National Prisons Hepatitis Network – Minutes of the 2018 Annual Workshop

November 2018, Kirby Institute, UNSW, Sydney

The Meeting commenced with a **progress report** by Professor Lloyd regarding the National Prisons Hepatitis Network activities over the preceding 12 months. In relation to the action items from the 2017 meeting, the progress was summarised as follows:

1. Enhanced surveillance – 'bottom up' figures (gathered from Network members) regarding the number of prisoners assessed and/or treated in the first 12 months of DAA access via the PBS were summarised. It was estimated that 2052 HCV treatments were initiated within the custodial setting from March 2016 to April 2017, accounting for 6% of all HCV treatments prescribed in Australian during this time frame. In discussion, the current limitations in surveillance were noted including: a dearth of knowledge regarding those at risk, those offered and/or completing HCV testing, and the proportion of those infected who were linked to prison based viral hepatitis care
2. Establishing Key Performance Indicators (KPI) for prison-based HCV services: It was noted that only two states (NSW and Victoria) had designated KPIs for DAA treatment initiations. In discussion it was suggested that consideration of KPIs at the individual prison level may be required to account for heterogeneity in HCV services within certain jurisdictions, and also between publicly and privately-operated prisons.
3. A National Prisons HCV Service Dashboard was created following the 2017 meeting including designation of key characteristics of existing services (nurse-led, specialist-led, GP-led etc) with a view to annual updates with contemporary data. In discussion, it was flagged that this dashboard may need to be resolved at the individual prison level to account for heterogeneity in HCV services within certain jurisdictions, and also between publicly and privately-operated prisons.
4. Facilitating HCV treatment scale up: Education was identified as a priority at the 2017 meeting to facilitate HCV treatment scale up. Various activities were reported directed at prisoners, custodians and clinicians. A coordinated national education initiative was re-endorsed as a priority.
5. Development of the infrastructure and administrative support for the National Prisons Hepatitis Network: An part-time administration officer (Yumi Sheehan) has been appointed. An Executive of the National Prisons Hepatitis Network has also been created, with representation from each state and territory.
6. Advocacy: Whilst advocacy for the prison sector was discussed at length at the 2017 meeting, it was unclear how this would be best instituted. Advocacy was nominated as a discussion point for resolution at the 2018 meeting

Given this backdrop the designated **priorities for discussion at the 2018 meeting** included: i) development of a National Prison-focused hepatitis Education Initiative; ii) development of a National Prisons Hepatitis Surveillance System; and iii) strategies for advocacy for enhanced prison hepatitis Service in each jurisdiction.

An innovative, interactive format for the day was outlined including a range of group activities to jointly explore the three priorities, including: a) speed-geeking session in which selected experts facilitated small group discussions on a range of topics related to HCV care

within the custodial setting; b) World Café in which further larger group discussion and prioritising of ideas in relation to the priorities was undertaken; and c) Open Space Fish Bowl which sought to further facilitate whole group discussion and formulation of action plans. The detailed notes outlining the discussion in these sessions are attached (see Appendix following).

The **finalised priorities** and associated **action items** for the Network, were as follows:

1. Hepatitis C education – the Network members recommended:
    a) Development of prison-focused hepatitis C education including targeted tutelage to prisoners, correctional officers, and healthcare staff
    b) Integration of hepatitis C education with other relevant educational activities including:
        - harm reduction, other blood borne viruses, and prisoner health needs beyond viral hepatitis
    c) A National Prisons Hepatitis C Education Strategy, with:
        - A national scoping exercise to inform the content of strategy
        - Coordinated lobbying of individual state and territories to establish the national hepatitis C education agenda
        - Inclusion of KPIs / targets for participating jurisdictions
    d) Improved education with regard to the transition to community on release, including:
        - Prisoner education to ensure continuity of hepatitis C care (where appropriate) and managing ongoing transmission risks on release
        - Transitional support sector education to understand the high prevalence of viral hepatitis amongst their clientele and to prioritise linkage to care
        - Integrated services recognizing the large numbers cycling between the community and custodial settings
    e) Enhancement of the role of peer educators in the prison sector, potentially including both prisoners and correctional officers
    f) Implementation of hepatitis C educational strategy:
        - Establishment of national prison hepatitis network education sub-committee with representation from each jurisdiction
        - Evaluation of effectiveness of education programs
2. National prisons hepatitis surveillance – the Network members recommended:
    a) Broadening and revision of the National Prisons Hepatitis Dashboard
        - Designation by individual prison to account for intra-jurisdiction heterogeneity
        - Description of hepatitis service characteristics, including resources and activities
    b) Development of a prison surveillance program for the hepatitis C care cascade:
        - Detailing HCV testing to SVR12 outcomes
        - Identification of HCV reinfection
        - Resolution of the best and most feasible methods, including: i) an annual survey ii) an observational data registry; or iii) data linkage
3. Advocacy for enhanced hepatitis C testing and treatment in the prisons – the Network members recommended:
    a) Initiatives to be targeted at each of level of bureaucracy and prison management

- State and Federal government
- Ministries of Health and Corrections
- Prison health service managers and prison governors

a) Comparative data was considered key for advocacy for improved hepatitis service resourcing
b) Resolution of key high level administrative barriers to prison-based HCV care is required to inform priorities for advocacy
c) Advocacy for KPIs in the hepatitis C care cascade, including
   - Establishing benchmarks for HCV testing, assessment, and treatment
d) Advocacy to the broader community regarding public health benefits achieved through prisoner healthcare

Appendix: Detailed notes from the discussions

Hepatitis education:

The key points discussed regarding prison-focused hepatitis education included:

1. Tailored education should be delivered to all groups within the custodial setting including prisoners, corrective services staff and prison healthcare personnel, with a particular focus on incoming members of each group under a unified banner 'Everyone needs to know something about Hepatitis C'. Key messages for each group should include:
    a. Prisoners:
        i. The need for frequent hepatitis C testing in those at risk
        ii. The availability of simplified and well-tolerated DAA treatment regimens
        iii. The utility of harm reduction in the custodial setting including OST and bleach for the sterilisation of injecting equipment
        iv. Enhancing prisoners' self-worth and ownership over their health status
    b. Corrective services staff:
        i. Hepatitis C education to be provided for all new custodial staff including officers, managers, governors, and CEOs
        ii. Ongoing simplified HCV education in key areas including transmission, testing, and the availability of treatment for all prisoners
        iii. Hepatitis C education for parole officers to enhance linkage to care on release from prison
        iv. National HCV Elimination Goals and the potential major contribution of prison-based HCV testing and treatment to that effort
    c. Prison health services staff and other partner staff:
        i. HCV testing as a key element of routine care of prisoners, to be considered at each clinical interaction
        ii. Develop key knowledge criteria regarding HCV to minimise the existing variation between different prison healthcare services
        iii. Encourage discharge planning which includes viral hepatitis care on release to the community
2. The potential benefits of formal and informal peer-based education within the correction section to increase knowledge, testing and treatment scale up.
3. The development of KPIs to determine the impact of education initiatives i.e. rates of HCV testing amongst prisoners received into the custodial sector, targets for frequency of viral hepatitis education sessions to new and existing staff.
4. A national policy for prison hepatitis C education was recommended, including with the goal of rectifying the existing fragmentation within and between jurisdictions
    a. This should include expectations that education is provided similarly in both publicly and privately-operated prisons
    b. Collaboration between heath and correctional services is necessary to develop an education agenda which is relevant and applicable (an example of a collaborative action plan was identified in South Australia which included the utility of assigning responsibility to key stakeholders

Challenges impeding hepatitis C education within the prison were identified as:

- Fragmentation (i.e variation) between and within jurisdictions

- The lack of a national hepatitis C education benchmarks and recognition of the need for a national policy as well as potential discordance between expectations of such a national policy and limitation in state or territory resourcing which may threaten its relevance
- Lack of evaluation regarding the efficiencies and/or deficiencies of existing education initiatives
- Failure to provide tailored education to all key groups within the prison setting
- Lack of financial resources to develop and deliver education including the uncertain role of pharmaceutical sponsorship in the prison sector
- Discordance between HCV treatment programs and the limited availability of harm minimisation including NSPs could result in mistrust in the prisoner community

Potential solutions to promote prison-focused hepatitis C education included:

- A scoping exercise to assess outcomes from previous education initiatives to identify successful programs for continuation and expansion
- Utilisation of information technology and/or media within the prison to deliver hepatitis C education to prisoners
- Where possible, funding provided to existing NGO program providers by an application process to improve HCV education in prisons
- Enhancing connections between prison-based healthcare services, parole officers and community transition organisations
- Engagement of prisoners and correctional services officers in contributing to the formation of an education policy to ensure relevance amongst intended audiences
- Development of KPIs regarding educational activities
- Inclusion of education activities on the prison dashboard for comparison between states and territories

Prison hepatitis surveillance:

HCV surveillance in the custodial setting was considered important to determine the adequacy of existing prison-based HCV services and the areas requiring revision to improve hepatitis C testing and treatment across the sector. The key points regarding surveillance made by the delegates included:

1. Enhanced surveillance of the entire HCV care cascade including:
    a. Number entering judicial system; number at risk of HCV; number tested for HCV; percentage HCV seropositive; percentage HCV RNA PCR positive; frequency of linkage to care; frequency of HCV treatment initiation; frequency of cure.
    b. Data should be collected at individual prison level including both privately and publicly operated facilities.
2. Protocolised HCV RNA PCR testing amongst cured prisoner to detect reinfection.
3. Development of methods to capture the linkage to care on release as prisoners transition to the community, including:
    a. Prisoners released from the custodial setting with untreated HCV
    b. Prisoners released whilst on DAA treatment
    c. Follow up HCV PCR testing of those cured in the prison setting to assess for reinfection

4. Extend the current triennial National Prison Entrants Blood Borne Virus Survey to an annual survey
5. Consideration as to whether novel strategies such as finger-prick pint of care testing or incentivisation could improve engagement in testing and treatment, linkage to care on release, or ongoing testing
6. The potential for the Council of Australian Governments (COAG) or Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections (MACBBVS) to establish a national authority to oversee a central registry which receives surveillance data from each state and territory to:
    a. Improve accountability through state and territory KPIs
    b. Standardise data requirements across all jurisdictions
7. The clear potential of surveillance data to underpin mathematical modelling to future program performance in each jurisdiction and nationally, and to inform service change was recognised.

Barriers to surveillance

- No clear funding source to establish a national surveillance program
- Frequent staff turnover, inter-jurisdiction variation in data collection methods, and competing priorities versus other prisoner healthcare needs

Potential solutions to facilitating enhanced surveillance included:

- Utilising PBS data to determine number of prison-based HCV treatments. Prison treatments could be targeted by referencing postcodes or S100 prescriptions which are used primarily in the custodial setting
- Data transfer from electronic medical or pathology record systems and pharmacy records to estimate HCV testing and treatment rates

Advocacy:

The key aspects regard advocacy considered by the delegates included establishment of inter-jurisdiction KPIs and a service dashboard to highlight inadequacies and to advocate for appropriate hepatitis C treatment resources and facilities in each jurisdiction. Many delegates expressed that a national approach would greatly influence meaningful change in regard to advocacy for HCV prison treatment programs. The key points discussed by delegates regarding advocacy included:

1. Advocacy to state and territory service providers for the establishment of hepatitis C care KPIs to:
    a. Ensure appropriate resourcing and funding for prison-based HCV care from state governments
    b. Advocate for parity in services, facilities and resources between states and territories
    c. Establish transparent data regarding KPI performance to be shared between jurisdictions
    d. Set expectations for key aspects of prison-based HCV care including:
        i. BBV testing on prison reception
        ii. HCV PCR testing amongst those identified as HCV seropositive
        iii. HCV treatment initiation rates, per prison, per year

2. Lobbying
    a. Recognition of the importance of the National Strategies (i.e BBV, STI, ATSI Health or Drug strategies) to provide a framework for advocacy issues including testing and treatment of prisoners
    b. Recognition that the prison s will be critical to the national hepatitis C elimination agenda
    c. Lobbying for correctional services involvement in formulation of strategies relating to prisoners, to prioritise healthcare for prisoners, in addition to usual agenda of security and detention
    d. Lobbying to government for a coordinated prison hepatitis strategy including KPIs for testing and treatment
3. Advocacy to prison service providers:
    a. To prioritise the health and wellbeing needs of prisoners
    b. To foster peer education initiatives to increase treatment uptake, and to reduce HCV stigma and incident infections
    c. To engage prisoners to be involved in HCV initiatives to serve their community
    d. To establish the key prison-based health infrastructure to enhance hepatitis C testing and treatment programs, including:
        i. Electronic pathology records in all jurisdictions to improve data quality, avoid unnecessary testing, and facilitate timely engagement in the care cascade despite frequent prisoner movement, and centralisation of data to improve testing efficiency
        ii. Electronic medical records in all jurisdictions to improve data quality, and manage continuity of care despite frequent prisoner movement and centralisation of data to improve treatment efficiency
4. Removal of S100 prescribing requirements
    a. The dual classification under S85 and S100 prescribing allows reimbursement for HCV DAA therapy to be the responsibility of the federal government, so that individual prison healthcare budgets are not overwhelmed. Irrespective of the intention of this dual classification, it was discussed as a limiting factor to increasing HCV treatment throughput.
    b. The S100 prescribing requirements were discussed as a barrier to HCV treatment scale up in certain Australian jurisdictions, particularly where prison-based GPs were responsibility for viral hepatitis management with limited specialist involvement
    c. Further work is required to determine the impact of the dual classification and the benefits and risks of recategorization.
5. Recognition that rather than considering prisoners as a fixed group, advocacy should be for people living with hepatitis C who spend time incarcerated.