Consensus Statement:

Addressing Hepatitis C in Australian Custodial Settings

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hepatitis australia

About Hepatitis Australia

Hepatitis Australia was formed in 1997 as the national peak body for the eight state and territory hepatitis community organisations who are our members.

The mission of Hepatitis Australia is to ensure effective action on hepatitis B and hepatitis C to meet the needs of all Australians. We do this through national leadership and advocacy and by forming strong partnerships with organisations and individuals who share our goals.

We advocate strongly to improve services for all people affected by hepatitis B and hepatitis C. We pay particular attention to those groups which are at higher risk of hepatitis B or hepatitis C infection and those groups which have a disproportionate burden of chronic disease. These include: people from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander peoples, children born to mothers with chronic hepatitis B, people in custodial settings, people with a history of injecting drug use, and new, and potential injectors.

For further information about Hepatitis Australia please visit www.hepatitisaustralia.com

Consensus Statement: Addressing Hepatitis C in Australian Custodial Settings

Hepatitis C infection, which is both preventable and treatable, is endemic among Australian prisoners. Overall, hepatitis C prevalence in custodial settings has been estimated to be between 23-47%, with some studies reporting prevalence in excess of 70% for female prisoners. Hepatitis C in custodial settings is a public health concern due to the dynamic movement of people in and out of custody. As the health status of prisoners moves with them between prison and their home and community, addressing, or neglecting, their health care needs, has a substantial impact for better or for worse on the health of the general community.

The prison environment is positioned in the literature as a 'powerhouse' for hepatitis C. This is due to the high prevalence of infection among prison entrants coupled with high-risk activities for transmission of the blood borne virus within custodial setting. These activities include the sharing of contraband such as non-sterile equipment used for injecting drugs, tattooing and body piercing. The shared use of non-sterile barbering and shaving equipment also poses a risk for transmission of hepatitis C within custody. The significant risk of hepatitis C transmission in custodial settings combined with the movement of people in and out of custody has the potential to increase infection rates in the general community.

Custodial settings provide a unique opportunity to protect and enhance the health of marginalised individuals and populations through prevention and treatment programs. In taking up this challenge, correctional and health services have the benefit of an extensive evidence-base showing that prevention and harm reduction measures for hepatitis C and clinical treatment can be safely and effectively introduced into custodial settings. Prisoner access to the means of hepatitis C transmission prevention and to hepatitis C treatment and drug treatment services equivalent to those provided in the community must be ensured. Given the inability of custodial authorities to achieve and maintain the unrealistic expectation of a drug-free prison environment, prevention strategies using proven harm reduction measures including prison-based Needle and Syringe Programs (NSPs) should be introduced in the interests of public health, duty of care and human rights obligations.

The Hepatitis C Prevention, Treatment and Care: Guidelines for Australian Custodial Settings issued in 2008 by the Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis are evidence-based and provide a framework, which if implemented, would enable prisoners to receive health care services equivalent to those provided to the rest of the community and consistent with international human rights instruments and medical, ethical and professional standards.

The need to protect the health of prisoners and the health of the general community and to ensure the occupational health and safety of prison staff and by extension their families, demands the implementation of these evidence-based guidelines in each Australian jurisdiction.

Australian governments should provide sufficient funding to allow the introduction of comprehensive hepatitis C education, prevention, and harm reduction measures, as well as fund the expansion of access to hepatitis C treatment to a level which is at least equivalent to that which is available in the community.

Appropriate funding is also required to enable research bodies and organisations to increase the quantity and quality of evaluation of prevention, harm reduction and treatment strategies for different custodial settings and populations to ensure that data collection and evaluation is consistent across Australia.

Hepatitis Australia together with the undersigned call on Australian jurisdictions to recognise and fulfil international human rights obligations; to recognise the nexus between prison health and public health, and to:

- Adopt, monitor and report on the implementation of the Hepatitis C Prevention, Treatment and Care: Guidelines for Australian Custodial Settings which is based on sound evidence.
- Provide to all custodial personnel education and training to enable them to understand hepatitis C; its epidemiology, transmission, prevention, care, management and treatment, as well as the management of occupational health and safety matters related to working with a population with high-risk of hepatitis C infection.
- Provide access to hepatitis C education, prevention, harm reduction, treatment and care which is equivalent to that within the general community and which is tailored to the needs of different groups, including Aboriginal and Torres Strait Islander peoples, women, people with low levels of English literacy and juveniles.
- Ensure throughcare and aftercare to facilitate continued hepatitis C treatment and care when movements between custodial settings occur, and on re-entry to the community.
- Trial and evaluate across all jurisdictions a range of proven harm reduction measures, including Prison-based Needle and Syringe Programs and appropriate infection-control procedures for tattooing, body art and barbering.
- Resource and support the involvement of people with relevant personal experience to ensure that policies and practices are based on reality and grounded in lived experience to have the best chance of being effectively applied.

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Evidence Base and Recommendations for Action for Addressing Hepatitis C in Australian Custodial Settings

Introduction

Hepatitis C is a blood borne viral disease; its treatment and prevention is a significant public health priority in Australia.

> An estimated 217 000 people were living in Australia with chronic hepatitis C infection at the end of 2009, including 46 000 with moderate to severe liver disease.
>
> In 2009, chronic hepatitis C infection was the underlying cause of liver disease in 28.1% of liver transplants. (National Centre for HIV Epidemiology and Clinical Research, 2010)

Chronic hepatitis C can result in severe health problems such as inflammation of the liver, liver disease, cirrhosis, liver cancer and/or liver failure (DoHA 2008a). The virus is transmitted through blood-to-blood contact with the majority of hepatitis C infections in Australia occurring due to unsafe injecting drug use practices, such as the sharing of non-sterile injecting equipment (DoHA, 2008a).

Australian and international research has consistently found higher rates of hepatitis C and other communicable diseases in the prison population than in the general population (Hunt & Saab, 2009; Sutton et al, 2008).

> Compared to a prevalence rate of approximately one in a hundred in the general population, the prevalence of hepatitis C among prisoners is:
>
> about one in three for male prisoners
>
> two in three for female prisoners (Black et al, 2004; Miller et al, 2006; AIHW, 2010).

The short, average anticipated period of incarceration [1] means that failing to take up the opportunity to prevent, treat and manage hepatitis C in the high risk prison population will undermine Australia's efforts to reduce transmission in the community. Custodial services across Australia are uniquely placed to provide interventions that will have a positive impact on prevention of hepatitis C and the treatment and care of people with hepatitis C in custody. This benefit will consequently flow on to the community. Conversely, failure to maximise this opportunity will compromise Australia's national response to hepatitis C.

This paper commences with an outline of the importance of hepatitis C in custodial settings in Australia. The international human rights framework and the evidence-base for effective hepatitis C education, prevention, harm reduction, treatment and care in custodial settings are then documented. Following this, Australia's response to its human rights obligations and to the evidence is documented and analysed. Current challenges impeding progress are then discussed. The paper concludes with a statement of the actions that, in the view of Hepatitis Australia, are now required as a matter of urgency.

[1] ABS 2010: Mean length of anticipated period of imprisonment nationally for all sentenced prisoners is 3.6 years; median of 2 years; Mean length of imprisonment for all non sentenced prisoners is 5.2 months; median of 3.1 months.

1. The significance of hepatitis C in Australian custodial settings

This section commences by outlining the prevalence of hepatitis C and risks for its transmission in Australian custodial settings. Priority populations and the implications of the prevalence and risk factors for transmission are then discussed. The section concludes with a discussion of the social, economic and personal costs of hepatitis C in custody.

1.1 Prevalence and risks

Prisoner health studies in Australia have estimated the overall prevalence of hepatitis C infections to be between 23% and 47% for male prisoners, rising to between 50% and 70% for female prisoners (Black et al, 2004; Miller et al, 2006).

Demographic trends associated with the prevalence of hepatitis C in Australian custodial settings include:

- increasing prevalence with age
- higher prevalence among female prisoners
- higher prevalence for Indigenous prisoners
- increasing prevalence with multiple admissions to prison (AIHW, 2010).

Incarceration itself is a risk factor for hepatitis C transmission due to high-risk activities such as the sharing of non-sterile equipment used for injecting drugs, tattooing, body piercing and barbering within prisons. (Dyer & Tolliday, 2009; Hunt & Saab, 2009).

Injecting drug use in custodial settings places inmates at high risk of hepatitis C.

About half of Australian prisoners have a history of injecting drug use.

About half of all imprisoned people who inject drugs continue to inject drugs in prison (Crofts, 2005).

Over half of prison entrants surveyed in a four-state *Blood borne Virus Survey* (Butler & Papanastasiou, 2008), reported injecting drug use in the previous month. Indigenous prisoners reported injecting drug use at a higher rate than non-Indigenous prisoners (64% compared to 58%). Other important research findings include:

- twenty per cent of the prison entrants who had a history of injecting drugs reported sharing injecting equipment in the month preceding admission to prison (Butler & Papanastasiou, 2008)
- while 75% of people who inject drugs in NSW prisons had used clean equipment in the community, 68% had shared injecting equipment in prison (Indig et al. 2009)
- people who inject drugs in prison were at least eight times more likely to contract the virus than those who use drugs in prison without injecting (Vescio et al, 2008)
- approximately 32% of Western Australian prisoners reported that the last time they injected drugs was in prison (Kraemer et al, 2009).

Given the inability of custodial authorities to achieve and maintain the unrealistic expectation of a drug-free prison environment, imprisonment exposes people who inject drugs to greater risks of infection with hepatitis C than those in the community.

These findings confirm the risk posed to public health by the current failure to effectively educate, prevent, treat and reduce the harm associated with hepatitis C in Australian custodial settings.

1.2 Priority groups within custodial settings

Prisoners as a whole are a group that automatically becomes more prone to hepatitis C infection because the means of protection are 'contraband' or prohibited; these include sterile equipment for injecting drugs, tattooing, body piercing and barbering.

As well as people who inject drugs, the population groups at greatest risk of hepatitis C in prison are women, Aboriginal and Torres Strait Islander peoples and people from culturally and linguistically diverse backgrounds (MACASHH, 2008).

The high prevalence of hepatitis C among women in prison is due in part to the high proportion of women who have had one or more terms of imprisonment for illicit drug offences, and the high proportion of women who have injected drugs prior to imprisonment and who continue to do so, both during imprisonment and upon release.

The prevalence of hepatitis C among Indigenous prison entrants is higher than for non-Indigenous prison entrants, with 43% of Indigenous prison entrants testing positive for hepatitis C, and 42% testing positive for hepatitis B. Almost three quarters (72%) of female Indigenous prison entrants tested positive for hepatitis C (Butler & Papanastasiou, 2008). This higher prevalence among Indigenous prison entrants reflects the higher prevalence of hepatitis C in Indigenous communities in the general population. The prevalence of hepatitis C for Indigenous people in the general population is reported as being at least three times higher than for the non-Indigenous general population (NCHECR, 2009a).

People from culturally and linguistically diverse (CALD) backgrounds in Australian custodial settings are a diverse group and include people from some of the highest hepatitis C prevalence regions of the world, including Africa, South America, Pacific Ocean and South East Asia. Data from the Australian Bureau of Statistics show high rates of imprisonment for people born in countries in these regions, including Vietnam, Fiji and Sudan (ABS, 2010). As in the general community, prisoners from CALD communities may have been less able to engage with health services due to the competing demands of migration, or of seeking asylum. As a result, diseases like hepatitis C are frequently diagnosed later. In prison, people who do not speak English as a first language often find it difficult to access information in their own language about hepatitis C, its prevention and available health services both in correctional facilities and in the community (Women's Health Victoria, 2008).

1.3 Implications for the health of the general community

As most prisoners return to the community within two years of incarceration (ABS, 2010), custodial settings play a significant role in the epidemiology of hepatitis C and its transmission. This back and forth movement of people already infected with hepatitis C, or at high risk of the disease between custody and the community, without access to effective education, prevention, treatment and follow-up, gives rise to the risk of the spread of hepatitis C both within, and

beyond, the criminal justice system. Upon release, conditions, including hepatitis C, which are contracted, transmitted, or made worse in prison, become issues of public health concern for the wider community (RACP, 2007).

> Addressing the relationship between prison health and overall public health is fundamental to improving health in the community.

There is an urgent need for all Australian governments to understand and acknowledge the important role that custodial settings must play in the prevention and management of hepatitis C in order to protect public health. It is imperative that the opportunities presented by imprisonment to both prevent and treat hepatitis C be acted upon nationally.

Prevention and treatment responses must be based on scientific evidence and on sound public health principles with the involvement of all custodial and health sectors and the affected groups.

1.4 Social and economic costs

The costs of hepatitis C to the community are significant, the National Centre in HIV Epidemiology and Clinical Research (NCHECR), in a recent study reported that the annual health care costs of hepatitis C is about $850 per diagnosed patient in the early stages of disease, increasing to $120 000 for patients requiring a liver transplant. Treatment costs are $10 000 to $20 000 per year depending on the length of treatment (NCHECR 2010). Under current treatment rates, the cost of antiviral therapy for hepatitis C is at least $46 million per annum. Other health sector costs are estimated at $56 million per annum.

According to the NCHECR report, the financial burden on patients and families ranges from $2 800 per annum for early disease, to $13 700 for a liver transplant. Lifetime productivity costs per person are estimated to be approximately $19 624 (NCHECR, 2010).

At a personal level, a person might become unable to work and therefore experience financial distress. Relationship breakdown, stigma, discrimination and isolation are also potential personal impacts of infection. Hepatitis C infections most commonly arise from injecting drug use; an illegal behaviour. Imprisonment compounds the experience of stigma and marginalisation.

The risk of the transmission of hepatitis C has significant implications for the health and safety of all who are detained, or who work within custodial settings, and by extension, their families and the communities in which they live.

2. Australia's international human rights obligations

In seeking to address hepatitis C in custodial settings, Australian governments need to be mindful of, and guided by, a number of international human rights instruments and protocols to which our nation is a signatory.

> People should not leave custody in a worse condition, or with poorer health than when they entered.

Many international laws and related declarations are relevant to prisoner health and well-being, and, by extension, to the provision of evidence-based preventative health and health treatment services in prison. They include the following:

- *International Covenant on Civil & Political Rights* (ICCPR) – refers to humane treatment in detention
- *International Covenant on Economic, Social and Cultural Rights* (ICESCR) – refers to the right to the highest attainable standard of physical & mental health
- *United Nations General Comment on the Right to Health* – refers to Availability (e.g. existence, affordability & location of services), Accessibility (e.g. non-discriminatory services), Acceptability (e.g. quality); and Adaptability (e.g. relevance of service to the particular population)
- *United Nations Basic Principles for the Treatment of Prisoners* – refers to the requirement that prisoners shall have access to the health services in the country without discrimination on the grounds of their legal situation
- *United Nations Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment* – refers to the requirement that prisoners shall be provided with medical care and treatment whenever necessary and that care and treatment shall be provided free of charge
- *United Nations Standard Minimum Rules for the Treatment of Prisoners* – refers to the requirement that the medical services in prison should be organised in close relationship to the general health administration of the community or nation.
- *When a state deprives people of their liberty, it takes on a responsibility to look after their health in terms both of the conditions under which it detains them and of the individual treatment that may be necessary (World Health Organization, 2007)*.

The international community has accepted that prisoners retain all rights that are not taken away as a fact of incarceration. This includes the right to the highest attainable standard of health care. This means that prisoners with hepatitis C, or at high risk of infection are entitled, without discrimination, to a standard of health care equivalent to that available in the outside community, including preventative measures. Far from a reduced right to appropriate health care, the opposite is the case. Correctional and health administrations have a responsibility not simply to provide health care, but also to establish conditions that promote the well-being of both prisoners and prison staff.

The doctrine or principle of *equivalence* provides a strong human rights argument for the introduction for Australian prisoners of prevention, harm reduction, treatment and aftercare of hepatitis C. To deny protection against disease transmission in such a high-prevalence and closed population may be viewed as inhumane and in violation of Australia's international human rights obligations.

Fundamentally, custodial and health authorities have a professional duty of care to ensure a safe environment and to provide prisoners with appropriate treatment when required, and with the means to prevent transmission. As well as common law precedents and respective

professional codes of conduct and ethics, this duty of care is reinforced by *United Nations Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.* This international human rights instrument refers to the duty of health care personnel, particularly physicians, charged with the medical care of prisoners to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard in the community.

Failure to address the risk of transmission amounts to a failure by custodial and health authorities to acquit their duty of care by providing prisoners with the means of preventing hepatitis C while under their supervision and care. This in turn creates the potential for prison authorities to be sued for a breach in their duty of care to prisoners as they have not fulfilled their obligation to take all reasonable measures to manage the foreseeable risk of hepatitis transmission between prisoners.

3. The evidence-base for the prevention & treatment of hepatitis C

This section provides an outline of the evidence for treating and preventing hepatitis C, both in the general community and in custodial settings.

3.1 Treating and preventing hepatitis C in the community

Whilst there is currently no vaccine for hepatitis C, it is both preventable and treatable. As hepatitis C is a blood borne virus, infection control measures in health care settings and tattoo parlours for example, are essential to prevent transmission. Prevention of hepatitis C amongst people who inject drugs in the community is based on the principles of harm minimisation. This pragmatic approach adopted by Australian governments in 1985 as the foundation of the first National Drug Strategy and existing to this day, incorporates three cornerstone principles:

- supply reduction, for example through law enforcement
- demand reduction, for example through provision of drug treatment programs
- harm reduction as in government-funded needle and syringe programs.

This multi-faceted approach aims to minimise the harm from illicit drug use for both individuals and the community as a whole.

The National Corrections Drug Strategy 2006-2009 adopts these same three pillars of harm minimisation as its foundation.

According to a report by the *National Centre in HIV Epidemiology and Clinical Research*, Needle and Syringe Programs in the general population have directly averted an estimated 97 000 new hepatitis C infections and an estimated 32,000 new HIV infections during 2000–2009 (NCHECR, 2009b).

> It is estimated that for every dollar invested in NSPs, more than four additional dollars were returned during the 10 years in direct health care-related cost savings. Methadone maintenance programs also play a significant role in reducing health care costs (National Centre in HIV Epidemiology and Clinical Research, 2009b).

The treatment of hepatitis C has improved markedly in recent years with the use of Pegylated Interferon and Ribavirin combination therapy. This treatment, administered over a period of either 24 or 48 weeks, consists of weekly injections combined with daily oral medication. The therapy is fully subsidised by the government; in 2009 just fewer than 4,000 people living with chronic hepatitis C accessed treatment. (NCHECR, 2009a). Dore et al. outline the evidence concerning cure:

> *Acute and chronic hepatitis C infection can be cured. This would have been a bold statement to make several years ago; however, currently available antiviral therapy can achieve sustained viral eradication – cure – in over 50% of patients with chronic hepatitis C infection (Sievert, 2009).*

Cure rates vary according to a number of factors including the strain of the virus and the degree of fibrosis (liver scarring) already present. Up to 7 out of 10 people with the most common strain of hepatitis C can be cured when treated before fibrosis has started. Cure rates ranging from 80% to 90% occur for people with hepatitis C genotypes 2 or 3 who undergo the current treatment regime (DoHA 2008, p.134). As cure rates decline with increased fibrosis, it is important for people to be aware of, and understand treatment options, and to seek treatment as early as possible. Successful treatment reduces injury to the liver, halts the progression of severe liver disease and reduces rates of liver cancer. Successful treatment also results in long-term gains in quality of life and productivity. Importantly, successful treatment results in improved survival rates.

A recent review by NSW Health of hepatitis C treatment and care services recommends the adoption of a goal to double treatment rates to improve health outcomes for people with hepatitis C, which would reduce the long-term burden on health services (NSW Health, 2008).

3.2 Treating and preventing hepatitis C in custodial settings

The WHO Declaration on Prison Health as part of Public Health provides evidence-based guidance on fundamental international standards. The Declaration recommends on measures for improving the health care of all detained people, protecting the health of custodial personnel and contributing to public health. Measures of high relevance to prisoners with hepatitis C include:

- the development of close working links between the health and correctional ministries and the administrations responsible for the custodial system so as to ensure high standards of treatment for detainees, protection for personnel, joint training of professionals and continuity of treatment between prison and the community
- the provision of necessary health care free of charge to those deprived of their liberty.

Also emphasised is the need to ensure that harm reduction becomes the guiding principle of policy on the prevention of hepatitis transmission in custodial settings, as is the case in the general community. The WHO provides the following definition of harm reduction:

> *In public health "harm reduction" is used to describe a concept aiming to prevent or reduce negative health consequences associated with certain behaviours. In relation to drug injecting, "harm reduction" components of comprehensive interventions aim to prevent transmission of HIV and other infections that occur through sharing of non-sterile injection equipment and drug preparations (WHO, 2005).*

Approaches to reducing harm in custodial settings are based on public health, duty of care and human rights principles and recognise that many people who inject drugs cannot totally abstain from doing so in the short term. The experience of imprisonment for many compounds the difficulty in ceasing to inject drugs. Harm reduction strategies aim to help prisoners who use drugs to not start to inject drugs and to help prisoners who do inject drugs to stop, or to reduce their injection frequency. Importantly, harm reduction strategies also seek to ensure that those who do inject drugs can do so safely. Harm reduction strategies thereby further reduce harm by assisting to prevent the transmission of diseases, including hepatitis C, which can be spread via the sharing of non-sterile drug injecting equipment.

The WHO document, *Health in Prisons,* summarises experience, research and expert opinion, and urges member nations to introduce a range of evidence-based measures for treating and preventing hepatitis C including:

- hepatitis C treatment
- providing a protected and safe environment for those motivated to undergo drug treatment which affords a distance from the drug scene in prison
- education for prisoners and custodial staff about the transmission, prevention, treatment, harm reduction and aftercare of hepatitis C and other communicable diseases;
- safer-use training for prisoners who inject or take drugs
- implementing vaccination programs against hepatitis A and hepatitis B;
- testing and counselling performed on a voluntary basis
- making bleach and other decontaminants available
- making facilities, or the means for safe tattooing available
- introducing Needle and Syringe Programs
- throughcare and aftercare, which are essential elements of efforts to reduce relapse and re-offending
- partnering housing and employment services with aftercare treatment programs to help reduce relapse and re-offending
- providing the diversity of measures that are offered outside of custody including rehabilitation and support, family support services, drug-care units, drug counselling and treatment services (including harm reduction).

All of these interventions have proven effective in reducing the risk of the transmission of hepatitis C and other communicable diseases in custody without unintended negative consequences (Hunt & Saab, 2009).

The *WHO* has detailed the crucial role of NSPs in the prevention of transmission of communicable diseases such as hepatitis B, hepatitis C and HIV, and has pointed explicitly to the necessity of NSPs in custodial settings.

The WHO *Status Paper on Prisons, Drugs and Harm Reduction*, calls on all prison systems to develop and implement measures including:

- *a planned and comprehensive clinical treatment program for drug-dependent prisoners, including the use of opiate substitution maintenance therapy*
- *a needle syringe program equivalent to that available in the community, especially if the local prevalence of HIV or hepatitis C is high or if injecting drug use is known to occur in the prison* (WHO, 2005).

Needle and Syringe Programs have been available in custodial settings in some countries for over 10 years, including Switzerland, Germany, Spain, Moldova, Belarus and Kyrgyzstan. These programs have been shown to consistently improve prisoner health and reduce needle sharing in prison while not undermining institutional safety or security (Lines et al, 2005). The available scientific evidence suggests that such interventions can be reliably expanded (Jurgens et al, 2009; AIHW, 2009).

There is a strong evidence-base internationally for the prevention, harm reduction, treatment and aftercare of hepatitis C in custodial settings.

Evaluations of NSP programs in custodial settings have shown that such programs:

- do not endanger staff or prisoner safety, and in fact, make these settings safer places to live and work
- do not increase drug consumption, or injecting
- reduce risk behaviour and the transmission of the hepatitis C virus
- have other positive outcomes for the health of prisoners, including a drastic reduction in overdoses reported in some prisons and increased referral to drug treatment programs
- have been effective in a wide range of custodial settings
- have successfully employed different methods of needle distribution to meet the needs of staff and prisoners in a range of prisons
- have successfully complemented other custodial programs for preventing and treating drug dependence.

Currently, and despite the evidence, there are no regulated NSPs in Australian custodial settings. In some jurisdictions, bleach or bleach alternatives (which can be used to sterilise some injecting equipment) are available (Dolan, 2000). However, the results of laboratory-based studies are clear in questioning the stand alone efficacy of bleach to inactivate the hepatitis C virus (MACASHH, 2008). Further, the Australian Institute of Health and Welfare (AIHW) argues that a fear of being searched, or drug tested, might deter prisoners from asking prison officers for bleach (AIHW, 2009).

The availability of hepatitis C treatment to prisoners remains inconsistent. Despite the evidence concerning cure rates when treatment is commenced as early as possible, there is often reluctance among health service providers to commence treatment while a person with hepatitis C is in custody. Reasons for this reluctance are multifaceted and include the availability

of specialist services and operational difficulties and logistical issues associated with treatment completion in view of the average period of incarceration. Further issues are security concerns with inmate transport to and from treatment and competing custodial, health and funding priorities (MACASHH, 2008).

If Australian jurisdictions were to conduct an audit of their responses to the treatment and prevention of hepatic C in custodial settings against the evidence-base, and with reference to human rights standards and principles, each jurisdiction would be found to **not** have in place the key components required for effective treatment, prevention and harm reduction.

4. Australia's response

The Australian Government has described itself as a world leader by having introduced in 1999 the first strategic response to hepatitis C through the *National Hepatitis C Strategy 1999-2004.* This initial strategy was generally recognised as having established a sound approach to combating hepatitis C in Australia. Since then, successive Australian Federal governments have recognised the importance of increasing treatment rates and of strengthening prevention efforts. Like the first strategy, the second strategy, the *National Hepatitis C Strategy 2005-2008*, recognised that people who inject drugs, people in custodial settings and Aboriginal and Torres Strait Islander peoples are disproportionately affected by hepatitis C. Efforts were strengthened to improve the access of those most at risk to education, prevention, treatment and care and support services.

This section outlines Australia's policy response through the *Third National Hepatitis C Strategy 2010–2013* and through the *National Guidelines for the Prevention, Treatment and Care of Hepatitis C in Custodial Settings* produced by the Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis (MACASHH, 2008).

4.1 Australia's policy response

The Australian Government's *Third National Hepatitis C Strategy 2010–2013* and the *Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010-2013,* recognise prisoner populations as priority populations for hepatitis C.

These national strategies released in 2010 also emphasise the role of custodial settings in assisting to prevent transmission to high risk groups and of being a focal point for hepatitis C testing, education and treatment with priority populations.

The Third National Hepatitis C Strategy builds on the previous two strategies by introducing a human rights framework for addressing the stigma and discrimination experienced by people with, and at risk, of hepatitis C. In particular, the Third Strategy gives priority to addressing the stigma and discrimination among those most affected by hepatitis, including those in custody.

The national strategies call on Australian jurisdictions to implement and maintain the following evidenced-based measures in custodial settings:

- screening for blood borne viruses and vaccination where indicated
- increasing the provision of, and access to, bleach and disinfectants where no safer alternatives are provided for decontaminating spills, surfaces and equipment
- providing accessible education and counselling, including peer education and support as a fundamental health promotion technique to support risk reduction practices
- increasing access to drug treatment programs, including opioid pharmacotherapy programs, as well as detoxification and drug rehabilitation programs
- exploring measures for developing and promoting Australian infection-control standards for tattooing and body art
- trialling of the provision of sterile injecting equipment i.e. Needle and Syringe Programs (NSP).

The national strategies also affirm that the *Hepatitis C Prevention, Treatment and Care: Guidelines for Australian Custodial Settings* (MACASHH, 2008) provides appropriate models of care for people with hepatitis C in custody, but notes that the guidelines have not been implemented.

The Corrective Services Ministers Conference and the Conference of Correctional Administrators in their revision of the *Standard Guidelines for Corrections in Australia*, state that prisoners are entitled to the same standard of evidence-based health care provided in the general community.

> *Every prisoner is to have access to evidence-based health services provided by a competent, registered health professional who will provide a standard of health services comparable to that of the general community. Notwithstanding the limitations of the local community health service, prisoners are to have 24-hour access to health services. This service may be on an on-call or standby basis (Corrective Services Ministers Conference, 2004.*
>
> The *Standard Guidelines for Corrections in Australia* also states:
>
> *Prison systems should have a comprehensive and integrated drug strategy that seeks to prevent the supply of drugs into prison, reduce the demand for drugs and minimise the harm arising from drug use in prisons through education, treatment and enforcement.*

The relevant National Strategies and Corrections Guidelines envisage all correctional services providing:

> *... a full range of health and drug services and support for prisoners with hepatitis C or who are at risk of infection including taking action to minimise the harm experienced by drug users when, despite efforts aimed at prevention and desistance, they continue to use drugs in a manner that is harmful to themselves or to others and which increases the risk of the transmission of hepatitis C* (Corrective Services Ministers Conference, 2004).

4.2 Australia's treatment and prevention response

As noted, the Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis has produced the *National Guidelines for the Prevention, Treatment and Care of Hepatitis C in Custodial Settings* (MACASHH, 2008). A supplementary document, Evidence Base for the Guidelines, assists stakeholders to understand the evidence base underpinning the guidelines.

The Guidelines also address the prevention and treatment of hepatitis C and workforce development within custodial settings.

Key *prevention activities* outlined in the Guidelines include the following:

- education, including peer education about hepatitis C and the routes of transmission for inmates
- infection control
- recreation, sport and exercise to improve and promote general health
- provision of bleach and disinfectant and education about their use
- access to razors, toothbrushes and safe barbering
- education and counselling related to injecting drug use
- drug treatment
- tattooing and body art under appropriate infection-control procedures
- Prison-based Needle and Syringe Programs.

The Guidelines emphasise the importance of voluntary testing in accordance with the National Hepatitis C Testing Policy which provides the framework for testing for hepatitis C in Australia, including within custodial settings.

Key *activities for treatment and care* of people living with hepatitis C in custody provided in the Guidelines include the following:

- assessment and referral for ongoing care and treatment
- counselling and discussion of treatment options
- treatment planning
- ongoing care and symptom management
- access to drug substitution and pharmacotherapy
- monitoring of hepatitis C for inmates who are not receiving treatment
- post release planning and care.

The Guidelines emphasise the need for inmates who are preparing for, or who have started treatment, to be provided with support and continuity of care upon release.

> *Careful planning to maximise access to health care after release is critical to the inmate's well-being. The establishment of sustainable links between custodial health services and community health and support agencies is integral to successful post release care* (MACASHH, 2008).

The Guidelines conclude with provisions for workforce development. The following reasons are given for why both custodial and health services staff should become experts in their respective fields for hepatitis C prevention, treatment and care:

- *custodial facilities have an obligation to take reasonable measures to effectively manage all foreseeable risks of harm to inmates, including exposure to blood borne viruses such as hepatitis C*
- *inmates will return to society after their imprisonment, therefore their health is an issue of concern to the general community*
- *the health of inmates is important for the occupational health and safety of the staff of custodial facilities* (MACASHH, 2008).

Practice informed by, and consistent with the best available evidence, will not only assist to prevent the transmission of hepatitis C, it will also address the risks which currently endanger workplace health and safety in custodial settings. According to the Guidelines, education and training should be provided to all who work within custodial settings to assist them to understand hepatitis C:

> *...its epidemiology, transmission, prevention, care, management and treatment and the practical on the job consequences of working with a population with high levels of infection* (MACASHH, 2008).

All staff are given education, information and training about hepatitis C, at orientation and with updates and refreshers through the course of their work within custodial services. Training should address matters relating to attitudes and values.

Training must include... infection control strategies and should address matters relating to attitudes and values (MACASHH, 2008).

Despite Australia having the benefit of a consistent evidence base, and despite the Australian Federal Government having acted on the evidence and through MACASHH, produced evidence-based guidelines for addressing hepatitis C in custodial settings, little progress has been made to strengthen prevention efforts for this priority population and to improve the access of prisoners to education, testing, treatment and support.

The evidence-based guidelines for addressing hepatitis C in custodial settings remain largely unimplemented. Further, Australian governments have collectively failed to establish an effective process for monitoring and reporting progress against the guidelines and for informing the public of progress made and challenges encountered.

A number of significant challenges confronting progress despite the overwhelming evidence base are outlined in the next section.

5. Addressing challenges

While the Federal Government has responsibility for providing leadership nationally and for promoting and supporting compliance of jurisdictions with international human rights instruments to which Australia is a signatory, each state and territory is responsible for the administration of police, justice and custodial settings including juvenile institutions within their jurisdiction. The provision of, and responsibility for health services within custodial settings differs from state to state, with some prison health services being administered by the health portfolio and others administered by justice and/or corrections portfolios. In some states, prison health services are publicly administered while in others, a mixture of both public and private health service providers are engaged. Irrespective of these differences, each state and territory through their corrections, health, and human services has a duty to protect the health and safety of prisoners, staff and their families. The transmission of hepatitis C in prison poses a significant threat to all of these groups as well as to the community. Interventions and measures are required to address the health care needs of those with hepatitis C and those at high risk of becoming infected while in custody.

> The period of incarceration should be viewed as a public health window of opportunity (MACASHH, 2008).

Health services provided for the prevention, treatment and care of hepatitis C in custodial settings should be equivalent to those provided to the rest of the community. These services should also be consistent with national and international human rights instruments and evidence-based treatment standards and guidelines. The *Hepatitis C Prevention, Treatment and Care: Guidelines for Australian Custodial Settings* provide a framework which, if implemented, would enable such consistency. The need to protect public health and to ensure the occupational health and safety of staff and their families demands the implementation of these guidelines in each Australian jurisdiction. Challenges and barriers to their implementation include:

- jurisdictional differences
- legal barriers
- treatment challenges
- stakeholder views
- concerns about trials as against national implementation
- the need to overcome stigma and discrimination and to involve those with personal experience
- research and evaluation requirements.

These challenges are discussed in turn.

5.1 Jurisdictional differences in the administration and governance of health services within custodial settings

The *Third National Hepatitis C Strategy* outlines the range of challenges arising from each state and territory having its own independent and different systems for the administration of justice and custodial facilities including juvenile facilities. Major challenges include:

- health services within custodial facilities being administered variously by justice or health portfolios
- health services being supplied in different ways by both public and private providers
- the dispersal and isolation of custodial facilities
- the different systems for, and relationships between, custodial governance and clinical governance.

An overriding challenge is ensuring that health services in custodial settings are sufficiently staffed by trained, licensed and qualified health professionals. A further challenge is ensuring that health professionals are not constrained or prevented by custodial policies, regulations and practices from providing health care services that are equivalent to those provided in community clinical care settings (WHO 2007).

Systems for clinical governance are needed to enable health professionals to support prisoners with, and at risk of hepatitis C to access appropriate education, prevention, treatment, care and support services.

Currently, custodial policies and competing resource and funding priorities are key obstacles to the health interests of a prisoner at risk of, or living with hepatitis C being addressed in accordance with internationally acceptable and evidence-based health care standards. At present, when health interests arising from hepatitis C are perceived to be in conflict with security interests, the latter most commonly prevails.

However, the international research and literature has consistently demonstrated that providing prisoners with the means to protect themselves from contracting hepatitis C, or to provide them with appropriate treatment does not jeopardise security and safety within custodial settings. As stated earlier, failure to prevent the transmission of hepatitis C in custodial settings and to provide opportunity for treatment undermines Australia's national public health response to hepatitis C.

A starting point in overcoming these attitudinal and administrative obstacles to equivalency of preventative and curative health care between community and custodial settings is the strengthening of custodial workplace education programs about transmission factors, prevention, the possibility of cure and the benefits of prevention and treatment for both settings.

5.2 Legal barriers

Legal barriers to implementation of the *National Guidelines for the Prevention, Treatment and Care of Hepatitis C in Custodial Settings* arise from the fact that equipment used to inject drugs is generally illegal, or an offence against prison regulations. This issue could be addressed in different ways including the authorising of sterile equipment used for drug injection if it is obtained through a prison or health service sanctioned NSP for the purpose of hepatitis C prevention, and/or prevention of other health conditions.

5.3 Challenges associated with hepatitis C treatment within custodial settings

Correctional and prison health authorities view as problematic the requirements of hepatitis C combination therapy – i.e. weekly injection of Pegylated Interferon for either 24 or 48 weeks and the taking of Ribavirin daily throughout this period. Prison health authorities are also mindful that this course of treatment must be continuous, and that the length of treatment depends on the strain of hepatitis C and response to treatment. Monitoring, by means of blood tests, needs to occur throughout treatment (AIHW, 2010).

Given the length and requirements of hepatitis C treatment, prison health services are reluctant to commence treatment unless it can be completed before the prisoner is released. Continuity of care between prison and community is currently difficult. However, the problems involved with ensuring continuity can be overcome in a number of ways including involving community providers of treatment, support, and care from the outset.

Treatment commenced in prison should be regarded as a care continuum between prison and community. Strong functional links are required between the prison health service providers and providers of health services, counselling around drug and alcohol use, employment services and family support services in the community.

While in prison, a person with, or at risk, of hepatitis C should be offered the opportunity to meet and be linked with agencies in the community that could support their ongoing treatment and offer ongoing support and care upon release. Transition back into the community without interruption to ongoing treatment and care is possible with sound coordination.

Given the importance to public health of addressing hepatitis C in custodial settings, Australian governments should collaborate to provide sufficient funding to allow comprehensive interventions for the prevention, treatment, harm reduction and aftercare of hepatitis C to be expanded to meet the personal and public health needs of custodial staff and prisoners, their families and their communities.

5.4 Stakeholder views about implementation of the guidelines

Views about the need to, and the steps involved with implementing the National Guidelines for addressing hepatitis C in custodial settings are varied, and far from homogenous, both between and within stakeholder groups. For example, some correctional administrators, correctional officers and officials of various unions understand and are concerned by the link between prison health and safety and public health and safety. Some view addressing hepatitis C in custody as a key issue for occupational health and safety therein. Others are concerned about the possibility of equipment used for injecting being used to harm officers or fellow inmates. Though the research does not support these fears, the concerns must be acknowledged, discussed and addressed in planning and program development for the implementation of the Guidelines. For example, overseas experience which can be drawn upon in Australia shows that NSPs can be devised and administered in such a way as to prevent and minimise risk.

Concerns of stakeholders can be addressed in a number of ways including:

- conducting education programs with correctional staff to increase awareness of risks, treatment options and cure benefits
- holding similar education programs with staff of prison health services to those being conducted with GPs and their practice nurses.

- providing key groups with the opportunity to liaise with police officers involved with the introduction of community-based needle and syringe programs in Australia
- providing key groups with the opportunity to visit, or liaise with overseas facilities which have successfully implemented measures for hepatitis C prevention and harm reduction, including prison-based Needle and Syringe Programs

These measures would strengthen the capacity of correctional and health personnel to educate and support prisoners using their services about the risks and measures for preventing hepatitis C and to inform them of the existence of effective treatment and the requirements for treatment to commence.

A further initiative which would assist to allay ongoing or residual concern would be the provision of recurrent additional funding for specialist nurses to be employed within custodial settings to oversee the continuation of education for both prisoners and staff about hepatitis C. This education could focus on transmission risks, prevention, treatment, the possibility of cure and the associated benefits for both prison and community health and safety.

5.5 Concerns about trials

There are many who argue that the evidence warrants comprehensive national implementation rather than piecemeal trials and fear that trials will delay the full implementation of the *National Guidelines for Addressing Hepatitis C in Custodial Settings.* The Australian Federal Government could promote progress by initiating in collaboration with the states and territories, a funding program to support jurisdictions, wishing to proceed with the development, implementation and evaluation of programs for addressing hepatitis C in custodial settings that are tailored and targeted to those with, or at high risk, of hepatitis C.

5.6 The need to overcome stigma and discrimination and to engage those with personal experience

As with addressing hepatitis C and other critical public health issues in the general community, involving people with personal experience of injecting illicit drugs in custodial settings and of living with hepatitis C will ensure that policies and practices are based on reality, grounded in lived experience and have the best chance of being effectively applied. Efforts to address stigma and prevent discrimination of people living with, or at risk, of hepatitis C, must be continued and must include a focus on human rights in custodial settings.

There is a strong case for funds to be made available to state and territory-based hepatitis organisations to enable people with relevant lived experience to work with governments, correctional authorities and prison health services and to provide input to local policy and program development during the implementation of the National Guidelines. Funds are also needed to support the provision of peer education and peer support for prisoners with, or at risk, of hepatitis C.

5.7 Research and evaluation requirements

There is concern that uncoordinated trials and programs will be established on an ad hoc basis without time limits, in isolation from each other, and without evaluation of findings contributing to a shared national evidence base. A related concern is that the findings of evaluation in one jurisdiction will not be considered relevant by other jurisdictions. Rather, there is a need for cross-jurisdictional time-limited trials that lead to the national adoption of the evaluation findings and recommendations.

Appropriate funding is required to enable research bodies and organisations to increase the quantity and quality of evaluation of treatment, prevention and harm reduction strategies for different custodial settings and for priority populations to ensure that data collection and evaluation is consistent across Australia.

6 Conclusions & recommendations for action

Hepatitis C is endemic among Australian prisoners. Overall, hepatitis C prevalence in custodial settings has been estimated to be between 23-47%, with some studies reporting prevalence in excess of 70% for female prisoners (AIHW, 2010; Butler & Papanastasiou, 2008). Hepatitis C in custodial settings impacts population health via the dynamic movement of people in and out of custody As the state of health of prisoners moves with them between prison and their home and community, addressing, or neglecting their health care needs has a substantial impact for better, or for worse, on the community's health.

The prison environment is positioned in the research as a 'powerhouse' for hepatitis C due to the high prevalence of infection among custodial populations, the prevalence of high-risk populations, and the incidence of high-risk activities such as the sharing of non-sterile equipment used for injecting drugs, tattooing, body piercing, barbering and shaving. This significant risk of hepatitis C transmission in custodial settings combined with the movement of people in and out of prison has the potential to translate into increased infection rates in the general community.

Importantly, incarceration provides an opportunity to affect positively population health through prevention and treatment programs. Custodial settings provide a unique opportunity to address the health of marginalised individuals and populations. In taking up this challenge, correctional and health services will not be uninformed. Rather, they will have the benefit of an extensive evidence-base showing that prevention, treatment and harm reduction measures for hepatitis C can be safely and effectively introduced into custodial facilities.

Given the widespread popularity of tattooing and body piercing both inside correctional settings and outside in the broader Australian community, it is vital that the means to safe and sterile tattooing and body piercing be made available in all correctional settings, so as to help achieve equivalence with health protection capacity in the broader community.

Prisoner access to clinical hepatitis C treatment and counselling and drug treatment and counselling services (where required) equivalent to those provided in the community must be ensured.

Given the inability of custodial authorities to achieve and maintain the unrealistic expectation of a drug-free prison environment, prevention strategies using harm reduction measures, including Prison-based Needle and Syringe Programs should be introduced in the interests of human rights obligations, duty of care and public health interests.

The Hepatitis C Prevention, Treatment and Care: Guidelines for Australian Custodial Settings are evidence-based and provide a framework, which if implemented, would enable prisoners to receive health care services equivalent to those provided to the rest of the community and consistent with international human rights instruments, medical standards and ethical professional standards.

Further, the need to protect prisoner and public health and to ensure the occupational health and safety of staff working in custodial settings and their families demands the implementation of these evidence-based guidelines in each Australian jurisdiction.

Australian governments should provide sufficient funding to allow comprehensive interventions for the prevention, treatment, harm reduction and aftercare of hepatitis C to be expanded to meet the personal and public health needs of prisoners and all who work in custodial settings, their families and the community.

Appropriate funding is also required to enable research bodies and organisations to increase the quantity and quality of evaluation of treatment, prevention and harm reduction strategies for different custodial settings and for priority populations to ensure that data collection and evaluation is consistent across Australia.

We the undersigned national organisations call on Australian jurisdictions to recognise and fulfil international human rights obligations; to recognise the nexus between prison health and public health, and to:

1. Adopt, monitor and report on the implementation of the *Hepatitis C Prevention, Treatment and Care: Guidelines for Australian Custodial Settings* which is based on sound evidence.
2. Provide to all custodial personnel education and training to enable them to understand hepatitis C; its epidemiology, transmission, prevention, care, management and treatment, as well as the management of occupational health and safety matters related to working with a population with high-risk of hepatitis C infection.
3. Provide access to hepatitis C education, prevention, harm reduction, treatment and care which is equivalent to that within the general community and which is tailored to the needs of different groups, including Aboriginal and Torres Strait Islander peoples, women, people with low levels of English literacy and juveniles.
4. Ensure throughcare and aftercare to facilitate continued hepatitis C treatment and care when movements between custody occur, and on re-entry to the community.
5. Trial and evaluate across all jurisdictions a range of proven harm reduction measures, including Prison-based Needle and Syringe Programs and appropriate infection-control procedures for tattooing, body art and barbering.
6. Resource and support the involvement of people with relevant personal experience to ensure that policies and practices are based on reality and grounded in lived experience to have the best chance of being effectively applied.

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