POLICY STATEMENT ON CUSTODIAL SETTINGS AND HEPATITIS C: HARM REDUCTION AND CONTINUITY OF CARE

This Policy Statement summarises content from AIVL's 'Missing Connections: Service user experiences of people living with hepatitis C exiting custodial settings' report, which is available at: http://aivl.org.au/resources/

Background:
At present there are no needle and syringe programs (NSPs) within custodial settings in Australia. NSPs have been officially operating within the Australian community since 1987 and have proven to be a highly effective public health and harm reduction measure by preventing the transmission of blood borne viruses (BBV) including hepatitis C (HCV) and HIV.

Australia is working towards the World Health Organization's (WHO) goal of eliminating HCV by 2030. As part of this commitment, in 2016 the Australian Government made a significant investment to list new direct acting antiviral drugs (DAAs), which have a 98% rate of curing HCV, on the national Pharmaceutical Benefits Scheme (PBS).[i]

Given that injecting drug use is a primary form of transmission of HCV and due to the criminalisation of drug use, people in custodial settings are disproportionately affected by HCV. In 2018 alone there were 10,913 new notifications of HCV.[ii]

A number of European and Middle Eastern countries, and most recently Canada, have been operating NSPs in prisons since as far back as 1992. This important harm reduction measure has proven successful in reducing rates of BBV transmission while there has been no recorded incident of correctional services staff safety being jeopardised.

Key Issues:
The *Fifth National Hepatitis C Strategy*, released by the Australia Government in December 2018, acknowledges the critical role that NSPs in custodial settings and peer-based programs have to play in eliminating HCV as a public health threat.

Currently, the Australian Capital Territory (ACT) is the only jurisdiction in which the government has an existing policy framework in place which supports the implementation of NSP in prison. State and territory governments need to be re-engaged in dialogue regarding this public health issue to help ensure that evidence-based policy decisions are made which provide equivalence of care to people within custodial settings.

Continuity of care is a crucial element of custodial settings health care. Although a person may be released from incarceration, any treatment they commenced whilst in custody should not be jeopardised. With regard to DAA treatment, policies and procedures to provide continuity of care for people who are exiting custodial settings – and people's experiences of how these are applied - vary greatly across jurisdictions and even within facilities.

The Australian prison system sees a high number of prisoners being routinely moved within and between prisons. During the period of 2017-18, prisons in Australia were operating at 116% of design capacity[iii]. A strategy employed to manage these situations is to move people between prisons which in turn makes the provision of health care more difficult and inconsistent. Furthermore, it is relatively commonplace for a person on remand to leave prison to attend court, and then be released directly from court to the community.

Whilst transitioning back to community life, issues of homelessness, unemployment and drug use as well as other complex factors can have an impact on HCV treatment compliance. Navigating the primary health care system can be challenging for anyone at the best of times, let alone for someone who has a number of competing priorities and often minimal resources at their disposal.

The importance of peer-to-peer education is recognised and well documented. The effectiveness of peers is due to others seeing them as a credible source of information and being seen as trustworthy, which other professionally delivered services struggle to achieve due to a lack of rapport. Furthermore, it is known that stigma and distrust often drive people who use/inject drugs away from accessing essential health care[iv].

Recommendations:
AIVL believes that a full suite of evidence-based harm reduction measures and peer-based support programs should be available to people within and exiting custodial settings, which supports the reduction of HCV transmission. Key recommendations for best practice include:

1. *Focus on peer-based support programs*
   People exiting custodial settings would benefit from enhanced access to peer support programs which could help them navigate health care and welfare systems on release. Relationships could be established whilst someone is still incarcerated; relationship and rapport building does not have to wait until someone has been released. Proactive measures could be taken if supported by jurisdictional correctional services policies and processes. Any such programs and supports should also be cognisant of the different needs of women and be adapted accordingly.

2. *Implementation of Prison Needle and Syringe Programs*
   Custodial settings will continue to act as an incubator for HCV despite universal access to DAAs unless NSPs are introduced in prisons. Harm reduction measures available in the community should also be available within the confines of custodial settings. Ensuring equivalence of care is a human rights issue and ought to be a consideration at the forefront of decision-making processes which affect the health and wellbeing outcomes of detainees.

3. *Workforce development within custodial settings*
   Each custodial facility is governed by different policies and procedures, however there ought to be consistency in the knowledge of correctional officers, health care and other relevant staff. Not only does this include an understanding of the risk factors associated with HCV but also understanding adverse effects that stigmatising language have on the health and wellbeing outcomes of detainees. Staff should be encouraged and supported to undergo necessary professional development within this context.

4. *Equity of access to services in rural, regional and remote areas*
   Regardless of where in Australia someone is incarcerated, they ought to have reasonable access to the same health care and harm reduction resources as any other Australian. Disadvantage should not be experienced due to location. This also means that there should be reasonable and fair equity not only within jurisdictions, but across them.

5. *Rectify Medicare access barrier*
   This reflects a long standing and complex systems issue which creates a financial barrier to ex-detainees making the appropriate and necessary health care connections in the community. This serves to only further penalise people who are trying to re-establish their lives in the community. Achieving better health outcomes for former detainees is in everyone's interest, and at the very least policies and procedures should ensure that all people leaving custodial facilities do so with a valid, current Medicare card.

This policy document was adopted by AIVL and our member organisations in 2019 and is due for revision in 2022.

[i] Dore, G. (2017) 'Australia leads the world in hepatitis C treatment – what's behind the success?', *The Conversation*. https://theconversation.com/australia-leads-the-world-in-hepatitis-c-treatment-whats-behind-its-success-81760

[ii] Australian Institute of Health and Welfare. (2019) *The health of Australia's prisoners 2018*. Retrieved from https://www.aihw.gov.au/reports/phe/246/health-australia-prisoners-2018/contents/table-of-contents

[iii] Australian Institute of Health and Welfare. (2019) *The health of Australia's prisoners 2018*. Retrieved from https://www.aihw.gov.au/reports/phe/246/health-australia-prisoners-2018/contents/table-of-contents

[iv] Global Commission on Drug Policy. (2013) *The negative impact of the war on drugs on public health: The hidden hepatitis C epidemic*. Retrieved from https://www.globalcommissionondrugs.org/wp-content/uploads/2016/03/GCDP_HepatitisC_2013_EN.pdf