

Care for people with hepatitis C in provincial and territorial prisons

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Correctional Service Canada recently quadrupled its budget for hepatitis C virus (HCV) treatment for 2017/18, ensuring that the estimated 2700 people with chronic HCV who are in federal custody have access to treatment.¹ The same commitment toward elimination of HCV has not yet been made for the 4380 people living with chronic HCV infection in provincial and territorial prisons.^{2,3}

Several factors, including high turnover rates owing to short incarcerations, frequent prison transfers, and the high cost of curative treatments (direct-acting antivirals), may be deterrents to establishing programs for HCV treatment in nonfederal institutions. However, limited HCV care and treatment for people in Canadian provincial and territorial prisons contribute to persistent inequities in access to care. Improved access to health services that includes screening for HCV, treatment and linkage to care strategies facilitated by pre-discharge planning and post-release transportation will ensure that no one who spends time in prison is left behind.

The HCV cascade of care describes successive health care steps specific to chronic HCV infection that result in optimal health outcomes.⁴ Screening, the first step of the HCV care continuum, lays the foundation for subsequent linkage to care, initiation of treatment and achievement of HCV cure. The World Health Organization (WHO) recommends that all people in prison be tested for HCV;⁵ however, this standard has not been met yet in Canada. Currently, systematic screening programs do not exist in any provincial and territorial prisons except for those in British Columbia. The result is that a limited number of people with HCV infection are made aware of their potential need for treatment. Drawing on best practices from the United States and some Canadian jurisdictions, universal screening could be offered to people in custody shortly after admission. An opt-in approach would respect individual rights while simultaneously identifying a greater number of new infections.

Strategies aimed at improving access to treatment during and following incarceration should be explored in provincial and territorial prisons. However, there are a few challenges that should be considered if HCV treatment is started in these settings. Although maximum sentences in provincial and territorial prisons are two years less one day, the median time in custody is less than one month.³ A course of direct-acting antivirals is typically

KEY POINTS

- Care for patients with hepatitis C virus (HCV) infection has not been prioritized in most provincial and territorial prisons in Canada.
- Successful completion of HCV treatment begun in provincial and territorial institutions may be challenging.
- Universal screening, treatment and linkage to care are viable programmatic options to increase engagement with the HCV cascade of care.
- Multidisciplinary care can improve health outcomes for people with HCV infection who are in custody.

12 weeks, which means that completion of treatment is often unlikely before release. Because of the inherent challenges in ensuring continuity of care at the time of release, there may be an increased probability of treatment interruption that results in treatment failure and the emergence of treatment-resistant HCV strains, complicating future attempts at cure.⁶

A recent study comparing HCV cure (as determined by sustained virologic response [SVR]) among people in custody found that SVR rates were highest for those who completed treatment in prison (74%), compared with those who were transferred (59%) or released during treatment (45%).⁷ These findings highlight the potential for treatment failure when starting HCV treatment for individuals who may be transferred or released during therapy. Conversely, a Canadian study showed that if appropriate follow-up is in place at the time of release, a higher proportion of this population is likely to achieve SVR (65%), which suggests that treatment initiation could be considered a feasible option in prison settings.⁸

The standard procedures needed to facilitate linkage with care post-release do not exist in many provincial and territorial institutions. Evidence suggests that people in prison who receive pre-release discharge planning (i.e., scheduled medical appointments) and post-release transportation to their appointments are more likely to be retained in care.⁹ Such strategies could be provided by an onsite multidisciplinary care team, as multidisciplinary care is associated with improved engagement along the HCV care cascade and patient-reported outcomes.¹⁰ In addition, persons in custody could benefit from nurse-led HCV

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education and liver fibrosis characterization via transient elastography, each of which has been associated with increased linkage to care following release.^{9,11} Proper investment in these clinical care pathways could also improve adherence for those being treated while in custody and those released before treatment completion. Furthermore, in the context of a population with multimorbidity, strengthening linkages with primary care, rather than disease-specific specialty care following release, may be the ideal long-term solution. With the advent of simpler direct-acting antiviral regimens, integrating HCV care into primary care is also a feasible alternative.

People in prison are at higher risk for reinfection given that many acquired HCV through substance use and specifically through injection. Minimizing the risk for reinfection (or primary infection) through drug addiction counselling and access to prison-based needle and syringe programs, in addition to regular HCV testing for those at high risk, should be offered to all people in custody as part of comprehensive HCV prevention and care. Advocacy for access to harm reduction programs (e.g., sterile syringes) and materials for safer tattooing within and outside prisons to limit both new and recurrent HCV infections remains important.

The Global Hepatitis Strategy, 2016–2021, that was put forth by the WHO¹² aims to reduce global HCV infections by 90% as of 2030. Canadian provincial and territorial prisons must do their part by offering screening to inmates, and ensuring necessary individualized treatment and linkage to care that is rooted in a multidisciplinary approach involving nurses, social workers and patient navigators. Such processes are not currently in place. Scaling-up HCV treatment should be the objective of all correctional facilities, not just federal ones. Proactive care models could substantially improve patient-related health outcomes as

well as the effectiveness and cost-effectiveness of prison-based treatment as prevention strategies.

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