Research paper

How to build trustworthy hepatitis C services in an opioid treatment clinic? A qualitative study of clients and health workers in a co-located setting

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ABSTRACT

Background: Given the increasing burden of hepatitis C (HCV) related liver disease, innovative health care models are required to extend the reach of HCV care and treatment. Opioid substitution treatment (OST) clinics are places of high HCV prevalence. The OST clinic is a complex environment, quite distinct to other health care settings, with punitive regulations and practices, and a client population likely to be mistrustful of systems of authority. Nonetheless, trust is widely documented as essential to effective therapeutic encounters. This paper examines what is required to develop a trustworthy service in a place, the OST clinic, described by some critics as a site of “social control”.

Methods: In-depth interviews were conducted with 57 clients and 19 staff from four NSW pilot clinics participating in the Australian ETHOS study.

Results: Interview data were examined using Hall’s framework of trust, involving five principle domains: fidelity, competence, honest, confidentiality and global trust. ‘Honesty’ was found to be key to participants’ establishing trust in the co-located service and its staff. However, the clinic site was also found to be a place of rationed trust, in which the themes of OST as “ruling peoples’ lives” and the fear of repercussions resulting from perceived transgressions against clinic rules, threatened to over-ride or undermine the development of trust in HCV services. Client participants described trusting health workers “to a point”. They expressed concerns about the fidelity of co-located HCV and OST services and described fears of “institutionalised lies” and breaches of confidentiality. Anxieties around the latter revealed a sense of “us and them” held by some clients, one in which health workers were perceived to “stick together” by putting their own interests before those of the clients.

Discussion: Although the co-location of HCV and opioid treatments makes intuitive policy sense, HCV health workers in the OST space may be seen as representatives of a deeply mistrusted system. For the effective development of a trustworthy HCV care service, policy and practice activities are required to engender trust through clearly articulated explanations of service boundaries and the promotion of “success stories” through trusted peer networks.

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INTRODUCTION

There are over 220,000 Australians living with chronic hepatitis C (HCV) infections yet treatment uptake rates remains low (National Centre in HIV Epidemiology and Clinical Research, 2010). The national health policy imperative to double the number of people undertaking treatment (Australian Government Department of Health and Ageing, 2010) has resulted in an expansion of health care models to better suit the needs and preferences of people living with the virus, most notably the introduction of HCV care within opioid substitution treatment (OST) (Bruggmann & Litwin, submitted; Novick & Kreek, 2008; Sylvestre, Litwin, Clements, & Gourevitch, 2005; Walley, White, Kushel, Song, & Tulsky, 2005). All effective models of care depend on establishing and maintaining trust between client, health provider and system (Hall, Dugan, Zheng, & Mishra, 2001). In contrast, critics have described OST as a system of social control characterised by discipline and distrust (Bourgois, 2000; Harris & McElrath, 2012). This paper examines what is required to build trust when a new model of HCV care is introduced within the OST setting.

There is a large body of literature examining trust in health care and it is beyond the scope of this paper to summarise its many nuances and complexities (see Meyer, Ward, Coveney, & Rogers, 2008 for review). Modern life, the literature suggests, is
characterised by a culture of increasing public scepticism and the concomitant disintegration of trust (Davies, 1999). Trust in institutions and their professionals can no longer be automatically assumed, requiring instead that it be continually worked on and won (Mechanic & Meyer, 2000). While a decision to trust is based on past experiences it also requires a judgement about the motivations or intentions of the other (Gibson, 2003). Trust is linked with notions of risk and vulnerability: it is required in situations in which a person cannot know the outcome and must therefore rely on the assistance of others (Hall et al., 2001).

Trust between clients, practitioners and the health system is essential to effective therapeutic encounters: facilitating a willingness to seek care, change behaviour, use services and encouraging uptake and adhere to treatment (Hall et al., 2001). Trust in relation to health care has been defined as an optimistic belief that the health system and its professionals will act in the best interests of the client (Abelson, Miller, & Giacomini, 2009). Thus, trust is critical to both the relationship between client and health worker and client and health system (Meyer et al., 2008). Finally, scholars have also highlighted the inter-related nature of trust: trust in the health system may be related to trust in other social systems, such as those concerning employment, welfare and criminal justice (Meyer et al., 2008; Ward & Coates, 2006).

The successful development and implementation of new, trustworthy services—and ultimately, the achievement of desired health outcomes—thus requires an understanding of the sources of (mis)trust within existing health services. Previous analyses of trust in regards to newly developed services demonstrates the importance of understanding the context of health care both in relation to specific issues of trust, and in particular, to the central role of risk (Gidman, Ward, & McGregor, 2012: Hall et al., 2001). However, previous research on trust has tended to explore interpersonal relationships (such as between patient and provider) and less has explored the role of setting in trust relations (Harris, Rhodes, & Martin, 2013). The framework proposed by Hall et al. (2001) has been used in previous research on integration of health services (Gidman et al., 2012). This framework includes five dimensions (presented below) that allows for exploring the relationship between clients and health workers as well as directing attention to issues of trust in health systems as produced by social and structural conditions.

In terms of trust, considerable challenges threaten the successful integration of HCV within the clinical and social spaces of OST. Previous critical scholarship describes the OST clinic variously as: a ‘highly surveillant and regulated environment’ (Rance, Newland, Hopwood, & Treloar, 2012, p. 245); a system which ‘operates in ways unhinkable in other treatment formats’ (Fraser & Valentine, 2008, p. 86); and one ‘characterised by intensive social control’ (Harris & McElrath, 2012, p. 811). While OST clients are registered with a licensed medical prescriber and may have regular, frequent interaction with the service (familiarity being a key facilitator of trust (Gidman et al., 2012)), the nature of the exchange is typically limited to the dispensation and consumption of OST. Critics have noted that aspects of the OST system more closely resemble an extension of the criminal justice system than they do a form of healthcare for some of society’s most vulnerable and disadvantaged (Bourgois, 2000; Smith, 2011). For many OST clients the possibility of establishing effective and trusting therapeutic relationships is further prejudiced by the treatment population’s enduring reputation as ‘inherently dishonest drug users’ (Fraser & Valentine, 2008, p. 251). Here OST is caste as a ‘privilege’ rather than a right and clients’ tenure experienced as fragile and precarious (Rance et al., 2012). While differences across OST operational cultures and the philosophical approaches of individual workers are apparent and important, the prevailing culture of mutual suspicion remains an influential (if unspoken) determinant in the establishment of client–staff relations and needs further exploration. In this paper we examine the experiences of clients and staff in a trial of HCV care and treatment in OST settings to address the question of what is required to develop a trustworthy service in this space.

Method

As described in detail elsewhere (Alavi et al., 2013), the ETHOS study is a prospective observational cohort, designed to evaluate an innovative model for the provision of HCV assessment and treatment among people with a history of injecting drug use in NSW, Australia. The core components of the ETHOS model include the provision of on-site HCV nursing and physician assessment and treatment in clinics with existing infrastructure for addiction care (the majority of services had limited previous experience in providing HCV care). Study recruitment was performed through a collaborative network of nine clinics (six OST clinics, two community health centres and one Aboriginal Community Controlled Health Service including 1 rural, 1 regional, and 7 metropolitan clinics) undertaking HCV assessment, treatment and monitoring among people with a history of injecting drug use. Two services incorporated peer workers employed by the NSW drug user organisation, New South Wales Users and AIDS Association (NUAA).

This qualitative study recruited a sub-sample of people enrolled in or eligible for the ETHOS study: individuals attending select OST clinics who self-reported living with chronic HCV. Three groups of client participants were recruited: firstly, those who did not have any engagement with HCV; secondly, those who attended for initial HCV assessment but did not progress further with HCV care or treatment; and finally, those who had moved towards or were undertaking HCV treatment. Interviews with a range of clinic staff and peer support workers involved in the ETHOS project were also conducted.

Recruitment and interviewing took place across four ETHOS pilot sites in NSW: three within OST clinics (inner city private clinic, outer metropolitan public clinic, regional city public clinic) and one within a NSW community health centre (large rural town) operating a public OST clinic. Sites were selected to include two currently providing peer support programs (inner city and regional city) and two which were not (outer metropolitan and large rural town). Flyers were posted in waiting areas of each clinic advising clients of the study and how they could participate. In addition, clients were advised by word-of-mouth as to when the researcher was onsite and available for interviewing. Interviews with relevant staff and peer support workers were facilitated by the clinic manager at each site. All interviews were conducted within a private space at the clinic. That the research was conducted by an independent body to the clinic and that participant anonymity would be protected was reiterated for all participants. All interviews were conducted by one researcher (JR) and ranged from 20 to 40 min in duration. All interviews were conducted in 2011–2012 which was 1–2 years after the establishment of the HCV services in each clinic.

Semi-structured interview schedules were constructed around a set of core issues. OST client interviews included: a brief demographic and clinical overview (including drug treatment history); recollections of initial HCV diagnosis and subsequent management; attitudes towards and/or experiences of HCV treatment (including motivations, barriers and reasons for ‘deferment’ or non-engagement); general thoughts regarding the co-location of HCV treatment within OST; understanding of, attitude towards, and engagement with, peer support. Issues raised with staff participants included: their initial expectations of the ETHOS initiative; client responses; barriers to client engagement with HCV treatment (including stability on OST, fear of side-effects, absence of family support etc.); organisational issues; and attitude
towards peer support. Interviews with peer support workers explored: motivations for undertaking the role; thoughts on the ETHOS initiative (including service user reactions); barriers to client engagement with HCV treatment; staff reactions to peer support role; organisational issues; and the impact generally of the peer support program on the clinic.

Digitally recorded interviews were transcribed verbatim. The transcripts were then ‘cleaned’ to remove any identifying details and each transcript was given a pseudonym. Transcripts were then entered into a qualitative software program (NVivo 8) to assist in identifying and organising participants’ interview responses.

The study was approved by the Human Research Ethic Committees of the University of New South Wales and NSW Health. Informed consent, either written (for face-to-face interviews) or audio recorded (for telephone interviews), was obtained from all participants. OST client participants were reimbursed $20 for their time and expertise.

A coding framework was developed to capture participants’ experiences of the trial project, as well as codes developed from the literature, including one for ‘trust’. These latter codes were constructed in preparation for a theoretical thematic analysis. Our particular focus on trust reflected both our pre-existing interest in this theoretical area and its emergence in data collection (Braun & Clarke, 2006). Sections of interviews that spoke of relationships between the client, health worker and health (or other social systems) were included in this code (by JR). Analysis of the themes emerging were informed by Hall’s five dimensions of trust (2001): (1) ‘fidelity’ – care and respect of clients is a central notion in which health professionals are seen as acting in a patient’s best interests and not taking advantage of vulnerability; (2) ‘competence’ – in which clients assess a professional’s ability to avoid mistakes and achieve best results. Judgements about competence are very tightly bound to judgements about communication skills, as clients may find it difficult to judge technical competence of a health professional; (3) ‘honesty’ – while directly dealing with telling the truth and avoiding intentional falsehoods, honesty also encompasses admission of lack of knowledge and disclosure of conflicts of interest (which is itself a component of fidelity); (4) ‘confidentiality’ – the proper use and protection of personal information. This component of trust is also discussed in relation to the specific concerns of vulnerable populations, such as people on OST and who live with HCV; (5) ‘global trust’ – which has been described as the “soul of trust” as well as encompassing concerns of trust that do not exclusively match or fit with the other four dimensions. However, analysis of these data (conducted by CT) prioritised trust as something that was socially produced and reproduced and dependent on structural conditions (in this case of the OST clinic) rather than relating only to motivation or experience of individuals. Meaning derived from coded data was presented and discussed until consensus was reached between the researchers. Quotes from interviews are presented using pseudonyms, participant group and clinic number. This analysis does not focus on the peer support program operating in two sites which will the subject of another publication.

Results

A total of 76 in-depth interviews were completed. Face-to-face interviews were conducted with 57 service users, ranging in age from 29 to 58 years. Of the service user sample, 17 ‘declined assessment’, 21 were ‘initial assessment only’ and 19 were ‘awaiting or initiated treatment’: about half were men (n = 32), nearly all were social security recipients (n = 52), with seven in either full time or part time employment (two participants reported being both employed and receiving social security), and one in five identified as Aboriginal or Torres Strait Islander (n = 11). The 19 staff participants included 9 nurses, 4 clinical managers, 2 administrators, 1 medical practitioner and 3 peer support workers. Trust was identified by client participants as a key issue in their identity and interaction with health services, suggestive of the notion of ‘global trust’. Experiences of socio-economic disadvantage and psychological vulnerability, alongside breaches of trust by health and other social systems, featured strongly in participants’ interviews. The experience of ‘institutionalised lies’ among people who inject drugs (PWID) in their dealings with health services and the adoption of ‘oppositional’ or ‘anti-authority’ identities by some clients were described as contributing to a generalised distrust of ‘the system’. While acknowledging the very real issues of power and (mis)trust present within the OST system, Lilly spoke of her own ‘maturing out’ of her earlier, rebellious identity and of the subsequent opening up of possibilities for different (and potentially more trusting) relationships with OST staff.

And they’ve gotta understand that we have big trust issues. We’ve been fucked-over all our lives. That’s why most of us are addicts because we’ve fuckin’ had bad … not so much bad upbringing but bad experiences … Experiences of violence in the family, alcoholism … all that sort of thing. (Drew, clinic 3, declined assessment)

And it’s just those sort of lies that, that are being institution- alised, that [PWID don’t] trust anymore after being … through rehab, detox, … treatment. They just don’t believe the lies anymore … so they don’t put complete trust in the health department. (Hannah, peer worker)

[The relationship with staff] just comes I guess from that men- tality of authority and not trusting … I think for most people it’s just … screws and crims, you know, it’s that mentality … But, at the end of the day, sometimes you’ve gotta talk to those screws. It’s just the way it is … Then you get older … tailing off, growing out of it, moving on … we get past that. You get past that, that mentality. I can’t tell them I smoke pot. Oh my God! Like fuckin’ of course I can! What are they gonna do? Seriously. … with maturity I guess comes wisdom as well. (Lilly, clinic 3, declined assessment)

Client participant concerns about trusting HCV services within the OST space centred around the inter-related dimensions of ‘honesty’, ‘fidelity’ and ‘confidentiality’. Clients highly valued the honest engagement of health workers as key to building trusting relationships.

Attentiveness. Yeah. Empathy, definitely. Honesty. Honesty’s gotta be the biggest one for me. Honesty. Yeah, other than that, just the basics—integrity, all that stuff. But honesty mate. That’s what I like: honesty. … If that’s all I can get from [staff] is their honesty, their opinion, or, or, or unless they’re spinning facts, you know. But yeah, just honesty, gutless honesty. Because then it builds a, builds a trusting relationship for next time, you know. (Leonard, clinic 3, initial assessment)

While valuing honesty from health workers, client and staff par- ticipants identified that there were significant barriers to clients’ honest engagement with some workers. These barriers were closely aligned with concerns of fidelity (putting clients’ concerns first) and confidentiality. Clients noted the possibility that information provided to HCV health workers may be shared with OST staff, potentially endangering their access to OST. Participants spoke of rationing their trust in OST workers, providing only minimal or
selective information. In this sense, client participants were wary and distrustful of health workers prioritising their professional concerns and collegiality over and above clients' vulnerability.

With the [OST] caseworker . . . I trust her to a point. . . . I can, you know, go in there and have a cry if I need to about something. But I don't feel like I could give her the details of something 'cause I don't know if it's gonna get mentioned at a staff meeting . . . . The thing is with the staff and the system is they all back each other's back. And if they've got it in for you, they've got it in for you. (Barbara, clinic 2, awaiting or initiated treatment)

I guess the only thing holding me back with clinic staff is I don't speak as candidly about my drug use to them I'm not gonna tell them I had a shot this morning or something because then they won't dose me . . . you have to bullshit them . . . they're all working in the same office (Dave, clinic 2, initial assessment)

I find the clients . . . when they see [the HCV nurse], they tell her different things than they tell us [OST staff] . . . Because she's in a different role now and she finds they, they'll tell her stuff that they wouldn't tell their case worker (Mary, staff, clinic 2)

These concerns were directly raised in relation to the ETHOS trial in relation to confidentiality and global issues of mistrust. Participants concerns about the degree of confidentiality between – and the appropriate separation of – OST and HCV service arms as directly linked to the development of clients' trust in the HCV service and the subsequent success of the ETHOS trial. Confidentiality concerns and lack of trust in OST systems more generally were central to participants' views that OST clients will actively censure their disclosure and ration their honesty with OST, and perhaps HCV, staff for fear of repercussions that may endanger their access to OST. Fear of repercussions was also cited as a reason that OST clients will not engage with HCV treatment in the OST clinic.

So when I started here, I made it clear to them that ETHOS is a separate part of the clinic . . . ETHOS does not go over to that other part [of the clinic]. It wouldn't work. As soon as that confidentiality in there [is compromised] and ETHOS is broken, no-one's gonna trust it to be the way it should be (Hannah, peer worker)

So I really think a lot of people that have trouble with clinic staff and that, it's just because they're still in that mode of "You're behind the fuckin' thing. You've got control of the pump. You're authority. You're no good and I'm not gonna talk to you. I'm not gonna interact with you. Dose me and fuck off." . . . So that's what often holds them back from talking to staff; it's the repercussion, the fear of that if I do, what will happen? They might tell on me! Ah! I might get kicked off . . . So they're gonna speak to someone outside of the clinic. (Lilly, clinic 3, declined assessment)

People are scared that they're gonna be like judged or say they tell their caseworker: "okay, well I've had a shot of speed" and that's what's going to deter people from wanting to get [HCV] treatment . . . People are worried about that on a daily basis . . . I can say a lot of other people, for that reason, are not doing [HCV treatment in the OST clinic]. (Crystal, clinic 2, declined assessment)

In relation to the dimension of competence, particularly regarding interpersonal communication, client participants described the importance of staff dealing with them in a non-judgemental manner and offering practical assistance when needed. Staff participants, identified the connection between providing practical assistance and the development of patient–provider trust.

Just that they understand what you're going through and they just don't, they're not, how do you put it? [Interviewer: Judgmental?] Exactly, yeah, judgmental. And they don't judge you . . . Not at all. And they're like, they're there for you and they listen to you. And they, when you tell them that this is how you're feeling, they believe you . . . It's like they sit there and they go, "Oh shit, like we'll do this for you and that," and they do listen to you, and they do help you. (Jim, clinic 4, awaiting or initiated treatment)

To be able to assist them with [HCV] . . . when they hear that and they hear that there's, there's a helping role, they actually open up a lot more and they start to become more comfortable. [Interviewer: Isn't that interesting? What do you think, what, what do you think that's about?] Just basically you're being proactive towards them. You're actually taking concern in their welfare. And that you're actually going to try and help them sort of process. So that makes them feel, I guess it develops a trust and that this person does, is concerned. And there's support there, and there's help for the client as well. So it all rolls into one. (Teresa, staff, clinic 3)

As an example of strategies used by new HCV clinicians to build trust with OST clients, Anthea exemplified the notion of demonstrating respect and care towards them (related to the dimension of 'fidelity'). Thus she relied on establishing ongoing, informal communication, often about issues unrelated to either HCV or OST; seen as 'competence' in inter-personal communication.

I've spent hours in the dosing line chatting to people, remembering peoples' kids' names . . . The human condition makes us warm to people who remember personal stuff about ourselves so, and I'm pretty interested in people anyway so I think just, you know, at first it might have absolutely nothing at all to do with hep C. You know, "How did you go and where's your little boy? Oh, you've got a broken foot. How did that happen?" . . . "You've got a doctor's appointment. How did that go?" Things like that really, really make a difference in developing a trust. That people feel that they can come and chat to you. And I've done everything within this room from, you know, looked at boils to check for nits to looked at scabby feet, and everything in between. Given advice on sexual health. To establish that I do have information and I, you know, I don't think less of people for whatever they're talking about. And once you've established that relationship, the rest is, is easy. Once they know you . . . And word-of-mouth is, if we get new people here, the people who are already here will say that I'm okay to talk to. (Anthea, staff, Clinic 1)

A small number of client participants spoke directly of experiencing high levels of trust in their relationships with OST staff: someone seeking immediate assistance from her OST doctor after experiencing adverse effects from a drug injection (a proscribed practice for a client on OST); as a catalyst in decision-making about HCV treatment; and as a result of practical assistance and honesty from an OST staff member.

[The ETHOS model] might not work because some people might not think like me and they'd rather go out of their clinic to do things. But I'm really sort of an honest person and, and I'm fair dinkum. Like a few years ago, well when I first started here, I
shot up in my groin and I got really sick. And my thing was I went straight down to my doctor here and said, “Please look at it!” I could have got in big trouble for that but because I told her the truth and I got her to look at it, and da, da, da, da . . . and that’s because I trust what, I guess I trust this clinic. I trust the doctor I have, which makes the world of difference. . . . I trust my doctor here and yeah, I believe if . . . they got a bit more involved with it, the doctors and stuff, I mean they’re pretty busy and stuff but I’d go for it. [HCV treatment] hook, line and sinker if it was here. (Rachel, clinic 1, initial assessment)

[The OST manager] had positive words about it [HCV treatment] and stuff, you know. And for a person to take the time out and actually talk to me about it, I trusted her and I thought, you know, “Well maybe I should give it a go.” (Tracy, clinic 4, initiated or awaiting treatment)

I just, when I met [the OST nurse] . . . she listened to me. . . . And I didn’t piss in her pocket. I just told her how it was. And I was with me girlfriend at the time and we were havin’ a baby together and that. And she gave us all the help we (she) could. . . . And she knew I was on benzos for drinking. . . . And when I got down here [years later], [the OST clinic] wanted me to blow in their bag every day. Like for three months or whatever. [Interviewer: For the grog?] Yeah. Then that stopped. You know what I mean? I said, “Look, I’m on benzos. I’m not drinking.” So they done it a couple of times and then that just stopped. . . . She’s just, just common, like she’ll talk to ya. . . . and she’d listen and that (Barry, clinic 3, declined assessment)

Discussion

The OST setting is a unique and complex environment within the broad health care arena, with strict, if not punitive, regulations and practices and a client group often deeply distrustful of systems of authority. Given the central role trust plays in the provision of effective health care, the introduction of HCV treatment within this complex social and clinical space raises particular challenges and is by no means guaranteed to succeed. Our analysis has endeavoured to outline the principal challenges via the five dimensions of trust present in client and staff experiences of the HCV-OST integrated care model.

These findings suggest that the notion of “global” trust was central in shaping client participants’ views of the trustworthiness of HCV services provided in the OST space. Numerous experiences over a long period of time and in various settings determined the possible positions that clients took when evaluating this new service offered in a deeply mistrusted place, particularly in relation to their assessment of the fidelity and confidentiality that this service could offer them. In turn, HCV staff participants developed strategies to demonstrate the practical assistance, confidential service and honest relationships that they could offer.

These results are important as previous trials of integrated care for people with HCV have paid little attention to place. While acknowledging the limitations of current models in providing fragmented care that does not meet the complex needs of clients (Kodner & Spreeuwenberg, 2002), trials of integrated care for HCV have focused on clinical outcomes or matters of implementation, such as service mix and education needs of clients (Ho et al., 2008; Knott et al., 2006; Tait, McIntyre, McLeod, Nathwani, & Dillon, 2010). Given the analysis presented here, these factors will not address issues particular to the OST space that will effect implementation of HCV care.

There is little within existing OST operations or culture likely to challenge or dislodge the generalised sense of mistrust that currently prevails. As long as the client population continues to be stereotyped as ‘inherently dishonest drug users’ and access to OST caste as a privilege – with clients’ treatment tenure experienced as fragile and precarious – the ‘power of the pump’ will remain both a pragmatic and symbolic ‘bottom line’. Added to this, HCV is noted as clustering “among the most impoverished, disadvantaged and stigmatised members of almost any population”, thus highlighting the socio-economic and cultural marginalisation and disadvantage experienced by many living with HCV (Fraser & Seear, 2011, p. 5). Hence clients’ decisions about trust in the OST space are high risk ventures for people with little power or resources to negotiate outcomes.

These data suggest a number of policy and programmatic issues to address in planning and implementing integrated services in distrusted spaces. These data suggest that to build a trustworthy service within a space historically distrusted by its clients requires an understanding and an explicit acknowledgement that health workers may well be perceived as representatives of a deeply mistrusted system. In establishing an integrated service, the ways and means by which confidentiality will be maintained between the two treatment systems needs to be embedded in clinic policy and staff practice as well as thoroughly and repeatedly explained to those at risk from its violation: the clients. This not only serves its own end but, just as importantly, demonstrates an understanding of, and a responsiveness to, clients’ concerns. Peer workers can play an important role in the building of trust within the new service by speaking to clients’ concerns, reinforcing professional boundaries for clients and staff and promoting stories of success in HCV care and treatment (Crawford & Bath, 2013; Galindo, Maginnis, Wallace, Hansen, & Sylvestre, 2007; Norman et al., 2008). However, peer workers too must negotiate a similarly honest means of working between OST and HCV systems.

A second key issue for service integration relates to preparedness for changes in staff-client relationships giving changing organisational contexts. Restricted resourcing of OST clinics means that much-needed ancillary services are generally not available and service cultures have developed to revolve around the dispensation of pharmacotherapy rather than recognition of the therapeutic benefits of social engagement between clients and staff (Fraser & Valentine, 2008; Smith, 2011). Offering HCV treatment that incorporates provision of practical assistance, non-judgemental and honest conversations and so forth allows the social and clinical spaces of OST to be contested and remade, and hence, the meaning and practice of place potentially transformed. The introduction of a new treatment modality and form of care (i.e. HCV) can disrupt the minimal, routinized interaction typical of OST, allowing other, more holistic and therapeutic forms of engagement to develop between client, worker and system (Rance & Treloar, in press). It is important to recognise and prepare staff for such possibilities as their views, skills and therapeutic orientation to clients may have become constrained by the restricted roles and organisational cultures in which they have previously operated (Treloar, Newland, Rance, & Hopwood, 2010).

Our qualitative study should be interpreted with caution as the experiences of our participants may not be reflective of the experiences of others, particularly when HCV care is operated in OST clinics with significantly different organisational cultures, practices and resources. However, we did seek (and have presented here) experiences from a range of clients including those who had decided to engage with HCV care in this space, and those who had not. In addition, we have taken care to look for and present disconfirming cases (Patton, 2002) where trust between clients and staff in OST were facilitative of HCV and other health care.

The OST setting appears to present unique challenges to the establishment of honest, transparent client-provider communication; challenges which in turn hold implications for the successful
integration of HCV care and treatment. In the context of a treatment regime where infringements are penalised by the withdrawal of takeaways doses or even discharge from the service, the fear of reprisals was widespread and substantive. The ‘power of the pump’ is a powerful organising and omnipresent figure for client participants and needs to be competently dealt with to alleviate concerns in any future OST–HCV co-located services.

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