A needs analysis for people living with HCV after leaving custodial settings in Australia

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AIVL is the Australian national peak organisation representing the state and territory peer-based drug user organisations and issues of national relevance for people with lived experience of drug use. AIVL's purpose is to advance the health of people who use/have used illicit drugs. This includes a primary focus on reducing the transmission and impact of blood borne viruses (BBVs) including HIV and hepatitis C – including for those accessing drug treatment services - through the effective implementation of peer education, harm reduction, health promotion and policy and advocacy strategies at the national level.

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Introduction

This project was commissioned by the Australian Injecting and Illicit Drug Users League (AIVL) to provide a jurisdiction-based needs-assessment report for the Australian Government Department of Health on the needs of People Living with Hepatitis C (PLWHCV) as they are discharged from custody to improve the completion rate and success rate of their hepatitis C (HCV) treatment.

The hepatitis C virus can cause both acute and chronic hepatitis, ranging from a mild illness lasting a few weeks to a serious, lifelong illness. It is a blood-borne virus whose common modes of infection are through unsafe injecting practices, unsafe health care, and the transfusion of unscreened blood and blood products.

Globally, an estimated 71 million people have chronic HCV infection. A significant number of those who are chronically infected will develop cirrhosis or liver cancer and approximately 399,000 people worldwide die each year from HCV. Antiviral medicines can cure more than 95% of HCV cases, thereby reducing the risk of death from liver cancer and cirrhosis, but access to diagnosis and treatment is low. There is currently no vaccine for HCV, although research in this area is ongoing.

In Australia, over 30% of males and 50% of females in custodial settings have HCV[1],[2]. However, there are significant gaps in our understanding of the provision of HCV treatment in custodial settings, including poor data on the number of people living with HCV and the support available upon release. There is also a lack of information available on the level, if any, of consultations that are occurring with PLWHCV being released from custody.

The aim of this needs assessment is to identify gaps and opportunities for people within custodial settings to access HCV treatment and identify where resources and/or additional work are needed to ensure a seamless transition to care after release from custody. The underlying principle informing the project is that people in custodial settings should receive equivalent health care to the general community, including access to uninterrupted HCV treatment and care. This project also recognises that custodial settings present a significant opportunity to address long-term health concerns, including HCV, and that treatment uptake could be significantly increased.

To achieve the equivalency of health care between custody and the general community, treatment should be offered to everyone with HCV in a custodial setting. This should include having protocols in place that allow for both the commencement of HCV treatment in custody and transfer to a community prescriber and pharmacy on release from custody to allow for a seamless continuity of treatment into the community. The ideal process would be one where people in custodial settings have comprehensive and unrestricted access to HCV assessment and treatment regardless of the length of prison sentence and release date.

Evidence suggests that HCV treatment can be an opportunity for marginalised people to engage more broadly in health care.

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1 Black, E, Dolan K and Wodak, A. 2004. Supply, Demand and Harm Reduction Strategies in Australian Prisons. Australian National Council on Drugs: Research Paper No 9. Australian National Council on Drugs, Canberra, ACT.

2 Butler, T, Boonwaat L and Hailstone S. 2005. National Prisons Entrants' Blood-Borne Virus Survey Report, 2004. Centre for Health Research in Criminal Justice and National Centre for HIV Epidemiology and Clinical Research, University of NSW, Sydney.

Needs Assessment Methodology and Framework

The needs assessment comprised a desktop review of the current environment in order to identify gaps that require further investigation and consultation with relevant jurisdictional partners. A review of current academic and grey literature, policies and epidemiological data and other sources of evidence to establish the current situation for people living with HCV within custodial settings was undertaken; best practices in Australia or internationally for providing a high standard of care both within custodial settings and during transition back into the community were also reviewed.

Our investigation covered the epidemiology of HCV among people, the numbers screened for HCV upon entry and during their incarceration, and numbers treated. Data were collected on relevant policies for transitioning to community-based treatment; we also corresponded with relevant jurisdictional authorities to collect and collate data that could not to be located via the desktop review process – see **Appendix A**.

Correspondence was also sent to all jurisdictional Corrections and Health Departments to obtain information on PLWHCV in custody and on release, in order to enhance the literature review – see **Appendix B**.

Furthermore, an online survey was developed and disseminated widely through AIVL and Harm Reduction Australia (HRA) networks to collect and collate the experiences and understanding of people working in the field, such as health workers, HCV nurses and doctors, as well as community-based HCV treatment prescribing doctors and HCV specialists – see **Appendix C**.

The survey was completed by 62 participants across a range of professions and jurisdictions. Their responses provided an important insight into the issues around HCV testing, treatment and transition in custodial and post-custodial settings – see **Appendix D**.

Structured interviews were conducted with Key Informants to gain a deeper understanding of the policies and practices for PLWHCV in custody and after release from custody – see **Appendix E**.

Please note that due to budget constraints it was not possible to conduct focus groups with PLWHCV recently released from custody in each jurisdiction.

The Project Steering Committee

The challenges in accessing custodial data across all jurisdictions were acknowledged and the report was guided by a Steering Committee with expertise in locating this data or developing proxy measures and data in order to inform the project staffs' understanding of the issue.

The Steering Committee comprised the following members:

- State based DUO representatives (2).
- Representatives from jurisdictional health authorities with carriage over HCV treatment in custody (1).
- Policy and academic experts (1).
- People with HCV and an experience of custody (2).

The Committee was chaired by AIVL and had agreed Terms of Reference to guide its work managing the accepted HRA proposal – see **Appendix F**.

AIVL – Australian Injecting and Illicit Drug Users League

AIVL represents people who use drugs and state and territory drug user organisations on issues of significance at the national level. AIVL's mission is to advance the health and human rights of people who use drugs, which includes a primary focus on reducing the transmission and impact of blood-borne viruses (BBVs), including Hepatitis C and HIV. AIVL operates on a peer-based, user-centred philosophy, which means the organisation is run by and for people who use/have used illicit drugs and proactively encourages and supports people who use illicit drugs and people in drug treatment to speak on their own behalf and have control of their own organisation.

Results

Table 1: Jurisdictional responses to requests for data.

	Response	Requested data provided	Comment
ACT Justice Health	✔	✗	Limited data provided
ACT Corrections	✗	✗	
Vic Health	✔	✗	
Vic Corrections	✔	✗	Late correspondence received - See Appendix I
NSW Health	✗	✗	
NSW Justice Health	✗	✗	
NSW Corrections	✗	✗	
SA Health	✔	✗	Limited data provided
SA Corrections	✗	✗	
Tasmania Health	✔	✗	Limited data provided
Tasmania Corrections	✗	✗	
Queensland Health	✔	✗	Limited data provided
Queensland Corrections	✗	✗	
WA Health	✔	✗	
WA Corrections	✔	✗	Limited data provided
NT Health	✗	✗	
NT Corrections	✗	✗	

Limited data provided refer to only some data being provided rather than all the information requested or in some cases only general information being provided about the processes involved in how to access data.

Prevalence of HCV in Prisoners [i]

The National Prison Entrants Blood-Borne Virus Survey provides prevalence estimates among prison entrants. In the study, consecutive prison entrants are surveyed over a two-week period (See Tables 2 and 3). Data from the last two surveys in 2010 and 2013 appear below. All data are reported in percentages of HCV prevalence among a) all entrants, b) entrants who inject drugs and c) entrants who do not inject drugs across jurisdiction and by sex.

Table 2: HCV prevalence among prison entrants in 2010

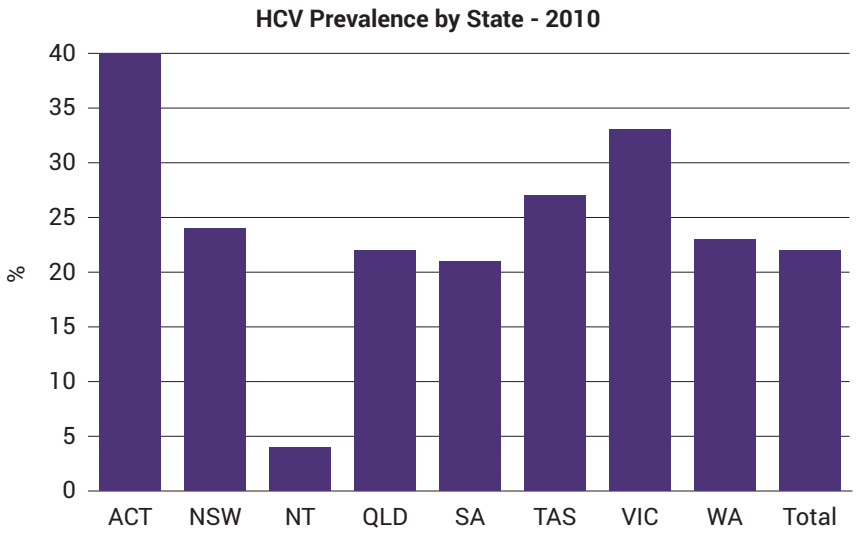
Sex	Status	ACT %	NSW %	NT %	QLD %	SA %	TAS %	VIC %	WA %	Total %
Male	All	50	24	5	18	19	28	28	24	21
	IDU	100	62	43	50	40	47	40	37	49
	Non-IDU	0	2	0	0	6	0	10	0	1
Female	All	0	29	0	43	29	0	60	0	34
	IDU	0	67	0	86	50	0	100	0	68
	Non-IDU	0	0	0	0	0	0	0	0	0
Total	All	40%	24%	4%	22%	21%	27%	33%	23%	22%

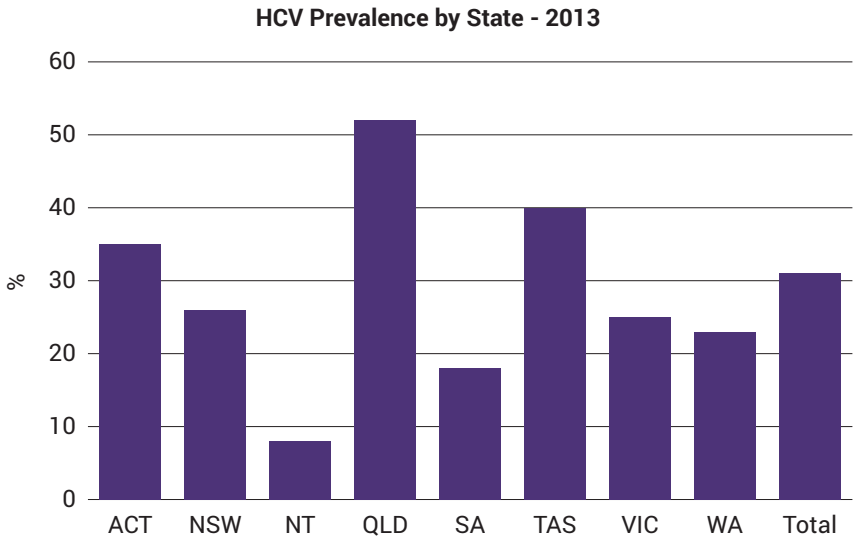
Table 3: HCV prevalence among prison entrants in 2013

Sex	Status	ACT %	NSW %	NT %	QLD %	SA %	TAS %	VIC %	WA %	Total %
Male	All	33	27	9	51	15	41	23	19	29
	IDU	57	63	100	70	28	75	61	28	56
	Non-IDU	13	0	3	9	0	0	4	5	4
Female	All	40	22	0	52	100	33	38	45	41
	IDU	67	40	0	71	100	100	69	63	67
	Non-IDU	0	0	0	13	0	0	8	0	6
Total	All	35%	26%	8%	52%	18%	40%	25%	23%	31%

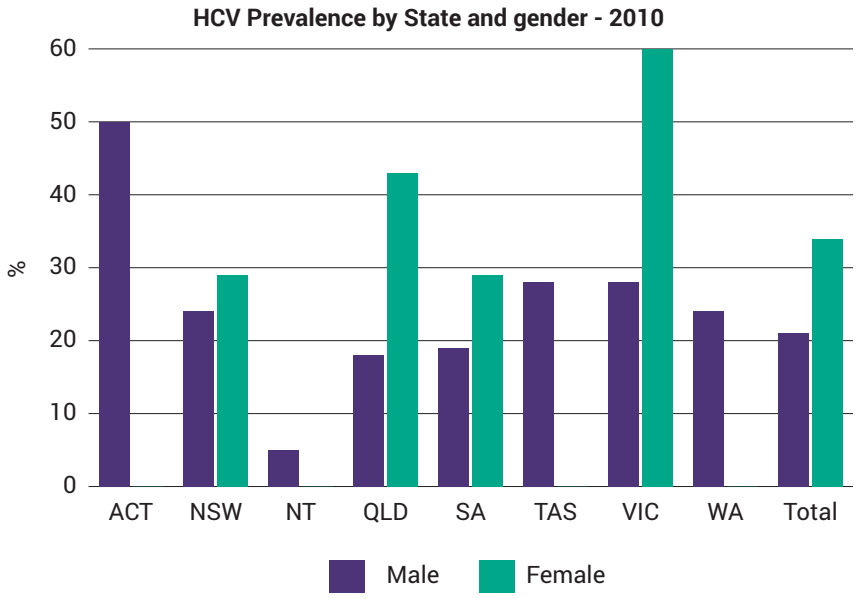
In 2013, the national prevalence of hepatitis C infection among prison entrants was 31%, an increase from 22% in 2010. Among States with more than thirty prisoners tested for hepatitis C infection, the prevalence ranged from 52% in Queensland to 8% in the Northern Territory. As in previous surveys, hepatitis C prevalence was higher among those with a history of injecting drug use than those who had no such history, and higher among women who inject drugs than men who inject drugs.

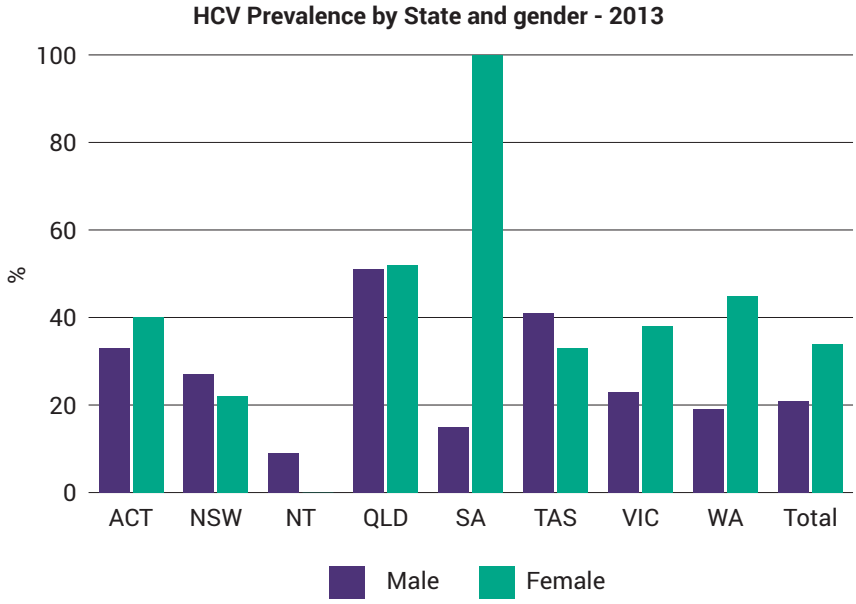
Graphs 1 and 2: The prevalence of HCV infection among prison entrants in 2010 and 2013



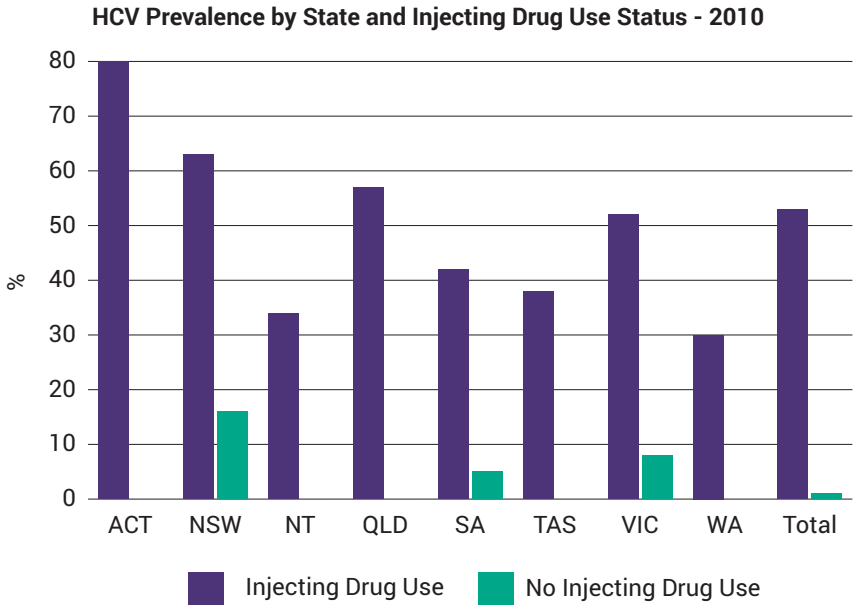


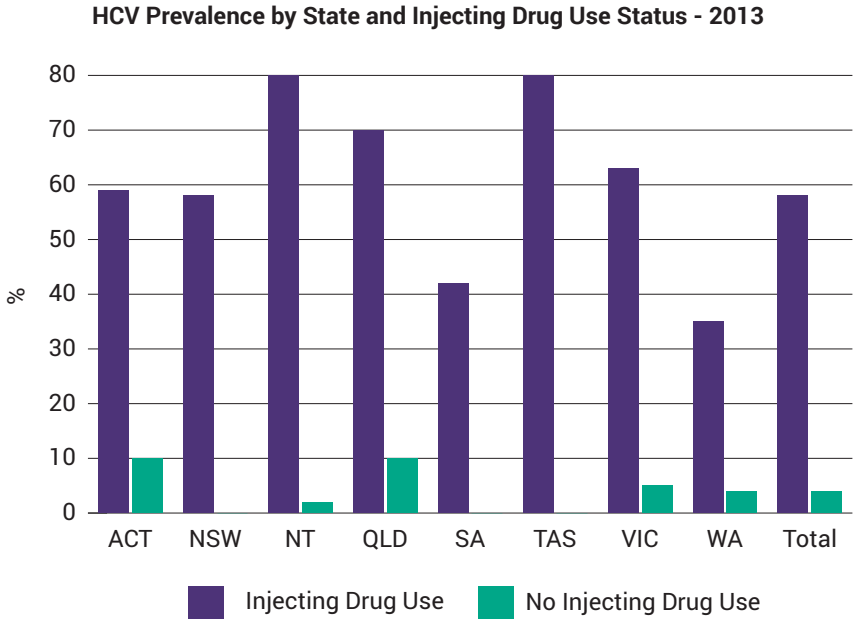
Graphs 3 and 4: The prevalence of HCV infection among prison entrants by State and gender in 2010 and 2013





Graphs 5 and 6: The prevalence of HCV infection among prison entrants by State and IDU status in 2010 and 2013





Incidence of HCV in Custodial Settings

As per Table 4 below, the evidence base for HCV incidence in custodial settings across Australian jurisdictions is scarce. Only NSW has conducted a series of published, peer-reviewed studies that investigated a number of different demographics in light of their exposure to HCV in custodial settings. Three studies listed below report on HCV incidence among detainees who inject drugs at different points in their prison cycle, one of which also reports on the people who inject drugs with HCV who remained continuously inside. The last study reports on the crude incidence of notifications among a large cohort of prisoners who have injected drugs in NSW custodial settings.

Table 4: HCV incidence in Australian prisons

Category	ACT	NSW	QLD	NT	VIC	SA	TAS	WA
IDU	✗	14.82[ii] 31.63[iii] 11.44[iv]	✗	✗	✗	✗	✗	✗
IDU continually Inside	✗	6.35[v]	✗	✗	✗	✗	✗	✗
Non IDU	✗	✗	✗	✗	✗	✗	✗	✗
Notifications	✗	5.16[vi]	✗	✗	✗	✗	✗	✗

The incidence of HCV among people who inject drugs has ranged from 14.8% between 2005 and 2009[vii] to 11.4% between 2005 to 2014[viii]. The incidence of HCV was 11.4% among inmates with a history of injecting drug use when studied over a ten-year period, but some of these inmates had been released and re-entered prison. Among those who remained continuously incarcerated, the incidence rate was 6.3 per 1200 person years[ix].

Information on HCV Transmission in Custodial Settings

Data on the rate and number of HCV cases of transmission in custodial settings are scarce. A review of grey literature revealed limited self-reported snapshots from Tasmania and the ACT (in the case of the ACT, the data are also likely to be unreliable because of the existing recording and testing inconsistencies). The two NSW studies report on the number of infection cases per 100 prison years; the first study applies to IDUs in prisons; the second is a prospective study of users continually in custody.

Table 5: HCV Transmission in Custodial Settings

ACT	NSW per 100 py	QLD	NT	VIC	SA per 100 py	TAS %	WA
Less than five cases recorded[x]	34.2 people who inject drugs[xi] 10.26[xii] continually inside	✗	✗	✗	4.6[xiii]	2011-2012 – 10-12%[xiv]	✗

Screening for HCV of Australian Dischargees Across Jurisdictions - 2015

The only recent published data on the health of Australian prisoners across jurisdictions, including the levels of screening for HCV, comes from the 2015 Australian Institute of Health and Welfare (AIHW) report, *The Health of Australian Prisoners*. The sample size was 437 and excluded NSW, which did not provide discharge data in 2014. [xv]

Table 6: Percentage of inmates tested prior to release

	ACT	NSW	QLD	NT	VIC	SA	TAS	WA
Tested on discharge %	80	✗	65	94	49	50	84	89

Treatment Information for Australian Prisoners Across Jurisdictions

The following collation is a summary of findings on the current state of HCV treatment in custodial settings across jurisdictions.

Apart from the first column, which comes from the 2015 AIHW report *The Health of Australian Prisoners*, all information has been collated from jurisdictional responses to requests for information and the literature review performed in May-August 2017. The AHIW report indicated that there were 244 prisoners who commenced on treatment for HCV during 2014, at a rate of 8 per 1,000 prisoners received into custody. These data exclude NSW, as it did not provide data for this indicator.[xvi]

The remaining information comes from jurisdictional responses, publicly available reports and media.

Table 7: information on treatment imitation, completion and clearance for inmates

	Dischargees who've taken medication %17	Initiating Treatment	Completing Treatment	Clearing HCV	Treatment continued outside	Other
ACT	2	In the year from March 2016 to March 2017, 58 detainees commenced treatment, 55 with successful outcomes. [xviii] As of 5/07/17 80 people commenced treatment with DAA.[xix]	As of 5/07/17, 78 detainees completed treatment. 15 were released on treatment, 4 with scripts, 2 lost to follow-up post-release.[xx]	As of 5/07/17, 78 out of 80 cases had success confirmed at 12-week test.[xx]	19 detainees transitioned since March 2016 during or prior to treatment. Since March 2016, Justice Health initiates and completes treatment authorised by community providers on entry. Canberra Hospital and Hepatitis Resource Centre provide support. [xxi]	✗

	Dischargees who've taken medication %17	Initiating Treatment	Completing Treatment	Clearing HCV	Treatment continued outside	Other
NSW	✗	Between 1 March 2016 and 31 March 2017 633 people initiated treatment in Justice Health. The proportion of Indigenous prisoners initiating treatment ranged from 27% to 39% between Q2 (April-June) 2016 and Q1 (January-March) 2017. Data was not available for Q1 (January-March) 2016.[xxiii] 2014: 111 people initiated treatment for chronic HCV, 25 (22.5 %) among them Indigenous.[xxiv] 2015: 125 prisoners initiated treatment; 35 were Indigenous.[xxv] In 2016 297 residents initiated treatment, with 68% of patients (n=201) initiating treatment prescribed by a non-specialist (GPs and other prescribers) and 32% (n=96) initiating treatment prescribed by a specialist.[xxvi]	In 2014 90 people completed treatment.[xxvii] In 2015 76 people completed treatment.[xxviii]	✗	✗	2014: 189 or 3.5% - received treatment in custody.[xxix] 142 treated in custody in 2015.[xxx]

	Dischargees who've taken medication %17	Initiating Treatment	Completing Treatment	Clearing HCV	Treatment continued outside	Other
QLD	1	✗	At least 90% of treated prisoners complete treatment before release. Monitoring of Sustained Virological Response (SVR) testing after release is difficult[xxxi]	All those known to have completed treatment and returned SVR testing have been successfully treated[xxxii]	✗	✗
NT	1	✗	✗	✗	✗	✗
VIC	0	✗	✗	✗	✗	✗
SA	0	About 8 people per month commence treatment.[xxxiii]	✗	✗	✗	Between 2013-14, 6% of HCV treated in custodial settings[xxxiv] Of approx. 788-1,050 prisoners living with HCV, 13 were treated in Sept 2016 The number who accessed treatment in 8 months post-DAA (Mar-Oct 2016) was equivalent to the aggregate total for previous 3 years (56 v 60).[xxxv]

	Dischargees who've taken medication %17	Initiating Treatment	Completing Treatment	Clearing HCV	Treatment continued outside	Other
TAS	1	✗		Since 2008, TAS reports 95% cure rate; 1 individual did not complete treatment[xxxvi]	Less than 10% of those treated are released while on treatment[xxxvii]	Since 2008, 250 treated with a 95%[xxxviii] success rate.
WA	1	✗	Number of people who have not completed treatment since April 2016 is low (3); the available cure data is incomplete[xxxix]	✗	✗	Since Apr'16 (access to DAA) approx. 150 treated (previously approx. 50 p/a treated.[xl]

Summary of Qualitative Data in Relation to HCV Prevalence, Screening, Treatment, Follow-up and Other Related Activities and Guidelines Across Jurisdictional Custodial Settings

Collated information has been sourced from self-reported jurisdictional responses to requests for information and the literature review performed in May-August 2017.

Table 8: Summary of Qualitative Data

NEW SOUTH WALES
2014
• Justice Health (JH) had the third most notifications of HCV among local health districts: 340 or 10% of hepatitis C notifications in NSW, and an increase of 31% from 2013 (259). 37% of notifications were reported to be among Indigenous Australians; 39% were non-Indigenous, with 24% unknown. Although Indigenous Australians are over-represented in prison populations (23%), the number of notifications among Indigenous Australians was still higher than expected.
• In the 10 years to 2014, JH had experienced the third largest decrease in notification numbers. In 2014 JH reported both the highest number (108) and the highest proportion (32%) of notifications in 15-24 year olds. High numbers of notifications in custodial settings are partly due to targeted screening programs, and may include people who have been previously diagnosed interstate or overseas.
• 1624 people received OST in prison. JH assessed 276 people for HCV treatment, 61 of those (22.1%) were Indigenous Australians, a slightly lower percentage than the proportion of Indigenous custodial population.
• 4% of those using needle and syringe programs reported being in prison in the past month. [xli]

2015

- The numbers of notifications are partly due to targeted screening programs. JH provides assessments to all people commencing full-time custody, including those remanded into custody. Screening for BBV and STI is offered to those who report risk factors. Patients may also be tested through other health services while in custody.
- JH had the third most notifications among local health districts – 317, accounting for 9% of notifications in NSW, a decrease of 6.8% since 2014 number (340). JH reported the highest number (96) and the highest proportion (30%) of notifications in 15-24 year olds. Indigenous Australians comprised 24% of the population and accounted for 131 or 41% of the notifications. 128 (40%) were non-Indigenous Australians.
- Of the 317 notifications in JH in 2015, 287 (90.5%) were in males and 30 (9.5%) were in females. Among males, infection was most commonly diagnosed in those aged 20-24 years; among females in custody, hepatitis C was most commonly diagnosed in those aged 30-34 years.
- 182 people were assessed for treatment in Justice Health; 30 (16%) were Indigenous Australians.
- 1726 people participated in OST while in custodial settings.
- Among NSP clients, 5% reported being in prison in the past month.[xlii]

2016

- High numbers of notifications are partly due to a higher proportion of people with risk factors for HCV in the population, targeted screening programs, and the inclusion of people who have been previously diagnosed interstate or overseas.
- 465 notified (second largest among LHDs) or 11% of all in NSW, and an increase of 45% compared to the 2015 number.
- JH reported the highest number and highest proportion of notifications in 15-24 year olds. 108 notifications were reported in 15-24 year olds, or 23% of all notifications.
- 422 (91%) notifications were in males and 43 (9%) were in females. Infection was most commonly diagnosed in those aged 25-29 years among both males and females.
- 1677 (7% of NSW clients) participated in OST in JH. In the reporting period, the number of people in NSW prescribed OST in JH declined by over 25%, from 1,882 in 2007 (11.6% of NSW clients) to 1,500 in 2016 (7.4% of NSW clients). Between 30 June 2007 and 30 June 2016, the per-capita rate of participants in OST decreased from 1,827 per 10,000-prisoner population to 1,188 per 10,000-prisoner population. This trend is magnified by the increase in the population from 10,300 in 2005, to 12,629 in 2016.
- 9% NSP users reported being in prison in the past year.[xliii]

Other

- All prisoners are offered testing on entry. Data on screening for HCV and completion of treatment is not available publicly.[xliv]
- New, highly effective Direct Acting Antiviral treatments were made available on the PBS on 1 March 2016. Treatment has been rolled out by JH in a planned approach prioritised by clinical need. Throughout 2015/16, 83% of scripted treatment was delivered via the JH nurse-led model of care. A NSW Health pilot of the model demonstrated its effectiveness. The remaining patients were provided with treatment through hepatologists.[xlv]
- Per a 2015 report, previously almost 80% of patients were able to commence treatment via phone or teleconference with specialists.[xlvi]

AUSTRALIAN CAPITAL TERRITORY

- In 2010, 48% of persons who were tested for hepatitis C antibody (132) were tested positive. 16 were hepatitis C PCR positive (not all individuals with positive results for antibodies were also tested for hepatitis C PCR)[xlvii]
- As of October 2016, 40% survey respondents were exposed to HCV, with a 20% rate of infection.
- In a July 2017 estimate, 15-20 out of 446 prisoners were suspected of being infected and untreated for a number of reasons.[xlviii]
- In a 2010 report, record keeping in relation to HCV testing was described as inadequate and limiting evaluations of interventions. Testing was mainly occurring at reception; the testing algorithm was not best practice. There were no accredited counsellors; delays in obtaining results were noted. The report referenced a lack of clear policy guidance and a poor governance structure. Harm reduction activities were judged not best practice.[xlix]
- Justice Health (JH) and the Correctional Services offer a nurse-led model, with testing on entrance, via health consultations or self or peer referral. Each inductee over 7 days is offered an optional test. In May 2017, 17 people were offered; 14 or 83% accepted.[l]
- Expanding access to hepatitis treatment has been identified as a policy direction by Justice Health. Good levels of BBV-related health promotion were reported. In 2010, HCV treatment was available but delays were occurring in accessing treatment.[li]
- As of July 2017, the rates of HCV decreased from 30% of screened detainees in 2017 to around 3% of screened detainees post PBS-funded treatment.[lii]
- A $5 million investment in custodial HCV treatment was reported in July 2017.[liii]
- Support for the introduction of a professional tattooing program was reported in 2011. No progress on the proposed needle and syringe program has been made to date.[liv]

VICTORIA

- All prisoners are offered testing on entry and when moving between sites.[lv]
- The nurse-led models of care were introduced in 2016. Seropositive prisoners referred to the state-wide HCV clinics at each site for assessment by a Clinical Nurse Consultant.[lvi]

TASMANIA

- Approx. 30-40% prisoners live with HCV; rates vary depending on prison. Out of the average muster of 550, around 220 are estimated to be positive at any time. As an increased number is treated, fewer patients are presenting with acute symptoms. TAS estimates that the rates of transmissions and new infections are decreasing. [lvii]
- No specific policies on screening and treatment exist. Corrections employ an overarching Mental Health and Statewide Services assessment procedures as a guide. Between July 2016 and April 2017 an average of 129 patients are screened a week. A proportion of these are re-incarcerated; as a result, the true number of new tests is unknown. Testing is also available after a risk event or on demand.[lviii]
- A full screening service has been optional since 2008, with the uptake of 95% of admissions. Positive HCV tests are followed up with further testing and treatment.[lix]
- Improved hepatitis C and B virus treatment to prisoners has been identified as a policy direction. TAS keeps comprehensive electronic health records; once the status confirmed as chronic, prisoners are offered treatment, ongoing testing and referrals as required.[lx]
- A referral to appropriate services is offered if a patient is discharged prior to treatment commencement/ completion, including to the Anglicare HCV Prevention Program and the needle syringe program. Anglicare and TasCAHRD also provide HCV education sessions.[lxi]
- Links have been established with hepatology clinics to ensure proper post-release referrals. Research into treatment post-release is to be undertaken within a year. [lxii]

QUEENSLAND

- Preliminary results from the Kirby prison entrants survey for 2016 indicate 25.4% prevalence of HCV among all entrants, 46% for people who inject drugs and 0% for those who do not inject drugs. 24.6% of performed tests reactive (1,535 out of 6,231). Prevalence varies between 4-41% between centres.[lxiii]
- All entrants are offered optional tests on reception, with a majority accepting. The e-health record system is in development; testing rates are currently not available. Between 1/07/16-30/07/17 there were 6,231 requests for tests.[lxiv]
- QLD does not have a centralised prison health system and no state-wide policies. In-reach services are available through sexual health and tele-health services and specialists in secure units. No one was treated with DAAs prior to incarceration as per the entrants' survey 2016 (versus 27% Queenslanders surveyed in the 2016 NSP survey). Treatment provisions are low in relation to potential demand; a number of initiatives to remedy this are underway. One centre in North Queensland introduced enhanced protocols for screening and treatments. Some centres do not offer treatment unless a prisoner is likely to remain for 6 months or more.[lxv]
- Queensland Health is increasing the number of treatment providers via a new approval process for authorised HCV S 100 prescribers. Queensland Health funds Hepatitis QLD to develop a model for promoting testing and access to Fibroscan in correctional centres in South East QLD.[lxvi]

WESTERN AUSTRALIA

- A July 2017 self-estimate claims approximately 1,048 (out of 6,722) prisoners have hepatitis C, but the real number might be higher.[lxvii]
- Testing is voluntary and offered to all with informed consent, including when risk factors identified, following exposure to risk and on request. Testing is covered by the Adult Justice Services Health Services Procedure CD01.[lxviii]
- There is easier access to DAA in regional centres, with a waiting list reported in Perth. There is no specific HCV treatment policy; WA follows the National Guidelines and the Chronic Hepatitis B and C Pathway Care document.[lxix]
- WA reports that it is working on improving planning and referrals to community providers.[lxx]
- Prisoners are provided with a combination of treatment/script on release; correctional services will link dischargees with an external provider if prisoners consent.[lxxi]

NORTHERN TERRITORY

N/A

SOUTH AUSTRALIA

- A snapshot from January to March 2017 shows that 24% of 457 were positive.[lxxii]
- Prisoners are offered screening on entry, during an annual check and opportunistically. The lack of electronic files makes it difficult to track prisoners for follow-up care, both as they are moved around and after they leave.[lxxiii]
- The Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) has produced a tool which is used to screen prisoners.[lxxiv]
- Opt-out testing is available; the possible introduction of rapid testing was announced in 2017. Between 1/07/14 to 30/06/15, 1,301 tests were performed; 273 were positive, or 21% based on the approximate prevalence estimates by ASHM. Among the total number of admissions of 5,725 approximately 23% were tested.[lxxv]
- DAA treatment is offered in consultation with Royal Adelaide Hospital.[lxxvi]
- An increase in HCV treatment and monitoring will be implemented via the Viral Hepatitis Nurses program providing support to prison nursing staff.[lxxvii]
- OST available in all SA prisons. Approximately 9% of prisoners receive OST at any one time. Treatment standards differ between the incarcerated and non-incarcerated. There is currently no access to sterile needles, sterile tattooing and piercing equipment and bleach, no or difficult access to condoms and lubricant and limited access to new tooth brushes. The recent prevention plan commits to the delivery of disinfectants, clean barbering and shaving equipment, toothbrushes, condoms and lubricants. Other 'evidence based harm reduction strategies' and barriers to their implementation are to be investigated and reported on during the course of the plan (2017- 2020). The plan also commits SA to improved testing and record keeping, enhanced treatment protocols, workforce development and access to specialists including via tele-health. [lxviii]
- Between 2013/14 and 2014/15, there was an increase in prisoners attending education sessions (from 81 to 458); 412 attended in the 2015/16 financial year. The highest recorded rate represents 17% of the daily average (2,625) number of prisoners, and 8% of the total number (5,725) of individuals admitted that financial year. Education approach is determined by each prison with some outreach offered by NGOs.[lxxix]
- SA is trialling HealthELink with Royal Adelaide to facilitate transition; dischargees are referred to a community nurse.[lxxx]

Note:

Review the upcoming publication from Centre for Social Research in Health at the University of NSW– see **Appendix G**

Table 9: Availability of opioid substitution treatment in Australian prisons, states and territories

	Methadone		Buprenorphine		Buprenorphine/naloxone	
	Maintenance	Initiation	Maintenance	Initiation	Maintenance	Initiation
NSW	✔	✔	✔	✔	✗	✗
VIC	✔	✔	✔	✗	✔	✔
QLD	✔	✗	✔	✗	✔	✗
WA	✔	✔	✗	✗	✔	✗
SA	✔	✔	✔	✔	✗	✗
TAS	✔	✗	✗	✗	✗	✗
ACT	✔	✔	✗	✗	✔	✔
NT	✔	✗	✗	✗	✗	✗

Notes:
In Queensland, OST maintenance is available to female prisoners only.
In the Australian Capital Territory, Suboxone (Buprenorphine/naloxone) is available for withdrawal and 2 weeks prior to release only.

Survey of People Working with PLWHCV

A survey to determine the level of policy and practice awareness among people working with PLWHCV in custody and the community was conducted in July 2017. In particular, an area that was deemed to be of significant importance after the review of publicly available policies and literature was the potential disparity between policy and practice. Accordingly, the survey was designed and circulated to canvass the range of opinions and perceptions of professionals who work with PLWHCV.

The survey was circulated via relevant forums such as the AOD E-Network (Update) and the Needle and Syringe Program Forum, as well as sent via the networks of the authors and the Steering Committee. The process resulted in 62 completed responses to the survey and the responses are summarised below.

Employment

The main professional or work categories of respondents were Health or Medical Professional (65%) and Advocacy & Support for People with HCV (37%). There were a few respondents from Education (8%) and Corrective Services (4%). Other professional categories nominated by respondents included NGO worker, mental health, drug and alcohol, NSP worker and a staff member from a hepatitis organisation. There were no respondents from Law Enforcement (Police, courts etc.), Legal or Academic/Research categories.

Location

Most respondents were based in NSW (39%), Victoria (19%) and Queensland (16%). The remainder were based in WA (13%), ACT (6%), SA (3%) and NT (3%). No one named Tasmania nor the nation as a whole as their base. In terms of geographical location, most respondents worked in an urban setting (72%), followed by a rural/regional setting (43%) and then a remote location (10%).

Contact with People Living with HCV

Almost all respondents (93%) reported that they had direct contact with PLWHCV at their work, with just seven percent reporting no such direct contact. When respondents were asked if this contact was with people in custody (prison and police cells), 37% said it was, while 59% said it was not and 3% were unsure. A follow on question asked respondents if they were providing services to HCV positive people and 31% were while 65% were not.

Awareness and understanding of policies on HCV testing in prison

Respondents were asked about their awareness of prison policies on testing for HCV, and 34% said they were aware while 50% were not and 16% were unsure. A follow-on question asked respondents about their understanding of these policies. The replies with regard to testing and treatment were as follows: testing and treatments are available, inmates are tested on arrival but not on exit, all entrants are offered testing and again on yearly review, testing can also be on request, such as after a potential exposure and testing is mandatory on entry.

When asked about other services available, just over one third of respondents (37%) reported being aware of these for PLWHCV in custody. These included the HIP HOP program, the prison hepatitis C help line, treatment and health support and BBV prevention and awareness education in formal face to face education classes. One respondent mentioned that services change depending on budget, availability and even if a new drug has been added to the list.

One respondent summed it up as “Basically anyone in custody should have access to the same services and treatment as someone in the community i.e. not in custody”. In contrast, one respondent noted that voluntary testing is available to inmates in all jurisdictions, with the exception of the Northern Territory, where testing is mandatory at reception.

Awareness and understanding of policies on HCV catering for the needs of people leaving prison

Just 15% of respondents were aware of policies that specifically cater for PLWHCV being released from custody, 72% were unaware and 13% were unsure. A follow on question asked for their understanding of these policies. Responses included the pre-release policy for external appointments, provision of an exit pack containing harm reduction information and condoms and an 1800 line for health professionals to obtain health information.

One respondent cited the recently released South Australian *Prisoner BBV Prevention Action Plan* and another mentioned that detainees have health plans prepared to support their release from custody. Detainees are provided with contact information for community based hepatitis organisations. This will ensure continuity of treatment, if the patient is still undergoing treatment when released. They establish linkages with external agencies and organisations to plan for and maximise access to post release ongoing care.

Treatment and support services for People Living with Hepatitis C in custody

When asked if they thought that there are adequate treatment and support services available for PLWHCV in custody, the majority (76%) said no they were not, with just 10% thinking they were adequate and even more 27% unsure.

Services available for People Living with Hepatitis C being released from custody

A similar response was when respondents were asked if they thought that there are adequate services available for people being released from custody, with over half (56%) disagreeing, just 11% agreeing while 32% were unsure.

Over three quarters of all respondents (76%) thought that services for PLWHCV in custody could be improved, while just 5% thought no and 19% were unsure.

Better pathways to connect with treatment post release

When asked how services could be improved, respondents suggested better pathways, specifically free medication and referral to clinics and social and emotional support groups for advocacy and support with diet, housing, employment and information for family and community. Respondents indicated it is important to link ex-inmates with services upon release so they can start treatment as soon as possible. Common suggestions were that dedicated resources were needed for released prisoners on DAA to ensure they complete treatment and for follow-up serology. Otherwise too many people who are released to freedom do not follow through on treatment. Respondents also mentioned that the follow-up with 12-week SVR is very patchy.

Prisoners are often not provided with follow-up appointment for treatment continuation or for linkage to a service or GP to provide them with information/treatment that they did not receive in prison. They often give the client a name and contact details for a service only.

A helpful suggestion was for inmates to join a waiting list to see a prescriber whilst in jail, which would lead to fast tracking into treatment upon release. This could be coupled with follow-up appointments via referral to GPs from the custodial medical team. Another suggestion was the involvement of probation services, with the possibility of mandated treatment.

It should be policy that people living with HCV are either treated in jail, or connected to a treatment service on release (along with the many other services they will require at that stage). One respondent suggested that ex-inmates needed secure housing along with treatment as its “hard to do treatment without stable housing”.

Support for ex-inmates

Other avenues to foster transition were the use of advocacy and peers to build rapport prior to exit and follow up on release and the suggestion that ongoing support of ex-offenders could come from self-help groups.

Another suggestion was to model services on the Connections Program (NSW) for all patients being release from custody. This is a wraparound service that assertively assists drug and alcohol clients with re-entry on release. A similar suggestion was that as well as a standard pathway for effective transition of care that starts in custody, it must be practically followed through with assertive follow up by Health or an NGO, which must be done in conjunction with some form of drug and alcohol treatment /support to minimise the risk of ongoing injecting drug use. Another respondent thought a one-stop shop for follow-up, treatment and ongoing health care is essential as is the link with treatment and harm minimisation services pre-release.

Harm reduction

Several respondents mentioned harm reduction services could be improved including providing clean injecting equipment, condoms and lubricants, opiate substitution therapy and more to prevent transmission inside. Other suggested services were education on blood-borne viruses, HIV, sexually transmitted diseases and First Aid.

Transmission in prison

Although respondents were not asked about transmission within prison, two offered observations.
One respondent said that a number of their clients contract HCV in prison by sharing (injecting) equipment.
Another respondent reported that the rate of prisoners who acquire HCV in prison is very high due to sharing of needles, tattooing and sharing toiletries.

Challenges

One main difficulty is that when prisoners are released straight from a court appearance they often do not come back to the prison to collect their belongings, including referrals and/or medication. Also, there are barriers to treatment for people who are transient or have chaotic lifestyles. One respondent said: "I had one recently released person come to me who had a complete set of blood test results and a request for treatment, but this is not the norm. Many people do not know what their status is when they are released."

Key Informant Interviews

To supplement and provide more depth to our understanding of the survey responses (described above) a number of Key Informant interviews with people working directly in the areas of HCV and with people in custody were conducted. It was agreed before the interviews were conducted that the Key Informants would not be named and, where feasible, the information they provided for this report would not be jurisdictionally identifiable. These caveats were implemented to provide Key Informants with the greatest level of confidence to speak freely.

Presented below is a summary of the responses.

Are there explicit policies that address hepatitis C infection and treatment in prison?

Some prisons are better than others in ensuring PLWHCV receive access to information and/or treatment. Other than a limited number of brochures, information can generally be obtained only by harassing and persisting with medical staff. Access to medical treatment is even more difficult at times.

A typical experience of what occurs in many jurisdictions is the development of a conceptually very good overarching policy, however it does not always follow that good policy becomes good practice. Inconsistent access to bleach, a refusal to implement a regulated NSP, and management refusal to release staff for BBV-related training often occurs.

It was clear that most jurisdictions have policies but many need updating and have significant gaps. In particular, there is a lack of continuity for people transiting from custody to community and some policies are not specific to prisons but rather receive a secondary mention in a broader health policy.

There is a need for a national approach. The National Hepatitis C Strategy (2014-2017) identifies people in custodial settings as a priority population and yet, with the exception of improvements in treatment access, the issues and considerations (p39) identified at publication in 2014 remain current.

In your opinion are the policies sufficiently comprehensive or are there areas that the policies still need to address?

Policies are comprehensive but access to treatment varies between prisons, and often depends on the length of the prisoner's sentence. Consequently, only a very small fraction of PLWHCV in prison are actually receiving correct information or their entire treatment program while in custody. Waiting times are also extensive, with some prisoners waiting up to 6-12 months so a medical escort can take them to hospital for a biopsy or consultation with a liver specialist. Furthermore, there are rarely follow ups between prison and community medical facilities.

It was agreed that ideally more screening should take place; however, this is challenging with increasing inmate numbers, access to patients (e.g. Corrective Services need to escort patients to clinic and return to wings), physical infrastructure, and no substantial growth of health staff to enable increase in screening.

Another major challenge is people coming into custody who have already commenced treatment but do not bring their treatment with them. If the medication has already been dispensed in the community, the public health service operating in the custodial setting may have to pay the full cost of drug (which is substantial) through re-dispensing.

In addition, new patients at reception may not always tell health staff that they have commenced treatment for a number of reasons, which can result in treatment interruption. Accessing patients Medicare cards and numbers can also be difficult, significantly holding up treatment in some cases.

Securing access to federally funded HCV DAAs in prisons was an incredible achievement and has significantly increased access to treatment across jurisdictions. However, there is a hidden downside to this Commonwealth subsidy, because jurisdictional governments have little incentive to implement evidence-based harm reduction strategies to prevent HCV infections. In short, they don't pay the cost for a failure to prevent infections.

Stigma and discrimination (resulting from illicit drug use and from BBV status) were also seen as ever-present. For example, without ongoing BBV awareness and prevention education for corrections staff it cannot be expected to have a nuanced debate about NSP in prisons. Additionally, corrections staff can at times exhibit ignorance about BBVs and yet there is seemingly no incentive to become informed.

Getting the policy settings correct is necessary but without proper implementation it can become meaningless. There may be a need to get strategic targets translated into performance indicators in correctional staff contracts to narrow the gap between policy and practice.

In summary, with 250,000 people to treat and a large proportion of PLWHCV in prison it is critical that prisons are part of any national strategy for elimination of HCV. There is a real need for a national policy to guide prisons in jurisdictions.

How well do you think that these policies are currently being delivered to PLWHCV in custody?

The responses varied from very well on the whole to very sporadic.

This was due to the variation between jurisdictions and prisons within jurisdictions, the responsiveness of medical staff, the sheer numbers and access to screening and the challenges of sudden release or movement that does not allow for planning and could result in a break in treatment or failure to connect into care if being released.

Anecdotally access to treatment is good in some jurisdictions, and is getting better in others. It can be improved by, for instance, ensuring that all HCV positive prisoners are tested and considered for treatment from the moment they are received into the prison health system. One of the reasons that some detainees are not treated for HCV is because they might be released before the treatment concludes. Now that treatment for most PLWHCV is 8-12 weeks, more urgency in identification, work-up and treatment access could ensure more people are cured before release.

One area of related concern is the access to opioid pharmacotherapies which is inconsistent nationally.

It was also clear that the health services have a key role to play in scale up of HCV treatment delivery.

Do you think that there are adequate treatment and support services available for PLWHCV in custody?

Again, there was a variation in responses ranging from strongly negative (given that treatment levels depends on the prison, the length of the sentence, the prisoner's behaviour, and attitudes of prison and medical staff) to very positive from a health perspective. The latter description was qualified as a result of variable access, since every prison is different and guided by the security risks of minimum, medium, and maximum classifications. Even minimum prisons pose a challenge as inmates are often out at work and may be reluctant or unable to attend clinics, particularly if regular attendance is required.

The other major challenge highlighted was reinfection. This risk is very high in the absence of NSP and there is limited information available on how easily and effectively inmates access and use cleaning materials/agents to clean equipment. Cleaning agent availability can also be sporadic and knowledge on effective use differs depending on education availability, literacy skills, culture, and perceived stigma. There are also concerns that identification as an injector further contributes to a reluctance to use available cleaning agents.

Access to HCV treatment is available but there are significant barriers to service delivery brought about by operational matters (e.g. detainee movements) that could be mitigated through improved treatment protocols. Prison management's inability to release staff to attend workforce development training (with the exception of BBV awareness training during new recruit induction training) was also seen as unfortunate in the broader context of better service delivery.

Again, the issue of reinfection rates was raised in regard to the need for it to be tackled via harm reduction strategies rather than steadfastly sticking with many current policies that actually serve to undermine HCV elimination policies.

It was also highlighted that the number of PLWHCV entering the prison system each year is in the thousands and that the targets and achievements each year often fall well short of the number actually requiring treatment. There is clearly a lot of room for a scale-up to meet the need.

How could these services for PLWHCV in custody be improved?

A number of suggestions were provided by Key Informants, these included:

- Ability to increase BBV testing.
- Introducing NSP/improved harm reduction measures.
- Better access to patients.
- Fewer movements of patients.
- Greater investments in any/the assessment process and time, skill sets and infrastructure are required.
- Prevention services for PLWHCV in custody could be improved through the application of evidence-based policy.
- Policies and procedures need to be the same for prisoners at every prison and regardless of sentence length. If a prisoner is trying to access proper treatment and services, then it should be an absolute priority to provide them. If the patient's treatment plan is incomplete, follow ups are necessary upon release.
- The need for a national policy framework for BBV management in prisons with set targets and measure progress towards them.
- Addressing the inconsistencies in access to HCV treatment for prisoners in mental health facilities. Whilst these facilities are not prisons, many of their residents are 'detained'.

- Providing regulated access to “ice pipes” as this may be embraced by some prisoners as a safer way (non-injecting route of administration) to consume methamphetamines in prison.
- Having policies that are in line with current knowledge to minimise unnecessary spending and redirect resources to infrastructure and skills. For example, removing the need to test viral load as treatment is effective for low and high loads; and updating assessment guidelines for cirrhosis testing as for some drugs it is irrelevant. In addition, drugs are becoming safe enough not to require continual in-treatment testing, with testing only necessary at the start and end of treatment and once as a follow-up. This streamlining of tests could significantly increase throughput for treatment.

Are you aware of any policies or services that specifically cater for PLWHCV being released from custody?

Some jurisdictions have transition guidelines that are embedded in policies but staff knowledge can vary on these policies. As a result, many prisoners frequently slip through the gaps if they are released without notice, an especially common occurrence with those on parole or following court. There is also the issue of prisoner follow-up on referrals and their experiences with health services when they do make contact.

Many policies also refer to services available, such as testing on exit and referrals to GPs but in reality the uptake is very low.

It was also noted that while in the 2017 DAA era there are a lot more people being released to freedom after full treatment, in the event treatment has not been completed there are complications regarding the S100 scheme that applies in prison pharmacies which is different to the system that occurs in the community.

Do you think that there are adequate services available for PLWHCV being released from custody?

Generally, the response was characterised as inadequate although it was noted that there are pockets where it is good within some jurisdictions.

Highlighted issues included post-release location of ex-inmates, with rural and remote areas identified as especially challenging, and low follow up rates amongst rural Indigenous due to remoteness or stigma. Low levels of health literacy among patients and the difficulty many patients have in navigating the health system were raised; this included issues such as keeping appointments and not having their Medicare card. Another significant problem was the lack of funding for follow-up treatment, which often excluded prisoners with short sentences from commencing treatment. While this may seem pragmatic it is arguably better to commence treatment and ensure continuity of care.

How do you think that services for PLWHCV being released from custody could be improved?

- A commitment from the prison hierarchy to support appropriate policy and practice amongst their health staff is required.
- Dedicated health staff to connect and follow up patients into care in the community.
- Roundtable consultations led by PLWHCV consumers/clients to develop real and practical solutions. Governments, policy advisors, and health specialists must come together in negotiations led by consumers/clients of PLWHCV.
- Health services to be better funded and made available to the many prisoners deserving of lifesaving treatment. A follow up by peer organisations would also be beneficial.

- People entering custody should be encouraged to take up BBV testing as part of their initial health screening. They should then be tested again three months later, on occasions during detention, and again prior to release. This protocol would ensure that all occasions of in-prison BBV transmission are notified and people exiting prison would be certain of their status.
- With HCV treatment now being very effective and access to treatment greatly improved, testing prior to release from custody has become critical. Not only do prison health managers and advocates need the data (i.e. surveillance), but detainees need to know their status.
- Justice-based health services should do more to connect (refer) exiting detainees to community services (i.e. community hepatitis organisations, drug user groups, NSP networks, community mental health support services, access to naloxone).
- NSPs must be implemented and treatment services must be made more accessible.
- The importance of peer education cannot be overemphasised and should be available both during prisoners' time in custody and afterwards. It provides individuals with access to essential information from trusted peers and is cost effective.
- People in prison are excluded from MBS and PBS subsidies;[1, 2] one consequence is that there is no sustainable, scalable mechanism for supporting in-reach by primary care providers, despite strong evidence that early contact with primary care after release from prison is associated with better health outcomes.[3-5] The Federal Health Minister has the authority to end this exclusion under S19(2) of the Federal *Health Insurance Act* (1973).
- A major barrier to improved health outcomes for people transitioning from prison to the community is continuity of care. This includes continuity of treatment (including medications), maintenance of rapport with healthcare staff, and transfer of health and medical information about the patient. This is particularly relevant with respect to HCV treatment, which would be commenced in prison under the S100 scheme, despite the fact that the new DAAs are now available as S85 medicines in the community. The continuity of HCV treatment between prison and community is suboptimal, and one reason is that the current funding arrangements present a barrier to continuity of care. As such, the government's decision to continue to exclude people in prison from Medicare and PBS subsidies (in clear contravention of their human rights) undermines their investment in treating HCV in prison.
- An important advantage of the new DAAs is that treatment duration is much shorter. Because most prison systems do not commence treatment for people who may be released before treatment is completed, this means that many more people are potentially eligible for treatment. However, it is still the case that a proportion of prisoners will be excluded from treatment because their sentences are short (short sentences are more common in people convicted of low-level drug and acquisitive crimes). There is no evidence regarding (a) which prisons do and do not commence treatment for people who may be released prior to treatment completion, and why/why not; or (b) for those who are released during treatment, whether treatment is completed and what barriers/enablers exist. There is a clear and urgent need for better evidence regarding (a) current models of HCV treatment in prisons throughout Australia, (b) retention in HCV treatment for those released from prison during treatment, and (c) barriers and facilitators of treatment retention.

Recommendations

There are a number of important issues raised within this report that require consideration. However, in order to focus on some wider issues, the following key recommendations are made:

Policy

1. Develop, fund and implement a dedicated National Strategy for the prevention, diagnosis and treatment of blood-borne viruses and drug use in correctional settings (including juvenile justice) – noting that the Ministerial Council on Drug Strategy's first National Corrections Drug Strategy in 2008 could be utilised as a basis for its development.
2. Develop a more consistent and comprehensive national reporting system for hepatitis cases and treatment episodes including completion rates for all prison health systems.
3. Introduce mechanisms to ensure prison authorities become more transparent and accountable in meeting public health needs, particularly in relation to reporting and allowing access to infectious diseases data. Not all jurisdictions responded to our call for data and those that did provide data, provided very limited data.
4. Develop protocols for the prison based HCV treatment system to be mainstreamed as part of the community HCV treatment program. The transfer of patients from prions health services to community health services must be a priority to ensure treatment continues.

Resources / Programs

5. Increase the capacity of the health infrastructure in prisons to deliver treatment and meet demand for PLWHCV.
6. Increase drug treatment and harm reduction measures in all Australian prisons, especially in states where severe restrictions exist on OST as in Queensland.
7. A trial of a needle and syringe program in prison is recommended, in addition to increasing access to sterile tattooing and barbering equipment.
8. Increase access to resources and information to support people exiting custodial settings to continue HCV treatment in the community.
9. Increase information for post-release community organisations to support people exiting custodial settings to manage their HCV treatment.

Research

10. Determine the rate of BBV transmission *and* reinfection among prisoners in every jurisdiction, especially in jurisdictions where no information was located. There should also be a particular examination of non-injecting routes of transmission, such as tattooing and bloody fights.
11. All jurisdictions need to make a greater investment in prison-based BBV treatment, drug treatment, harm reduction, education and support services and alternatives to custody for minor offences.
12. Review the Stop C program in NSW - https://kirby.unsw.edu.au/project/stop-c with a view to expand into other jurisdictions.
13. Assess the newly established national network of people who work with treatment and testing HCV in prisons being established to determine if it should be supported – see **Appendix H**

Appendix A

National strategies, policy statements and guidelines:

Fourth National Hepatitis C Strategy 2014–2017

Fourth National Aboriginal and Torres Strait Islander Blood-Borne Viruses and Sexually Transmissible Infections Strategy 2014-2017

National Sexually Transmitted Infections Strategy 2014-2017

Hepatitis C Prevention, Treatment and Care - Guidelines for Australian Correctional Settings 2008

Consensus Statement: Addressing Hepatitis C in Australian Custodial Settings, Hepatitis Australia 2011

Australian recommendations for the management of hepatitis C virus infection: a consensus statement, ASHM 2017

Australian Hepatology Association Consensus-Based Nursing Guidelines for the Care of Patients with Hepatitis C, 2012

AMA Position on Blood-Borne Viruses 2017

The Silent Disease – House of Representatives Inquiry into Hepatitis C in Australia, 2015

Australian Government response to the House of Representatives Standing Committee on Health report: the Silent Disease, 2016

National Corrections Drug Strategy in 2008

NSW

NSW Hepatitis Strategy 2014-2020

NSW Hepatitis Strategy 2014-2020 Annual Data Reports 2014, 2015, 2016

Justice Health Hepatitis C Strategic Plan 2007-10

Justice Health Infectious Diseases Policy

Justice Health Communicable Diseases Policy

Justice Health Hepatitis C and B: Care, Management and Treatment

Justice Health Early Detection for Blood-Borne Viruses and Sexually Transmissible Infections

Justice Health Service Agreement 2016-2017

NSW Health Hepatitis C Control Guideline

Corrective Services Operations Procedures Manual on Infectious Communicable Disease

Corrective Services Operations Procedures Manual on HIV/AIDS/Hepatitis C Issues

ACT

ACT Health Adult Corrections Health Services Plan 2008-2012

HIV/AIDS, Hepatitis C, Sexually Transmissible Infection: A Strategic Framework for the ACT 2007-2012

Draft Drug Policies and Services Framework for the Alexander Maconochie Centre 2012-2014

Strategic Framework for the Management of Blood-Borne Viruses at the Alexander Maconochie Centre 2013-2017

ACT Statement of Priorities 2016–2020

Victoria

Victorian Hepatitis C strategy 2016–2020

Justice Health Communicable Disease Framework

Corrections Alcohol and Drug Strategy 2015

Tasmania

Healthy Prisons, Healthier Communities – Blood-Borne Virus Strategy 2010-2013

Queensland

Queensland Hepatitis C Action Plan 2016-21

Strategic Directions for HIV/AIDS, Hepatitis C and Sexual Health 2009-2012

Strategic Directions for Communicable Disease Prevention and Control 2009-12

Management of occupational exposure to blood and body fluids 2017

Corrective Services Procedure - Communicable Diseases

Sexual Health Strategy 2016-21 (in consultation)

WA

WA Hepatitis C Strategy 2015–2018

Assessment of Clinical Service Provision of Health Services of the WA Department of Corrective Services 2010

Adult Justice Services Health Services Procedure CD01 Blood-Borne Virus Testing and Notification of Results for Adult Patients

Chronic Hepatitis B and C Primary Care Pathway

SA

SA Prisons Blood-Borne Virus Prevention Action Plan 2017-2020

SA Hepatitis C Action Plan 2009-2012

South Australian Hepatitis C Implementation and Evaluation Plan 2015-2016

SA Hepatitis Implementation Plan 2016-2020

South Australian Sexually Transmissible Infection Implementation Plan 2016-2018

SA Prison Health Service Model of Care

NT

Hepatitis B and C Custodial Care Guidelines

Highly Specialised drugs (HIV, HBV, HCV)

Medical Practitioners Prescribing DAA in Consultation with Specialists for Treatment of HVC Infections

Appendix B

Letter sent to all jurisdictional Corrections and Health Departments:

- ACT Corrective Services
- NSW Department of Corrective Services
- NT Department of Justice
- QLD Department of Corrective Services
- SA Department for Correctional Services
- TAS Department of Justice
- Corrections Victoria
- WA Department of Corrective Services
- ACT Health
- NSW Health
- NT Department of Health
- Queensland Health
- Commonwealth Department for Health and Ageing
- TAS Department of Health & Human Services
- VIC Department of Health and Human Services
- WA Department of Health

Dear

RE: Request for Information on Prisoners with Hepatitis C Virus (HCV)

As you may be aware, the Australian & Injecting Illicit Drugs Users League (AIVL) has been funded by the Federal Government to provide a report on the needs of people living with hepatitis C virus (PLHCV) being released from custodial settings into the community.

Accordingly, I am writing to seek your assistance in accessing information about the services your Department provides and some of the data you may have regarding these services.

Specifically, we are seeking your information and data concerning:

1. Number of people in [state/territory] custodial settings who are screened for HCV upon entry
2. Number of people in [state/territory] custodial settings living with HCV
3. Number of people in [state/territory] custodial settings commencing HCV treatment.
    a. Number of people who complete treatment in custody;
    b. Number of people who do not complete treatment due to being released or other reason

We are also seeking [state/territory] correctional services policies regarding:

1. HCV screening
2. HCV treatment
3. Other support in accessing treatment (clinical trials or other research studies)
4. Referral and transition from custodial HCV treatment into community based HCV treatment

Finally, any information you can provide quantitative and qualitative data on the:

1. Efficacy of custody to community HCV treatment referral and transition processes
2. Community support available for accessing treatment and transitioning to community-based treatment upon release.

Our aim is to provide a comprehensive report on the needs of PLHCV in transition and after being released from custodial settings.

I also want to inform you that a similar letter has been sent to [corresponding department] requesting information.

Should you require any further information regarding the information being requested please do not hesitate to contact one of the consultants for this project:

Prof Kate Dolan
Ph: 02-9385-0331
Email: K.Dolan@unsw.edu.au
Postal: NDARC, UNSW, Sydney NSW 2052

Conversely you can contact me directly on 02-6279-1600 or via email on melaniew@aivl.org.au

Any information and/or advice you could provide prior to 3 July 2017 would be most gratefully received.

Yours sincerely

Melanie Walker
Chief Executive Officer
Australian Injecting & Illicit Drug Users League

Appendix C

Survey Dissemination Email

Dear Colleagues

As many of you would know, there are significant gaps in our understanding of the landscape of hepatitis C virus (HCV) treatment in custodial settings, including poor data on the number of people living with HCV, service accessibility and the support available upon release.

As part of AIVL's ongoing commitment to ensuring the development and delivery of best policies and service practices for people living with HCV, we are currently preparing a report commissioned by the Commonwealth Department of Health on the current situation and needs of people living with HCV being released from custody. Our goal is to identify gaps and opportunities for people within custodial settings to access HCV treatment and to identify where resources and/or additional work is needed to ensure a seamless transition to care after release from custody.

The underlying principles informing our project are that people in custodial settings should receive equivalent health care to the general community, including access to uninterrupted HCV treatment and care. Our project also recognises that custodial settings present a significant opportunity to address long term health concerns, including HCV, and that treatment uptake could be significantly increased.

To gain a better understanding of the situation faced by people living with HCV both in custody and after release we are conducting a short survey of people who provide services for people living with HCV in the community and/or in custody.

Your assistance by completing this survey, and disseminating it to others who may be able to contribute, would be greatly appreciated - please

click here to complete the survey.

For further information on AIVL or this project please feel free to contact me at jamesd@aivl.org.au

Closing date – Friday 4th August 2017

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Appendix D

What is your professional or work category – please tick and more than one category can be ticked:

- Advocacy & Support for People with HCV
- Health or Medical Professional
- Corrective Services
- Other Law Enforcement (Police, courts etc.)
- Legal
- Education
- Academic/Research
- Other – please write your category

1. State/Territory you work in – please tick and more than one can be ticked:

- QLD
- NSW
- ACT
- VIC
- TAS
- SA
- WA
- NT
- All (Federal)

2. How would you describe the geographic area you work in? – please tick and more than one can be ticked:

- Remote
- Rural/Regional
- Urban

3. Do you have direct contact with People Living with the Hepatitis C Virus in your professional capacity? – please tick

- Yes
- No
- Unsure

4. Do you have direct contact with people in custody (prison, police cells etc.)? – please tick

- Yes
- No
- Unsure

5. Do you have direct contact with People Living with the Hepatitis C Virus in custody? – please tick

- Yes
- No
- Unsure

6. Are you aware of Hepatitis C Virus testing policies in prisons? – please tick

- Yes
- No
- Unsure
- If yes, please describe your understanding of these policies in a few sentences:

7. Are you aware of any other services for People Living with the Hepatitis C Virus in custody? – please tick

- Yes
- No
- Unsure
- If yes, please describe your understanding of these policies in a few sentences:

8. Are you aware of any policies that specifically cater for People Living with the Hepatitis C Virus being released from custody? – please tick

- Yes
- No
- Unsure
- If yes, please describe your understanding of these policies in a few sentences:

9. Do you think that there are adequate treatment and support services available for People Living with the Hepatitis C Virus in custody? – please tick

- Yes
- No
- Unsure

10. Do you think that there are adequate services available for People Living with the Hepatitis C Virus being released from custody? – please tick

- Yes
- No
- Unsure

11. Do you think that services for People Living with the Hepatitis C Virus **in custody** could be improved? – please tick

- Yes
- No
- Unsure
- If yes, please describe how in a few sentences:

12. Do you think that services for People Living with the Hepatitis C Virus being **released from** custody could be improved? – please tick

- Yes
- No
- Unsure
- If yes, please describe how in a few sentences:

Thank you for your time and thoughts

Appendix E

1. Key Informant Interview Questions

2. We want to ask about services for People Living with the Hepatitis C Virus (PLWHCV) in custody and in the community.

3. Which jurisdiction(s) in Australia are you able to comment upon in this regard?

4. Are there explicit policies that address hepatitis C infection and treatment in prison?
   In your opinion are the policies sufficiently comprehensive or are there areas that the policies still need to address?

5. How well do you think that these policies are delivered to PLWHCV in custody?

6. Can you list the services that are available for PLWHCV in custody?

7. How well do you think that these services are delivered to PLWHCV in custody?

8. Do you think that there are adequate treatment and support services available for PLWHCV in custody?

9. How could these services for PLWHCV in custody be improved?

10. Are you aware of any policies or services that specifically cater for PLWHCV being released from custody?

11. Do you think that there are adequate services available for PLWHCV being released from custody?

12. How do you think that services for PLWHCV being released from custody could be improved?

13. Any other comments?

Appendix F

Request for Quote

Consultant to undertake the development of a needs analysis for people living with HCV after being released from custodial settings

Project Aim

To understand the needs of people living with HCV after being released from custodial settings.

Tasks

The external consultant will:

- Undertake a review of current academic and grey literature, policies and epidemiological data and other sources of evidence to establish the current situation for people living with HCV within custodial settings, and best practices in Australia or internationally for providing a high standard of care both within custodial settings and during transition back into the community. This is undertaken in line with the Project Needs Assessment Methodology and Framework.
- Undertake a program of consultations with people exiting custodial settings who have had or are currently living with HCV and other key informants, in line with the Project Needs Assessment Methodology and Framework.
- Develop a draft and final report that incorporates a literature review, consultation data, analysis of consultation data and recommendations for action that include responses at the national level and within states and territories.
- Undertake this work under the direction and guidance of the Project Steering Group and AIVL staff.

Relevant documents

- Project Needs Assessment Methodology and Framework (Appendix 1).

Requirements

The external consultant should have:

- Experience undertaking multi-jurisdictional consultations with both community members and professionals.
- Knowledge of and experience working with justice health agencies and stakeholders connected to the justice system.
- Strong written, data collection and data analysis skills.
- High level understanding and knowledge of harm reduction approaches and philosophies, and hepatitis C and blood-borne viruses.
- Experience working with people who inject drugs.

HRA Proposal

Methodology:

The key part of the project will involve a two-stage desktop review that will focus on:

1. available epidemiological data of HCV among people in custodial settings and

2. policies and resources pertaining to HCV screening and treatment in custodial settings.

The first part of the review will focus on the epidemiological data of HCV among people in custodial settings across all jurisdictions, including:

- Number of people in custodial settings who are screened for HCV upon entry.
- Number of people in custodial settings living with HCV.
- Number of people in custodial settings commencing HCV treatment.

Among those who commence treatment in custody, we will look at:

- Number of people who complete treatment in custody;
- Number of people who do not complete treatment due to being released or other reason and whether or not they complete treatment in the community and why.

The second part of the review will focus on policies and resources in custodial settings pertaining to:

- HCV screening.
- HCV treatment.
- Other support in accessing treatment (clinical trials or other research studies) in each jurisdictional custodial setting.
- Current guidelines, policies and processes for referral and transition from custodial HCV treatment into community based HCV treatment.
- Efficacy of custody to community HCV treatment referral and transition processes including both quantitative and qualitative data.
- Community support available for accessing treatment and transitioning to community-based treatment upon release.

Given that a substantial proportion of this epidemiological and policy data and information is not expected to be available publicly (via desktop review), there will be a need for direct correspondence with each relevant Department (Corrections and Health) to be prepared and managed by the project team (including follow-up correspondence, where required) and distributed by AIVL to each jurisdiction.

Key Informant Interviews

Structured interviews will be conducted with PLWHCV recently released from custody – these interviews will be undertaken by an organisation in each jurisdiction, based on the advice of the project steering committee and AIVL.

Surveys

An online survey (utilising Survey Monkey) will be developed and circulated via existing networks established by AIVL and the steering committee to a range of key stakeholders. The results of these surveys will be collated and analysed to add to the depth of knowledge on current practices for PLHCV released from custody.

Best Practice Information

Based on the desktop review, information received from relevant Departments, key informant interviews and online survey of key stakeholders the project team will prepare some information on best practice for PLWHCV being released from custody.

Appendix G

Title: Overlooking the obvious: Australia leads the world in HCV treatment, yet its policies fall short in prison settings

Running Title: Policy constraints of HCV treatment scale-up in the prison setting

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Appendix H

Australian Prisons Hepatitis C Network

This document describes a proposal to develop a National Prisons Hepatitis C Network to facilitate improvements in testing and antiviral treatment of prisoners with hepatitis C (HCV) infection. The proposal includes an initial national workshop, a collaborative workplan with regular information exchange and collection of surveillance data, a possible collaborative research program, and an administrative infrastructure to support these Network activities.

Background:

Almost a quarter of a million Australians are affected by chronic hepatitis C (HCV) infection, with the overwhelming majority infected via injecting drug use. As there is a close relationship between imprisonment, injecting drug use, and HCV, in any given year, at least 15,000 of those infected spend time in prison. This group are likely to constitute one of the most marginalised patient groups affected by HCV who are unlikely to access health services in any other setting. In addition, this group features high rates of ongoing HCV transmission both in prison and in the community. In combination, these attributes argue for high priority to be placed on antiviral treatment of prisoners.

The pharmaceutical development and recent Australian Pharmaceutical Benefits Scheme (PBS) listing of direct-acting antiviral agents (DAAs) now offers well-tolerated, short course, highly curative treatments for HCV, including S100 prescribing for prisoners. Australia is in a unique position globally with universal, heavily subsidised access both to testing (for HCV antibodies and the virus), as well as to DAA treatments. These elements underpin Australia's strategy towards the World Health Organisation 2030 HCV elimination goals. The major residual challenge for Australia is development and implementation of the health service infrastructure and models of care to ensure comprehensive access and uptake of DAA treatments to all those affected.

Delivery of health services in the prison context is challenging, as prisons feature complex bureaucratic structures, overcrowding, frequent movements, high rates of mental illness, and uncontrolled exposure to violence and illicit drugs. Despite these challenges, in collaboration with the Justice Health & Forensic Mental Health Network (JH&FMHN) in NSW, Professor Andrew Lloyd has established a safe, effective, and efficient hepatitis service in the NSW prisons with task transfer to hepatitis-skilled nurses, telemedicine links to specialist support, portable fibro-elastography to assess liver scarring, as well as structured protocols and proformas. A similar nurse-led model of care has also recently been successfully implemented in the prisons system in Victoria by Professor Alex Thompson. By contrast, available data suggests that more limited services exist in correctional facilities in other states and territories.

Accordingly, **the first goal** of this proposal is to establish a national network of the key stakeholders to facilitate information exchange and support to enhance development of health infrastructure for testing and treatment of HCV in the custodial sector nationally.

As laboratory notifications for HCV do not specifically identify prisons as a testing source, only regular surveys such as the triennial National Prison Entrants' Blood-Borne Virus and Risk Behaviour Survey (NPEBBVS) offer insights into HCV prevalence. In addition, the PBS does not specifically identify antiviral treatments originating in prison, although estimates via S100 prescriptions offer some insights. Hence, **the second goal** is to support the Network in developing data capture systems to measure testing and treatment rates in the prison sector.

The third goal of the Network will be to facilitate health services research to drive policy making for scale-up of HCV treatment in the prisons. For instance, data regarding efficiencies and costs of the nurse-led model of care in NSW are currently being gathered in the PACT study (Prisons Alliance for hepatitis C Treatment) led by Professor Lloyd with support from the NHMRC Centre for Research Excellence in Prisoner Health. In Phase I of PACT, the existing protocols and proformas for the nurse-led model of care in NSW prisons have been updated

for the DAA era, and the efficiency and timeliness of the care cascade are being assessed. In Phase II, the aim is to develop and evaluate comparable, or more suitable, locally-adapted models of care in other states, including with cost-effectiveness analyses linked to existing mathematical models in the Kirby Institute for both the prisons and community sectors, with resource utilisation and costings data collection to allow epidemiological modelling of the impact and cost-effectiveness of treatment scale-up in the prisons, and bench-marking against comparable community estimates.

Workshop and Network:

An initial national workshop is planned to gather key stakeholders from corrections and health organisations in each state or territory for a one-day meeting, including specialist physicians, general practitioners, nurses, health administrators, prison managers, as well as community representatives. A similar successful and influential workshop was held in 2013 which delineated a national roadmap for enhancement HCV treatment in custodial settings (Mina M, et al. *Medical Journal of Australia* 2014 Jan 20; 200(1):15-6). The primary outcome was awareness raising, with many challenges identified and some potential solutions proposed – largely pending DAA availability. From this workshop, it is anticipated another Perspectives article for the Medical Journal of Australia (or similar) will be produced delineating the role of the corrections health sector in HCV elimination in Australia.

Once formed, the Network will resolve mechanisms for regular information exchange, joint efforts to enhance surveillance of testing and treatment, and collaborative research activities. It is anticipated a webpage will be established – initially via the NHMRC Centre for Research Excellence in Offender Health, quarterly teleconferences for selected groups (surveillance, treatment, policy), and an annual workshop will follow.

Finally, the Network may then engage in collaborative research with the goal of maximizing the scope and efficiencies of HCV treatment scale up in the corrections sector.

Strategic Alignment:

This Network is closely aligned with the Fourth National Hepatitis C Strategy (2014-2017), which indicates: "The vast majority of people living with HCV are people who inject or have injected drugs. This group must be prioritised in efforts to improve treatment opportunities." In particular, the Strategy designates priority populations, as including "people in custodial settings" and "people of Aboriginal and Torres Strait Islander backgrounds". This Network will seek to support these strategic goals by providing an opportunity for key stakeholders in all states and territories to evaluate the current health care systems in their respective jurisdictions with a view to improving access to treatment for prisoners and to "work on refining and developing indicators… for the measurement of appropriate HCV treatment and management" by developing a collaborative network of those involved in surveillance and treatment, and thence the data collection infrastructure for the HCV care cascade in the custodial sector nationally. It is also hoped the workshop will contribute to reducing HCV incidence in the custodial setting by exploring strategies to facilitate the scale-up of treatment and thence prevention of new transmissions in the closed prison environment (treatment-as-prevention).

Appendix I

Information provided by the Victorian Department of Justice and Regulation

1. Number of people in VIC custodial settings who are screened for HCV upon entry

As per the Justice Health Quality Framework, medical practitioners conduct a health assessment on all prisoners in the first 24 hours of reception into prison, which includes family history, medical history, alcohol and other drug use, blood-borne viruses, sexually transmissible infections and mental health, in order to ensure appropriate management and/or referral to other health professionals. All prisoners are offered screening for communicable diseases. Each time a prisoner moves between prisons they must be seen by a registered nurses within 24 hours of transfer with a full health assessment conducted.

2. Number of people in VIC custodial setting living with HCV

The National Prison Entrants' Blood-Borne Virus and Risk Behaviour Survey reported hepatitis C rates of 25 per cent among Victorian prison entrants in 2013.[1] By comparison, around one per cent of the general population are diagnosed with the virus.[2] The survey found 41 per cent of screened prison entrants that identified as Aboriginal and/or Torres Strait Islander tested positive to hepatitis C, compared with 23 per cent of non-Indigenous prison entrants. The prevalence of hepatitis C is reflective of the high proportion of prisoners in Victoria who are imprisoned for drug related offences and the high proportion of prisoners with a history of injecting drug use.

3. Number of people in VIC custodial settings commencing HCV treatment

a) Number of people who complete treatment in custody

b) Number of people who do not complete treatment due to being released or other reason

On 1 April 2015, the then Minister for Corrections approved the establishment of a hepatitis assessment, consultation and treatment program within Victorian prisons (the Program), with the program to be delivered by St Vincent Hospital Melbourne (SVHM). The Program is based on a comprehensive nurse-led model of care, adapted from a program run by the New South Wales Justice Health Department, for hepatitis assessment and the treatment of prisoners with chronic hepatitis B (HBV) and C (HCV).

Through this program, a statewide network of hepatitis clinics has been established throughout the Victorian prison system to ensure prisoners are assessed and treated for hepatitis C. Prisoners receive support to manage their disease under the program, which includes dedicated nurses, specialist physicians and an education program for prisoners and prison staff. The aims of the Program is to deliver best practice clinical care and also to improve health outcomes for prisoners living with chronic HCV infection and chronic HBV infection. The is being achieved by implementing a HCV and HBV program service delivery model that provides a comprehensive evidence-based model of care for prisoners in all Victorian Prisons.

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1 Butler T., Callander, D., Simpson, M. {2015). National Prison Entrants' Blood-Borne Virus and Risk Behaviour Survey 2004, 2007, 2010 and 2013. Kirby Institute (UNSW, Australia).

2 Australian Institute of Health and Welfare {AIHW) (2012). The health of Australia's prisoners 2012.Cat. no. PHE 170. Canberra: AIHW.

The Program deliverables include:

- To increase rates of voluntary screening for HCV and hepatitis B virus infection amongst Victorian prisoners
- To provide each prisoner referred to the Program with a liver health assessment and liver health care plan, whether undertaking treatment or not, which can be utilised on release from prions.
- To provide a comprehensive education program to primary health care staff to ensure health staff have information protocols and pathways for treatment.
- To implement a model of hepatitis care for prisoners in Victoria's prison system, including education of prisoners and prison correctional staff.
- To deliver statewide decentralised care for patients through a protocol-driven, structured assessment and management of antiviral therapy by Program Nurses.

The new HCV treatments have been introduced into prisons and the Program has produced promising results. The Program commenced in July 2015 with assessment clinics commencing October 2015. Since the commencement of the assessment clinics 1,334 prisoners have been assessed. The HCV treatment program commenced on 1 March 2016 and as of 31 July 2017, 1,379 prisoners have been assess for HCV treatment and 885 prisoners have commenced on HCV treatment.[3]

VIC correctional services policies regarding:

4. HCV screening

5. HCV treatment

Justice Health has a number of policies and programs which aim to provide strategic guidance to prevent, detect and treat blood-borne viruses and sexually transmissible infection among Victorian prisoners.

The updated Justice Health Communicable Disease Framework 2017, which replaces the 2012-2014 framework, sets out the Department of Justice and Regulation's goals and objectives for action on communicable disease, including hepatitis C. The Framework sets out two goals and 10 objectives to govern holistic and effective action on communicable disease. The Framework is available online via the department's website at www.corrections.vic.gov.au.

The Framework should be read in conjunction with the *Corrections Alcohol and Drug Strategy 2015* which guides the prevention of drugs entering prison and contributes to the development of harm reduction, prevention and treatment approaches to the health impacts of drug use among prisoners.

6. Other support in accessing treatment (clinical trials and other research studies)

Participation of prisoners in clinical trials needs to be balanced with the State's non-delegable duty of care for prisoners and the provision of informed consent in the context of the low literacy of what can be a vulnerable population. Research involving prisoners in Victoria should only be conducted if there is a clear benefit to the prisoners involved. Notwithstanding this, Justice Health is supportive of prisoner participation in clinical trials and therefore contribution to potentially beneficial research, based on the principle of provision of community equivalence in healthcare.

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[3] Data source: St Vincent's Hospital (Melbourne) Gastroenterology Department. Statewide Hepatitis Assessment and Treatment Program

7. Referral and transition from custodial HCV treatment into community based HCV treatment

Quantitative or qualitative data on the:

a) Efficacy of custody to community HCV treatment referral and transition processes

b) Community support available for accessing treatment and transitioning to community-based treatment upon release

The Statewide Hepatitis Assessment and Treatment Program (the Program) includes a comprehensive communication and referral pathway for prisoners who are to be released including those who have completed or are yet to complete their treatment.

The contracted health service provider develops a liver health assessment and liver healthcare plan to all prisoners who are referred to the Program. Permission is sought from the prisoner to forward the details of this liver health care plan to the Patient's local GP once released.

The contracted health service provider uses the liver health care plans in the pre-release planning and coordination of care with community based hepatitis services for prisoners on release. A post-release referral is made to a local GP, as well as the local specialist hepatitis clinic. Additionally, a referral is provided to the local community hepatitis nurse to facilitate and follow-up GP and liver clinic review in accordance with local services. All prisoners are released with a summary statement of their participation in the Program, as well as their liver care plan. The contracted health service provider sends copies of these documents to the local GP, community hepatitis nurse and specialist clinic.

The contracted health service provider also follow up prisoners who are deemed unsuitable for antiviral treatment, or who chose not to receive antiviral treatment, in accordance with a monitoring program.

In addition, Hepatitis Victoria delivers hepatitis education for prisoners, prison staff as well as peer educator program. The program aims to reduce the risk of transmission and increase awareness of and support for the people with viral hepatitis in custodial settings. All prisoners have access to the Hepatitis Infoline whilst they are in prison. Upon release the Infoline continues to be available in the community. It provides information, support (to assist people to be able to make positive decisions related to their health and wellbeing) and referrals (including to specialist services such as liver clinics, complementary therapists, multicultural and multilingual support services, youth and Indigenous services) for people living with hepatitis C or B.

References

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[xii] Luciani, Bretana, 2014

[xiii] Miller, Bi, Ryan, 2009

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[xvi] The health of Australia's prisoners 2015

[xvii] The health of Australia's prisoners 2015

[xviii] World Hepatitis C Day – Effective treatment reducing Hepatitis C rates at AMC

[xix] Correspondence from ACT Health, July 2017

[xx] Correspondence from ACT Health, 2017

[xxi] Correspondence from ACT Health, 2017

[xxii] Correspondence from ACT Health, 2017

[xxiii] Correspondence from NSW Health, August 2017

[xxiv] NSW Hepatitis Strategy 2014-2020 Annual Data Reports 2014

[xxv] NSW Hepatitis Strategy 2014-2020 Annual Data Reports 2015

[xxvi] NSW Hepatitis Strategy 2014-2020 Annual Data Reports 2016

[xxvii] NSW Hepatitis Annual Data Reports 2014

[xxviii] NSW Hepatitis Annual Data Reports 2015

[xxix] NSW Hepatitis Annual Data Reports 2014

[xxx] NSW Hepatitis Annual Data Reports 2015

[xxxi] Correspondence from Qld Health, July 2017

[xxxii] Correspondence from Qld Health, 2017

[xxxiii] Correspondence from SA Corrective Services, July 2917

[xxxiv] Hepatitis SA Submission to the House of Representatives Inquiry, 2015

[xxxv] SA Prison Blood-borne Virus Prevention Plan 2017-2020

[xxxvi] Correspondence from TAS Department of Health and Human Services, July 2017

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[xxxix] Correspondence from WA Corrective Services, July 2017

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