15 December 2014

Ms Stephanie Mikac

Committee Secretary

Standing Committee on Health

POB 6021

Parliament House

CANBERRA ACT 2600

Dear Ms Mikac

Attached, please find my submission to the Standing Committee on Health's inquiry into Hepatitis C in Australia.

The submission addresses Term of Reference (b) (iv) – Hepatitis C early testing and treatment options available through prisons. I offer six recommendations for the Committee's consideration

I would be willing and able to attend, if invited, the *Roundtable* scheduled to be held in Melbourne on Wednesday 21 January 2015.

Yours sincerely

Professor Michael Levy AM

Michael Levy is the Clinical Director of Justice Health Services (ACT). He is a Public Health and a Clinical Forensic Physician with national and international experience in prisoner health. He has worked with the World Health Organization and the European Committee for the Prevention of Torture - "CPT"; missions to Hungary and the United Kingdom). Between 1995 and 1997 he worked at the Global Tuberculosis Programme at World Health Organization Headquarters (Geneva, Switzerland).

He was a co-founder of the Australian Council of Prison Health Services and has been an examiner for the Australian Faculty of Public Health Medicine. He is currently the Chair of the Prisoner Health Information Committee (Australian Institute of Health and Welfare).

He has visited health services at prisons in over 20 countries (including China, Mongolia, the Philippines and Kiribati).

He has a distinguished publication record with over 100 peer-reviewed publications since 1987, and a number of book chapters. His is on the Editorial Board of the International Journal of Prisoner Health. He has an appointment with the School of Medical Australian National University (Professor).

He maintains a very active teaching commitment through co-ordinating the Custodial Medicine unit for the Master of Forensic Medicine at Monash University. He is an international leader in the field of application of harm minimisation to the prison environment. He has been an observer and presenter to the WHO Health in Prisons Program (European Regional Office) and actively engaged in promoting a similar initiative through the Western Pacific Regional Office.

He was the Secretary of the New South Wales Justice Health Human Ethics Research Committee from 2000 to 2006, and served briefly on the ACT Health Human Ethics Research Committee in 2010, developing expertise in the issue of human research with populations in unequal relationships.

He chaired the review of the 1st Hepatitis C Strategy, that wrote the report "The Road Not Taken" (2002).

He has resumed active clinical practice since 2007, developing the primary care model for adult and juvenile persons in detention. Among the initiatives that have been initiated at regular medication audits (focussing on proper prescribing of analgesic and sedating medication, and commencement of treatment for hepatitis B and hepatitis C infected persons). He has been an authorised Opiate Pharmacotherapy Prescriber in New South Wales from about 1999 until 2007, when he moved to the Australian Capital Territory.

He is a Board Member of the Community Restorative Centre, a non-government organisation concerned with the welfare of families of prisoners and the re-integration of ex-prisoners back into the community.

He is an advocate for the full implementation of all harm minimisation modalities for prisoners, at the threshold of a decision by the ACT Government to allow a regulated injecting equipment exchange in the ACT prison.

In June 2014 he was recognised for meritorious service with the Member of the Order of Australia in the General Division (AM) – "For significant service to medicine in the field of public health as a clinician, academic and educator".

The part prisoners play in the epidemiology of hepatitis C infection was described by Australian clinicians and researchers such as Professor Andrew Lloyd and Professor Tony Butler, from the Kirby Institute at the University of New South Wales. The early reports go back to the 1990s, at the very beginning of the described epidemic of hepatitis C. No jurisdiction, and none of the hepatitis C strategies have made any impact on the epidemic within Australia's prisons.

1 FLAWED SURVEILLANCE FOR HEPATITIS C INFECTION

Earlier than that period, what was later to be identified as hepatitis C virus, was simply referred to as "non-A, non-B hepatitis". The first laboratory test for hepatitis C virus infection was an Antibody test, but this antibody is neither protective to the infected person, nor is it a measure of new infection. These are important considerations, because from the beginning of our understanding of hepatitis C infection, confusion and misunderstanding has been introduced – both have relevance in understanding the particular role that prisons (the environment) and prisoners (the population) play in this infection.

Being "hepatitis C positive" meant that an individual had been infected by the hepatitis C virus at some time in the past – it provided no information on whether the person was still infected, or not (i.e. in which case the virus had either been spontaneously cleared, or the person was successfully treated). The test result was "HCV Antibody Positive". Still today, the surveillance definitions, and most population-based surveys simply report on antibody status.

What had started as an extremely intricate and expensive test by the mid-1990s, should now be the basis of all clinical and epidemiological testing – namely the "PCR test" (The polymerase chain reaction (PCR) is a biomedical technology in molecular biology used to amplify a single copy or a few copies of a piece of, in the case of the hepatitis C virus, RNA across several orders of magnitude, generating thousands to millions of copies of a particular RNA sequence). In essence, this is a test of the virus itself. This test result changes from negative to positive when an individual becomes infected (or as has been the case of too many prisoners – re-infected), and vice versa, from positive to negative when the virus is spontaneously cleared, or treatment has been successful.

Because the insensitive Antibody test is the mainstay of Australian surveillance systems for hepatitis C, re-infections are under enumerated. This is of particular importance in the prisoner population, because the risks of re-infection are so great.

At least one-third of prison acquired infections are re-infections. As treatment programs are offered to more prisoners, while the risks of re-infection remain unaddressed, the proportion can only be expected to rise.

RECOMMENDATIONS:

1. PCR testing be offered to all HCV Ab positive people.
2. 6-monthly testing be promoted (once informed consent has been obtained) to all prisoners.
3. The national surveillance definitions take consideration of PCR results, particularly when a prior negative result is followed by a subsequent positive result.

2 HUMAN RIGHTS AND PRISONER HEALTH – HEPATITIS C SHINES A MIRROR ON SYSTEMIC DEFICIENCIES

The recent Australian Bureau of Statistics (ABS) report on Australian prisons highlights the atrocious state of Australian social dependence on a failed system. Year-on-year this report can merely re-state the former year's failings, and prepare the nation for yet another dose of failure 'next year'. The ABS can report numbers of prisoners, the disproportionate increase in the already disproportionate increase in Aboriginal incarceration, the disproportionate increase among the elderly and women, and … elderly women. The number of prisoners increased nationally by 10% - in just the last year! Australia is spending $1,000,000 more every day, than the previous day – on prisons! 59% of Australian prisoners had served prior adult custodial sentences. Aboriginal and Torres Strait Islanders now constitute 27% of Australia's prisoners. (It is to be expected that next year it will be 28%, and the following year 28%).

The ABS cannot report systematically on the impacts that these data are having on the hepatitis C epidemic, nor the abject failure year-upon-year of the nation's eight jurisdictions in dealing with the collision of hepatitis C and our love of incarceration.

As hepatitis C is a bloodborne virus, it is spread by blood-to-blood transmission. This is not fatuous – it is a fact. This is an absolute truth, not a nuanced truth. If you concentrate hepatitis C infected individuals in over-crowded institutions, and allow fights to occur, allow tattooing to occur under conditions that do not comply with community standard 'skin penetration guidelines', and do not control effectively the flow of illicit drugs and constrain access to injecting equipment, then the perfect storm for hepatitis C transmission has been created. And nurtured, year, upon year, upon year, upon year …… and this year and next year. The means of control are known to the medical community. The means of control are obstructed by the political and the custodial community. The trade union movement stands condemned, for providing Custodial Officers a platform to perpetuate their ignorance, and offering them a seat at the table to influence (aka obstruct) the full, complete, uncompromised … implementation of all measures to stop the transmission of hepatitis C infection among Australian prisoners. That means, the immediate implementation of tattooing programs, needle and syringe programs, safe barbering, safer sex programs in all Australian prisons – immediately. Civil society can no long trust a negotiated, staged approach.

Australia is on the thresh-hold of safe, effective curative treatments that will cost the nation $80,000 upwards. Offered to prisoners, and set them up to become re-infected, and possibly not eligible to retreatment is, according to the Convention Against Torture, by definition 'cruel, unusual and inhumane' treatment.

There is ample support from overseas prison-based programs – particularly in Spain and Switzerland. They are safe, effective and affordable. They prevent hepatitis C transmission, and they enhance the dignity not just of prisoners, but also prison officers.

So, at the time when treatment options will expand dramatically, the focus on prisons as the environment of greatest concern to the human rights and public health impacts is heightened. And at this time, the National Strategies have retreated from prison engagement!

RECOMMENDATIONS

4 Revise the current Hepatitis C Strategy, to re-engage with Health and Custodial authoroites – with one outcome – full implementation of all harm minimisation strategies within all Australian prisons, equitable to those available in the community.
5 Full implementation of tattoo programs in all Australian prisons.
6 Full implementation of needle and syringe programs in all Australian prisons.
7 Safe barbering training and implementation in all Australian prisons.

3 TREATMENT WITHOUT PREVENTION, CANNOT ACHIEVE 'TREATMENT AS PREVENTION'

It is best that I submit, as an attachment, a peer-reviewed article that I authored, which offers a different approach to the much promoted "Treatment as Prevention".

RECCOMENDATION

8 Prevention of re-infection should be the entry point for all prison-based treatment programs for hepatitis C.

Professor Michael Levy AM

Canberra, December 2014