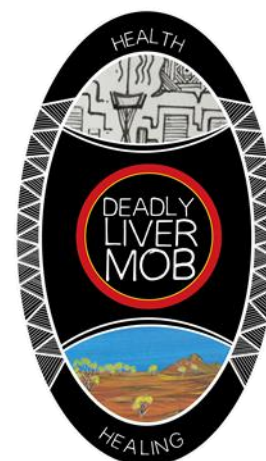


# Deadly Liver Mob Aboriginal Health Impact Statement



## Title of the initiative:

Deadly Liver Mob: Engaging Aboriginal people in viral hepatitis, HIV and sexual health services

## Organisation/Department/Centre:

### Local implementation

<Site to insert>

### Evaluation/research

Centre for Social Research in Health  
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**Date completed:** Date

## 1. The health context for Aboriginal people

Aboriginal and Torres Strait Islander (hereafter Aboriginal) people feature disproportionately in national profiles of blood-borne viruses (BBVs) and sexually transmissible infections (STIs). As such, Aboriginal people are a priority population for the respective national and NSW strategies (1, 2). Rates of Chlamydia, gonorrhoea, syphilis and hepatitis C (HCV) among Aboriginal people are diagnosed at 4, 30, 5 and 4 times respectively the rates of non-Aboriginal Australians (3). These infections are associated with behaviours (unsafe sex or injecting drugs) that can cause shame, stigma and barriers to engagement with health services (4).

Publicly-funded health services are key providers of care but there has been little innovation in this sector, low overall rates of participation of Aboriginal people in these services and consequently little change in overall infection rates. Since 2013, The Deadly Liver Mob (DLM) program has been running as a pilot project in one publicly-funded Needle and Syringe Program (NSP) in Western

Sydney. The project came about due to the overrepresentation of Aboriginal people at the NSP (16% in the 2013 NSW NSP Extended Data Collection) and very few episodes of care over the immediate preceding years in the adjacent sexual health clinic. The DLM combines health promotion and education delivered by Aboriginal health workers, a peer referral model of care and incentives to improve engagement, testing and treatment of STIs, HIV and hepatitis C among Aboriginal people who inject drugs and their peers including sexual partners who do not inject drugs.

Funded in June 2016, this NHMRC Partnership project will evaluate the roll out of the DLM program to new sites, while continuing to monitor progress in the existing two sites. This NHMRC Partnership Project represents an opportunity to evaluate a significant innovation with the aim of improving the health and well-being of Aboriginal people and providing evidence to shape policy, health care delivery and surveillance of BBVs and STIs among Aboriginal people in the public sector. The overall goal of this Partnership Project is to evaluate the health outcomes and impact of the DLM, to examine its acceptability and to establish a translational framework that would enable the DLM to be scaled up across New South Wales and further afield.

The specific aims are to:

- Evaluate the effectiveness of DLM project sites;
- Evaluate client and provider attitudes and barriers towards the acceptability of DLM; and,
- Develop a scale-up plan, implementation tool-kit and training program.

The Deadly Liver Mob (DLM) program combines health promotion and education delivered by Aboriginal health workers, a peer referral model and payment incentives to improve engagement, testing and treatment of BBVs/STIs. **The program is for Aboriginal people and is delivered by Aboriginal people.** Aboriginal people who are eligible to participate in the program are those that:

- Have ever injected drugs; OR
- Currently inject drugs; OR
- Are classified as “at risk” of injecting drug use and/or a blood borne virus or sexually transmissible infection\*

\* At risk is defined as prison history, unsafe/non-professional tattoos or piercings, living with a person/people who inject drugs, and involvement in fist fighting where there may have been exposure to blood. This definition may evolve over time.

## **2. The potential impact of the policy, program or strategy on Aboriginal people including approaches to mitigate any potential undesired effects**

In its first 12 months at the Western Sydney pilot site, DLM engaged more than 400 Aboriginal people in HCV health promotion with subsequent referral of over 300 people to sexual health screening, resulting in a 1023% increase in access to sexual health services. The roll out of DLM therefore has the capacity to significantly impact on the health of Aboriginal people in the localities surrounding the new sites, through provision of hepatitis C education by an Aboriginal peer, and facilitating access to sexual health screening and treatment for blood borne viruses and sexually transmitted infections. The Aboriginal DLM worker at Western Sydney, Kerri-Anne Smith, has remained in her role for this duration and continues to provide insights based on her experiences to

the new sites that commenced in 2017, and to the overall project as a member of the Management Committee.

Although the DLM program is for Aboriginal people, the screening and treatment of blood borne viruses and sexually transmissible infections among non-Aboriginal people who otherwise meet the eligibility criteria is important from a public health perspective. Any non-Aboriginal persons who meet these criteria should be provided services including education, needle and syringe or sexual health services. However, incentives are only provided to our target group. This rule extends to non-Aboriginal partners of DLM clients – while they should be encouraged to go through education and sexual health screening, non-Aboriginal partners will not receive any incentive payments.

The implementation of the DLM program is being evaluated as part of the NHMRC Partnership Project by the Centre for Social Research in Health at UNSW Sydney. Data collected as part of this evaluation include:

1. Routinely collected data from NSPs (specifically the numbers of people progressing through the program);
2. Routinely collected data from sexual health clinics via the ACCESS database;
3. Semi-structured interviews with DLM clients; and
4. Semi-structured interviews with health workers from each of the participating Local Health Districts.

To assist with monitoring and evaluation, an issues register will be used to compile, categorise and track issues related to implementation and evaluation of the program. Melinda Walker of CSRH will telephone key contacts identified by each LHD to identify and record issues arising throughout DLM every 6-8 weeks. Issues will be categorised by their type (e.g. workforce, security, data/information systems, patient population) and the severity of their impact on implementation and/or the evaluation. One of the key study outcomes of the DLM project is the development of an implementation plan for the scale-up of an incentive-based and peer-drive intervention in needle and syringe programs for blood borne virus and sexually transmitted infections assessment and treatment for Aboriginal people. The issues register will feed into development of the Implementation Manual, by providing insights into issues related to workforce capacity, budgeting, management and monitoring of DLM. These reports will be useful in advising future new sites that wish to run DLM on potential issues they may encounter and how they have been addressed in various LHD sites.

### **3. Engagement with Aboriginal people**

#### *Local implementation*

The DLM program is for Aboriginal people and delivered by Aboriginal people, with the aim of improving engagement, testing and treatment of blood borne viruses and sexually transmissible infections among Aboriginal people who inject drugs and their peers including sexual partners who do not inject drugs. At the local implementation level, each site is required to recruit a paid Aboriginal worker to run the program. Consistency in the Aboriginal worker is critical to build rapport with the local Aboriginal community, and to also prevent clients from participating in the program and receiving incentives more than once. To overcome barriers for Aboriginal people in

receiving testing and treatment for these infections, clients are not required to sign consent forms to take part in the program.

<Site to insert local detail>

### *Evaluation/research*

The chief investigators listed on the project include a designated Aboriginal researcher, James Ward. James Ward is a Pitjantjatjara Nurrunga man, and is the Head of Infectious Diseases Research Program-Aboriginal Health at the South Australian Health and Medical Research Institute. The associate investigators listed on the project also includes a designated Aboriginal researcher, Kerri-Anne Smith. Kerri-Anne Smith is the Aboriginal Hepatitis C Health Promotion Officer at the Mount Druitt Needle and Syringe Program located within Western Sydney Local Health District. She is a Wiradjuri woman on her paternal side, and her maternal background is Scottish. Kerri-Anne has been the educator on the DLM program since its commencement.

The evaluation project is guided by a Management Committee which, as per standard Governance policy at the University of New South Wales, includes at least 2 nominees from the Chief Investigators and up to 2 nominees from each Partner Institution. Thus, the committee includes the chief investigators of the project (including one Aboriginal investigator) and representatives from the NSW Ministry of Health, WSLHD, NBMLHD, SESLHD, MNCLHD, NNSWLHD, WNSWLHD and FWLHD. Committee membership is for the life of the project. The partner organisations are asked to appoint at least one relevant Aboriginal staff member to participate in the committee. Any outcomes arising from this project will be distributed to the Management Committee for comment and feedback. CSRH also employs an Aboriginal Cultural Mentor/Advisor to projects in Aboriginal health at CSRH, including DLM. The Aboriginal Cultural Mentor/Advisor is L. Clair Jackson, who is Ugarapul/Githabal (Jagara Nation, SE Qld) on her father's side and French and German on her mother's side. Aunty Clair provides advice on the DLM project and is a standing member of the DLM Management Committee. Every three months, the CSRH team also consult with the Aboriginal Health and Medical Research Council to provide a project update and seek feedback on the project's strategies for engaging Aboriginal people. The DLM project has also been subject to ethical review and approval from the Aboriginal Health & Medical Research Council of NSW (AH&MRC).

The CSRH team organises a regular teleconference (every 4-6 weeks), which brings together representatives from each site. Again, the partner organisations are asked to appoint at least one relevant Aboriginal staff member to participate in the meeting. The purpose of the meeting is for each site to provide an update on progress (e.g. participant numbers), but also to share any issues that have arisen with the implementation of the project and brainstorm solutions.

An annual DLM workshop is held in Sydney, which brings together the chief investigators and representatives from each of the partner organisations. Sites are asked that at least one representative is a designated DLM Aboriginal worker. The purpose of the workshop is to discuss progress-to-date and present preliminary data for discussion. Space is designated for the Aboriginal workers to meet and debrief about the program without upper management present, and also provides opportunity for capacity building and networking. For example, in 2017 the breakout session for Aboriginal workers consisted of a workshop on self-care. This strategy was recommended by the AH&MRC as a way to foster a community of DLM workers, improve staff retention, and

provide networking and capacity building opportunities. Travel support is provided via the NHMRC project budget.

This project will also see the establishment of a community reference panel, which consists of a group of people with a range of experience relevant to the research that CSRH does. This includes people with experience of drug use, hepatitis C or prison, and Aboriginal people with these experiences. Aboriginal panel members will be invited to act in an advisory capacity on the DLM project, by providing advice on the direction of the project and any materials developed for DLM clients. The community reference panel is managed by Melinda Walker and Kim Beadman of CSRH, both of whom are Aboriginal women. Melinda Walker is a Gumbaynggirr woman from Bowraville, NSW, and has worked in Government and NGO agencies around the Sydney Metropolitan region. She has a Diploma in Counselling and Groupwork, a Diploma in Child, Youth and Family Intervention, and is currently completing a Bachelor of Social Work. Kim Beadman is a Wadi Wadi Wonnarua woman from LaPerouse in NSW. Kim has completed a Bachelor of Nursing (UTS) with post graduate studies in Perioperative Nursing (UTS), Drug & Alcohol Nursing (CAN), and Forensic Mental Health Nursing (SUT), with experience across a number of other areas including, intensive care, sexual health and oncology. She is currently completing a Bachelor of Psychological Science and Criminology at UNSW.

The project also has a Publication Plan, covering all research outputs arising from the DLM project including, but not limited to, peer reviewed publications, books and book chapters, conference papers and presentations, and social and mass media publications. The policy outlines that particular efforts will be made to ensure that Aboriginal investigators have the opportunity to participate in authorship. While the significant contribution of all partners and stakeholders is invaluable and appreciated, the DLM project is for Aboriginal people and delivered by Aboriginal people. Therefore, Aboriginal people will be encouraged to co-author publications arising from this study. In particular, where partner and stakeholder organisations are invited to recommend a staff member for authorship, Aboriginal staff should take precedence. Aboriginal authors will be provided with the opportunity to describe their nation, mob, role in the community or other relevant information in the Acknowledgements section of any publications. This project recognises the invaluable contribution of Aboriginal people in the design and implementation of the project. Where Aboriginal people do not meet criteria for authorship, their contributions will be included in the Acknowledgements.

DLM workers will be given the opportunity to submit abstracts to present on DLM at conferences. The NHMRC project will be able to provide some financial support (e.g. registration costs), and where funding is not available the LHD may be asked to cover travel costs. For example, in 2018 Aboriginal workers Melinda Walker (CSRH) and Kerri-Anne Smith (WSLHD) are submitting an abstract to the Australasian Viral Hepatitis Conference to co-present on the DLM project and an offer has been made to support another Aboriginal worker to attend this conference.