Victorian Aboriginal Legal Service Submission to the Consultation on RACGP Standards for Health Services in Australian Prisons (2nd edition)

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Victorian Aboriginal Legal Service

BACKGROUND TO THE VICTORIAN ABORIGINAL LEGAL SERVICE

The Victorian Aboriginal Legal Service (VALS) is an Aboriginal Community Controlled Organisation (**ACCO**). VALS was established in 1973 to provide culturally safe legal and community justice services to Aboriginal and/or Torres Strait Islander people across Victoria.[1] VALS' vision is to ensure that Aboriginal people in Victoria are treated equally before the law; our human rights are respected; and we have the choice to live a life of the quality we wish.

Legal Services

Our legal practice serves Aboriginal people of all ages and genders in the areas of criminal, family and civil law. We are also in the process of relaunching a dedicated youth justice service, Balit Ngulu. Our 24-hour criminal law service is backed up by the strong community-based role of our Client Service Officers (CSOs). CSOs are the first point of contact when an Aboriginal person is taken into custody, through to the finalisation of legal proceedings.

Our Criminal Law Practice provides legal assistance and representation for Aboriginal people involved in court proceedings. This includes bail applications; representation for legal defence; and assisting clients with pleading to charges and sentencing. This includes matters in the generalist and Koori courts.[2] Most clients have been exposed to family violence, poor mental health, homelessness and poverty. We aim to understand the underlying reasons that have led to the offending behaviour and equip prosecutors, magistrates and legal officers with knowledge of this.. We support our clients to access support that can help to address the underlying reasons for offending and so reduce recidivism.

Our Civil and Human Rights Practice provides advice and casework to Aboriginal people in areas, including infringements; tenancy; victims of crime; discrimination and human rights; Personal Safety Intervention Orders (PSIVO) matters; coronial inquests; consumer law issues; and Working With Children Check suspension or cancellation.[3]

Our Aboriginal Families Practice provides legal advice and representation to clients in family law and child protection matters.[4] We aim to ensure that families can remain together and children are kept safe. We are consistent advocates for compliance with the Aboriginal Child Placement Principle in situations where children are removed from their parents' care.

[1] The term "Aboriginal" is used throughout this submission to refer to Aboriginal and/or Torres Strait Islander peoples.
[2] In 2019-2020, VALS provided legal services in relation to 1,873 criminal law matters. In 2020-2021, VALS has provided legal services in relation to 805 criminal law matters (as of 19 March 2021).
[3] In 2019-2020, VALS provided legal services in relation to 827 civil law matters. In 2020-2021, VVALS has provided legal services in relation to 450 civil law matters (as of 19 March 2021).
[4] In 2019-2020, VALS provided legal services in relation to 835 family law and/or child protection matters. In 2020-2021, VALS has provided legal services in relation to 788 family law and/or child protection matters (as of 19 March 2021).

Victorian Aboriginal Legal Service

Our Specialist Legal and Litigation Practice (Wirraway) legal advice and representation in civil litigation matters against government authorities. This includes for claims involving excessive force or unlawful detention; police complaints; prisoners' rights issues; and coronial inquests (including deaths in custody).[5]

Community Justice Programs

VALS operates a Custody Notification System (CNS). The Crimes Act 1958[6] requires that Victoria Police notify VALS within 1 hour of an Aboriginal person being taken into police custody in Victoria.[7] Once a notification is received, VALS contacts the relevant police station to conduct a welfare check and facilitate access to legal advice if required.

The Community Justice Programs Team also operates the following programs:

- Family Violence Client Support Program[8]
- Community Legal Education
- Victoria Police Electronic Referral System (V-PeR)[9]
- Regional Client Service Officers
- Baggarrook Women's Transitional Housing program[10]

Policy, Research and Advocacy

VALS informs and drives system change initiatives to improve justice outcomes for Aboriginal people in Victoria. VALS works closely with fellow members of the Aboriginal Justice Caucus and ACCOs in Victoria, as well as other key stakeholders within the justice and human rights sectors.

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[5] In 2019-2020, VALS Wirraway provided legal services in relation to 2 legal matters. In 2020-2021, VALS Wirraway has provided legal services in relation to 53 legal matters (as of 19 March 2021).

[6] Ss. 464AAB and 464FA, Crimes Act 1958 (Vic).

[7] In 2019-2020, VALS CNS handled 13,426 custodial notifications. In 2020-2021, VALS CNS has handled 8,366 custodial notifications (as of 19 March 2021).

[8] VALS has three Family Violence Client Support Officers (FVCSOs) who support clients throughout their family law or civil law matter, providing holistic support to limit re-traumatisation to the client and provide appropriate referrals to access local community support programs and emergency relief monies.

[9] The Victoria Police Electronic Referral (V-PeR) program involves a partnership between VALS and Victoria Police to support Aboriginal people across Victoria to access culturally appropriate services. Individuals are referred to VALS once they are in contact with police, and VALS provides support to that person to access appropriate services, including in relation to drug and alcohol, housing and homelessness, disability support, mental health support.

[10] The Baggarrook Women's Transitional Housing program provides post-release support and culturally safe housing for six Aboriginal women to support their transition back to the community. The program is a partnership between VALS, Aboriginal Housing Victoria and Corrections Victoria.

ACKNOWLEDGEMENT

VALS pays our deepest respect to traditional owners across Victoria, in particular, to all Elders past, present and emerging. We also acknowledge all Aboriginal and Torres Strait Islander people in Victoria and pay respect to the knowledge, cultures and continued history of all Aboriginal and Torres Strait Islander Nations.

SUMMARY OF RECOMMENDATIONS

Recommendation 1. The Guidelines must incorporate obligations and guidance from relevant international instruments relating to the prohibition of torture and other cruel, inhuman or degrading treatment or punishment, including, but not limited to, the following:

- *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment;*
- *UN 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;*
- *United Nations Istanbul Protocol - Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*

Recommendation 2. The Guidelines must explicitly require that incarcerated people "enjoy the same standards of health care that are available in the community, and should have access to necessary healthcare services free of charge, without discrimination on the grounds of their legal status," and state that the right "to the enjoyment of the highest attainable standard of physical and mental health".

Recommendation 3. The Federal Government must ensure that incarcerated people have access to the Pharmaceutical Benefits Scheme (PBS) and the Medicare Benefits Schedule (MBS).

Recommendation 4. The Federal and State Governments must ensure that incarcerated people have access to the National Disability Insurance Scheme (NDIS) and are assessed for eligibility for NDIS upon entry to a prison or youth prison.

Recommendation 5. Health care must be delivered through Health Departments rather than Justice Departments, and not through private, for-profit organisations (particularly noting the issue of inconsistent, fragmented service provision across prison systems).

Recommendation 6. The Guidelines must properly address the issue of individual and systemic racism, as this is essential to preventing Aboriginal and/or Torres Strait Islander deaths in custody. The medical care provided to people in custody must be provided in a manner that is competent, culturally safe and free from racism or discrimination.

Recommendation 7. "Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism."

Recommendation 8. The Guidelines must mandate that healthcare providers respect Aboriginal and/or Torres Strait Islander people's culture.

Recommendation 9. The Guidelines must mandate that healthcare providers maintain a publicly available cultural safety policy and require staff to undertake appropriate training and education (including cultural awareness, anti-racism and human rights training), which is co-created and co-delivered with Aboriginal Community Controlled Organisations. Training must be delivered at regular intervals, as refreshers are essential.

Recommendation 10. The Guidelines must mandate that healthcare providers employ Aboriginal health, and social & emotional wellbeing officers at all prisons. Aboriginal Health Workers and Wellbeing Officers should see an Aboriginal person within hours of their entry into prison or youth prison. Under *Criterion C1.1 – Information about your health service* ("Our patients can access up-to-date information about the health service"), it should be made clear that this information must be provided upon reception.

Recommendation 11. The Guidelines must address the importance of Aboriginal Self Determination and the role of Aboriginal Community Controlled Health Organisations (ACCHOs). A model of delivery of primary health services by Aboriginal Community Controlled Health Organisations in places of detention should be supported, in consultation with ACCHOs.

Recommendation 12. The Guidelines must prohibit requiring incarcerated people to pay out-of-pocket medical expenses. Incarcerated people have been deprived of their liberty by the State, and are entirely dependent on the State for both their (drastically reduced) income and healthcare provision.

Recommendation 13. Incarcerated people must be entitled to a second medical opinion.

Recommendation 14.

- The Guidelines must be amended to reflect a higher threshold for the use of restrictive practices, as a patient being 'uncooperative' or 'disruptive' is an inappropriately low threshold.
- Restraints must not be used:

  - "unless a procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or the safety" of the incarcerated person or others, and
  - it "presents no hazard to [the incarcerated person's] physical or mental health."
- Use of restraints must not be used for punishment, discipline, or to facilitate compliance with an order or direction.
- Any use of force/restraint should be exceptional, as a last resort, when all other control methods (including de-escalation techniques) have been exhausted and failed.
- The safety of the patient must be a prime consideration.
- Use of force should be used restrictively, for no longer than is strictly necessary.
- A minimum level of restraint/degree of force should be used.
- Use of force/restraint should never involve deliberate infliction of pain and should not cause humiliation or degradation.
- The "use of methods of chemical restraint must be avoided. When sedation is used as chemical restraint it must be strictly controlled and limited solely to the prevention of acts of violence against others or of self-harm."[11] The use of chemical (medical and pharmacological) restraints on children must be prohibited.
- Staff who use restraint or force in violation of the rules and standards should be punished.

Recommendation 15. The Guidelines must provide guidance on the use of solitary confinement in all prisons and youth prisons, including for the purposes of controlling infectious diseases.

- No person should ever be placed in solitary confinement, noting people who are particularly vulnerable to the harms – Aboriginal and/or Torres Strait Islander people, children, people with mental or physical disabilities, people histories of trauma.
- Prolonged solitary confinement can amount to torture, and no one should be subjected to this.

Recommendation 16. The Guidelines must clearly state that any adverse impact/reprisals as a result of an incarcerated person making a complaint are prohibited (including, but not limited to, the quality of healthcare provided), and will lead to staff disciplinary processes, including termination in serious instances.

Recommendation 17. The Guidelines must clearly state that the health care staff's clinical autonomy must take precedence over operational considerations of the prison/youth prison, except in exceptional circumstances.

Recommendation 18. The need and priority for clinical care must not to be determined by prison staff. They do not have the qualifications to make such critical decisions. Prisons must provide 24 hours a

[11] Means of restraint, available at https://www.apt.ch/en/knowledge-hub/detention-focus-database/safety-order-and-discipline/means-restraint

day access to appropriately qualified medical practitioners and nursing staff, who are adequately equipped and available to conduct a meaningful physical review of the person on the premises. This is also essential to enable clinical handover, addressed in the Guidelines.

Recommendation 19. The Guidelines must make the following harm reduction programs mandatory:

- an opioid agonist therapy program;
- access to substance misuse counselling;
- information on the prevention of transmission of blood-borne viruses;
- the distribution of condoms and lubricant.

Recommendation 20. The Guidelines must make the following mandatory:

- Physical cell checks of persons in custody must be frequent and thorough, including meaningful assessments of health and wellbeing. People who are identified as at-risk must be regularly monitored.
- Where a person has exhibited any signs or symptoms of illness, cell checks must be completed by qualified medical staff.
- Cell checks should never be conducted in a cursory fashion through a cell 'peep hole', under any circumstances.
- Where prison officers or medical staff observe behaviour during routine cell checks, whether by reason of its unusualness or because it is inexplicable on the known facts, that is sufficient to cause concern, the incarcerated person should be taken immediately to a hospital, or a doctor summoned, so that a proper diagnosis can be made.

Recommendation 21. In all cases where there are known health conditions, or the person reports any unexplained symptom or pain, it is incumbent on officers to act with urgency when the condition manifests and provide urgent review by a qualified medical practitioner.

Recommendation 22. In all cases where a person in custody reports a sudden, unexpected, or medically significant increase in pain, or new or changing symptoms, the person should be immediately conveyed to hospital by ambulance.

DETAILED SUBMISSIONS

Torture and Cruel, Inhuman or Degrading Treatment or Punishment

The *UN 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*[12] are not addressed in the Guidelines. VALS particularly highlights Principle 4(b):

> It is a contravention of medical ethics for health personnel, particularly physicians… To certify, or to participate in the certification of, the fitness of prisoners or detainees for any form of treatment or punishment that may adversely affect their physical or mental health and which is not in accordance with the relevant international instruments, or to participate in any way in the infliction of any such treatment or punishment which is not in accordance with the relevant international instruments.

The Guidelines also make no mention of the *United Nations Istanbul Protocol - Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*,[13] which are "intended to serve as international guidelines for the assessment of persons who allege torture and ill-treatment, for investigating cases of alleged torture and for reporting findings to the judiciary or any other investigative body." The Protocol states that:

> This manual was developed to enable States to address one of the most fundamental concerns in protecting individuals from torture—effective documentation. Such documentation brings evidence of torture and ill-treatment to light so that perpetrators may be held accountable for their actions and the interests of justice may be served.

RECOMMENDATION

Recommendation 1. The Guidelines must incorporate obligations and guidance from relevant international instruments relating to the prohibition of, and accountability for, torture and other cruel, inhuman or degrading treatment or punishment, including, but not limited to, the following:

- *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment;*
- *UN 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;*
- *United Nations Istanbul Protocol - Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*

[12] Available at https://www.ohchr.org/en/instruments-mechanisms/instruments/principles-medical-ethics-relevant-role-health-personnel
[13] Available at https://www.ohchr.org/sites/default/files/documents/publications/training8rev1en.pdf

Victorian Aboriginal Legal Service

Equivalency of Healthcare

The Guidelines state the following:

> All people in prison must be able to access timely and effective primary healthcare, commensurate with the healthcare that would be available in the Australian community for their condition/s and identified level of vulnerability.

The Guidelines must, instead, require that the healthcare provided is equivalent to that provided in the community. The Guidelines must reflect the language used in international law. The *United Nations Standard Minimum Rules for the Treatment of Prisoners*[14] (the Mandela Rules) make clear that "prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary healthcare services free of charge, without discrimination on the grounds of their legal status." The obligation to provide equivalence of medical care to people deprived of their liberty is echoed in the *International Covenant on Economic, Social and Cultural Rights*,[15] which emphasises "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

The Guidelines discuss comparable medical care to that in the community, but fail to address some of the fundamental issues that impede truly equivalent care being provided to incarcerated people. There is a passing mention of Medicare, and no mention of either the Pharmaceutical Benefits Scheme (**PBS**) or National Disability Insurance Scheme (**NDIS**). The need for Health Departments to provide healthcare in prisons, and the problematic privatisation and fragmentation of healthcare across prison systems are not given the requisite attention.

The challenges inherent to a fragmented, privatised system are alluded to in the Guidelines:

> Prisoners may be frequently and rapidly transferred to alternative locations. To ensure continuity of care across health services in different prisons, your health service needs to develop a routine procedure for the way in which health information is transferred to a new location.

RECOMMENDATIONS

Recommendation 2. The Guidelines must explicitly require that incarcerated people "enjoy the same standards of health care that are available in the community, and should have access to necessary healthcare services free of charge, without discrimination on the grounds of their legal status," and state that the right "to the enjoyment of the highest attainable standard of physical and mental health".

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[14] Available at https://www.unodc.org/documents/justice-and-prison-reform/Nelson_Mandela_Rules-E-ebook.pdf

[15] Available at https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights

Recommendation 3. The Federal Government must ensure that incarcerated people have access to the Pharmaceutical Benefits Scheme (PBS) and the Medicare Benefits Schedule (MBS).

Recommendation 4. The Federal and State Governments must ensure that incarcerated people have access to the National Disability Insurance Scheme (NDIS) and are assessed for eligibility for NDIS upon entry to a prison or youth prison.

Recommendation 5. Health care must be delivered through Health Departments rather than Justice Departments, and not through private, for-profit organisations (particularly noting the issue of inconsistent, fragmented service provision across prison systems).

Systemic and Individual Racism

The Guidelines only mention racism once: "As a peak representative body for Australian general practitioners, the RACGP plays a critical leadership role in challenging discrimination and institutional racism in healthcare."

Last year, a Guardian analysis of 474 Aboriginal and/or Torres Strait Islander Deaths in Custody since 1991, on the 30th anniversary of the report of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC), found that:

> For both Aboriginal and Torres Strait Islander people and non-Indigenous people, the most common cause of death was medical problems, followed by self-harm. However, Indigenous people who died in custody were *three times more likely not to receive all necessary medical care*, compared to non-Indigenous people. For Indigenous women, the result was even worse – *less than half received all required medical care* prior to death.[16]

The Australian Health Practitioner Regulation Authority has defined cultural safety as follows:

> Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare *free of racism*.[17]

The Guidelines must more comprehensively address the issue of individual and systemic racism.

[16] Allam, L. et al. (2021). The facts about Australia's rising toll of Indigenous deaths in custody. Available at https://www.theguardian.com/australia-news/2021/apr/09/the-facts-about-australias-rising-toll-of-indigenous-deaths-in-custody.

[17] Australian Health Practitioner Regulation Authority, National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy, available at https://www.ahpra.gov.au/About-Ahpra/Aboriginal-and-Torres-Strait-Islander-Health-Strategy/health-and-cultural-safety-strategy.aspx

We also note that the number of Aboriginal deaths in custody since the Royal Commission into Aboriginal Deaths in Custody is incorrect; the figure is, devastatingly, now more than 500.

RECOMMENDATION

Recommendation 6. The Guidelines must properly address the issue of individual and systemic racism, as this is essential to preventing Aboriginal and/or Torres Strait Islander deaths in custody. The medical care provided to people in custody must be provided in a manner that is competent, culturally safe and free from racism or discrimination.

Culturally Safe Healthcare

VALS notes the above definition of cultural safety.

VALS also brings to the RACGP's attention the following:

> Cultural safety is an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening.[18]

Under *Criterion C2.1 – Respectful and culturally appropriate care*, we recommend elevating the obligation from "considers" to "respects":

> Our health service, in providing patient healthcare, considers patients' rights, beliefs, and their religious and cultural backgrounds.

The following should be mandatory (in the Guidelines, this is discretionary):

> maintain a cultural safety policy for the health service team and patients so that your health service team knows they are required to provide care that is respectful of a person's culture and beliefs, and that is free from discrimination
> provide appropriate training and education so that the health service team knows how to help patients feel culturally safe in the service provide access to cultural awareness and cultural safety training for the health service team and keep records of the training in the health service's training register.

VALS also highlights that there is no mention of Aboriginal Self Determination in the Guidelines, nor is there any mention of Aboriginal Community Controlled Health Organisations (ACCHOs). This is a glaring oversight, that should be addressed.

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[18] Robyn Williams, 'Cultural Safety – What does it mean for our work practice?' (1999) 23 Australian and New Zealand Journal of Public Health 2.

RECOMMENDATIONS

Recommendation 7. "Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism."

Recommendation 8. The Guidelines must mandate that healthcare providers respect Aboriginal and/or Torres Strait Islander people's culture.

Recommendation 9. The Guidelines must mandate that healthcare providers maintain a publicly available cultural safety policy and require staff to undertake appropriate training and education (including cultural awareness, anti-racism and human rights training), which is co-created and co-delivered with Aboriginal Community Controlled Organisations. Training must be delivered at regular intervals, as refreshers are essential.

Recommendation 10. The Guidelines must mandate that healthcare providers employ Aboriginal health, and social & emotional wellbeing officers at all prisons. Aboriginal Health Workers and Wellbeing Officers should see an Aboriginal person within hours of their entry into prison or youth prison. Under *Criterion C1.1 – Information about your health service* ("Our patients can access up-to-date information about the health service"), it should be made clear that this information must be provided upon reception.

Recommendation 11. The Guidelines must address the importance of Aboriginal Self Determination and the role of Aboriginal Community Controlled Health Organisations (ACCHOs). A model of delivery of primary health services by Aboriginal Community Controlled Health Organisations in places of detention should be supported, in consultation with ACCHOs.

Out-of-Pocket Healthcare Costs

Under *Criterion C1.5 – Costs associated with care initiated by the health service*, the following is stated:

> Where a referral is required to an external service, patients must be informed that there may be a cost of engaging private services. Such referrals may also incur transport costs to the patient.

Yet, earlier in the Guidelines, the following was highlighted:

> People who are detained in prison are considered to be one of the most vulnerable and disadvantaged groups in Australia. Compared to the general population, a large proportion of the prison population have experienced homelessness and periods of long-term unemployment. Many of those who end up in prison are also likely to be or have been victims of sexual and/or domestic abuse and violence.

Incarcerated people do not receive welfare benefits. Those who are able to work while incarcerated, earn very little, much less than they would earn in the community. For example, in Victoria, at Level 1 people earn $8.95 per day, at Level 2 $7.75 per day and at Level 3 $6.50 per day. People on remand or with short-term illnesses (less than 4 weeks) earn $3.30 per weekday, and incarcerated people aged over 65 years or with a long-term certified illness earn $6.00 per weekday.[19]

Incarcerated people's families are frequently not in a position to pay for medical costs. Requiring incarcerated people to pay out-of-pocket medical expenses when they are in such a disadvantageous position is not equivalency of medical care, and puts their health and lives at risk.

RECOMMENDATION

Recommendation 12. The Guidelines must prohibit requiring incarcerated people to pay out-of-pocket medical expenses. Incarcerated people have been deprived of their liberty by the State, and are entirely dependent on the State for both their (drastically reduced) income and healthcare provision.

Second Opinions

Criterion C2.1 – Respectful and culturally appropriate care states the following:

> Patients with decision-making capacity have the right to refuse a recommended treatment, medicines, advice or procedure and to seek clinical opinions from other healthcare providers. However, there may not be an obligation on the health service to enact such a request in the prison setting.

It also states the following regarding second opinions:

> If the practitioner is aware that the patient wishes to seek another clinical opinion they could offer to provide a referral to the provider who is to give that opinion. Document in the patient's health record:
> - the patient's decision
> - the actions taken by the practitioner
> - any referrals to other care providers.
>
> You can also encourage patients to notify their practitioner when they decide to follow another healthcare provider's advice so that the practitioner can discuss any potential risks of this decision. In prison settings, there are scenarios where it may not be possible to refer a patient for a second opinion. If this is the case, practitioners must explain to the patient the reasons for not being able to refer and document this in the patient's health record.

RECOMMENDATION

Recommendation 13. Incarcerated people must be entitled to a second medical opinion.

[19] Corrections Victoria, Deputy Commissioner's Instruction - 3.03 Prison Industries

Restrictive Practices

Restraints

Under *Criterion PHS 2.4 – Transfer of care and the patient–practitioner relationship,* the Guidelines state the following:

> The health service must uphold the rights of an individual in prison to be treated in the least restrictive environment and to the extent that it does not impose serious risk to the individual or others. The safety of the patient, health service and prison staff, and any staff transporting a patient are paramount. In instances such as where an individual in prison is uncooperative, disruptive or violent, restraints could be considered as a last resort by clinical staff. If so, restraint must be used to the minimum extent necessary to provide care or transfer a patient. In prison, restraints are administered by prison staff under the advice of a member of the clinical team. If a chemical restraint is used, it must be administered and supervised by a member of the clinical team.
>
> The health service must maintain a policy on the use of restraints and comply with relevant state and territory legislation.
>
> Your health service will not make decisions regarding restraint in isolation of a governing body's policy. Your health service must:
>
> - maintain a policy on the use of restraints
> - respect the safety and dignity of any individual being restrained
> - demonstrate how the health service policy on the use of restraints integrates with any policies
>   enforced by an agency (eg the Department of Justice)
> - document all use of restraints, including:
>   - the assessment for use of restraint
>   - the reasons for restraint
>   - the instruments and method used to restrain an individual
>   - any injury received as a result of restraint
>   - any further reporting of the use of restraint outside of the health service.

The threshold identified above is too low – "In instances such as where an individual in prison is *uncooperative, disruptive* or violent, restraints could be considered as a last resort by clinical staff" – and there is insufficient guidance in the Guidelines regarding the use of force.

VALS brings to the RACGP's attention Principle 5 of the *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:*

> It is a contravention of medical ethics for health personnel, particularly physicians, to participate in any procedure for restraining a prisoner or detainee unless such a procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or

> the safety of the prisoner or detainee himself, of his fellow prisoners or detainees, or of his guardians, and presents no hazard to his physical or mental health.[20]

VALS also highlights the position of the Association for the Prevention of Torture, that the

> use of methods of chemical restraint must be avoided. When sedation is used as chemical restraint it must be strictly controlled and limited solely to the prevention of acts of violence against others or of self-harm.[21]

RECOMMENDATION

Recommendation 14.

- The Guidelines must be amended to reflect a higher threshold for the use of restrictive practices, as a patient being 'uncooperative' or 'disruptive' is an inappropriately low threshold.
- Restraints must not be used:
  - "unless a procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or the safety" of the incarcerated person or others, and
  - it "presents no hazard to [the incarcerated person's] physical or mental health."
- Use of restraints must not be used for punishment, discipline, or to facilitate compliance with an order or direction.
- Any use of force/restraint should be exceptional, as a last resort, when all other control methods (including de-escalation techniques) have been exhausted and failed.
- The safety of the patient must be a prime consideration.
- Use of force should be used restrictively, for no longer than is strictly necessary.
- A minimum level of restraint/degree of force should be used.
- Use of force/restraint should never involve deliberate infliction of pain and should not cause humiliation or degradation.
- The "use of methods of chemical restraint must be avoided. When sedation is used as chemical restraint it must be strictly controlled and limited solely to the prevention of acts of violence against others or of self-harm."[22] The use of chemical (medical and pharmacological) restraints on children must be prohibited.
- Staff who use restraint or force in violation of the rules and standards should be punished.

[20] Available at https://www.ohchr.org/en/instruments-mechanisms/instruments/principles-medical-ethics-relevant-role-health-personnel

[21] Means of restraint, available at https://www.apt.ch/en/knowledge-hub/detention-focus-database/safety-order-and-discipline/means-restraint

[22] Means of restraint, available at https://www.apt.ch/en/knowledge-hub/detention-focus-database/safety-order-and-discipline/means-restraint

Isolation

The Guidelines are silent on solitary confinement and prolonged solitary confinement.

The UN Mandela Rules define solitary confinement as the "'confinement of prisoners for 22 hours or more a day without meaningful human contact," and define prolonged solitary confinement as solitary confinement for a time period in excess of 15 consecutive days.[23] They state that solitary confinement "shall be used only in exceptional cases as a last resort, for as short a time as possible and subject to independent review, and only pursuant to the authorization by a competent authority."[24] They prohibit the use of solitary confinement for people "with mental or physical disabilities when their conditions would be exacerbated by such measures."[25]

The UN Havana Rules, which focus on children, state that "all disciplinary measures constituting cruel, inhuman or degrading treatment shall be strictly prohibited, including corporal punishment, placement in a dark cell, closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile concerned."[26] The Committee on The Rights of the Child has reiterated that solitary confinement should not be used on children.[27]

Solitary confinement has a particularly detrimental impact on Aboriginal people, with the Royal Commission into Aboriginal Deaths in Custody noting that it is "undesirable in the highest degree that an Aboriginal person in prison should be placed in segregation or isolated detention."[28]

RECOMMENDATION

Recommendation 15. The Guidelines must provide guidance on the use of solitary confinement in all prisons and youth prisons, including for the purposes of controlling infectious diseases.

- No person should ever be placed in solitary confinement, noting people who are particularly vulnerable to the harms – Aboriginal and/or Torres Strait Islander people, children, people with mental or physical disabilities, people histories of trauma.
- Prolonged solitary confinement can amount to torture, and no one should be subjected to this.

[23] Rule 44 of the Mandela Rules.
[24] Rule 45(1), ibid.
[25] Rule 45(2), ibid.
[26] Rule 6.7 of the Havana Rules.
[27] United Nations Committee on the Rights of the Child (2019). General Comment No. 24 on children's rights in the child justice system, at (95(h).
[28] Available at http://www.austlii.edu.au/au/other/IndigLRes/rciadic/

Complaints Processes

Under *Core Standard 3: Health service governance and management*, *C 3.1 Our health service has a complaints resolution process*, the Guidelines state that, “[y]ou must maintain a complaints resolution process.” While the Guidelines do require “ensuring the complaint does not adversely affect the patient’s care”, the Guidelines do not address the risk of broader reprisals.

RECOMMENDATION

Recommendation 16. The Guidelines must clearly state that any adverse impact/reprisals as a result of an incarcerated person making a complaint are prohibited (including, but not limited to, the quality of healthcare provided), and will lead to staff disciplinary processes, including termination in serious instances.

Clinical Autonomy

Under *Criterion C5.2 – Clinical autonomy for practitioners*, it states that:

> Our clinical team can exercise autonomy, to the full scope of their practice, skills and knowledge, when making decisions that affect clinical care.
>
> You must give practitioners autonomy in relation to
>
> - overall clinical care of their patients
> - referrals to other health professionals
> - requesting investigations
> - duration and scheduling of appointments.

Under *Criterion PHS 1.3 – Care outside of normal hours of health service operation,* the Guidelines state that:

> Patients sometimes require medical care outside the normal hours of health service operation. Individuals in prison are unable to access community after hours health service providers and thus require a system to access urgent care if needed. Where possible and practicable, the need and priority for clinical care is not to be determined by prison staff.
>
> The prison health service may be the only way for individuals in prison to receive medical attention. If this is the case, your health service must have arrangements in place with the clinical team to ensure care can be provided at any time.

RECOMMENDATIONS

Recommendation 17. The Guidelines must clearly state that the health care staff's clinical autonomy must take precedence over operational considerations of the prison/youth prison, except in exceptional circumstances.

Recommendation 18. The need and priority for clinical care must not to be determined by prison staff. They do not have the qualifications to make such critical decisions. Prisons must provide 24 hours a day access to appropriately qualified medical practitioners and nursing staff, who are adequately equipped and available to conduct a meaningful physical review of the person on the premises. This is also essential to enable clinical handover, addressed in the Guidelines.

Harm Reduction Programs

The Guidelines permit discretion, in relation to harm reduction programs, where they should be mandated. The Guidelines state:

> Your health service could implement a range of harm reduction programs relevant to its patient population… the distribution of condoms and lubricant…
> You could provide access to an opioid agonist therapy program… access to substance misuse counselling… information to patients on the prevention of transmission of blood-borne viruses (eg HIV, hepatitis B, and hepatitis C).

RECOMMENDATION

Recommendation 19. The Guidelines must make the following harm reduction programs mandatory:

- an opioid agonist therapy program;
- access to substance misuse counselling;
- information on the prevention of transmission of blood-borne viruses;
- the distribution of condoms and lubricant.

Cell Checks

The Guidelines should provide robust guidance on cell checks.

RECOMMENDATION

Recommendation 20. The Guidelines must make the following mandatory:

- Physical cell checks of persons in custody must be frequent and thorough, including meaningful assessments of health and wellbeing. People who are identified as at-risk should be regularly monitored .
- Where a person has exhibited any signs or symptoms of illness, cell checks must be completed by qualified medical staff.
- Cell checks should never be conducted in a cursory fashion through a cell 'peep hole', under any circumstances.
- Where prison officers or medical staff observe behaviour during routine cell checks, whether by reason of its unusualness or because it is inexplicable on the known facts, that is sufficient to cause concern, the incarcerated person should be taken immediately to a hospital, or a doctor summoned, so that a proper diagnosis can be made

Urgent Medical Attention

PHS 2.4 - Our health service identifies the need for and facilitates the timely transfer of patients that require urgent medical attention should include the below recommendations.

RECOMMENDATIONS

Recommendation 21. In all cases where there are known health conditions, or the person reports any unexplained symptom or pain, it is incumbent on officers to act with urgency when the condition manifests and provide urgent review by a qualified medical practitioner.

Recommendation 22. In all cases where a person in custody reports a sudden, unexpected, or medically significant increase in pain, or new or changing symptoms, the person should be immediately conveyed to hospital by ambulance.