on-line and face-to-face training and on-the-job training (delivered by the BBV Nurse).

4.3.1 Data Collection

Training about HCV and other Blood Borne Viruses was offered to a range of Addaction staff including clinical and non-clinical staff, paid staff and volunteers.

Participants in the Workforce Development sessions were asked to complete two questionnaires – one before and one after their training session. These questionnaires measured staff members' confidence in their knowledge of general and specific information relating to HCV, symptoms, testing and treatment, as well as in their ability to provide relevant information on HCV, or assess or support clients for testing or treatment.

4.3.2 Workforce Development Activity

A total of 394 questionnaires were completed - 205 were marked as having been completed before a workforce development session and 189 after a session. The data indicates that at least 205 staff members took part in a workforce development session. The average attendance at any given training session was 11 Addaction representatives. The largest training event was delivered to 18 attendees and the smallest to 6.

Figure 19 – Numbers of Questionnaires Completed

Questionnaire Timing	Number of Questionnaires Completed
Before	205
After	189
Total	394

4.3.3 Evaluation Questionnaires

It is not known what proportion of attendees completed a questionnaire, so it is not possible to comment on the representativeness of the sample. Because no names or identifiers were recorded on the questionnaires, it was not possible to 'pair' individual staff members' pre- and post-training questionnaires to measure individual improvement. Thus 'before' and 'after' questionnaires have been examined as complete groups to give an overview, both separately and in terms of differences between the 'before' and 'after' conditions. Given that not all attendees completed a 'before' and 'after' survey the two data sets are not an exact match.

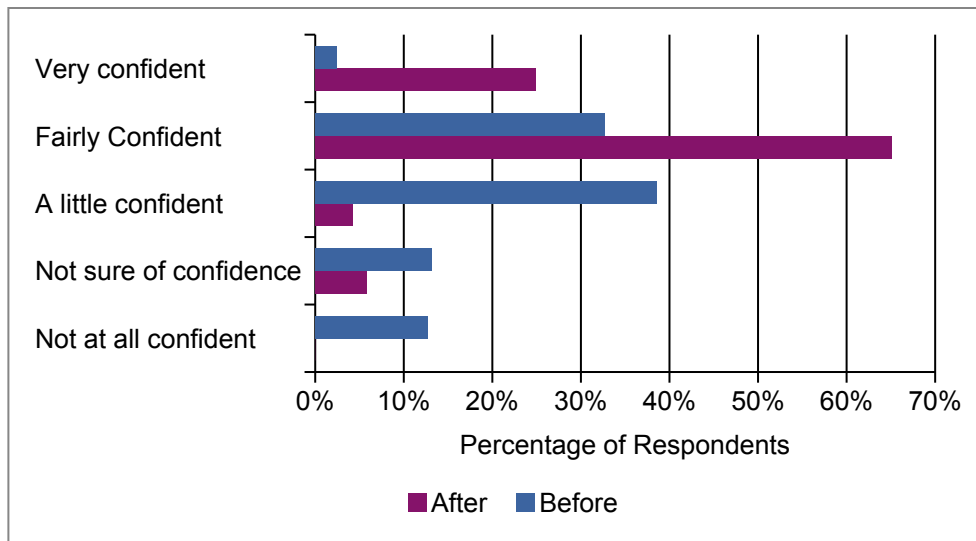
Furthermore, given that the questionnaires were anonymous, it was not possible to match pre and post training results to measure the 'distance travelled' of any given participant. The results below therefore indicate an aggregate picture of change rather than a perfect like-like match of change. The approach does however give an indication of the general trend of change.

Session participants were asked a series of questions rating their confidence in their own knowledge and ability in relation to HCV and advising/assisting clients. The results for those answering the questions after the workforce development session are compared to pre-session responses below.

Confidence in knowledge of BBVs in general

There was a considerable improvement in staff members' self-reported confidence in their own knowledge of blood-borne viruses in general from before to after the session – with an increase from 35% to 90% of attendees reporting they were 'fairly' or 'very' confident and a reduction in those stating they were 'not at all confident' from 13% to none.

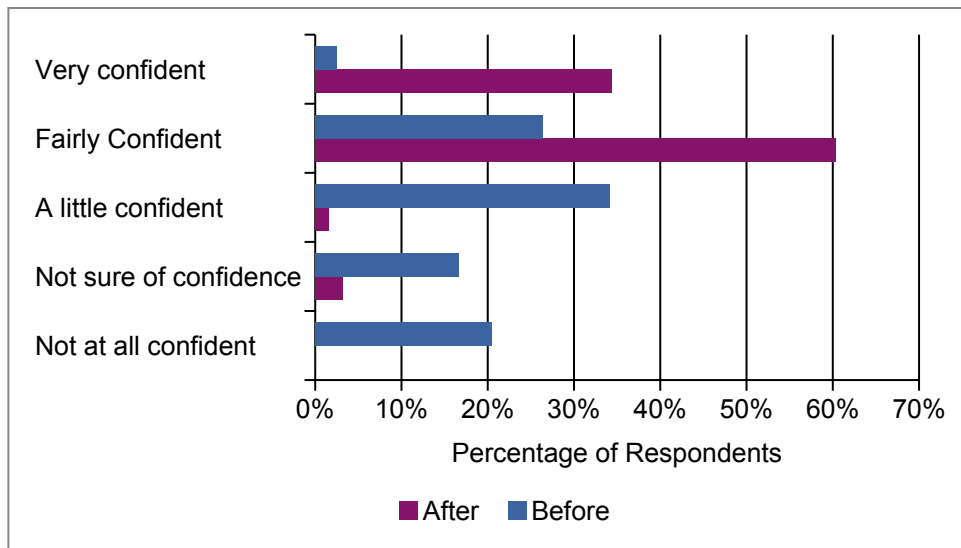
Figure 20: Self-reported confidence in knowledge of BBVs in general



Confidence in knowledge of HCV in general

Self-reported confidence in knowledge of information about the HCV virus in general also increased substantially from before to after the workforce development sessions, with the proportion of participants reporting they were 'fairly confident' in their knowledge more than doubling, and the proportion stating they were 'very confident' increasing from 2% to 34%.

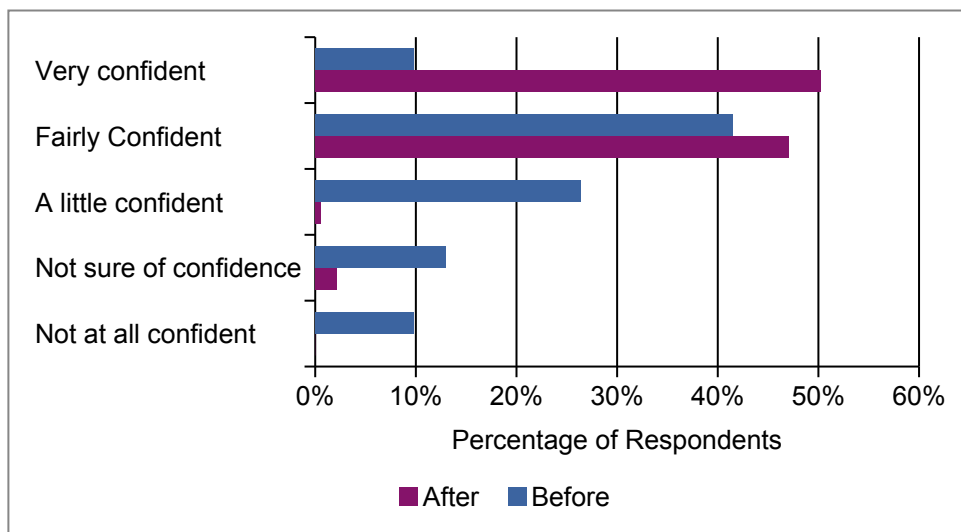
Figure 21: Self-reported confidence in knowledge of HCV in general



Confidence in knowledge of risky behaviours and transmission of HCV

Staff members’ confidence in their knowledge of transmission of HCV increased by an even greater margin with the proportion reporting themselves ‘very confident’ in their knowledge on this topic increasing from 0% before the session to 50% after, and a further 47% of respondents feeling ‘fairly confident’ in their knowledge following the session.

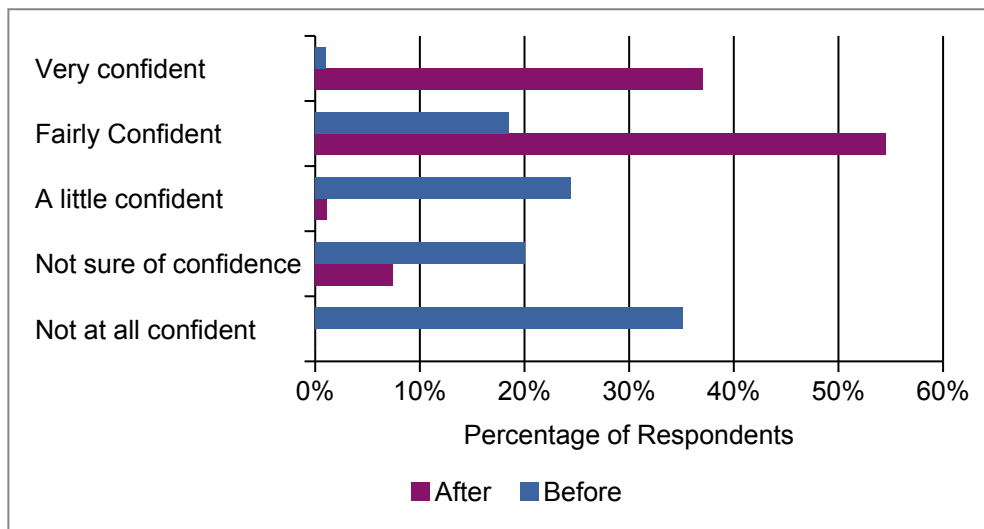
Figure 22: Self-reported confidence in knowledge of risky behaviours and transmission of HCV



Confidence in knowledge of symptoms and progression of HCV

Confidence in knowledge of the symptoms and progression of the virus also increased with the proportions of attendees feeling 'very' or 'fairly' confident increasing considerably following the training session.

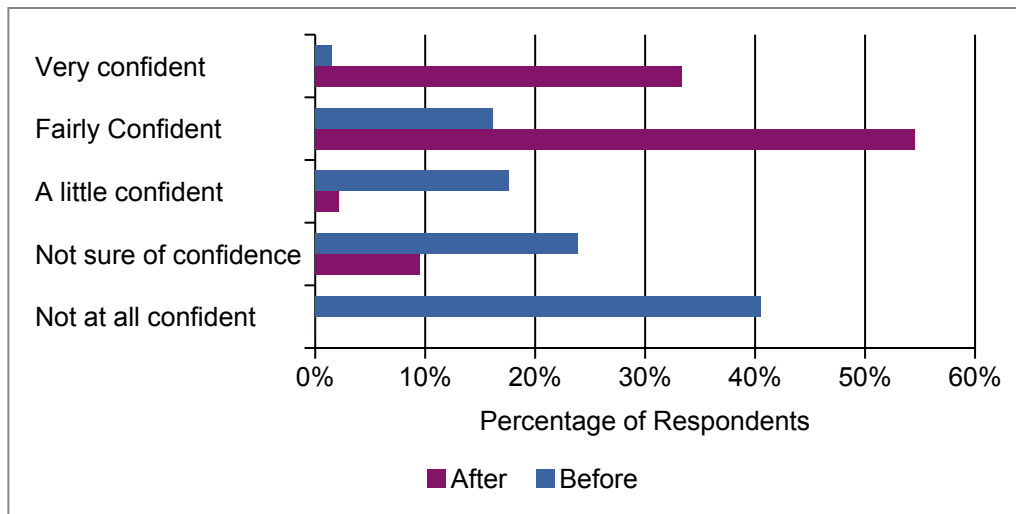
Figure 23: Self-reported confidence in knowledge of symptoms and progression of HCV



Confidence in knowledge of testing procedures and tests required for diagnosis

Knowledge of testing for HCV improved, from 40% of participants before the session feeling 'not at all confident' in their own knowledge, to 54% 'fairly confident' and 33% 'very confident' after the session.

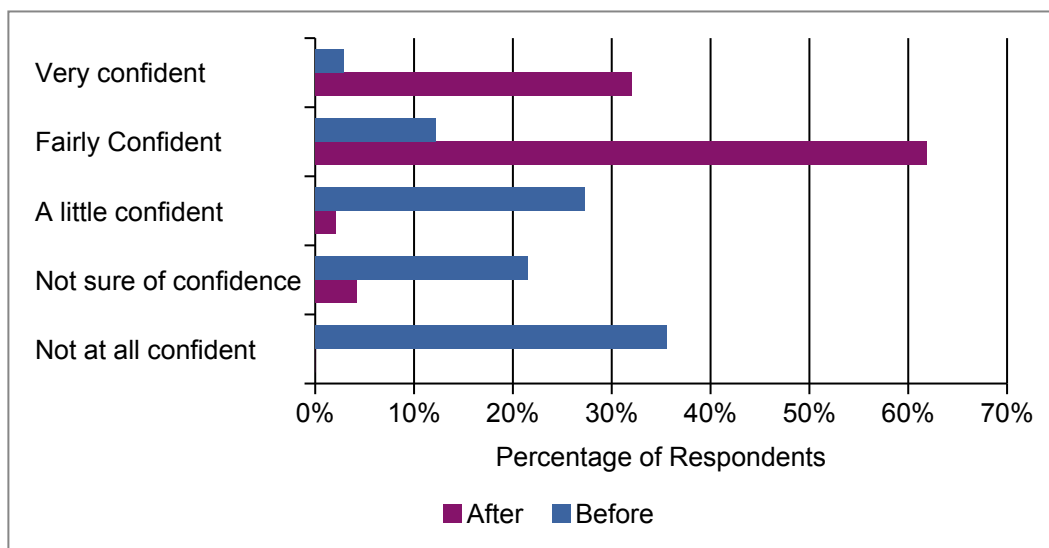
Figure 24: Self-reported confidence in knowledge of testing procedures and tests required for diagnosis



Confidence in knowledge of treatment of HCV

Confidence in knowledge of treatment for HCV also showed an improvement.

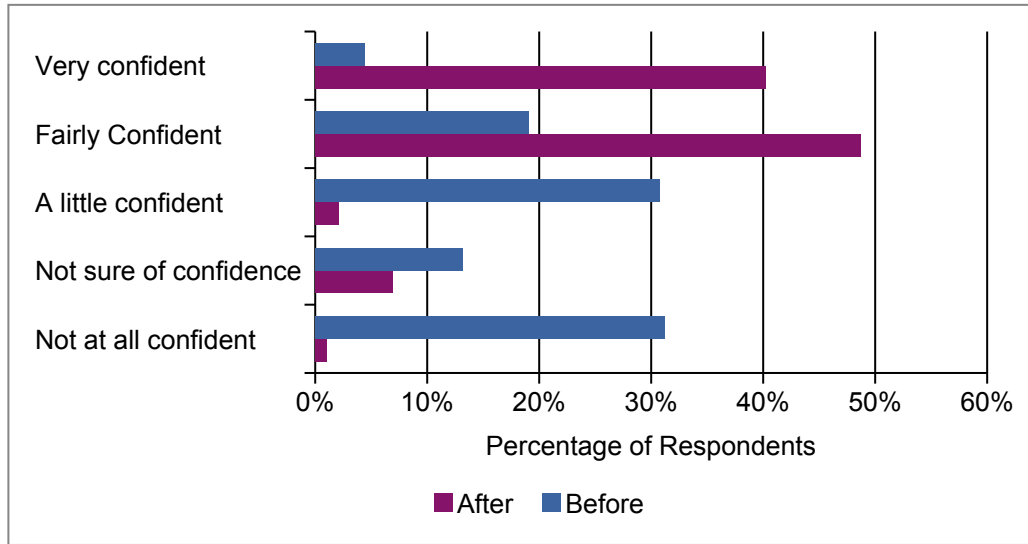
Figure 25: Self-reported confidence in knowledge of treatment of HCV



Confidence in knowledge of availability and location of nearby support, testing and specialist care services

As in other areas of knowledge, confidence about knowledge of local testing, support and specialist care for HCV improved; however, unlike on other topics, a very small proportion of attendees (1%) remained lacking in confidence on this topic.

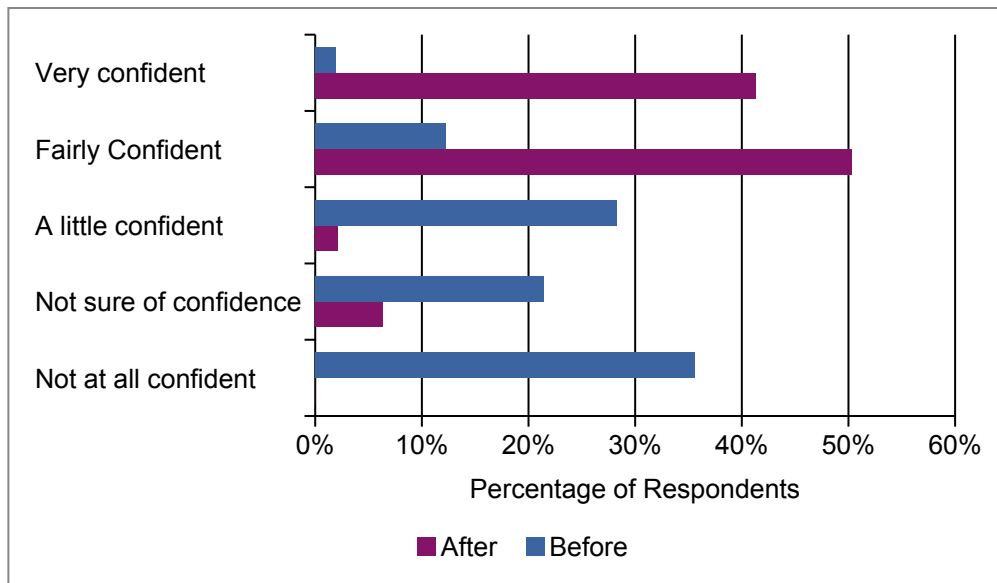
Figure 26: Self-reported confidence in knowledge of availability and location of nearby support, testing and specialist care services



Confidence in ability to provide up to date info or tackle myths and misunderstandings

As in other areas, confidence in ability to provide up to date knowledge improved following the training.

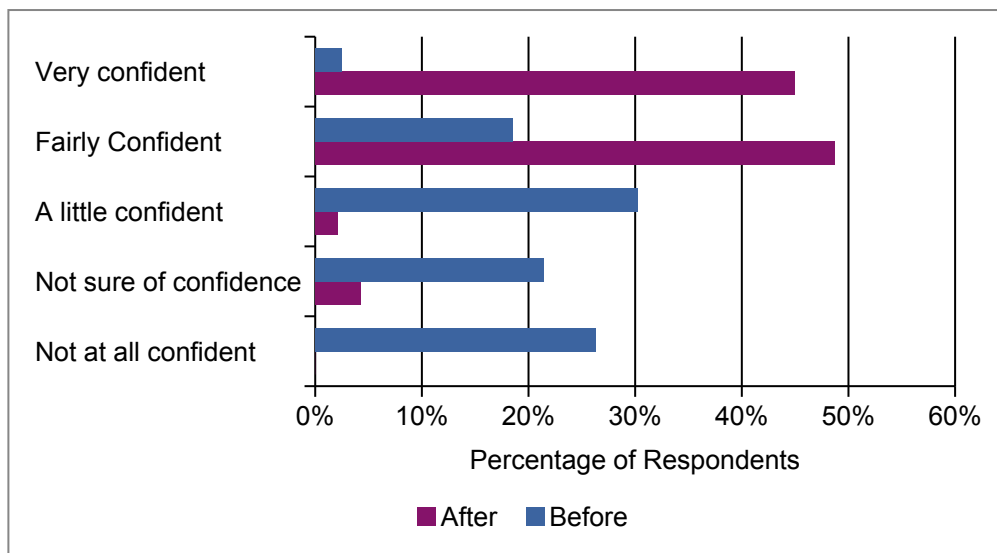
Figure 27: Self-reported confidence in ability to provide up to date info or tackle myths and misunderstandings



Confidence in ability to assess, support or promote safer behaviour, testing and specialist care options

Again, staff members’ self-reported confidence in their ability to assess and support clients showed a notable increase following the workforce development sessions, although confidence in this area was higher before training compared to other topics.

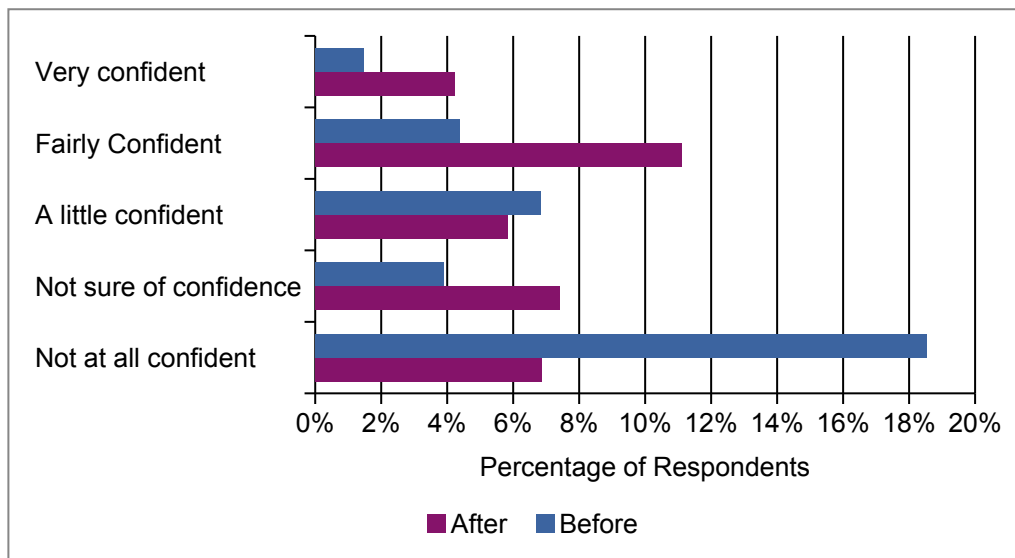
Figure 28: Self-reported confidence in ability to assess, support or promote safer behaviour, testing and specialist care options



Confidence in ability to update online notes and database

This question was only included in 35% of the questionnaires (from which we can assume that the questionnaire evolved over the period which the evaluation was carried out as all services moved over to the revised questionnaire over the data collection period). Confidence in this area showed the least improvement, with 7% of participants remaining 'not at all confident' following training.

Figure 29: Self-reported confidence in ability to update online notes and database



Overall, the workforce development training seems to have increased staff members' confidence in their knowledge about HCV, and their ability to use this knowledge to the benefit of their clients, to a substantial degree. Following the training, no participants reported feeling 'not at all confident' in their knowledge or ability on most topics covered. Only two stated they did not feel confident in their knowledge of local testing and specialist care services, and 13 stated they did not feel confident updating online information (this was only asked of 35% of respondents).

5. Peer Education Workshop Longitudinal Analysis

The evaluation sought to determine the impact of the peer education workshops in a more longitudinal fashion – that is, determining the impact of the workshops at a period several weeks and months after the workshops (as opposed to immediately after, as captured by the self-completion surveys and explored at section 4.1 above).

Of the 806 individuals recorded as attending a peer-led workshop during the evaluation period, 687 completed a questionnaire (at least in part). Of these, The Hepatitis C Trust initially had contact details for 277 individuals who had consented following the session to be contacted for the evaluation. In total, 45 (16%) of these then agreed to be interviewed for the evaluation when contacted later by a representative of The Hepatitis C Trust to establish consent (some declined to participate; some had changed telephone numbers or simply did not answer the phone). CPI attempted to contact all of these individuals. We were able to contact and interview a total of 34 individuals – 76% of the 45 we attempted to contact, 12% of those who initially left contact details, and 4% of all attendees. All of those interviewed had attended a peer education workshop in areas where the pilot is supported by both Addaction and The Hepatitis C Trust (i.e. these workshops were only delivered in Addaction where the programme was running and not across all areas where Addaction delivers services).

Figure 17: Conversion Rates for Interviews

	Number of Attendees	Percentage of Previous Step	Percentage of All Attendees
Total Attendees	806		
Completed Questionnaire (at least in part)	687	85%	85%
Gave contact details	277	40%	34%
Consented at time of evaluation	45	16%	6%
Able to contact and interview completed	34	76%	4%

A total of 13 peer education workshop attendees were interviewed during an initial round of interviews in May and June 2016. A further 21 participants were interviewed during this round of the evaluation (in October 2016).

In addition, five (of the original 13) participants were re-interviewed in October with participants who had attended the workshops between November 2015 and May 2016, and had previously been interviewed in May-June. These re-interviews aimed to establish whether participants' recall of the key messages and the session itself had been maintained 4-5 months later. The timeframe was deliberately selected to determine medium to longer term retention of key messages.

Both sets of interviewees were asked a series of questions aiming to establish how well they recalled the five key messages of the workshops:

1. Sharing equipment (including spoons, filters, water, swabs or tourniquets) when injecting drugs is a way to catch Hepatitis C (True)
2. You can only catch Hepatitis C through blood to blood contact (True)
3. Having Hepatitis C antibodies means you also have the virus (False)
4. Visiting a specialist is the only way to see how much liver damage you have (True)
5. Hepatitis C treatment is not available for drug users (False)

Interviewees were initially encouraged to 'free recall' anything they found memorable about the workshop, before being guided through any of the key points they had not recalled independently to establish whether the concepts were familiar. Participants were then asked whether they had been tested for HCV (and whether this was as a result of the session), and whether there was any other information they remembered, thought was important, or wanted to add.

5.1 Participants

Of the 34 interviewees, all remembered participating in the peer education workshop (a few required some prompting but later independently offered recollections about the session, indicating they did remember). Those interviewed in October tended to have better recall of the session than those interviewed in May and June, perhaps because less time had elapsed between attendance and recall – October interviewees had generally attended the peer education workshop between July and October, while those interviewed in May/June had attended between November 2015 and May 2016, many during November and December.

Where interviewees expressed any uncertainty regarding the key themes or requested clarification or further information, our researcher discussed this and provided any clarification or detail necessary.

Of the 34 interviewees, 22 had been tested at some point for HCV (although not necessarily following the training). Of these, two had previously been treated (successfully) for the virus, and two were HCV positive and awaiting treatment. Both HCV positive interviewees did report considerable benefit from the session, despite already being aware of much of the information.

“I’ve got it (HCV) – Type 1 xenovirus. I thought the session was a helpful reminder to be extra careful – like if I cut myself or something to avoid contact with other people and take steps not to pass it on to them. I don’t inject any more so the sharing thing isn’t an issue – I’m in detox at the moment. I was tested a bit before the session so I already knew, but I do think it helped. I would recommend it to others in the same position as me, I feel like it’s helped me be more aware of things and more confident in getting treatment. I was already in contact with them and I’m booked in to start treatment once I’ve finished my detox.” (HCV positive interviewee)

“I’d come across most of the information before but there were a few bits and bobs I didn’t know. I’m not sure if I knew and forgot or didn’t know, but it was a surprise to me that it’s not sexually transmitted. I’m waiting for treatment at the moment, but apparently there’s only 11 people each year accepted onto the treatment course here in Bath. I’m on the waiting list but I’m expecting a long wait.” (HCV positive interviewee)

Of the other 20, all of whom had tested negative, three reported having been tested immediately after and as a result of the peer education workshop (although another one had attended the workshop because it was offered when he attended Addaction for his test). Two stated an intention to seek out a further test as a result of the workshop, having been tested years or months previously and wanting to ensure they were still free of the virus. A number of interviewees, including one who was HIV positive, reported having regular tests including for BBVs as part of ongoing health monitoring (mainly as a result of health problems resulting from alcohol use).

Of the twelve who had never been tested, ten reported that this was because they were not aware of any situation where they had been at risk. Most of these were ex-alcohol users, while one reported some injecting drug use but had been extremely fastidious about using sterile equipment. One interviewee reported having made the decision to be tested as a result of the

peer education workshop, but had been unable to do so yet because of family issues and commitments.

5.2 Main Themes

The main themes from the interviews are presented below – these are themes that were brought up by multiple interviewees – learning points they took away, information they found particularly memorable, or consideration of how useful the information had been to them.

5.2.1 Transmission via sharing equipment for sniffing drugs

The potential risk of transmitting the virus through sharing notes or tubes for sniffing drugs was remarked upon by almost all of the interviewees as something they had learnt from the workshop, and had retained because they had been surprised by the information. As noted above, more than half of the interviewees described themselves as alcohol users rather than drug users, but a number of these stated they either currently or previously had used ‘party drugs’ which were snorted. As a result, the risks of sharing notes or other drug sniffing equipment had been useful information.

“It’s definitely changed my behaviour – I do still use drugs but I’d never share a fiver with someone now. It’s made me very aware of the possibility of transmission so I am more cautious. I’ve never shared works but I definitely wouldn’t in future because of this.”

“There’s lots of things you just don’t think about – I’d have had no idea about catching it from notes. Luckily I’ve not done anything like that for a long time, but it was nice that they impressed upon us that even if you’re not still using or not still doing risky things, you can still get tested and still be helped.”

“The education session was quite an eye-opener – I found it quite shocking how easy it can be to catch and the ways you can catch it – it’s not just people who inject hard drugs who might be at risk.”

“I did learn some new things – about how it’s risky to share other things not just needles – like sharing notes, I didn’t know you could catch it by doing that. I’ve been abstinent for a long time so I’m not at risk at all, but I would pass that information on to someone still using if I thought it might help them.”

“I injected twice ever, and made sure I used all sterile equipment – I used to work in a hospital so I knew about these things. Because of my past jobs I did have some knowledge before the session but it was interesting and reminded me how important it is to be careful – not that I use drugs any more and I only injected those two times. I have to say though I was surprised to learn that you can get it by sharing notes and things for snorting drugs.”

One interviewee also commented that this risk would also apply to the use of a tube or pipe used to smoke drugs.

“I’ve used heroin but never injected. I didn’t realise at all about passing on a tube – that if your lip was bleeding or something it could pass something on, and if someone else had a cut or something you could catch the virus. I’m on a script now since the session, it’s not just because of that [that I’ve gone into treatment] but it’s a factor.”

5.2.2 Blood to blood contact

Almost all of the interviewees had retained the ‘key messages’ regarding transmission of the virus – namely, that it was possible to transmit the HCV virus by sharing drug taking equipment (including needles, other injecting equipment and drug-sniffing paraphernalia); and that transmission is via the blood. Almost every interviewee, when asked what they remembered most about the peer education workshop, immediately recalled the blood-to-blood transmission of the virus. Several commented that they had been surprised that the virus was not sexually transmitted.

A common benefit of the session was cited as a general increase in awareness about the risks of contact with blood – participants noted they felt they were now more aware of the risks and were more cautious in situations where they could be at risk (for most these were everyday situations as they were no longer engaging in high risk behaviour such as drug use).

“One thing that sticks in my mind is how you catch it – by blood to blood contact. It’s harder to catch than I had previously thought, I’d thought it was any bodily fluid.”

“I didn’t know there were so many ways to catch it... it isn’t just IV drug users who might be at risk.”

“I think the main thing I took away from it was that it’s not just about people who use needles – it’s any blood contact that can put you at risk, and how long it can survive outside the body. It made me think it was easier to catch something like that than I’d thought, so it made me think about being more careful. I don’t use drugs any more so it’s not about not sharing things, though I’d tell people I know if I thought they’d be at risk. But things anyone could come into contact with like sharing a toothbrush or something could put you at risk.”

“I got a blood transfusion a few months ago which is why I attended the session to find out more about it. It was really helpful for my awareness as previously I didn’t know anything. I think it’s improved my awareness of all blood borne viruses and brought it to the front of my mind so I’m more likely to remember to be careful. I learnt it’s not sexually transmitted but I’m a gay man so there are

more possible risks of catching a blood borne virus through sex. It's made me think about it when I hadn't really before, and now I get regular blood tests just for peace of mind."

A number of interviewees reported having previously been aware of various harm reduction messages around not sharing injecting equipment, and that the peer education workshop had served as a reminder to them of the importance of these messages. Some reported that the workshop had made them think about their health in general and feel a desire to implement more healthy behaviour in a wider sense. One interviewee spoke of feeling empowered by the workshop to take action (being tested for HCV) because the peer education workshop removed any worries he might have had about going through treatment.

"In the early days of using yeah I did share – I'm careful now, I'm more aware and I only ever use my own stuff, but after that session I'm even more vigilant because it brought home to me what some of the risks are of not being."

"I think the session really made me think – it made me a bit more open-minded and willing to learn more about HCV and other things like that – about health risks and what I can do to stop them, if made me think I should care more about my health. I got tested after the session – I thought even if I'm careful now I might be at risk from my past so it's better to know, and the information from the session made me think I could cope with the treatment if I needed it. It came back negative though so that was good to know."

There were some remaining misconceptions about the causes and transmission of the virus. Two of the 34 interviewees misremembered this information and thought that the virus was sexually transmitted as well as being transmitted via the blood (our researcher took steps to clarify this with these interviewees). One interviewee was unclear whether HCV could result from prolonged alcohol misuse – this was discussed during the interview and clarified that HCV is caused by a blood-borne virus so cannot result from alcohol use, although the general term 'hepatitis' means inflammation of the liver so this could be alcohol-related.

5.2.3 Availability of Treatment

Another point recalled frequently by interviewees was that treatment is available – and both more accessible and less unpleasant than previously.

"There's new treatments available now – this new pill – and it's a much easier treatment than it used to be with the old interferon. The guys giving the talk had had this treatment himself and was telling

us about his experience – it was helpful to have someone who’s been through it, you could tell he really knows what he’s talking about.”

“It was almost incurable at one point – the treatment was really unpleasant, took 6-9months and a lot of people found it really depressing and struggled with the mental health side of it. I’ve heard of people who’ve started using again because they had such a bad time with interferon. But now they’ve got this new treatment that’s very quick and easy. So that stuck in my mind – that it is curable, it’s not the end of the world if you do have it. I have to say that made me feel better about the idea of getting tested.”

5.2.4 Retention of key messages

Almost all interviewees, either independently or with minimal prompting, retained three of the key messages well:

- transmission via blood to blood contact,
- that drug-taking paraphernalia is a route of transmission, and
- that effective treatment is available, including to drug users.

The other key messages (visiting a specialist is the only way to ascertain the level of liver damage, and having the antibodies doesn’t mean having the active virus) were only mentioned independently by two interviewees, though over half recalled this information when prompted. Most of the interviewees may have felt this information was not relevant to them as they did not have HCV and thus did not ‘need to know’.

5.2.5 Long term recall

In terms of long-term recall, all five of the re-contacted interviewees, questioned for a second time several months later, showed good recall of the same key points as those who had attended a workshop recently – transmission via blood contact, the risks associated with drug-taking paraphernalia, and availability of treatment were all well recalled. Equally, the less-remember key points regarding antibodies and liver damage were not independently recalled by any of the second-time interviewees, but were familiar when prompted. All recalled having been advised about testing should they wish to be tested for HCV; all but one had been tested (all prior to the peer education workshop); the interviewee who had not been tested did not think he had ever been at risk so had chosen not to pursue testing.

“I remember thinking it’s amazing how you can catch it from such a small amount, and how long it can survive outside the body even in dried blood! We were told about where to go for testing, that we

can go to our doctor, a clinic at the hospital, or at the R-Hub (Addaction service) where I go; and what the options were for treatment – it's handy to know I can give information to other people if I meet anyone who would benefit from it. I had another test about 6 months ago just for peace of mind. It's always good to be reminded to be careful about exposure and to get regular testing – at the R-Hub they're always reminding us. I would definitely advise someone to get checked out every couple of years at least."

"The session was fascinating – it dispelled some myths for me, I'd thought it was an STD but found out it's just through blood. I remember being surprised about being able to catch it by sharing notes for snorting stuff. I was last tested a couple of years ago and it was all clear. I think in general the session has just made me more aware, and a bit more careful."

5.2.6 Passing on information

Of the 21 recent interviewees, 9 explicitly mentioned that they had shared information from the workshop, mainly with friends and acquaintances, though two had volunteer roles in homelessness and substance misuse services and had found the information helpful for the clients they came into contact with. Some mentioned discussing the peer education workshop with friends, housemates and acquaintances who had HCV, and found it useful to know more about the symptoms and treatment of the condition.

"I've spoken about what I learned in the session with my partner who's also in recovery – we discussed the importance of being careful, the thing about notes which neither of us had known, and about the developments in treatment. I'd heard really bad things about interferon from some of our acquaintance – I've even known people to relapse because of it."

"I've talked about the session with a housemate who's just getting over HCV, it's been nice to know more about it and relate to what she's going through."

"The people who ran the session left some literature to take away and read later or pass on to other people if you knew someone who might benefit. I thought that was a really good idea, so you can pass it on without having to remember it all or risk getting any details wrong."

"I speak about it quite a bit with people I see in the service. I've also seen other service users who've been to the sessions telling others about it outside the main building – it's just quite an interesting topics, it's like one of those subjects at school where you want to come home and go 'Did you know...?'"

Of the previous interviewees, one mentioned discussing some of the information with his AA and NA groups, and another felt it had benefitted him and his acquaintances while living in

shared accommodation where he came into contact with injecting drug users. The main pieces of information interviewees reported sharing with others were the blood-borne nature of the virus and how it is transmitted (including through sharing notes) and about the availability of treatment. Other interviewees, who had not had occasion to share the information they had learnt, stated they would do so if they thought it could be helpful to someone.

“I’ve told my partner and my friends about it; they were shocked too at how easy it can be to catch. We’re all lucky really not to have it. I was tested a while ago and it was all clear.”

“I was in shared accommodation where there was a lot of drug users and there were a lot of needles around in the environment, so it was very relevant yeah – I knew about being able to catch things from needles but it helped remind me to be extra careful, and I did talk about it with people there and pass on the information. I don’t think it changed how I acted or anything, just made me more aware of the possible consequences and reinforced that I needed to be careful around sharps, which can never be a bad thing.”

“I have passed on some of the information in my AA meetings – there are several people who come who use both alcohol and drugs, and not all are abstinent, so it might be relevant to them. I’ve told people about the risks, and also about treatment now being less hassle and a better success rate – it’s not a death sentence any more.”

On the other hand, a few interviewees stated they had not discussed the workshop with anyone because they no longer had friends who used drugs or for whom they thought HCV was a realistic risk, so felt that sharing the information would not be beneficial to anyone they knew.

5.2.7 Comments and Suggestions

All 21 interviewees in the most recent round of interviews gave positive feedback – the workshop was generally felt to have been engaging, informative and interesting. Of those interviewed in May and June, two did not have clear memories of the workshop but on discussion of the key messages did seem to have retained some information and agreed this was useful. There is, however, some likelihood of bias in that those who did not enjoy the session may be less likely to wish to participate in the evaluation.

A number of interviewees commented on the skills of the peer educator they had personally encountered as a positive factor in helping them absorb and retain the information. One peer educator in North Somerset (Dave) was mentioned by name by two interviewees as being particularly knowledgeable. For most interviewees the most positive aspects was having an

individual who had 'been there' delivering the workshop – the educators' personal experiences gave them credibility and a depth of knowledge that was appreciated by attendees.

“Dave [the peer educator] really held my attention and was very good – you could tell he really knew what he was talking about, he wasn't just reading from a piece of paper. If anyone wanted more clarification or a bit more detail on something he could give it to them. I've attended the session a few times now but the first time I saw it, as a service user, I knew most things but didn't know about the different genome types and where they originated. I've heard people talk about that stuff since then and I think they remember the messages because having that extra information makes it more interesting. I also remember the information was presented in audio and visual forms, which makes it easier to remember.”

“The people presenting the course made us feel comfortable and explained everything well, I felt it was easy to ask questions if I wasn't clear on anything.”

“My dad has it and some of my friends have it, so I wanted to know more about it and what the risks are. The guy running the session had been through treatment himself so could really answer questions well. He talked about how easy it is to catch – I was shocked at how easy it is, with being able to catch it from notes and that.”

“I feel like now it's been explained and talked about, the risks are clear to me, and it really wasn't before so it's been really helpful.”

One interviewee suggested that steroid users are a potential at-risk population who would not necessarily have knowledge about blood borne viruses, and might benefit from similar information if they could be reached with it.

“I'm a bit of an unusual one because I've used steroids after I stopped using Class As, and honestly, people in that community just have no clue they may be at risk. People think if you're not a 'druggie' you'll be fine, but they do take risks.”

5.3 Peer to peer educators

As part of the evaluation, consultation was undertaken with those who carried out the peer to peer education workshops. In total four peer educators were interviewed in a focus group in July 2016. The educators were attending a conference in London to mark World Hepatitis Day and the opportunity was used to consult with them as a group.

All peer educators felt that the workshop that they offered was having an important impact. They noted that there are many misconceptions about HCV (and other BBVs) among the drug using population – not least that having HCV is a “death sentence”. They all noted that HCV is poorly understood and that drug users get their information through a process of “Chinese whispers” in which messages are distorted or exaggerated – particularly messages around the effectiveness of treatment and negative side effects.

The peer educators felt that they had an important role to play in clarifying these misconceptions and giving clear and accurate information. They stressed the importance of delivering the information in the language that a layperson can understand and noted that clinical staff can be too technical.

They stressed the value of conveying the messages from a peer perspective. One interviewee noted that some drug users face the barrier of self-esteem when listening to a professional or doctor and that this can make it difficult for them to take on board key messages. By providing the information from a peer perspective, these issues around self-esteem and self-worth are effectively managed. It is also a clear demonstration to attendees that having HCV is not a “death sentence” and that the condition can be successfully treated. All the peer educators noted that, when they share their story to attendees, there is a powerful sense of connection which changes the dynamic of the subsequent training.

The peer educators felt that the ability to provide dry spot testing immediately after their workshop would be of significant benefit. They noted that, whilst many attendees indicate that they plan to go on to get tested after the workshop, the chaotic nature of their lives means that this may not actually take place. By having testing immediately available they could better utilise the impact of the workshop and not lose the teachable moment. This feedback – about the value of the teachable moment of the workshop – was used to inform the Talk and Test approach that was later rolled out.

Peer educators all reported the positive impact that their work had had upon themselves. They felt that they were being given the opportunity to “give something back”. All reported a significant impact on their own confidence – from having to be a role-model and having the opportunity to use their experiences to help others. One noted that it had made him more compassionate and another noted that it helped underpin and strengthen his own recovery.

6. Conclusions

From the data set out a number of conclusions can be drawn. These are set out below in relation to each element of the pilot.

6.1 Peer education workshop

806 people attended over 112 HCV workshops that were delivered by peer educators. The initial conclusion to be drawn is that peer educators are an efficient and effective mechanism through which to provide important information to large volumes of people. The sheer volume of people engaged over the course of the pilot is to be applauded, particularly given that this is a “hard to reach” group of people who can be difficult to engage with.

Peer education is however evidently not just effective in terms of effective reach. The results would appear to demonstrate that the outcomes of the workshop are very good with 70% of those trained indicating that their knowledge had increased A Lot or Massively as a result of the workshop. Knowledge of the five key messages was high with an average of 89% of respondents answering the five questions correctly. It can therefore be concluded that the peer educators have proven to be an effective means through which to communicate a small number of core (but vital) messages about HCV to a high-risk group of clients.

The longitudinal qualitative aspect of the evaluation indicates that longer-term retention of the information provided in the peer education workshop is good with near universal recall among those interviewed of key messages in relation to: transmission routes, the role of blood to blood contact and the availability of new treatment. Some of those interviewed indicated that they had gone on to get tested as a direct result of the workshop and some were planning to do so. Of no little note, a number of those interviewed indicated that they had shared key messages about HCV with their partners, friends and peers. This would tend to indicate that the peer to peer education is embedding accurate information about HCV within the drug using community, the messages which are then being transmitted through the community. This is a very welcome finding.

While the results of the peer education workshops are on the whole very positive, some attention should be given to the profile of attendees. The results indicate large numbers of attendees who have not injected (whereas those who have injected are the most high risk group) and numbers of clients in alcohol treatment (a lower risk group). It may therefore be

beneficial to consider greater levels of targeting in relation to who workshops are delivered to so as to ensure that the most vulnerable engage and receive the important messages conveyed by the peer educators. However feedback from Addaction's service users suggests that with many people using multiple substances over their lifetime, providing HCV information to those people who may not have injected is important as they may inject at a later point.

It is worth noting that those interviewed emphasised the positive quality of the peer educators. The findings demonstrate the importance of using peers to deliver the workshops and particularly the fact that they have lived experience of HCV. This is possibly instrumental in achieving the results that are set out.

Whilst the introduction of "Talk and Test" (i.e. provision of testing immediately following workshops) was a later innovation the results would tend to indicate that this is leading to an increase in levels of testing among the target group and therefore consideration should be given to making this part of the standard delivery of the training.

6.2 Buddy scheme

As per the interim evaluation, there is insufficient data to draw any firm conclusions regarding the buddy scheme and its effectiveness as a method of support.

6.3 Workforce development

Over the course of the pilot in the region of 205 members of Addaction staff and volunteers have been trained about both HCV and other BBVs. The data from the surveys clearly indicates a positive impact of this training – 90% of attendees reported increased knowledge of BBVs, a third of attendees were Very Confident in their knowledge of HCV. Similar levels of positive reporting were identified across all other variables. The pilot has therefore had an appreciable impact among Addaction staff about BBVs and how to support their clients.

6.4 Other developments

Whilst not a core part of the programme, the recruitment of a fibroscan technician providing scanning in the community to Addaction clients has generated some interesting results in terms of levels of engagement and a reduction in patient son the waiting list awaiting a scan. Whilst the results are still emerging, the early findings would appear to be positive and ongoing monitoring should indicate whether this approach should be embedded as ongoing practice.

7. Recommendations

Following the conclusions set out above a number of recommendations are set out in relation to each of the strands of the pilot.

7.1 Peer education workshops

1. The peer education workshop strand should be rolled out across all Addaction areas to enable all Addaction clients to benefit from key and important messages about HCV.
2. Where possible workshops should be targeted at higher risk groups – particularly injecting drug users or those who have had some history of taking drugs intravenously.
3. In addition to heroin users it may be worth seeking to engage other types of injecting drug users – for instance those who use image/performance enhancing drugs. This recommendation was generated by attendees at the stakeholder workshop (and also by a peer education workshop attendee interviewed as part of the evaluation).
4. Should recommendation 1 be approved, additional peer educators should be recruited and trained to ensure that there is sufficient capacity to manage the increased demand.
5. A quality control programme should be introduced for peer educators to ensure that they are clear about the key messages that need to be delivered and are delivering these effectively to audiences. This could take the form of staff from The Hepatitis C Trust observing peer educators at regular intervals (perhaps six monthly) and regular ‘top-up’ training to ensure that peer educators are delivering the right message, whilst also providing an opportunity to share up-to-date information on HCV treatment and developments. ‘top up’ training should be provided annually. The quality control element should be overseen by The Hepatitis C Trust.
6. A peer educator professional development package should be put in place to enable peer educators to learn from one another, share good practice and develop their training skills. This should be tied into the ‘top up’ training (described at recommendation 5 above).
7. To the extent that it is possible, Talk and Test should be rolled out as standard across all peer education workshops ensuring that testing is available directly after all workshops. If universal testing is not viable, then Talk and Test should be targeted at those venues and groups where there are likely to be injecting drug users or those with a history of injecting drug use following the segmentation of workshop clients (see recommendation above on better targeting).

7.2 Buddy scheme

8. The buddy scheme concept should be re-tested in another area covered by Addaction to determine whether the concept proves more effective when located in another region.
9. If the buddy scheme is re-tested robust data should be collected about the activities that take place under the scheme to enable a determination to be made as to the effectiveness of the concept.
10. Currently large numbers of volunteers have been trained as buddies but are inactive. Consideration should be given to developing a smaller cohort of buddies who are more likely to be engaged and active. One mechanism may be to select buddies on the basis of lived HCV experience.

7.3 Workforce development

11. The questionnaire used in the workforce survey to test the impact on attendees should be amended to allow for a direct comparison to be made on individual's knowledge before and after training. This would allow "distance travelled" to be measured per attendee. The most straightforward approach would be for the before and after questions to be on either side of a single sheet of paper. This recommendation was generated by attendees at the stakeholder workshop.
12. BBV/HCV training in its current format should be rolled out to Addaction staff and volunteers as standard practice to ensure that the entire workforce has high levels of awareness and can therefore better support their clients.
13. Consideration should be given to short "top-up"/refresher training sessions to make sure that staff who have been trained retain knowledge of key concepts and ideas.
14. Addaction staff and volunteers should be given the opportunity to attend peer education workshops which may prove to be beneficial to them in terms of their learning and development. This recommendation was generated by attendees at the stakeholder workshop.

