T R A N S C R I P T

LAW REFORM, ROAD AND COMMUNITY SAFETY COMMITTEE

Inquiry into drug law reform

Melbourne — 4 September 2017

Members

Mr Geoff Howard — Chair
Mr Bill Tilley — Deputy Chair
Mr Martin Dixon
Mr Mark Gepp
Ms Fiona Patten
Ms Natalie Suleyman
Mr Murray Thompson

Witness

Ms Melanie Eagle, chief executive officer, Hepatitis Victoria.

Necessary corrections to be notified to executive officer of committee

The CHAIR — We are now meeting with Melanie Eagle, the CEO of Hepatitis Victoria. Welcome to the Law Reform, Road and Community Safety Committee. We noted that Hepatitis Victoria did present a submission to the inquiry in our written submissions, and we are pleased to have you here this morning to present further in regard to the issues that are relevant to Hepatitis Victoria. You will see that Hansard is there recording everything that is said, and a transcript of the notes from our discussion will come back to you in a couple of weeks for technical correction. After that they will be going on our public site and will be publicly available. You would understand parliamentary privilege applies to anything you say when you are speaking to us. I am not sure whether that is going to be relevant to you or not.

Ms EAGLE — I do not think so.

The CHAIR — Melanie, if you would like to start by leading us through some of the key points you would like to share with us, we will then be able to follow up with some questions to you and some discussion after that.

Visual presentation.

Ms EAGLE — Perhaps I will give just a brief overview of the paper that we did submit, although I am sure, as you say, you are familiar with that, and then I did concentrate a bit more on one of the three items that the organisation addressed.

I am the CEO of Hepatitis Victoria, the peak not-for-profit in the state, which is part of a coalition of bodies that comprise Hepatitis Australia. I am on the board of that as well, and this is an issue that is dear to all of our hearts and is something that we have sought to advocate around over a long period of time. The position that we come from both at Hepatitis Australia — but I am obviously speaking on behalf of Hepatitis Victoria — is that of harm minimisation and concern about transmission of hepatitis, largely hepatitis C. So I am not speaking on the broader range of issues that could possibly be considered around drug use but really as it pertains to transmission of bloodborne viruses and how to minimise that, and I am coming from the standpoint of harm minimisation. You would have, I am sure, heard many others address you on that point, but accepting realities and how can we reduce harm.

So just briefly, with hepatitis itself — and I am not sure how much that will have been a topic that you have been referred to — we are in a transformative phase in relation to hepatitis. We have global, national and state strategies, very excitingly, that speak to the elimination of hepatitis B and C. So the government has committed to that and the previous government as well in terms of the national strategies, and they all form a global strategy, and within that they talk about ramping up not only treatment but also prevention. I think a lot of what I am speaking to is more on the prevention side — how to prevent transmission. Using those points of intersection, I guess I am also speaking to referring people to testing and to treatment about hepatitis. I guess many similar things go in relation to HIV, but I am just talking from a hepatitis point of view and why this is so important.

As I said in the beginning of my paper from the organisation — our position paper — there are over 100 000 Victorians who live with chronic hepatitis B and C. Happily there is a reduction of hepatitis C through treatment, but the reduction rate is slowing and many people are now concerned that it is really not going to go as fast as we had hoped and that we are going to have a core group of people who are not engaging in treatment or care, and we have really got to find how to reach out to those and get them onto treatment and at the same time prevent transmission. I can expand, obviously, on any of that because that is something I deal with.

The CHAIR — Yes.

Ms PATTEN — Yes, great.

Ms EAGLE — To me it is all very obvious, but it is obviously not to everybody and was not to me before I was involved in the area. So, yes, it is very prevalent and it is still being transmitted, and it is actually also a very serious health burden.

What I said here was that four Victorians died a week as a consequence of viral hepatitis. Since that time the Kirby Institute data has come out and shows based on 2015 data that nearly six Victorians die a week of viral hepatitis. This is of road toll proportions, so we do have to think seriously, I feel, about our opportunities for

reducing that health burden. We need to be innovative and prepared to consider different ways of approaching it, because although Victoria has been innovative and we are well-regarded for what we have done in terms of the rollout of needle and syringe programs, for example, we are probably going to have to push that further if we are going to get to the harder to reach communities.

I have spoken a bit about our strategies, which was the next part that I talked to there, and the general approach that Hepatitis Victoria has in terms of harm minimisation. I can just touch on those three different areas. That is what I was proposing to do and then speak more in-depth about the situation in prisons, if that is okay.

You have probably heard plenty about needle and syringe programs. I do not know, I have not looked at who else has presented; I am not aware of that. But I guess the point there is that they have been around sufficiently long that we have been able to demonstrate them in the Australian community as having been effective in the reduction of bloodborne viruses including hepatitis C specifically, but B as well because while hepatitis B — without wanting to get too technical — is largely passed down mother to child, because it is a bloodborne virus, once a person has it, it can then be transmitted in any exchange of blood and so also through unsafe injecting practices. It is not how most people acquire it, but it then can be transmitted that way.

Hepatitis C is over 90 per cent transmitted in First World countries such as Australia through unsafe injecting practices. In many other countries it might be through poor medical procedures, unsafe hygiene practices, infection control et cetera, but in the First World the kind of nub of the problem is the unsafe injecting practices for hepatitis C mainly.

So, yes, we have the great programs, as I said, with needles and syringes, but we just have to get the reach further and the capacity of the workers who are in that situation to dispense to be more informed around hepatitis and the risk so that we use those opportunities to also educate and refer to treatment. I guess it is doing what we do, but doing it perhaps more and expanding the reach, particularly to rural and regional areas, but also to suburban areas and outer suburban areas.

The CHAIR — So where is that falling down at the moment? I mean, that is right, we have heard about needle and syringe programs. We would have thought those people would certainly understand the issues. They are working with as many people as they can who are either coming into their services or they have outreach services. Where are the key directions to improve?

Ms EAGLE — I asked a staff member on Friday who is our lead in the AOD area and has worked in this sector for a long time, and they said there are about 10 to 15 per cent who access needle and syringe programs intermittently but not regularly and so do not have safe injecting practices. So they might access needle and syringe programs but only intermittently, not sufficiently so that they are safe users, and are still exposing themselves to risk, for a range of reasons. Some are fatalistic about it, presume they have already got it — you know, this is the feedback — have been told for ages that there is no cure and still believe they are not going to be worthy recipients of treatment or do not engage in health services generally. Many of them are totally disconnected from many formal systems of service delivery. They might be homeless. They might be transient, so they do not make appointments certainly with doctors. They might only erratically turn up to bother to exchange needles, and they are living that very immediate situation of, 'I've got money; I'm going to use now. I'll do it where it's easiest'.

The CHAIR — So to address that do you need better social welfare outreach people, or how do you reach those people in a way that is going to be effective?

Ms EAGLE — One thing I thought was useful, and I can obviously forward this on, is that with the Burnet Institute we — and our little logo is there — were part of a Centre for Research Excellence into Injecting Drug Use, and this is a paper of theirs from 2015. I will just briefly refer to their key messages, and then I can forward it on. Basically:

> Australia's needle and syringe program (NSP) is a valuable, cost-effective, harm reduction service …

Hearing suspended.

The CHAIR — You were talking about how we might reach those vulnerable people that you are talking about.

Ms EAGLE — Despite already having the needle and syringe programs, yes.

Several contextual reasons are likely to contribute towards the prevalence of HCV —

hepatitis C —

including inadequate syringe coverage.

So I think that is just about the spread, and they have got a formula for how they calculate the ratio of number of sterile needles available to an individual's injecting frequency, and they talk about pre-exposure probability of hepatitis C transmission. The exposure probability obviously reduces as you increase the syringe coverage, and they have got a ratio even to document how that occurs.

If syringe sharing were to drop from 15 per cent to 10 per cent —

so that is not actually all that much —

an estimated 33 per cent reduction in HCV incidence would result.

So it is hearing how direct that relationship is. That is really where our new people acquire hepatitis C, and if we can get more needles out and utilised, which is perhaps a question —

Ms PATTEN — So we think that 15 per cent are still sharing?

Ms EAGLE — I think easily, yes, and perhaps Burnet spoke about their various research programs about how to reduce the likelihood of unsafe sharing and their networks work. So we do work in relation. We are involved in most of their research programs in relation to hepatitis C.

Syringe coverage could be improved by increasing the quantity and quality of NSP services.

Now, 'quality', I perhaps cannot unpack that in this instance. Partly it is about the capability of the staff, who are often stretched and seeking to do a whole range of different things and not necessarily taking the opportunities to give a one-on-one on hepatitis at those times. Suggestions include improving the distribution of syringe vending machines, which I know is occurring; increasing the range of injecting equipment available at NSPs, which I think is to cater for different people's styles; easing restrictions on the number of NSPs available per visit; implementing training for staff; and encouraging NSP partnerships with healthcare service offerings offering HCV testing and treatment, so where — and you may have become aware too — we work in relation to, for example, places like Health Works where they have virtually got on the one side of the building the access to the needle and syringe program and on the other side the doctor and the nurses and the project workers, as it were. That kind of direct connection helps so that where people are prepared and ready and engaged there is an easier way to transfer them into health care. And then there is other work that can be done in terms of more rapid testing and referral to specialist services — I do not mean tertiary care, but people who are experienced in the area.

I will perhaps leave the prisons until the end.

The CHAIR — Yes. Bill Tilley, Deputy Chair of the committee, is just joining us.

Ms EAGLE — I will just refer to the fact that we did also include supervised injectings or, as I say, a medically supervised pilot of injecting facilities, and we support that, but I am suspecting you have probably heard quite a lot on that. I am happy to speak to that.

The CHAIR — We welcome your added support, your added comments.

Ms EAGLE — Obviously we have got evidence from Australia and overseas indicating that they are an effective way of reducing the harms. I guess our focus was not specifically just on reducing deaths — much of the media commentary of late is around that — but our particular focus from Hepatitis Victoria is around reducing the risk of transmission by having people able to go and inject safely with clean equipment and also the accompanying education and referral to services. The referrals to health and social welfare services have also been demonstrated to be able to occur in Sydney.

If I go back to safe injecting in prisons, I will just say quite coincidentally we have a monthly staff meeting and we happened to have one of the nurses from the St Vincent's Hospital hepatitis treatment program. I am not sure if you are aware that there has been a fantastic situation actually commenced by the previous government and implemented with the current government of rolling out treatment for hepatitis B and C in prisons in Victoria. It is stunning, and they have cured about 500 people already. This is a fantastic opportunity in that closed environment of treating people where they can be relatively stable and ensuring that they have got pathways out as they leave also to maintain service delivery and support. Victoria has got something it can be proud of there. Our concern then is that it can be undermined — all that investment can be undermined by people actually using in prison in an unsafe manner.

The woman who came, who is one of the nurses from the St Vincent's program, spoke to our staff meeting last Tuesday. Her data said, for example, of the 417 people, and it is now more like 500, who had completed their hepatitis C treatment through that program and were surveyed about drug use at the beginning of the year — they do SVR testing; that is the viral load at 12 weeks afterwards — 94 per cent had been users and 68 per cent, so we are talking over two-thirds, used in the month prior to going into prison. So these are people whom you would not actually realistically expect would suddenly be different in their attitudes towards seeking to use. Fifty seven per cent had 'ever shared' in prison, meaning shared injecting equipment.

I come back to where we came from. We have come from a harm reduction principle around accepting the realities and trying to reduce the harms.

Ms PATTEN — Was that 57 per cent of —

Ms EAGLE — Of the 417 people who had completed hepatitis C treatment.

Ms PATTEN — Half of them had injected in prison?

Ms EAGLE — Yes, over half.

Ms PATTEN — More than half might have injected, but half of them had shared needles?

Ms EAGLE — Yes, and she said that is likely to be an underestimate because it is not something people actually boast of, and they probably feel a bit foolish for having received treatment and actually being cured and still using. There is actually concrete proof of people who have relapsed and acquired hepatitis as a result. Yes, we can all be angry that there has been this investment in care. Largely it has been fantastically successful, but there had been 10 people who had relapsed. Of those, half — 50 per cent of those — had admitted to sharing since they had been receiving treatment. That was five, so we are not talking mammoth numbers, but a course of treatment is not cheap and it is a significant investment in time and it is being undermined.

In terms of whether, of those five, they had actually acquired hepatitis C as a result, because you do not always, there was one person that they can definitely say had, because they had at their SVR12, the measurement that they do to test whether the person has successfully cleared. There is a 98 per cent cure rate with these new direct-acting antiviral treatments that we are so lucky to have, and they are why we are even talking about elimination of hepatitis C globally and in Australia. Anyway, at this time of testing, 12 weeks later, one had a different type of genotype. There are six genotypes, and we will not get too technical, but one had a different type of genotype — 3a rather than 1a, that they had at the beginning. So they had acquired a different genotype.

That is where I am coming from in terms of the practical realities. A fantastic treatment program is being rolled out, but there is this unfortunate potential to have it undermined, that investment. When I said to the nurse — and I was speaking to the staff member on Friday — 'Yes, but how does it happen? Obviously there is a lot of serious attention to try to prevent the use', and he said yes, so that is not new, but we have failed over decades really to do this. Then he said, 'Show me your pen'. I had brought this pen. You take the end off apparently — that is not hard — you cut it down, and he said the smaller you cut it down the easier it is to hide. You wash it out, the ink, and you put the drug in it that you have been able to get access to, and you inject. You do it unsafely because you do not want to be seen. If you are the kingpin you have it first, and then it is shared around. It becomes contraband. That is actually a currency.

So in fact it can be an aggravating factor — I am saying 'can'; he says it is. The fact that there are syringes aggravates the problems, because people can use them. They are very valuable. They are more valuable

apparently; a properly crafted and able-to-be-hidden syringe is more valuable than the drug itself. The drug is actually quite readily available, and these have to be hidden. So I guess the philosophy behind having safe needle and syringe programs is at multiple levels but one where you will not have an aggravating kind of power structure built around the access to unsafe injecting equipment.

Will I flick through the presentation? I do not know how we are going.

The CHAIR — It is a matter of going through it fairly quickly and picking out the key issues that you think are relevant.

Ms EAGLE — It is tricky. I have gone through wicked problems very quickly. It is tricky.

The CHAIR — You have gone through a number of the issues, so it is which bits that you think —

Ms EAGLE — Yes, certainly.

Mr THOMPSON — Chair, is the expression 'wicked problem' something that has been coined in Melbourne or is it an international turn of phrase?

Ms EAGLE — Sorry, Murray. There is me as an ex-public servant speaking.

Mr THOMPSON — It is not an important question.

Ms EAGLE — It is not a technical problem and it is nothing to do with hepatitis. I learned it in the state public service in Victoria, and it is one of those ones where there are no easy answers. You can see the multiple dilemmas and they are never going to be easy to implement, so you try to work through different options of how to address it. I had forgotten how that is just of limited use, and it may not even be in vogue now.

The CHAIR — Natalie Suleyman has just joined us.

Ms SULEYMAN — My apologies. I had a local event.

Ms EAGLE — Just in terms of the needle and syringe program in prisons, I realise I have mistyped this because I typed it late at night and realised the fairly recent opportunity to present some more information. So you will see a few typos, and when I have used the term 'PNSP' I actually mean 'prison needle and syringe program'. It is spelt incorrectly, but that is what I am meaning basically — a program for having access to clean injecting equipment in prisons.

I have listed some of the benefits. It ironically contributes to a workplace that is safer, because the injecting equipment that is then available is safe, clean and can be controlled. We currently have a needle and syringe program. As people wryly comment, we have one but it is an unsafe one, so this can contribute to greater workplace safety by having clean equipment in a controlled manner.

The CHAIR — Do we see places around the world where that has been demonstrated so we can argue the case, because clearly that is an issue that would be of concern to prison staff?

Ms PATTEN — Yes, and I think we even heard in Switzerland that prison staff prefer it because when they are doing bed searches and when they are doing cell searches, they are not fearful of getting a needle stick injury.

The CHAIR — If there might be one caught in the mattress or something.

Ms PATTEN — Yes, because people are not hiding them because they can access them.

Ms EAGLE — I have not gone to that, but I can forward you that as well. So we go to the international situation a little bit further on. Perhaps I will go straight onto that. Eleven countries have commenced the access of needle and syringe programs, and eight continue to do it. So all have introduced it in a pilot manner, whether they would continue it or not, so I am not hiding anything here. Some have chosen not to continue it, not because there have been any incidents globally of actual hepatitis — which is the area we come from — having been used as a weapon and, for example, hepatitis having been spread.

The CHAIR — So you are saying there are no such incidents anywhere in the world.

Ms EAGLE — Of them having been used as a weapon.

The CHAIR — Where staff have come into contact with such a syringe.

Ms EAGLE — I will also forward you a more detailed report on this which is referenced in here, but it is perhaps more convenient once I have referred to it to forward it on. So these are the numbers of countries. There are multiple prison sites within these countries. Eight of them continue to do it. The two that have been having access to prison needle and syringe programs for long enough for them to be evaluated are Switzerland and Spain, and I have got a little bit of a summary. I was just pulling it out from the report that I will forward on.

Why it is not consistent in all the different prisons in Switzerland is because each canton has its own capacity to decide whether they will introduce it or not. They have introduced them in seven, and they have continued to operate them after evaluation there. Spain is the one that has had the most comprehensive evaluation program. I have highlighted some of the data there after a 10-year evaluation. They have had a reduction in both HIV rates and hepatitis C rates. So, for example, for hepatitis C, which is the area that we are focusing on, the prevalence rates that had existed in the prisons after 10 years had decreased from 40 per cent to 26.1 per cent.

Then in the surveys from both the prisoners and the civil servants, meaning the staff there, for most the fears expressed prior were not founded and in fact their attitudes changed — they did not believe it had increased injecting drug use and it improved hygienic living conditions in prison. There is more refined data about that in terms of how their attitude had changed and how many did not support it at the beginning and then supported it at the end, for example, so I can refer you on to that.

Ms PATTEN — Was there any data — I feel like I heard some — that this also got people into opioid substitution treatment, or ORT, because they were acknowledging drug use and accessing the needle program?

Ms EAGLE — I am not sure of that, sorry, so I cannot comment. But here we are actually in this great situation: the treatment actually is available and offered to people and has had a reasonably good take-up rate. It is something to really celebrate in Victoria, but it is just that there is that ability — and it would appear to be a reality — that it can be undermined by people still using unsafe injecting practices.

The CHAIR — Do we also have an assessment of the cost to public health of people who have hep B or C and the cost savings, therefore, of reducing the prevalence?

Ms EAGLE — Unfortunately it is not well documented, partly because there is relatively limited research into hepatitis compared with something like HIV, so I am frustrated by this lack of data. Let me perhaps come at it in a couple of ways, and I will try to perhaps get you some up-to-date stuff that I will send as well. If you think of, say, a transplant — so the liver — hepatitis is a form of liver disease. Well, hepatitis goes to cirrhosis and potentially liver cancer. Liver cancer is the fastest growing cause of cancer death in Australia. So while we have done brilliant things in terms of breast cancer and prostate and things like that, we are not achieving that same sustained improvement. In fact it is the fastest growing cause. There are other contributors, like fatty liver and non-alcoholic liver, but the main one happens to be viral hepatitis. So I am coming about it from a different way, not with —

The CHAIR — Yes, the cost of cirrhosis effectively —

Ms EAGLE — That is right —

The CHAIR — and liver cancer.

Ms EAGLE — And if you think about the end point, for every liver transplant that occurs it is probably around $1 million. There is the direct treatment, say, at the Austin in Victoria. The direct actual transplant time might be about $250 000 but the lead-up and then the monitoring and the drugs to stop rejection and the follow-up is probably estimated to be about $1 million. And a course of treatment — well, that is happily on Medicare. It is paid for in Victoria in the prisons by the state government, because they do not get access to Medicare. A course of treatment varies depending on the arrangement that is negotiated between the drug companies and the federal government, but it is up to $80 000 for a course of treatment. It will go down once

there is more competition for that. And hepatitis B is totally vaccine preventable. So expanding vaccines, which are very cheap, for hepatitis B is easy to do.

Ms PATTEN — Is it still three —

Ms EAGLE — Three, yes. That is right. So another bit of data: we were arguing for the listing of hepatitis C treatment on the pharmaceutical benefits scheme, which it has been. Australia is the only country in the world that has unlimited access to hepatitis C treatment — these new direct-acting expensive antivirals for anybody. You do not have to have severe liver disease. So we have got much to be proud of, and I am really talking about just doing better.

Ms PATTEN — Then no-one is refused hep C treatment?

Ms EAGLE — Not in Australia, and we are the only country in the world. But we are poised and in a position to actually achieve elimination goals in a way that probably no other country in the world is, if we do the prevention side as well and reach the people currently not accessing treatment. It was very interesting: I was in Cairns for the Australasian Viral Hepatitis Conference a couple of weeks ago, and the international speakers were all saying, 'We're looking at you in Australia to see whether this fantastic situation you have got of this unlimited access to hepatitis C treatments and cures — you know, 95 to 98 per cent cures now — can actually really achieve elimination'. What we are concerned about is this drop-off in people taking up the treatment and not doing enough about prevention. These are the opportunities — these harder-to-reach populations, the drug users mainly and in prisons, for example, are where we have really got to reach out and make sure they get cured too and do not get reinfected.

Ms PATTEN — Is everyone tested when they go into jail?

Ms EAGLE — They are offered; it is not compulsory.

Ms PATTEN — Do we have any idea what percentage are tested?

Ms EAGLE — We did actually ask that. I think it is reasonable, the screening rates —

Ms PATTEN — We are actually seeing corrections this afternoon, so we will ask them.

Ms EAGLE — I think the screening rates are pretty good, but they are not tested on exit so that data on acquisition is only from those incidental types of indirect things I have done, such as acquiring a different genotype, a different form of hepatitis.

The CHAIR — In regard to the ACT, where of course it was recommended on a couple of occasions but they did not go ahead with this, is there any sign of any review in the ACT's position that you are aware of?

Ms EAGLE — I do not believe that it is a current platform kind of position. I think many are still aware of it as a real issue in the government and among people involved in prisons and my colleagues at Hepatitis ACT. One thing that my colleague there, for example, the CEO John Didlick refers to is the fact that four prison officers in the survey that was done — and it was very small; there is only one prison in the ACT, so there are not all that many prison officers — out of 16 did actually vote in favour. This is what he clings to — his hope is that it is not that it is total resistance — but there is a lot of formal union pressure to resist against that.

So it would have to be — and that is a point I make here — approached from an education point of view. It would have to be a very slow introduction of people being informed about why it is being done and in fact the advantage to prison staff as well. We have done that with smoking. There was resistance and it was not easy to be done, but we introduced, in a harm reduction kind of way, bans on smoking too.

Mr GEPP — You may come to this, but what are the different models? How does it practically work on the ground? We have got PNSP in a prison — how does it work?

Ms EAGLE — I think one of the main messages for this is that you would have to pay a lot of attention to that. They are all different models, and there are seen to be pros and cons. I have gone through some of them here; it states the pros and cons of different models. I have listed some of the different models.

Prison health staff actually handing them out happens in terms of Spain and Switzerland. External providers coming in and handing them out also happens. Peer educators: we do have a system, and when you hear from the corrections staff you might hear about this too. There is a system of peer educators in prison. We, for example, educate peer educators. There is a limited number of peer educators. They have to be people who are going to be around for quite a while in prison, but they can be entrusted with doing it. That does occur in Moldova. Sometimes there is a one-to-one exchange — a requirement to bring back before you get the next one — and sometimes there is the automatic dispensing where you can just go and get them. All of them have pros and cons, and they are listed in this report here about the pros and cons of the different programs. I will forward this one.

So I do not think there is any automatic version about how you do it. That would be also something that you would want to consult around. When I asked the staff member I was talking to on Friday in preparation for this, his emphasis was that you have to have something that the prisoners themselves are going to use, because if it is easier for them, they will continue to access their own ones. So it has to be kind of acceptable — something that is realistic for them to use, was his point. You can understand why wanting to have it done through the current health programs that we already have running in prisons would be seen as something that is more likely to be controlled and managed.

Mr GEPP — I may have missed this because I was not on the visit overseas: are any of these models, do you know, combined with any substance-testing regimes as well? Do we just accept that whatever the prisoner has got is okay to be injecting, or is there a combination of strategies that are used that you are aware of?

Ms EAGLE — A bit like pill testing at parties to keep it safe?

Mr GEPP — Well, yes. That is right.

Ms EAGLE — I am not aware, I am afraid.

Ms PATTEN — I think looking at your statistics about the random drug testing that has been going on in prisons it seems to be that there are amphetamines, but there was buprenorphine rather than heroin being tested more positively, which was probably more easily available.

Ms EAGLE — I think one of the things I perhaps did not highlight and that I re-read this morning is that, when we were talking about more effective needle and syringe programs, one of the things they were talking about to make them more effective was combining it with opioid substitution therapy and treatment — so combining it not only with, 'Here's your drug', but also, 'There's an alternative path'. So I guess that is the attraction of having it associated with health services.

Ms PATTEN — And that would already be occurring in some of the larger places, like some of the cohealth ones.

Ms EAGLE — Yes.

Mr TILLEY — Can you remind me just quickly: when was the change to the PBS for hepatitis?

Ms EAGLE — It was 1 March 2016.

Mr TILLEY — So, given that it was only 1 March 2016 and the uptake of treatment, is it premature to be able to establish what is happening in the general population and comparing that to the prison population at this stage?

Ms EAGLE — We are probably doing better in prison actually — in the prisons where it happens. So generally in the community — and in the Kirby data, and again I can easily forward this — we think that of the numbers of people who lived with chronic hepatitis C on 1 March to now probably 16 per cent of those have been cured. That is pretty phenomenal. The problem is that the rate of cure is slowing down because they were the people — we had this 'warehousing effect' that is referred to — who were already engaged and waiting at liver clinics, and their appointments were all queued up and ready to go because we knew that it was going to be approved. They were ready to go, and basically, as you might have heard also from clinicians, they were ready to write their scripts and go. The drop-off has now occurred, and we are fearful that it will plateau off and we will get people continuing to reuse or young people with risky behaviour acquiring hepatitis C. So it is now a

case of how can we make sure that does not happen — reduce the acquisition, prevent new people coming on board with hepatitis — and continue treatment.

But your question was comparing the general community with prisons. In the prisons where there is treatment — New South Wales and Victoria, for example — where there is a comprehensive treatment program the rate of cure is probably better than in the broader community. The problem is that because they do not get tested going in we do not actually know the rates, but generally people say the rates of people with hepatitis C in prisons — and you will have this confirmed by the corrections people — is between 40 and 60 per cent. It is higher for women with hepatitis C unfortunately.

They have got to have over a 12-week period of time in prison usually. They will commence it as long as they know that it is nearly that period of time and that they have got clear paths afterwards to treatment. If they are all offered a timely offering of treatment, then because the cure rate is so high — 95 to 98 per cent — people estimate that the reduction is going to be, over time, more effective than in the broader community because those same people, if they are in the broader community, are not engaged with care. They are not being offered care. They are not going to be visited next week. The nurse is not going to come and say, 'It's now time. How are you going on your medicines?' — blah, blah, blah.

Ms PATTEN — Whereas in prison they are.

Ms EAGLE — So it is this fairly unique situation of controlled service delivery.

Mr TILLEY — I just want to go back a little bit in what you are saying there about your concerns with those not taking up treatment and a rise back in the serum levels again. What gives that concern?

Ms EAGLE — The numbers that I was quoting were of the people who have been cured. Of the ones who are not accessing treatment, there is not actually data about the rates of those who have hepatitis C beyond that general figure of about 40 to 60 per cent. But of those who have taken up the opportunity to have treatment since it was made available earlier in the year — I think the figures were from about March — there were 416, and 57 per cent of those said to the health service providers that were asking the questions that they had shared in prison. So they are accessing treatment, but at the same time they are also using. Then we have to think: why are they using? It is because they are addicts. They are largely addicts, and they are in an environment where it is available and we have not been able to stop it from being available. We can have a range of different programs to try to make life a bit more meaningful in prison, but by and large it is not, and that is what some will resort to.

Mr TILLEY — So in the state of Victoria how many treating physicians would we have?

Ms EAGLE — Treating?

Mr TILLEY — Treating physicians for hepatitis in particular.

Ms EAGLE — There are three who work in prisons — all from St Vincent's, but they have their own program at St Vincent's. They have changed the situation since 1 March, since it became available, so that any GP can prescribe, which is fantastic, but the take-up from GPs doing that has been quite a slow burn because people are not familiar with it. It was always a specialist area. So we have got liver clinics in all the major hospitals, but then people from rural areas have to come down to those. Many rural people will not take up treatment for hepatitis in their own community because of the stigma associated with it. So they will wait until they can come down to Melbourne.

Mr TILLEY — I was pretty heavily involved with this on the border of New South Wales and Victoria. We had one treating physician, and there were a lot of people taking it up. In fact a former federal health minister was the sitting member there at the time, so I know actively how this works on the border. People were travelling to cities to get treatment.

Ms EAGLE — Some were. A board member of ours, Ian Gracie, that is how he got his treatment, and he is now cured of hepatitis C by coming down.

Mr TILLEY — So it is personal choice that they are choosing to leave there.

Ms EAGLE — Yes. But I know Tom Schultz, who goes out to Albury-Wodonga — fantastic, flooded out, got nurses supporting him — and it is a fantastic program run from Victoria up there.

Mr THOMPSON — What is the main drug that is being injected in prison? Is it heroin?

Ms EAGLE — I am sorry; that is my understanding, but I have not asked that specific question. I can check with that.

Ms SULEYMAN — Just a quick question in relation to vending machines. Hepatitis Victoria recommends extending the Victorian Needle and Syringe Program through appropriately locating vending machines across Victoria, where needles and syringes will be available on a 24-hour basis. My question is: is that due to there being a lack of availability at the moment and therefore having a 24-hour vending machine — and I think I have seen the one in Richmond — and that sort of concept across Victoria, is it about availability or is it about an increase in use in certain regional areas in Victoria?

Ms EAGLE — I think it is using availability in the broad sense. It is partly about people will use when they want to. It is an immediate need to use, so they want to have it at all different hours. So if they can get it safely and cleanly, then that is better than having to, in theory, wait until tomorrow morning at 9 o'clock or something. That will not happen; instead they will go and access it unsafely. So it is the hours but it is also the spread, the number of locations and just making it so you do not have to travel as far. I understand that we are rolling some vending machines out to further suburbs. So it is commending that and wanting to do more.

Ms SULEYMAN — And it would not be an isolated vending machine. It would be linked to a community centre or some sort of service?

Ms EAGLE — I happen to be on the board of a community health service and, yes, that is partly why I am familiar that we are doing it, because we have just put two out in other suburbs.

Ms PATTEN — Is that at Star Health?

Ms EAGLE — Yes, it is Star Health. It used to be Inner South Community Health Service, and that is now Star Health. We consult with our staff as to what would be the most effective places to use. So they actually have to be where they are going to be used and where people will not be under a floodlight in going to use them, but also where it is close to services. We have one at Star Health in one of our three locations. It is not at the front door, but it is right nearby.

The CHAIR — Thank you, Melanie.

Ms EAGLE — Sorry I was not able to answer to answer all of those questions, but I will forward some information.

Ms PATTEN — No, that was really interesting.

The CHAIR — And we are hearing from Corrections Victoria next, so you have been a useful lead-in for us.

Witness withdrew.