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RACGP Standards of health services in Australian prisons (2nd edition)
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Dear Colleagues,

The Australian Injecting and Illicit Drug Users League (AIVL) welcomes the opportunity to provide input to the *RACGP Standards of health services in Australian prisons (2nd edition)*.

AIVL is the Australian national peak body representing the state and territory peer-based drug user organisations in relation to issues of national relevance for people with lived experience of drug use. AIVL's vision is a world where the health and human rights of people who use/have used drugs are equal to the rest of the community. This includes a primary focus on reducing the transmission and impact of blood borne viruses – including for those accessing drug treatment services – through the effective implementation of peer education, harm reduction, health promotion and policy and advocacy strategies.

While AIVL has led the development of this submission, we have been fortunate to have had input from a range of other organisations, as outlined below.

Who we are

The organisations that have had input to the drafting of this submission are from a cross-section of the public health fields including:

- National peak organisations
- Consumer, peer and service delivery provider organisations
- Research centres and professional societies

This submission to the RACGP regarding the draft of the *Standards for health services in Australian Prisons (2nd edition)* was developed by a coalition of organisations working across the public health

sector who support the strengthening of equivalence of care and enhancement of harm reduction measures in custodial settings.

Collectively, we have a diversity of experience and knowledge which has informed our submission response (see organisational logos below).

This submission is laid out in two sections. The first section provides background information and context to the issues and perspectives which predominately underpin the nature of the feedback provided in the second section. Following on from that the second section of this submission provides the detailed suggested changes for specific criterion and text.

Summary

Custodial settings are uniquely placed to detect and address public health issues, especially in relation to the screening, treatment, management and prevention of the transmission of blood borne viruses (BBVs). Not only are there positive health outcomes for people who are incarcerated but the broader community receives benefits owing to an overall improvement in public health outcomes.

As has occurred overseas, the COVID-19 pandemic highlights the risk of communicable disease transmission which can occur from custodial staff to people who are incarcerated, and vice versa. In the case of BBVs such risks can be reduced through the implementation of evidence-based harm reduction measures.

Across the broader Australian community, some harm reduction measures have been in place for decades. These measures have proven to be practical, effective, and economically viable in terms of reducing health-related harms caused through injecting drug use. Moreover, people who are incarcerated are entitled to the equivalent standard of healthcare as would be dispensed to them in the general community in the same country.[1]

The *Fifth National Hepatitis C Strategy* notes:

> 'People in custodial settings are at a heightened risk of hepatitis C transmission due to the high hepatitis C prevalence among prison entrants and limitations on the delivery of evidence-based harm reduction and demand reduction programs such as provision of sterile needles and syringes, sterile tattooing and body piercings, and evidence-based

[1] United Nations Office on Drugs and Crime. (2015) *The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)*. Available at: https://www.unodc.org/documents/justice-and-prison-reform/Nelson_Mandela_Rules-E-ebook.pdf

opioid treatment programs (OTP). Current approaches to hepatitis C in these settings focus primarily on treatment. Opportunities for greater harm reduction and demand reduction need to be explored.'[2]

Data from the Australian Institute of Health and Welfare states that almost 1 in 6 (16%) of people discharged from prison reported using illicit drugs in prison, and about 1 in 12 (8%) reported injecting drugs whilst in prison.[3]

In relation to hepatitis C, custodial settings offer the opportunity to initiate people on direct-acting antiviral (DAA) treatment however treatment alone is problematic and is linked to the risk of reinfection if appropriate harm reduction measures are not available.[4] [5] It is noted by the Australian Government in the *Fifth National Hepatitis C Strategy* that a priority area of focus is to:

> 'Improve equitable access to successful preventative measures for all priority populations, with a focus on sterile injecting equipment through needle and syringe programs (NSPs).' [6]

With the above in mind, we believe the *RACGP Standards for health services in Australian Prisons (2nd edition)* document could be strengthened through a stronger emphasis on harm reduction principles. Being the esteemed organisation that it is, the RACGP is well-placed to lead by example in terms of use of language and opportunities, where possible, to educate and encourage clinicians, associated health-care and non-healthcare staff working within prisons in relation to the positive public health outcomes which can be achieved through a focus on harm reduction.

Additional considerations

Active consultation with affected communities and priority populations

On review it is apparent that the *Standards for health services in Australian prisons (2nd edition)* needs broader consultation with affected communities and priority populations to ensure their health needs are adequately and appropriately addressed. Results published in *National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey Report: 2004, 2007, 2010, 2013 and 2016* by the Kirby Institute, UNSW, indicated the following:

- 34% identified as Aboriginal and/or Torres Strait Islander
- 13% identified as female

[2] Australian Government. (2018) Fifth National Hepatitis C Strategy 2018 – 2022. Department of Health. Retrieved from: https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-bbvs-1
[3] Australian Institute of Health and Welfare. (2019) *The health of Australia's prisoners 2018*. Available at: https://www.aihw.gov.au/reports/prisoners/health-australia-prisoners-2018/contents/table-of-contents
[4] Kronfil, N., Linthwaite, B., Kouyoumdjian, F., Klein, M., Lebouché. B., Sebastianti, G., Cox. J. (2018) Interventions to increase testing, linkage to care and treatment of hepatitis C virus (HCV) infection among people in prisons: A systemic review. *International Journal of Drug Policy*. Vol. 57
[5] Lafferty, L., Rance, J., Treloar, C & on behalf of the SToP-C Study Group. (2018) 'Fighting a losing battle': prisoners' perspectives of treatment as prevention for hepatitis C with inadequate primary prevention measures. Drugs: Education, Prevention and Policy.
[6] Australian Government. (2018) *Fifth National Hepatitis C Strategy 2018 – 2022*. Department of Health. Retrieved from: https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-bbvs-1

- 80% of prisoners with a history of injecting drug use had reported previous incarceration, with 66% stating that they had been in prison in the past year. [7]

Impacts of COVID-19 pandemic

Whilst it is understood that the *Standards* need to be broad enough in their scope to have longevity, we feel it important that the welfare and mental health of people who are in prison during the COVID-19 pandemic is addressed. Many people who are incarcerated will experience no or reduced visitations, but also the quality of visitations will also be immensely compromised. For example, with physical distancing in place parents aren't allowed to hug their children otherwise they face penalties for doing so, and limits to the number of visitors means that families cannot be together at this time.

Additionally, people in prison face the inability to choose to self-isolate due to limitations on their capacity to do so. Therefore measures need to be put in place to ensure individuals whose health is compromised or have multiple comorbidities aren't at a heightened risk during this time.

The impact of these restrictions on mental health and wellbeing ought to be considered by clinicians whilst providing care and treatment.

Suggested changes to draft

Words suggested for inclusion, or language that has been changed is in **bold**. Text which is directly taken from the *Standards* document is in *italics*.

Page 4 Core Standard 1: Communication and Patient Participation

- *"It is important to ensure **only** relevant information is conveyed to the corrective services staff. The security staff should be provided **only** with the information needed to safely house the patient without infringing on the patient's privacy. A system should be in place to inform the security staff of such requirements. Circumstances where this may occur include:*
    - *access to food for diabetics*
    - *the need to be housed **separately or** with other people*
    - *physical accessibility needs*
    - *the need to have access to an EpiPen or asthma inhaler."*

Pages 9 - 11 Criterion C1.3 – Informed patient decisions

- In the 'Providing appropriate and sufficient information' section there is no mention of patient follow-up, nor post diagnosis counselling.

- "*direct patients to reliable health and medicine websites where they can find further information*" (p10) and "*maintain a list of electronic resources and services from which your health service or patients can access translated resources*" (p14) may not be practical recommendations for people in custodial settings.

[7] Butler, T. & Simpson, M. (2017) National Prison Entrants' Blood-borne Virus Survey Report2004, 2007, 2010, 2013, and 2016. Kirby Institute (UNSW Sydney). Available at:

- "*display posters containing information about specific diseases, such as diabetes and chicken pox*" (p11), this should include STIs and BBVs.

Page 17 Core Standard 2: Rights and needs of patients

- Introductory/overview text regarding the rights and needs of patients on page 17 could be significantly strengthened to include references to the importance of equivalence of care.

Page 50 Core Standard 4: Health promotion and preventive activities

- Examples provided could include the following:
    - **risk factors (e.g. does the patient smoke and/or use alcohol and other drugs?)**

Page 51 - 52 Criterion C4.1 – Health promotion and preventive care

- This section should be inclusive of information pertaining to harm reduction. Under *'Meeting each Indicator'* (p52), the following should be included:
    - **provide information regarding harm reduction measures and services**
    - **provide information regarding overdose prevention and use of Naloxone**
    - **provide information regarding the management of substance use/relapse prevention**

Page 76 - 80 C7.1 Content of patient health records

- Information provided in the 'LGBTQIA patient demographic information' section (p78) does not account for men who have sex with men (MSM). As it currently stands, the nuance of sexual behaviour in the prison context appears to have been overlooked. Same-sex practices in prison do not mean that someone identifies as part of the LGBTQIA community.

- Suggest the following track changes for the 'Lifestyle risk factors' section which includes removing the term 'lifestyle' (p80). The term 'lifestyle' is used consistently throughout the document to describe health risk behaviours, suggested this be amended to 'risk factors' in all instances.
    - ***Risk factors*** *such as smoking,* ***poor*** *nutrition, alcohol and* ***other drug use****, and* ***inadequate*** *physical activity are associated with many diseases. Record these risk factors in the patient health record and review management plans at defined intervals.*

Page 83 C8.1 Education and training of non-clinical staff

- Additional training areas for inclusion in '*Training relevant to the role':*
    - training which helps staff recognise and address stigma and discrimination
    - identification of overdose as well as Naloxone administration
    - training on the importance of health promotion and prevention programs (i.e. so non-clinical staff understand the importance of harm reduction)

- training on BBVs provided by qualified BBV trainers, which includes information about minimal transmission risk associated with occupational exposure

Page 94 QI1.3 – Improving clinical care

- Under 'Improving clinical practice' suggest the following amendments:
  - *systems used to identify risk factors for illnesses that are particularly prevalent in the health service's local community/ prison (e.g.* ***hepatitis B or hepatitis C****) and* ***ethnicity of*** *patient population****s*** *(e.g. Aboriginal and Torres strait Islander patients)*
  - **how the health service cares for patient's psychological health**
  - **best practice for Pre-Exposure Prophylaxis (PrEP) screening**

Page 97 QI2.1 – Health summaries

- Listed health risk factors should include 'substance dependence' or reference to 'other drug use'

- The above changes should also be reflected in the '*Why this is important'* section
  - *highlight* ***risk factors*** *(e.g. smoking,* ***poor*** *nutrition, alcohol and* ***other drug use****, physical* ***in****activity) that can help practitioners to promote healthy* ***behaviours***

Page 121 PHS 1.1 – Responsive system for patient care

- ***'****Managing cross-infection through triage'*
  Some patients may have a communicable disease and your health service needs to reduce the risks of the health service team, prison staff, visitors and other patients becoming infected. The health service team must be familiar with the health service's infection control procedures, including the use of standard and transmission-based precautions, spills management, and environmental cleaning.

  - At the time of writing there are reports of the first known case of COVID-19 within an Australian custodial setting.[8] Given the experiences of custodial settings overseas during the pandemic, we feel that information in this section could be strengthened. Furthermore, such text should be mindful that some custodial staff may have a communicable disease.

    Options include re-writing this section with a view to acknowledging and managing the risk of disease transmission from staff members to patients, or including a new section e.g. titled "Managing infection risk from staff to patient and prison population".

    In the context of COVID19, consideration should be given to advice re:

    - spacing patients more than 1.5 meters apart

[8] Mills, T., (2020) 'Knife edge': Remand centre prisoner tests positive sparing outbreak fears. *The Age*. Available at: https://www.theage.com.au/national/victoria/knife-edge-remand-centre-prisoner-tests-positive-sparking-outbreak-fears-20200717-p55d4r.html

- without compromising patient care, minimising contact with patients wherever possible
- patient PPE as well as staff PPE
- hand hygiene for patients before and after movement to/from health units

- *"Your health service must use transmission-based precautions for a patient known or suspected to be infected with a highly contagious infection (e.g.* ***corona virus*** *or influenza). You can minimise exposure to other patients and the practice team by:*
  - *implementing effective triage and appointment scheduling*
  - *using personal protective equipment (PPE) (e.g. masks)*
  - *implementing distancing techniques, such as:*
    - *spacing patients in the waiting room at least a metre apart*
    - *isolating the infected patient in a separate space (see Indicator PHS 4.1►E Our health service has a dedicated space for patient isolation when a patient presents a risk of infection to others (pg. XX) for more information)*
  - In the context of COVID-19 a dedicated space for patient isolation at the health service may become insufficient. It could be that each detention facility should make plans for options to isolate large numbers of detainee patients should an outbreak occur.

Page 122-127 PHS 2.1 - Continuous and comprehensive care

- *"Communicable diseases are known to be more prevalent in the prison population due to at-risk behaviours such as injecting drug use, needle sharing,* ***sexual practices****,* ***unsterile*** *tattooing and physical violence. Prison settings provide key opportunities for identifying and treating blood-borne viruses (BBVs) and sexually transmitted infections (STIs), therefore reducing* ***morbidity, mortality and transmission.****" (p122)*
  - This section could be further strengthened by including the lack of access to harm reduction measures as reason to greater prevalence of BBVs/STIs
  - Update second sentence to outline that treatment of BBVs/STIs has both individual and collective benefits including the health of people in prison and a safer work environment.
  - It is important to convey that without prevention and harm reduction measures, treatment alone is not sufficient.[9] [10]

- "*Following an initial assessment of an individual in prison, the practitioner can identify physical and/or mental illness and take necessary measures for new or continuing treatment* ***and care.*** *Health assessment on arrival allows the health service to:*

[9] Kronfil, N., Linthwaite, B., Kouyoumdjian, F., Klein, M., Lebouché. B., Sebastianti, G., Cox. J. (2018) Interventions to increase testing, linkage to care and treatment of hepatitis C virus (HCV) infection among people in prisons: A systemic review. *International Journal of Drug Policy*. Vol. 57

[10] Lafferty, L., Rance, J., Treloar, C & on behalf of the SToP-C Study Group. (2018) 'Fighting a losing battle': prisoners' perspectives of treatment as prevention for hepatitis C with inadequate primary prevention measures. Drugs: Education, Prevention and Policy.

- *isolate an individual in prison who is suspected of a highly communicable disease that may impact public health (e.g.* hepatitis C*) for the period of infection, providing them with proper treatment." (p122)*
    - It is not clinically required nor appropriate for a person living with HCV to be isolated for the period of infection. This is a concerning statement which contravenes national standards.

- "*Comprehensive care*

  The provision of comprehensive care for individuals in prison includes:

  - *proactive health promotion and preventive care including physical (encompasses appropriate developmental, age, gender appropriate, sexual health and obstetric health)* ***and psychological health needs (this sentence is incomplete in the draft, so this is a suggested way to complete it)***
  - *acute and chronic disease management*
  - *infectious disease management including addressing public health impacts within the prison*
  - *trauma informed* ***care*** *and mental health care including screening and access to counselling*
  - *treatment for substance dependency*
  - *advanced care planning and end of life care*
  - *effective referral pathways to other specialised health care providers and services*
  - *access to psychiatrists, dental specialists, optical, pathology and radiology services*
  - *access to appropriate prostheses and sensory and mobility aids required by an individual to carry out their normal activities of daily living.*
  - *appropriate care for individuals across the life span.*
  - ***patient centred health care.***
  - ***throughcare – the coordinated provision of health care and support to a person, beginning when they first go into prison and continuing until they are living a healthy life back in the community.***
    - Instead of referring to 'treatment for substance dependency' this could be given more detail and make references to; specialist alcohol and other drugs (AOD) services, group therapy, access pharmacotherapy such as opioid agonist therapy (OAT), and use of harm reduction measures.

Page 135 PHS 2.3 Engaging with other services

- *"By working cooperatively with other healthcare providers and services, you can provide optimal care to patients whose healthcare requires integration of multiple services. These services may include:" (p135)*

- Options listed should include reference to peer-based organisations and services as well as specialist AOD services.[11] [12] [13]

Page 140-2 PHS 2.4 Transfer of care and the patient practitioner relationship

- In the *'Why this is important'* section (p140) it is pleasing to note the acknowledgement of vulnerability of individuals during the period of release and re-integration into the community. It is important to include here that individuals are at higher risk of overdose during this period of time, and therefore people leaving prison should be equipped with Naloxone/Nyxoid where possible.[14]

- The '*Patient discharge'* (p142) can be further strengthened by inclusion of the following points:
  - Identification of a General Practioncer, Aboriginal Community Controlled Health Service and/or prison transition service provider
  - a list of community peer-based organisations and services
  - ensuring the continuance of pharmacotherapy treatment in the community
  - ensuring the individual has Medicare access to continue their healthcare treatment, obtain necessary medicines in the community, and if their Medicare coverage has lapsed make arrangements for support [15]
  - where possible and appropriate provide the individual with Naloxone
  - how investigations or treatments initiated by the prison health service will be continued
  - information about the medications supplied on discharge
  - access to relevant specialist reports
  - access to age-appropriate screening and preventative activities

- Despite there now being national screening, immunisation registers and MyHealth Record, these platforms contain insufficient detail about an individual's health and wellbeing at the time of discharge to ensure best practice continuity of care. Prison health services should provide client-held discharge summaries which could be shared with providers on an 'as required' basis to safeguard all concerned. Currently, primary care providers rely on faxing letters of consent on behalf of clients requesting information from custodial facilities. Responses are often delayed and occasionally provide incomplete or misleading information.

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[11] Crowley, D., Van Hout, C.M., Lambert, J., Kelly. E., Murphy, C. & Cullen, W. (2018) Barriers and facilitators to hepatitis C (HCV) screening and treatment – a description of prisoners' perspective. *Harm Reduction Journal*. Vol. 15 (62)

[12] Australian Government. (2018) Fifth National Hepatitis C Strategy 2018 – 2022. Department of Health. Retrieved from: https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-bbvs-1

[13] Australian Injecting & Illicit Drug Users League (AIVL). (2019) Missing Connections: Service user experiences of people living with hepatitis C exiting custodial settings. Available at: http://aivl.org.au/wp-content/uploads/2019/07/AIVL-Missing-Connections.pdf

[14] Australian Injecting & Illicit Drug Users League (AIVL). (2019) Missing Connections: Service user experiences of people living with hepatitis C exiting custodial settings. Available at: http://aivl.org.au/wp-content/uploads/2019/07/AIVL-Missing-Connections.pdf

[15] Australian Medical Association. (2012) *Position Statement in Health and the Criminal Justice System 2012*. Available at: https://ama.com.au/position-statement/health-and-criminal-justice-system-2012

Page 154 – 161 PHS 4.1 Infection prevention and control, including sterilisation

- *Why this is important* (p155)

  Having systems with clear lines of accountability and responsibility is part of good governance and the delivery of safety and quality care of patients.

  It is important to keep patients and the health service team safe from infection. Infection prevention and control reduces the risk of infection travelling from patient to patient, or ***between patients and members of the health service team.***

  …

  All members of the health service team must:

  - *have easy access to personal protective equipment (PPE) (e.g. masks, gloves, gowns, protective eye wear)*
  - *receive education about the proper use of PPE*
  - *have a clear understanding of the purpose of PPE and how to apply, remove and dispose of it appropriately*
  - ***know their health status and maintain currency of appropriate immunisations.***

    - The phrasing of the above paragraph frames transmission risk as patients carrying the burden of infection to members of the health service team, this could be reworded to take into account that it is possible that it is in fact the patients at risk from the health service staff. This is especially relevant in the context of COVID-19.

- *Infection control policy* (p156)

  Develop policies, procedures and tools such as checklists so that adequate steps are taken during the complete sterilisation process. Your infection control policy must contain:

  - *the name of the team member/s responsible for infection control and sterilisation processes*
  - *the appropriate use and application of standard and transmission-based precautions*
  - *management of sharps injury* ***including access to post-exposure prophylaxis where required***

- *Harm* ***reduction*** *programs (p157)*

  Your health service could implement a range of harm ***reduction*** *programs relevant to its patient population.*

  The implementation of needle and syringe exchange programs and opioid replacement therapy has been shown to help reduce disease transmission among ***people who inject drugs in prisons and in community settings****. Implementing harm* ***reduction*** *programs in your health service will allow you to better plan for the use of drugs, needles and syringes by your patient population and educate patients on the prevention of disease transmission (e.g.* ***hepatitis C*** *and HIV) among those who inject drugs and others in the prison and community.*

Other strategies that could be implemented include the distribution of condoms, lubricants and bleaching agents.

- Throughout this section of the document the term 'harm minimisation' is used (p154, 157, 158). This term has been used incorrectly and ought to be 'harm reduction'.
- Inclusion of the importance and use of Naloxone could also be added to this section.

- Text at the top of page 158 should make reference to 'blood borne viruses' rather than solely HIV

- *You could:* (p161)
  - *provide access to a needle and syringe exchange program*
  - *provide access to an opioid replacement therapy program*
  - *educate patients on the safe disposal and acquisition of needles and syringes*
  - ***provide discrete access to evidence-based bleaching agents and information about their use and efficacy***
  - ***provide discrete access to condoms and lubricants***
  - ***refer patients to appropriate harm reduction community-based services and resources for detailed information***
    - The range of harm reduction measures mentioned on page 161 could be expanded to include the above.

Page 173 PHS 5.3 – Portable equipment

- Suggested emergency medicines should include HIV post-exposure prophylaxis such as tenofovir and emtricitabine or tenofovir and lamivudine which are recommended as the preferred 2-drug PEP regime in the *Post-Exposure Prophylaxis after Non-Occupational and Occupational Exposure to HIV Australian National Guidelines (Second Edition)*.[16]

[16] Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM). (2016) Post-Exposure Prophylaxis after Non-Occupational and Occupational Exposure to HIV Australian National Guidelines (Second Edition) http://www.pep.guidelines.org.au/

In summary, we believe that the *RACGP Standards of health services in Australian prisons (2nd edition)* is an already well thought through document. However, we believe public health outcomes could be further strengthened by a stronger focus on harm reduction measures and person/patient-centred approaches.

Yours sincerely,

Melanie Walker
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