POLICY STATEMENT ON BLOOD BORNE VIRUSES (BBVs) AND EQUITY OF HEALTH CARE IN CUSTODIAL SETTINGS

Background:
It is well established that people in custodial settings experience some of the highest levels of marginalisation and disadvantage in Australia. This disadvantage manifests in a range of poor health and social outcomes, including incarceration:

"Consistent with global literature, prisoners in Australia experience profound health disparities relative to those who have not been incarcerated, with a disproportionate burden of mental illness, chronic and communicable diseases. Many prisoners have complex histories of disadvantage encompassing family violence, unstable housing, limited education, unemployment and economic adversity. Risky health-related behaviours including smoking, illicit drug use, harmful alcohol consumption and unsafe sexual practices are common in incarcerated populations[1]."

For people experiencing such profound socio-economic disadvantage, incarceration can provide much-needed access to a range of health services.

"Correctional settings are uniquely placed to detect health problems, initiate care and promote health in a way that is unlikely to occur in the community, with important public health implications for the communities to which prisoners return. It is paradoxical, therefore, that prisoners are excluded from Australia's universal health care scheme —Medicare — while incarcerated. Instead, health care for prisoners is transferred to state and territory government departments for the duration of their incarceration[2]."

In the absence of a nationally consistent framework for the provision of health care in custodial settings, access to BBV prevention, testing, management, treatment and aftercare services in custodial settings around the country is inconsistent at best. Further, access to related alcohol and other drug (AOD) and mental health services is often limited, impacting on BBV treatment compliance and health outcomes for those with complex needs, including Aboriginal and Torres Strait Islander people.

"Health care in Australian custodial settings is guided by the concept of community equivalence, as outlined in numerous national and international frameworks. In principle, this means prisoners are entitled to receive the same level of access and quality of health care as the general population. In

[1] Plueckhahn T., Kinner S., Sutherland G. and Butler T. (2015) *Are some more equal than others? Challenging the basis for prisoners' exclusion from Medicare*, Med J Aust 2015; 203 (9): 359-361. || doi: 10.5694/mja15.00588: https://www.mja.com.au/journal/2015/203/9/are-some-more-equal-others-challenging-basis-prisoners-exclusion-medicare

[2] Plueckhahn T., Kinner S., Sutherland G. and Butler T. (2015) Are some more equal than others? Challenging the basis for prisoners' exclusion from Medicare, Med J Aust 2015; 203 (9): 359-361. || doi: 10.5694/mja15.00588: https://www.mja.com.au/journal/2015/203/9/are-some-more-equal-others-challenging-basis-prisoners-exclusion-medicare

reality, however, persistent underinvestment in health services means that prisoners may miss out on certain treatments and medications[3]."

Key Issues:
In Australia, the median aggregate sentence length for sentenced prisoners is 3 years, with the median expected time to serve for sentenced prisoners being 2 years[4]. The one-third of prisoners who are on remand have far shorter periods of custody. Given that people in custodial settings are spending relatively short periods of time behind bars and then returning to their families and communities, the spread of BBVs in prisons and resultant community transmission post-release pose significant threats to the achievement of key national strategy goals:

"A continuing blight on Australia's record in responding to BBVs is the lack of evidence based prevention strategies in Australia's prisons. It is well documented that the prevalence of BBVs in prisons is higher than that in the general population. Adopting treatment based prevention strategies will be much more effective when complemented by a comprehensive suite of evidence-based prevention strategies, including access to sterile injecting equipment and opiate substitution therapy (OST), to reduce risks of primary and post-treatment reinfections[5]."

A chain is only as strong as its weakest link, and custodial settings are currently the weak link in Australia's response to BBVs:

"In summary, with 250,000 people to treat and large proportion of PLWHCV (People Living With Hepatitis C) *in prison it is critical that prisons are part of any national strategy for elimination of HCV. There is a real need for a national policy to guide prisons in jurisdictions[6]."*

Access to additional Medicare Benefits Schedule items - such as the Medicare Health Assessment for Aboriginal and Torres Strait Islander People and those relating to allied mental health services – would also help to address the significant disparity in health outcomes for people with complex needs and support the implementation of BBV and STI-related initiatives:

"Under the Health Insurance Act, the Health Minister has the power to grant an exemption to end prisoners' exclusion from Medicare, paving the way for rebates to be claimed for prison-based health care services in limited circumstances where demonstrable gaps exists in health service delivery. This would allow the prison system to retain the existing health service delivery model but to enhance this through access to selected Medicare items and PBS subsidies as outlined above. The costs incurred by Medicare would be minimal[7]."

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[3] Plueckhahn T., Kinner S., Sutherland G. and Butler T. (2015) Are some more equal than others? Challenging the basis for prisoners' exclusion from Medicare, Med J Aust 2015; 203 (9): 359-361. || doi: 10.5694/mja15.00588: https://www.mja.com.au/journal/2015/203/9/are-some-more-equal-others-challenging-basis-prisoners-exclusion-medicare

[4] Australian Bureau of Statistics (2016) *Prisoners in Australia 2016*, ABS, Canberra: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4517.0~2016~Main%20Features~Sentenced%20prisoners~10

[5] Hepatitis Australia (2017) *Responding to Blood-Borne Viruses in Australian Prisons*, Hepatitis Australia, Canberra: http://www.hepatitisaustralia.com/policy-papers/

[6] Harm Reduction Australia (2017) A needs analysis for people living with HCV after leaving custodial settings in Australia, AIVL, Canberra.

[7] Australian Medicine (2017) *Prisoners could get Medicare without a heavy taxpayer burden*, Australian Medical Association, Canberra: https://ama.com.au/ausmed/prisoners-could-get-medicare-without-heavy-taxpayer-burden

Recommendations:
To support a more effective response to BBVs in Australian prisons (and other related correctional settings) AIVL, Hepatitis Australia, the Australian Federation of AIDS Organisations (AFAO) and the National Association of People with HIV Australia (NAPWHA) have recommended that:

1. The Australian Government raise the issue of BBVs in prisons as a public health priority and calls for the establishment of national standards for health delivery in prisons as part of the Council of Australian Governments (COAG) Health Council process.
2. All Australian governments develop and enforce policies and practices that ensure people in prison receive health care equivalent to that available in the broader community, without discrimination based on their legal situation.
3. The 2018-2022 suite of National Strategies for BBVs and STIs (or a separate strategy as recommended by the Silent Disease Report[8]) recognises BBVs in prisons as a public health priority, acknowledges people in prison as a priority population and includes priority actions which cover:
    a. education about BBV transmission for people in prison and all prison staff
    b. access to confidential and culturally appropriate health services
    c. access to best practice BBV testing that is offered and provided by suitably trained health staff
    d. hepatitis B vaccination program for prison entrants
    e. ready access to medicines used to treat, prevent and cure BBVs
    f. ready access to sterile injecting equipment through prison-based exchange programs
    g. provision of bleach and disinfectant and education about their use
    h. access to opioid substitution therapy (OST) and other drug treatment and counselling services
    i. ready and discreet access to condoms and water-based lubricant
    j. ready access to personal hygiene products including razors, toothbrushes and safe barbering equipment
    k. infection-control procedures that enable safe tattooing and body art
    l. blood rules in sport or other physical engagement.
4. The 2018-2022 suite of National Strategies for BBVs make it a priority for federal, state and territory governments to develop a standard approach to data collection on the prevalence and incidence, risk behaviours and treatment access associated with BBVs in prisons and that this data is reported in a timely manner to inform Australia's response to BBVs in prison settings[9].

Further to these collectively adopted recommendations, AIVL has developed supplementary recommendations focussed particularly on ensuring that transitions from custodial to community settings are managed effectively for people with hepatitis C[10]. These additional recommendations build on the collective recommendations that relate to BBVs more broadly and highlight additional actions in the key areas of: policy; resources/programs; and research.

<u>Policy</u>

[8] House of Representatives Standing Committee on Health (2015) *The Silent Disease: Inquiry into Hepatitis C in Australia*, The Parliament of the Commonwealth of Australia, Canberra: https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health/Hepatitis_C_in_Australia/Report
[9] Hepatitis Australia (2017) *Responding to Blood-Borne Viruses in Australian Prisons*, Hepatitis Australia, Canberra: http://www.hepatitisaustralia.com/policy-papers/
[10] Harm Reduction Australia (2017) *A needs analysis for people living with HCV after leaving custodial settings in Australia*, AIVL, Canberra.

1. Develop, fund and implement a dedicated National Strategy for the prevention, diagnosis and treatment of blood-borne viruses and drug use in correctional settings (including juvenile justice) – noting that the Ministerial Council on Drug Strategy's first National Corrections Drug Strategy in 2008 could be utilised as a basis for its development.
2. Develop a more consistent and comprehensive national reporting system for hepatitis cases and treatment episodes including completion rates for all prison health systems.
3. Introduce mechanisms to ensure prison authorities become more transparent and accountable in meeting public health needs, particularly in relation to reporting and allowing access to infectious diseases data.
4. Develop protocols for the prison based HCV treatment system to be mainstreamed as part of the community HCV treatment program. The transfer of patients from prison health services to community health services must be a priority to ensure treatment continues.

Resources / Programs

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

Research

10. Determine the rate of BBV transmission *and* reinfection among prisoners in every jurisdiction. There should also be a particular examination of non- injecting routes of transmission, such as tattooing and bloody fights.
11. All jurisdictions need to make a greater investment in prison-based BBV treatment, drug treatment, harm reduction, education and support services and alternatives to custody for minor offences.
12. Review the Stop C program in NSW[11] - with a view to expanding into other jurisdictions.

In addition, AIVL supports the Australian Medical Association (AMA), Public Health Association of Australia (PHAA) and Royal Australian and New Zealand College of Psychiatrists' calls for the Health Minister to grant an exemption under s 19(2) of the *Health Insurance Act* to end prisoners' exclusion from Medicare, paving the way for rebates to be claimed for prison-based health care services in limited circumstances where demonstrable gaps exist in health service delivery[12].

This policy document was adopted by AIVL and our member organisations in 2017 and is due for revision in 2020.

[11] The Kirby Institute (2017) *Surveillance and Treatment of Prisoners with Hepatitis C (SToP-C)*, UNSW, Sydney: https://kirby.unsw.edu.au/project/stop-c

[12] Australian Medicine (2017) *Prisoners could get Medicare without a heavy taxpayer burden*, Australian Medical Association, Canberra: https://ama.com.au/ausmed/prisoners-could-get-medicare-without-heavy-taxpayer-burden