Public Health England

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TURNING EVIDENCE INTO PRACTICE

Improving access to, and completion of, hepatitis C treatment

What is the issue?

New treatments for hepatitis C virus (HCV) infection have shorter, easier, oral regimens with fewer side effects and better outcomes. These represent a real opportunity to reduce the incidence of HCV-related cirrhosis and liver cancer among people already infected with HCV and to remove the virus from the 'infection pool', resulting in reduced transmission among people who inject drugs and the general population. Treating hepatitis C infection is an effective and cost-effective way to substantially reduce prevalence, especially in areas where it is high. Compliance with the new treatments is easier and can be further improved by well-planned support for patients.[1]

Needle and syringe programmes (NSP) and opioid substitution treatment (OST) have been effective in capping English hepatitis C virus (HCV) rates at an average of around 50% among people who inject drugs.[*] There are wide geographical variations, with prevalence much higher in some cities and metropolitan areas. Sustained long-term increases in the coverage of NSP and OST could further reduce the virus's prevalence.

The rate of treatment for hepatitis C in people who inject drugs is extremely low (just 3% of people estimated to be infected with chronic infections access treatment each year) but it can be improved by attention to assessment and engagement pathways, peer and other support, improved staff awareness and attitudes, and better access. Evidence also shows that addressing people's healthcare needs, such as hepatitis, can help them progress in their drug recovery.

This briefing provides an overview of the key issues that local providers and commissioners of drug and hepatitis treatment should consider. Much of the content is based on the far more detailed public health commissioning report of the London Joint Working Group for Substance Misuse and HCV[2] which is recommended to readers.

[*] Most hepatitis C in people who inject drugs has occurred in those injecting psychoactive drugs, especially heroin although those injecting the new psychoactive substances (NPS) are also at risk. There is increasing concern at the risks associated with injecting image and performance-enhancing drugs (IPED). Throughout this document, and in all local considerations of need and commissioning, people who inject drugs should be taken to mean injectors of any and all drugs.

Drug treatment and criminal justice services

While HCV testing rates in the community are now very good, regular offers to re-test people at continuing risk could be improved. Opt-out testing in prisons is about to be rolled out.

Key to improving access to and completion of hepatitis C treatment will be what drug service and other staff do with a positive test: particularly the encouragement and support people receive to get treatment.

Some keyworkers may be reluctant to recommend treatment, aware that its demands and side-effects have sometimes previously impacted negatively on the wellbeing of their service users. Equally, many people have heard about or have experienced difficulties with interferon therapy and may be reluctant to consider HCV treatment. **Good evidence shows that people using illicit drugs can be safely and effectively treated for the virus,[3] and this is much more likely to improve with newer, much easier and more effective treatments.**

Providing effective hepatitis C treatment in a drug service means developing a suitable care plan to support engagement and communication with secondary care hepatology services, or working more closely with support, and sometimes governance, from liver or infectious disease specialists closely integrated within the drug service. This can involve dedicated hepatology clinics, and/or active monitoring of progress, for instance by having phlebotomy (blood collection) available on site in the drug service.

Treatment started in one environment needs to be seamlessly continued and supported when a patient moves to another. This is especially relevant to drug users being sent to or released from prison.

Prompts

1. Do drug treatment and other services, such as needle and syringe programmes (including in pharmacies), offer dried blood spot testing – and regular offers to re-test people at continuing risk?

2. Do drug treatment services work closely with hepatitis C treatment services to ensure that hepatitis C treatment is accessible to HCV-infected people who inject drugs?

3. Are treatment and other healthcare staff trained (and where appropriate given refresher training) to understand the latest on HCV testing and treatment, including what treatments are available and where, what those treatments entail and what demands they will place on patients, and what success rates different treatments have? Can they explain all this to service users clearly and simply, with encouragement?

4. Do staff promote and facilitate access to HCV treatment to service users? Do they help the people using illicit drugs get to treatment, making appointments with them, and putting them in touch with peer supporters who can accompany them?

5. Do patient support programmes include peer support?

6. Is onsite blood collection available in drug services?

Addaction
Using a secondment from the Hepatitis C Trust, Addaction services across the country are training their frontline drug service staff to diagnose and support people with hepatitis C. The goal of the training is to increase testing for hepatitis C and ensure that referrals are made to specialist care for people who are HCV positive.

Spectrum, Wakefield
Spectrum changed from a monthly, nurse-led clinic at the local drug service that had poor uptake, to a more frequent, opportunistic drop-in alongside GP-prescribing clinics at the service. Wellbeing nurses liaise with GPs, take blood samples, prompt when hospital appointments are due and offer support to motivate continued treatment. The nurses are complemented by a buddy service to support and educate people before they are referred for treatment, and to accompany them to hospital appointments.
The new service has referred substantially more people for assessment at the local specialist liver unit.

Hepatitis treatment services

Treating hepatitis in people who inject drugs (even those who continue to inject and risk re-infection) has good treatment outcomes and is cost-effective.[4] Adherence to treatment regimens is generally good and, with new and easier regimens, can only improve.

The NHS has allocated funding for the newer oral treatments for hepatitis C infection but it is not yet clear how quickly they will be widely available.[5] Services can still make their users aware that these improved options are becoming available. Treating health problems such as hepatitis may also support greater recovery from drug dependence. Areas where hepatitis treatment services have ‘reached out’ in partnership with drug treatment services to provide their services in the community can expect to have better treatment completion rates and ultimately lower incidences of long-term (and costly) severe hepatic disease.

Treatment can be provided by hepatologists, gastroenterologists or infectious disease specialists, and with simpler, shorter, non-injectable drug regimens, it is expected that treatment might increasingly be provided in primary care.

Prompts

1. Are hepatitis treatment staff trained to understand drug and alcohol issues?

2. Do hepatitis treatment services work closely with drug treatment services to ensure that they are accessible to HCV-infected people who inject drugs, and are they reaching out into the community to identify patients and to treat them at a convenient place?

3. Is peer support available for those considering or undergoing hepatitis C treatment?

4. Are patients, including those who drop out, followed up to ensure there is no further risk of spread of infection and to monitor those not yet ready for treatment?

Addaction Cornwall HCV treatment project
A blood-borne virus nurse, supported by peer mentors and volunteers, visits accessible community clinics across the county to treat service users who have HCV genotype 2 and 3. Before the service was set up, service users faced journeys of up to 40 miles to access treatment at Truro hospital or one of four outreach clinics. The nurse can independently practice and prescribe, with the hospital hepatology team providing clinical governance. The service reduces pressure on the out-patient clinics and markedly improves attendance and treatment rates by removing barriers such as lengthy and expensive travel.

Commissioning

HCV Action's review of the evidence found that "over a third of health and wellbeing boards do not consider hepatitis C at all within their joint strategic needs assessments or health and wellbeing board strategies, and a further third only give hepatitis C an isolated mention within other contexts."[6] The long-term care costs of untreated liver disease demand proper attention and careful consideration when considering the short-term costs of treating HCV infection.

Local data on hepatitis C includes:

- NDTMS reports on offer and acceptance of hepatitis C testing, and latest test date for all in treatment and new presentations
- PHE's commissioning template for estimating HCV prevalence

The diagram overleaf illustrates one possible model for commissioning and providing integrated hepatitis services for people who have injected drugs, covering elements of the pathway and where they might take place. This is only one model and it may be more effective for some drug and alcohol services to refer their service users into secondary HCV services for hepatitis C treatment.

Prompts

1. Does your area have a strategy to prevent and tackle liver disease and does HCV form a significant component of this strategy?

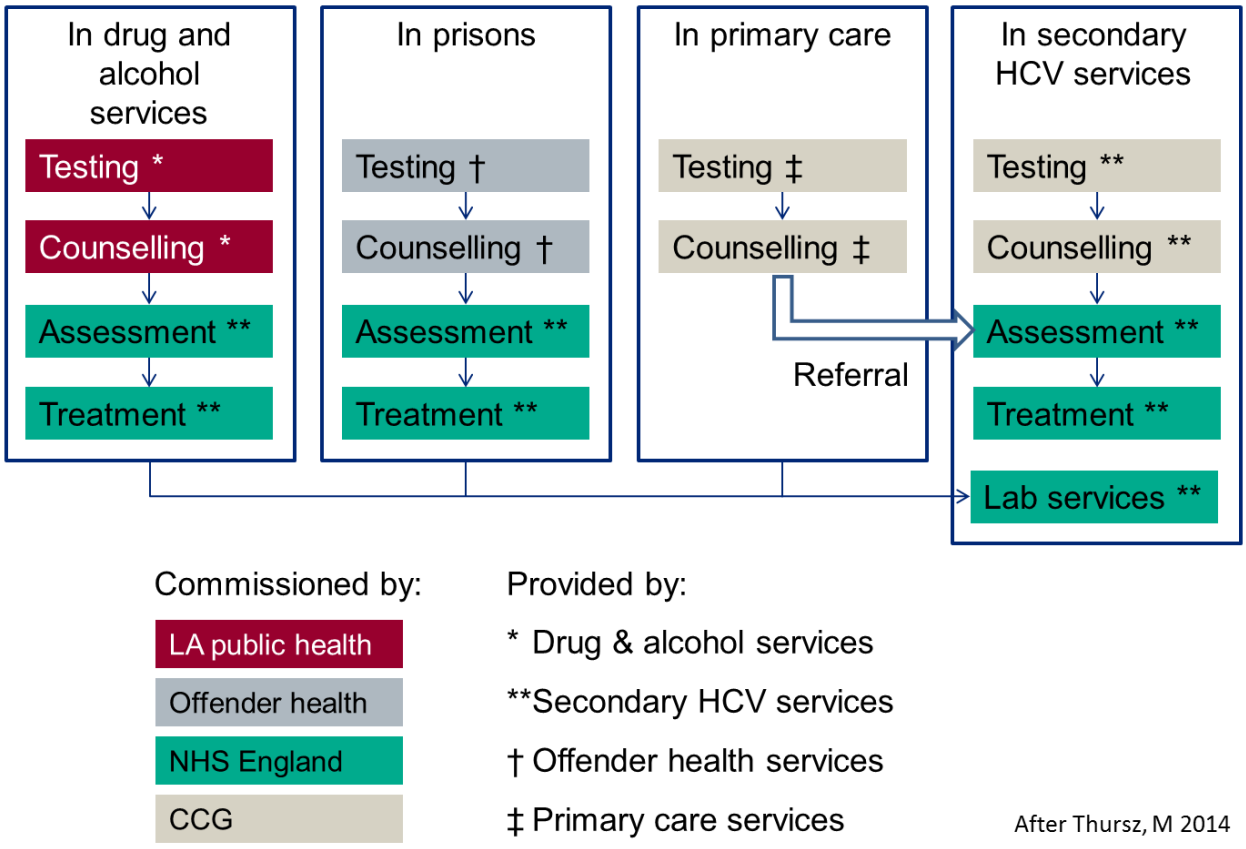
2. Do commissioners for drug treatment and for hepatitis treatment work together to commission integrated pathways for treating HCV-infected people who inject drugs?

3. Has your area considered commissioning an integrated service of HCV treatment in drug treatment services?

4. Do contract targets for drug treatment encourage increased rates of treatment initiation for people who currently or used to inject drugs?

5. Are primary care practices commissioned to offer HCV testing to people who used to inject drugs, and to refer people for treatment where appropriate?
6. Is there continuity of care in HCV management between prisons and the community?
7. Are patient support programmes, which include peer support, education and awareness raising programmes, commissioned to encourage uptake and completion of treatment?

A model of integrated provision of HCV services for people who have injected drugs



Stoke on Trent Community Viral Hepatitis Service
Stoke on Trent commissioned an integrated hepatitis C treatment service for people who inject drugs. Working closely with a local hepatologist, voluntary sector provider CRI tested and, where appropriate, linked its service users into treatment. In the two years after its launch the service referred the vast majority (93%) of its newly diagnosed service users to assessment and treatment. Only a small number dropped out or were assessed as unsuitable for treatment. More than 60% started treatment and nearly 40% were cured.

Useful resources

Hepatitis: Frequently asked questions – Briefing for councillors. LGA & PHE, 2013.

Public health report on commissioning of HCV services in London for people who inject drugs. Knight A, NHS Inner North West London & London Joint Working Group for Substance Misuse and HCV, 2013.

Case studies are detailed on the HCV Action website.

Hepatitis C and other materials from the Harm Reduction Works campaign are still available from www.harmreductionworks.org.uk

Other briefings in the 'Turning evidence into practice' series:

- Helping service users to access and engage with mutual aid [NTA, 2013]
- Helping service users to engage with treatment and stay the course [PHE, 2013]
- Biological testing in drug and alcohol treatment [PHE, 2013]
- Optimising opioid substitution treatment [PHE, 2014]
- Preventing drug-related deaths [PHE, 2014]

References

[1] Harris RJ, et al. Increased uptake and new therapies are needed to avert rising hepatitis C-related end stage liver disease in England: Modelling the predicted impact of treatment under different scenarios. J Hepatol. 2014 Sep 61(3): 530-7

[2] Knight A (2013) Public health report on commissioning of HCV services in London for people who inject drugs. London: NHS Inner North West London & London Joint Working Group for Substance Misuse and HCV

[3] Hellard M, Sacks-Davis R and Gold J. Hepatitis C treatment for injection drug users: a review of the available evidence. Clin Infect Dis. 2009 49 (4): 561-573

[4] Martin NK, Vickerman P, Miners A, Foster GR, Hutchinson SJ, Goldberg DJ, et al. Cost-effectiveness of hepatitis C virus antiviral treatment for injection drug user populations. Hepatology 2012; 55:49–57

[5] NHS England (2015) Clinical commissioning policy statement: treatment of chronic hepatitis C in patients with cirrhosis

[6] HCV Action (2014). Health and wellbeing boards & hepatitis C. London: HCV Action

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