NPHN
NATIONAL PRISONS HEPATITIS NETWORK

National Prisons Hepatitis Network's Fourth Annual Workshop 2022

Rapporteur's report

FAST FACTS	
Date & time	Friday 2nd December 2022, 10am-4pm
Land	Gadigal
Venue	Pullman Airport Hotel Sydney NSW
Format	In-person
Number of participants	56
Number of organisations represented	32
MC	Andrew Lloyd
Organising committee	Yumi Sheehan, NPHN Coordinator Andrew Lloyd, NPHN Chair Alexander Thompson, NPHN Co-vice Chair Mark Stoové, NPHN Co-vice Chair
Event sponsors	The Kirby Institute, UNSW Sydney Burnet Institute Melbourne St Vincent's Hospital Melbourne AbbVie Gilead Sciences
Rapporteur	Rebecca Winter

Welcome, acknowledgement of country and NPHN update

Presenters: Andrew Lloyd and Yumi Sheehan (The Kirby Institute)

Andrew Lloyd commenced the day's proceedings by acknowledging that the 2022 Annual Meeting of the NPHN was being held on the land of the Gadigal people of the Eora nation. Andrew provided a refresh on the existing objectives and priorities of the NPHN and gave an overview of 2022 activities and achievements.

Objectives	Priorities
To **connect key stakeholders from the corrections and justice health sector** across Australia to enhance development of infrastructure for testing, treatment, prevention, and continuity of care for HCV in the custodial sector nationally.	Enhance HCV testing and treatment infrastructure across Australia to increase access to care for people in prisons.
To **support the development of data capture systems** to measure HCV testing and treatment rates in the prison sector across all jurisdictions in Australia.	Establish a model for surveillance of HCV, HBV and HIV risk and infection rates and antiviral treatment uptake in the prison sector in each state/territory.
To **facilitate information exchange and support collaborative health services research**, to drive policy-making for scale-up of HCV testing, treatment, prevention, and continuity of care in the prison sector.	Facilitate collaboration and exchange of information amongst NPHN members regarding HCV testing, treatment, prevention, and continuity of care for people in prison across Australia.
	Advocate for continued scale-up of HCV services including testing, treatment, prevention and continuity of care, in the prison sector nationally.
	Establish a national prisons education initiative to develop a prison-focused HCV education program for people in prison, correctional officers, and healthcare providers in the custodial setting.
	Host networking and information exchange activities, including an annual workshop, virtual events, and a website, engaging all NPHN stakeholders.

The major activities of the NPHN in 2022 firstly included the release and online publication of the *National Consensus Statement on the Management of Hepatitis C in Australia's Prisons*. The consensus statement was launched at the 13th Australasian Viral Hepatitis Conference (Brisbane, Turrbal and Jagera land, 29-31 May 2022). At the same conference, the NPHN hosted a speed-geeking special session showcasing innovative programs from across Australia addressing hepatitis C among justice-involved populations, attracting a large audience. In October, the NPHN hosted a webinar with guest speakers providing an in-depth and contextual exploration of some of the recommendations from the consensus statement. A recording of the webinar can be viewed at https://www.nphn.net.au/annual-workshops. The NPHN also gathered and collated jurisdictional data on in-prison hepatitis C treatment initiations for *Australia's progress to hepatitis C Elimination: annual report 2022*.

Priority project updates: (1) AusHep commenced national prison BBV prevalence data collection in April 2022. NSW, SA and TAS have enrolled 857 participants, and QLD is underway. NT and WA are forthcoming in Q1 2023 while Victoria and ACT are not participating; (2) HepPEd, which has been delayed by jurisdictional ethical approval and governance processes, has developed prison-focused educational resources based on consultations with nationally representative steering committees formed for each of the target audiences (people in prison, correctional officers, healthcare providers) and is launching a research evaluation in six prisons in 2023. HepPEd is partnering with existing/forthcoming education providers in the prison sector for education delivery and the HepPEd program will then be rolled out in non-study states; (3) The Australian Prisons Pharmacy surveillance (APPs) aims to harness hospital pharmacy despatch record data for real-time in-prison treatment uptake. Scoping interviews have been completed around the country at 22 hospital pharmacies and a protocol and evaluation framework has been developed. These data will feed into the NPHN web-based dashboard for display of real time treatment initiations for key stakeholders in the sector.

The above projects will continue to be prioritised by the NPHN into 2023, alongside the annual workshop. Andrew and Yumi extended thanks to the NPHN Executive, acknowledging outgoing members from 2019-2022 (Michelle Kudell, Katerina Lagios, Robert Kemp, Graeme Macdonald, and Chris Wake) and welcoming new members from 2023 (Graham Kraak – QLD, and Deb Siddall - TAS).

The role of prisons in hepatitis C elimination

Presenter: Mark Stoové (Burnet Institute)

Mark presented research data to demonstrate an overall decline in DAA treatment initiations in Australia, driven by substantial declines in community settings and declines in prison settings in some states since 2018. The documented decline is attributed to the aftereffects of the original 'warehousing' – the pool of ready, eligible and willing people who were treated with DAAs between 2016-2018 which is now exhausted, and new strategies are needed to find the estimated remaining 110,000-120,000 people. However, treatment initiations are declining more rapidly in the community than in prison – prisons are essentially propping up the numbers (41% of all treatments in 2021). In this context, prison hepatitis services will become increasingly important to fortify Australia's strategy to meet hepatitis C elimination goals.

While acknowledging the surprising challenge of needing to case-find hepatitis C diagnoses in prison settings, and calling for continued attention to the decriminalisation of non-violent drug use and possession offences, there is strong evidence supporting the effectiveness and cost-effectiveness of hepatitis C detection and treatment for people in prison. Australian research has shown that it is cheaper to deliver hepatitis services in prison than in community settings, largely because it is easier to find people who are positive and therefore fewer resources need to be spent to find cases. In the prison setting, people are also highly likely to progress through to treatment, minimising attrition from the care cascade and reducing the cost per treatment episode. However, the achievements of in-prison hepatitis testing, assessment and treatment services are diluted by the number of re-exposures which underscores the need to ensure high coverage opioid agonist treatment (OAT) and to keep prison NSPs on the agenda.

NPHN Consensus Statement Overview

Presenter: Alex Thompson (St Vincent's Hospital Melbourne)

Alex gave an overview of the NPHN Consensus Statement on the management of hepatitis C virus in Australia's prisons. The objectives of the consensus statement are:

1. to present a critical analysis of the evidence supporting the importance of hepatitis C prevention, testing, and treatment for people in prison - both for the individual, as well as for national elimination efforts;
2. to describe current best practice recommendations for the diagnosis, clinical management and continuity of care of prisoners living with hepatitis C, as well as policy and practice to support hepatitis C prevention; and

3. to propose key performance indicators for the prevention, testing and treatment of hepatitis C in Australia's prisons.

The Consensus Statement makes 24 evidence-based recommendations and nominates key performance targets and indicators to set best practice standards in HCV diagnosis, treatment, and prevention in Australian prisons. The recommendations aim to increase testing rates and linkage to care, simplify the hepatitis C assessment and treatment algorithm (cirrhosis assessment), simplify the definition of cure, and expand treatment eligibility. The statement is a 'living document' and will be reviewed and updated during the latter half of 2023 following further consultation with Hepatitis Australia, AIVL and NACCHO.

Hypothetical – 'Geoffrey Robertson' style

The purpose of the hypothetical was to explore the practical application of the recommendations from the *Consensus statement on the management of hepatitis C in Australia's prisons* from the perspective of different stakeholders. The scenario featured a fictional character, 'Joey', who had newly entered prison for his first incarceration and had a history of injecting drug use and mental illness. Panel members representing a diverse spectrum of stakeholders (Table 2) were invited to give their views informing the processes, practices and ideals of the reception health assessment, hepatitis C testing, referral and treatment assessment – as well as wrap-around health service provision – in a hypothetical prison. Panel members highlighted the experience at reception for people imprisoned, the strengths and limitations of different policy approaches (e.g., opt-out testing: normalisation versus the potential for coercion), relationships and building trust and the role of stigma and unconscious bias in these clinical pathways, the timing of screening and minimising the number of appointments and blood draws (e.g., one blood sample only, reflex testing and full panel performed), and the necessity of obtaining a cure result after treatment. Panel members also discussed the overarching priorities for correctional and health providers and the benefits and limitations in having a sole employer structure for these workforces (versus delineated health and correctional organisations), which are also manifested in the challenges in providing continuity of healthcare when people leave prison (and return). The recording of the interesting and engaging hypothetical can be accessed here: https://www.nphn.net.au/annual-workshops

Table 2: Panel members and their assigned roles in the hypothetical

Panel member	Role in hypothetical
Andrew Lloyd	Moderator
Anonymous	Person with lived experience of incarceration
Charles Henderson	Advocate (people who inject drugs)
Russell Shewan	Consumer advocate (people living with hepatitis C)
Alex Thompson	Specialist physician working in a prison hepatitis service

Trish Collie	Health provider working in a prison health service
Chris Wallis	Prison hepatitis nurse practitioner
Colette McGrath	Prison hepatitis service administrator
Renee Smith	Correctional Service administrator
Bianca Prain	Health ministry senior administrator
Mark Stoové	Prison health researcher

What's new with point-of-care testing?

Presenter: Jason Grebely (The Kirby Institute)

Jason gave an overview of the current landscape in relation to rapid and point-of-care (POC) hepatitis C testing technologies and reflected on their application in prison settings. Given the often complex and lengthy process to diagnosis using traditional venepuncture with samples processed in offsite laboratories, POC testing offers a simplified and more streamlined pathway minimising potential delays.

The Cepheid GenXpert platform offers quantitative RNA results from a capillary blood sample obtained by fingerstick and has excellent specificity and sensitivity[1]. The test has approval for diagnostic use from the Therapeutic Goods Administration, making it a game-changer in terms of streamlining diagnosis and the potential for roll-out on a large scale. The utility of the Xpert HCV RNA VL test in prisons has been demonstrated in the PIVOT study which recorded higher uptake, quicker diagnosis and quicker treatment initiation among people in prison than standard care [2], as well as being acceptable to participants [3]. The Commonwealth government have funded the Kirby Institute to scale-up the roll out of hepatitis C POC testing over three years using the Xpert HCV RNA VL. Forty sites are currently active in five jurisdictions, testing blitzes (high intensity test and treat campaigns have been performed at nine prisons, 5,283 people have been tested (of which 3,368 were in prison) and infection has been detected in 619 people. Following diagnosis, participants are referred to standard care: treatment uptake has been 73% in the community and 86% in prison.

OraQuick is currently the main rapid hepatitis C antibody test on the market, but its application in Australia is limited by the lack of TGA approval for use in the diagnosis of hepatitis C exposure. Advocacy efforts are ongoing for approval and Medicare listing. Rapid antibody tests have application for screening populations which have low hepatitis C prevalence, followed by confirmatory RNA testing. Jason shared the preliminary results of a costing analysis using different configurations of test types and highlighted that the cost per treatment initiation when using POC hepatitis C antibody testing with reflex POC RNA testing and consideration of treatment experience was significantly cheaper than both standard care and universal RNA POC testing in prison, NSP and drug treatment settings [4]. However, the costings are subject to change depending on the population hepatitis C prevalence. The models indicate that POC RNA testing only becomes cheaper per treatment initiation than standard of care when the population hepatitis C antibody prevalence is higher than 35%, and is only cheaper than antibody screening/RNA confirmation and consideration of treatment history when antibody prevalence is over 79%.

Jason proffered that antibody screening and RNA confirmation conferred the benefits of both cost and time savings (as unexposed individuals can be detected in 5-20 mins) and is less resource intensive, making it a suitable approach for high intensity testing strategies (e.g., like the Kombi Clinic have undertaken at some prisons in QLD). Other POC testing methods include dried blood spots (DBS) which can be performed with minimal training, in non-clinical settings, have excellent specificity and sensitivity and don't require refrigeration or immediate processing. The NSW DBS Pilot study tested 7,392 people between 2016-2020 detecting HCV prevalence of 15% overall (14% in prisons) and an overall treatment uptake of 45% (63% in prisons).

Diagnostics in the future may include the Insti antibody test which returns a result in just one minute, and novel collection devices such as the BD Microcontainer® MAP microtube and Microvette® automated processing tube. The roll out of POC testing should help to improve testing uptake in prisons through improving acceptability and cost-effectiveness and may facilitate the exploration of sample collection in non-clinical areas of the prison.

Jurisdictional updates

Representatives from each state and territory were invited to give a brief jurisdictional update.

Jurisdiction	*Presenter/s*	Key/summary points
NT	Sally Greer Anshul Kaul	2019-2023 priority action areas: (i) education and prevention, and (ii) early treatment, care and support. Increased HBV and HCV testing since early 2020 (result of systems change). High percentage (68-96%) of new receptions tested for hep C since March 2020. Of those tested, approximately 1-2% Indigenous and 11-12% non-Indigenous tested positive. Darwin CC – 1,100 people imprisoned, 85% ATSI, sentenced and remand prison, males and females. Nurses all have portfolios (e.g., cardiac, BBV). Screening for early medical conditions. Reception nurse inboxes portfolio holder. STI panel and BBVs ordered. Straight to hep C RNA test if history indicates. Telehealth and liaison with specialists. Eight-week treatment regimen currently the preference. A community-based nurse follows people when they are released (currently ECA funded). Currently 30 people hep C antibody positive and none have detectable viral load.
VIC	Chloe Layton Anne Craigie	COVID-19 impacts were dramatic and continued through 2022. Time excluded from prison plus local lockdowns. New maternity leave backfill positions to be trained (1.5 FTE). Lengthy process for entry to prisons (COVID-19 rapid antigen testing and risk screening causing delays at the gatehouse). Quarantine requirements for people incarcerated impacted timely hep C testing, further complicated by furloughing and re-deployments of prison/health staff. Clinical care overview – referrals have dropped off in the Statewide Hepatitis Assessment and Treatment Program due to absence from prison sites reduced visibility, plus prison health staff are burnt out and still occupied by COVID-19 requirements. Case-finding methods include auditing OAT lists. Utilising high quality testing process – reflex testing Some re-exposures/re-infections being detected. Intensive client support – a lot more complexity, transitional support, co-morbidities, mental ill health. Changes in practice: (i) new Nurse Practitioner accreditation (Anne) allows for almost complete autonomy, (ii) quarantine requirements got reduced 6-8 weeks ago (Oct 2022), (iii) SVR4 testing to optimise cure results before they leave prison. St Vincent's Hospital Melbourne contract for viral hepatitis care in Victorian prisons ends on 30th June 2023. Re-tendered and outcomes not yet announced. Post-COVID-19 restrictions, collaborating with Victorian Integrated Hepatitis Nurses to offer testing and treatment to community corrections clients through a local provider (catchment based).
SE QLD	Chris Wallis	Chris (Nurse Practitioner) was the sole regional hepatitis C operator in south east Queensland until the recent appointment of a BBV clinical nurse. Relatively lucky with COVID impacts and was able to continue largely as per usual. Impacts were related to external clinical services. E.g., liver imaging service - quarantine on return to prison was a disincentive. Same-day treatment by Nurse Practitioner where possible; telementoring model when review is required. 2022 saw 523 treatment initiations (largest percentage in Wolston and Borallon). 16 people referred for specialist management (trending down). The autonomy of the Nurse Practitioner appointment compresses the care cascade, minimising opportunity for patient attrition. Roll out of stage 2 OAT from 1st July 2022 – capacity slowly building. Point-of-care testing – e.g., Kombi clinic prison high intensity test and treat campaigns and national program (Kirby). Growth in prisoner numbers: 4500 in West Moreton Hospital and Health Service, adding 1100 bed capacity 2023/2024. Insufficient medical clinic infrastructure (paper records). Increasing HCV re-exposure and re-treatments. Loss to follow up is a persistent issue making linkage to care in the community a crucial focus. One such effective model is that adopted by QuiHN which employs a nurse transition worker who engages people before they are released from prison. Still no access to sterile NSP and cleaning equipment.

TAS	Ben Thompson Deb Siddall (on behalf of David Onu)	A standing MoU between the departments of justice and health makes communication and collaboration simpler and less bureaucratic. Small team of dedicated health staff, no allocated hepatitis C nurse. Hepatitis C care is shared with RHH Liver Clinic. COVID hit Tasmania hard. In 2022 there were 23 DAA prescriptions dispensed (down from 44 in 2021 and 76 in 2020). Outbreak management. AusHep - ~170 tested, prevalence 3.5% (used to be approx. one-third a decade ago). HCV case identification relies on a manual review of files by Deb – no dedicated hepatitis C nurse to run clinics and testing etc. Population are keen and engaged. Only 2 refusals for AusHep participation. Keen to see a PNSP, but not using the Canada model. Workforce shortages are across the board, but in a small jurisdiction, have a considerable impact.
SA	Tom Turnbull Andrew Wiley	3304 people in custody (public = 2,377, private = 927). Testing about 25% of admissions (av. 118 per month), all venepuncture. Some preliminary AusHep data presented – overall low RNA prevalence 1-2%
NSW	Colette McGrath	Case study of Junee prison (private): 6-7% hepatitis C RNA prevalence, reflecting recent achievements in the prisons sector. Junee's hepatitis C response: small number of acute infections detected. Rapid response deployed to prevent a larger outbreak involving collaboration between Justice Health NSW, GEO Group, Flinders University and The Kirby Institute. Components of rapid response included health promotion (posters, staff education, harm reduction magazine, testing promotion and review of Fincol/condom access), testing (identified people at risk and tested in accommodation units using 5 point-of-care machines accompanied by a small questionnaire regarding risk behaviours). People detected as hepatitis C positive were channelled into existing standard of care pathway, developed over several years. Sixty-five percent of people in Junee prison were tested, of whom 8% (44/571) had detectable hep C RNA. Of these, 93% reported in-prison injecting drug use and 38% reported a previous hepatitis C treatment. Outcomes – no significant outbreak detected and concluded Junee not too different from other prisons. Dried blood spot testing strategies are being investigated to support ongoing testing.
WA	Joy Rowland	WA has the benefit of a single, state-wide electronic medical record system and a centralised BBV coordinator (a hepatitis C nurse located in head office who does site visits and undertakes a champion role). However, the structure of the WA prison system requires working with multiple departments so there are differing requirements based on regional jurisdictions. The starting point for staff education and clinical care is that hepatitis C is everybody's business. Clinical interactions are holistic – not single disease focussed. The most streamlined model is when treatment is GP-prescribed, then dispensed and initiated. 2022 saw a lower number of people tested than the same period in 2021. Prevention – roadblocks with OAT, as many want it but not all are eligible based on existing opioid dependency. Tricky to strike a balance between harm reduction and managing dependency. 'Opt in' for staff to follow hepatitis C clinical pathway. Push for site champions. Remand challenges – how to manage rapid turnover and linkage to care, trying to make it as easy as possible to engage in the care pathway. Overall hepatitis C prevalence is estimated to be 8.5% in the WA prison system.

Australian Harm Reduction in Prisons Working Group

Presenter: Stuart Loveday (officially retired)

Stuart Loveday gave an overview of the Harm Reduction in Prisons Working Group, which is auspiced and propelled by the Drug Policy Modelling Program at UNSW, chaired by Prof Alison Ritter. The secretariat is Liz Barrett. The inaugural meeting was held in June 2019 with eight people from six organisations. The key aim was to scope the appetite for getting prison needle and syringe programs (PNSPs) back onto the public policy agenda. As of November 2022, there are 33 members and the group acts as a forum for harm reduction advocates to work together on shared priorities. The purpose has evolved and now operates to also provide input on strategies to achieve the elimination of hepatitis C in prisons (via harm reduction) through sharing information, coordinating efforts, and advocating. The structure is informal which allows justice/health department employees to participate without approval or being representative of their organisation/s.

To date, the Prisons Harm Reduction Working Group have shared materials and experiences which have supported harm reduction practices; consulted legal experts about overcoming hurdles to implementing PNSP; facilitated online forums; fostered relationships with international practitioners with experience in implementing harm reduction in prison settings (e.g. Canada, France); conducted a mapping exercise documenting harm reduction activities/programs in prisons in each Australian jurisdiction; currently drafting a harm reduction consensus statement focused on making recommendations on the implementation of jurisdiction-wide initiatives/programs. The aim is to launch the document at the Harm Reduction International Conference (Melbourne, 16-19 April, 2023). Also planning on facilitating a PNSP-focused event at HRI23, however currently have no funding to support this. Potential strategies include bringing overseas corrections workers to Australia to facilitate information sharing peer-to-peer.

Talking points: a summary of key issues arising in delegate discussions throughout the day

Prison needle and syringe programs (PNSP)

- Keen interest in advocacy for an investment case for prison needle and syringe programs (PNSPs) was noted, similar to that which was calculated for the public health and financial impact of community NSPs in 2002 and 2009. The update on community NSP return on investment is due; perhaps as part of this include prisons?
- Interest from Commonwealth Dept that the PNSP is on the table for discussion.
- A major barrier to PNSP implementation in Australia is the opposition from correctional services unions. PNSP has been implemented in federal prisons in Canada – perhaps consider seeking funding for a correctional worker peer-to-peer speaking tour. Other countries – including Moldova - could also be considered, although language can be a barrier.
- Modelling in progress suggests the potential for a reduction in hepatitis C incidence in prisons following implementation of PNSP.

Terminology and stigma

- A call to no longer use the term 'reinfection' which places blame on individuals but rather 're-exposure' which is a preferable term.

Patient data management system challenges

- All jurisdictions have differing health data management systems, screening and referral processes including pathology and assessment for treatment, as well as variation in delegation for responsibility for aspects of patient management. These idiosyncrasies present locally unique challenges for improving patient flow and minimising attrition from the care cascade. For example, in SA and QLD health data in prisons are (still) paper-based, in WA clinicians have difficulty in retrieving individual test results which requires text input from the pathology provider and is incongruous with other clinical data.
- Ensuring information and medication flow is challenging when someone moves between a public and private prison.

Meeting consensus statement recommended KPIs for testing and treatment

- What accountability is there for jurisdictions to meet the recommended targets?
- KPIs can benchmark the resourcing requirements of prison health services and be utilised as a basis to advocate for more resources. KPIs are evidence-based and put forward to enable targets for implementation; states and territories will need local knowledge and inter-jurisdictional support to achieve these.

OAT practical challenges

- Key issue is access to OAT in the first period when newly incarcerated. Lack of prescribers, ageing workforce, access issues. Timely initiation/continuation of OAT on entry and at release is challenging.
- Limit to number of OAT 'places' and eligibility requirements such as minimum time remaining on prison sentence.
- SE QLD prison, 600-800 on OAT – not practical (aspiration versus reality). Interesting discussion here on person-centred care, OAT options, new vs existing drug dependency vs ethics of treatment and balancing harm reduction vs creating a new dependency.
- OAT initiation in prisons is often a punitive process. Barrier of dispensing fees when released to continue medication.

- Addiction medicine/viral hep disjointedness and requires a long-term reform agenda.

Knowledge gaps

- Reception testing coverage not known for many jurisdictions. While AusHep is providing some much-needed surveillance for prevalence insights, this is an important data gap.

Round table discussions: key themes

1. Addressing infection and re-exposure

1.1. Need to integrate prevention and harm reduction with testing and treatment efforts in the prisons.
- 1.1.1. Prisons as a venue for infection and re-exposure – a high priority
- 1.1.2. Ready access to harm reduction measures in prisons, including OAT and PNSP
- 1.1.3. PNSP implementation requires leadership, not permission
- 1.1.4. Medically-supervised in-prison injecting room

1.2. Other in-prison strategies
- 1.2.1. Need to increase testing coverage at reception and adoption of universal opt out screening. Tier 1 assessment should happen for everyone within 1-2 weeks of imprisonment.
- 1.2.2. Education/information
  - 1.2.2.1. Foster and promote peer education/peer champions
  - 1.2.2.2. Improve knowledge of hepatitis C status – to decrease risk behaviour.
  - 1.2.2.3. Improve understanding of nuanced risk for transmission – people saying they haven't shared needle/syringe, but have got reinfected.
  - 1.2.2.4. Teaching needle/syringe cleaning techniques for people in prison
  - 1.2.2.5. Staff education (mechanism to reduce stigma)
- 1.2.3. Universal opt-out testing (equivalence of care – Dr Jenny Hoy, Alfred Hosp, syphilis testing in community)
- 1.2.4. Eliminate hepatitis C to low rates through the combination of high intensity test & treat strategies and then a maintenance screening program, along with scale-up of treatment to achieve TasP.
- 1.2.5. Lowering barriers to testing, diagnosis, treatment, removing need for APRI, fibroscan and ensuring rapid pathways to treatment.
- 1.2.6. Improve OST access
- 1.2.7. Address unsterile tattooing

1.3. Reduce barriers to DAA prescription
- 1.3.1. People aged under 35, no cirrhosis could go straight onto treatment
- 1.3.2. Expand s100 to community pharmacy and doctor's list for difficult to treat people.
- 1.3.3. Retreat re-exposure cases without waiting for genotype result

1.4. NPHN role
- 1.4.1. Coordinate discussion and advocacy, lead an agreed framework and protocol
  - 1.4.1.1. Advocacy to influence hierarchy (commonwealth or state); lobby office of prison inspectors (for gaps reporting and lobbying to govt), group against torture in prisons
- 1.4.2. Advocacy for PNSP; present a concrete program (e.g., entry bundle: toothbrush, razor, sterile needle/syringe). Potentially target Serco or GEO (i.e private) prisons for a PNSP.
- 1.4.3. Support a community-led reform agenda – what does the community want?
- 1.4.4. Supporting research agenda
  - 1.4.4.1. Devise and trial different models of care, feasibility studies (e.g., catchment style model with LHS/PHU/HHS)
  - 1.4.4.2. Demonstrate to unions that custodial officers will be safer with PNSP
  - 1.4.4.3. Coordinate consistent national data collection and reporting for new infections and re-exposures
  - 1.4.4.4. Documenting jurisdictional differences in service provision
- 1.4.5. Provide leadership to support service delivery and tackle high-level reform

1.5. Aboriginal and Torres Strait Islanders in custodial settings
- 1.5.1. Address over-representation.
- 1.5.2. Need targeted resources/programs/staff
- 1.5.3. Co-design Aboriginal-specific measures and resources, in particular re-treatments

1.6. Stakeholders: unions, people in prison, peers, state and territory politicians and bureaucrats (dept health/justice), ACCHOs, state-based drug user orgs and service providers, state/territory hepatitis orgs and service providers, researchers, CRC, APSAD, ASCEND

2. Hepatitis C testing and treatment in community corrections

- 2.1. Need for post-release linkage to care – not enough focus on this gap in continuity of care
  - 2.1.1. Potential role for a liaison person or peer worker? Need both peer and clinical involvement in the model of care.
  - 2.1.2. Consider wider primary health care/social needs – comprehensive health check. Explore MBS item number for people leaving prison (e.g. free health check post-release). Integrate naloxone provision and information.
  - 2.1.3. Encourage connection to community health care
  - 2.1.4. Aboriginal and Torres Strait Islander chronic disease health check – add BBVs
  - 2.1.5. One-stop-shop also offering Centrelink contact, medicare, OAT, “health hub”
- 2.2. Need for high-level advocacy to underpin activities
  - 2.2.1. Written into national strategies
  - 2.2.2. Seek Ministerial endorsement
- 2.3. Explore the potential for decentralised healthcare provision
  - 2.3.1. Link CCS to Local Public Health Unit/Local Area Health Service
  - 2.3.2. NPHN role in establishing a model?
  - 2.3.3. Culturally appropriate care is missing – need an Aboriginal Health Worker/Peer
- 2.4. Reward/incentive system for engaging in care (e.g., decrease fines, work development order)
- 2.5. NPHN role
  - 2.5.1. Linking programs nationally and facilitate sharing of information and experiences
  - 2.5.2. Mapping exercise in each jurisdiction
  - 2.5.3. Mobilising stakeholders
  - 2.5.4. Supporting research agenda: establish cost-effectiveness of health intervention
  - 2.5.5. Explore availability of funding for workforce development from Commonwealth. Assign funding to PHNs – support local network priority setting
  - 2.5.6. Support, education of community health services, education for community corrections staff, help facilitate access to POCT
- 2.6. Piggy-back onto National POCT Program
    - 2.6.1.1. Surveillance through samples?
    - 2.6.1.2. How to identify patients to link to care
- 2.7. Key stakeholders: state-based hepatitis orgs, community health services, state and commonwealth govt health/justice depts, social workers who help ‘bridge’ transition from prison to community

3. Other emerging themes

- 3.1. Consideration of drug rehabilitation settings for hepatitis C care
- 3.2. Clarification/articulation of the role of the NPHN in relation to existing work with service delivery

Appendix 1: AGENDA

Time	*Topic*	*Presenter*
10.00-10.10	Introduction and welcome	Andrew Lloyd
10.10–10.20	NPHN updates and acknowledgements	Yumi Sheehan
10.20-10.30	Australia’s elimination strategy: the role of prisons	Mark Stoové
10.30-10.40	National consensus statement for the management of hepatitis C in Australia’s prisons	Alex Thompson
10.40-10.50	Q&A	All
10.50-11.15	Morning tea	
11.15am-12.15pm	Geoffrey Robertson-style hypothetical discussion activity: • Topic: NPHN Consensus Statement on the Management of hepatitis C in Australia’s prisons	Moderated by Andrew Lloyd
12.15-1.15pm	Lunch	
1.15-1.30pm	Latest in point-of-care testing/diagnostics	Jason Grebely
1.30-2.30pm	Project snapshots / jurisdictional updates	Various presenters
2.30-2.50pm	Tea break	
2.50-3.00pm	Prisons harm reduction working group	Stuart Loveday
3.00-3.40pm	Activity – Round table discussions on NPHN priority topics in coming years: • Community corrections • Incidence infection and reinfection • Other	Various facilitators
3.40-4.00pm	Action plans for 2023 and workshop close	Mark Stoové

Appendix 2: Small group round table discussion points

Participants were asked to help set the NPHN agenda for the coming year and were provided with the following potential discussion points.

Issue: enhancing HCV testing and treatment in Community Corrections

- In September 2022:
  - 77,861 people were serving community-based corrections orders in Australia (NSW: 33,844; Qld: 19,257; Vic: 9,995; 385 persons per 100,000)
  - 40,907 people were in prison (202 persons per 100,000).
- HCV testing and treatment has or is being scaled-up in prisons nationally (accounting for more than 41% of all HCV treatment prescribed in Australia), but there has been no coordinated effort for people in community-based corrections, despite larger population size, frequent movement of people between prison and community-based correctional settings, and similar risk profile (Queensland community corrections pilot: 67% history of injecting drug use, 22% HCV RNA detected).

Issue: addressing incident infection and reinfection

- The WHO target for incident infections is <2 per 100 person years (py) amongst PWID.
- In the SToP-C study (2015-19) in the NSW prisons which evaluated scale-up of treatment as prevention (TasP), the incidence among PWID was 39 per 100 py *before* treatment scale-up and 14 per 100 py *after* treatment scale-up
- The SToP-C study also showed the incidence of re-infection among PWID decreased from 15 per 100 py to 9·34 per 100 py.
- Hepatitis service in the prisons continue to document new infections and reinfections.

Questions (for both topics):

- How much of a priority should the NPHN make this topic for the future direction of the NPHN?
- What is the NPHN's role in addressing this issue?
- Who are the other key stakeholders to engage on this issue?
- How do we envisage this issue being addressed by the various stakeholders?
- What are the next steps?
- How do we make a difference in this issue at scale?

References

1. Catlett, B., B. Hajarizadeh, E. Cunningham*, et al.*, *Diagnostic Accuracy of Assays Using Point-of-Care Testing or Dried Blood Spot Samples for the Determination of Hepatitis C Virus RNA: A Systematic Review.* J Infect Dis, 2022. **226**(6):1005-1021.
2. Sheehan, Y., E.B. Cunningham, A. Cochrane*, et al. A 'one-stop-shop' point-of-care hepatitis C RNA testing intervention to enhance treatment uptake in a reception prison: the PIVOT study*. J Hepatol, 2023. DOI: 10.1016/j.jhep.2023.04.019.
3. Lafferty, L., A. Cochrane, Y. Sheehan*, et al.*, *"That was quick, simple, and easy": Patient perceptions of acceptability of point-of-care hepatitis C RNA testing at a reception prison.* Int J Drug Policy, 2022. **99**:103456.
4. Shih, S.T.F., Q. Cheng, J. Carson*, et al. Optimizing point-of-care testing strategies for diagnosis and treatment of hepatitis C virus infection in Australia: a model-based cost-effectiveness analysis*. The Lancet Regional Health – Western Pacific, 2023. DOI: 10.1016/j.lanwpc.2023.100750.