



Stuart A Kinner
 Luke Streitberg
 Tony Butler
 Michael Levy

Prisoner and ex-prisoner health

Improving access to primary care

This article forms part of our 'Access' series for 2012, profiling organisations that provide primary healthcare to groups who are disadvantaged or have difficulty accessing mainstream services. The aim of this series is to describe the area of need, the innovative strategies that have been developed by specific organisations to address this need, and make recommendations to help GPs improve access to disadvantaged populations in their own communities.

Prisoners have markedly elevated rates of mental illness, chronic disease, substance dependence and engagement in health risk behaviours. The prison setting provides a unique opportunity to address the physical and mental health needs of this disadvantaged group. However, any benefits gained by prisoners from contact with prison health services are often lost once they return to the community. This article outlines the health inequalities experienced by prisoners and ex-prisoners in Australia, describes the community health centre operating at the Alexander Maconochie Centre in Canberra, and provides practical suggestions for improving access to primary care for this population, both in custody and after return to the community.

Keywords

prisoners; vulnerable populations; delivery of healthcare

The prison setting provides a unique opportunity to address the physical and mental health needs of a profoundly disadvantaged population group, yet little is done to maintain or build upon the successes of prison health services once prisoners return to the community.¹

Australia's prison population grew to 29 106 – an increase of 30% – in the decade to 2011.² Indigenous Australians are over-represented in prison by a factor of 14, and this incarceration gap continues to widen. More than 50 000 adults pass through Australia's prisons annually³ and the ex-prisoner population in Australia is approximately 1.8% of the Australian population.⁴ Over 4% of Australian children and 20% of Aboriginal children experience parental incarceration before the age of 16 years.⁵

Prisoners have markedly elevated rates of mental illness, chronic disease, substance dependence and

engagement in health risk behaviours.^{6–11} More than one-third have been exposed to hepatitis C and transmission of bloodborne viruses (hepatitis B, hepatitis C and HIV) during incarceration in Australia.^{12–14} The 12 month prevalence of psychiatric illness is 80%⁸ and substance misuse is hyperendemic.⁹

Australia has recently developed a national minimum dataset for prisoner health that will enable changes in the health of prisoners to be monitored over time, assist in the identification of prisoner-patient health needs, and provide a basis for ongoing benchmarking of prison healthcare service models within Australian jurisdictions. The most recent report based on this dataset – The Health of Australia's Prisoners 2010¹¹ – highlights the diversity of health service models in Australian prison settings. Key findings of the report include that 31% of prison entrants had ever been told they have a mental disorder; 16% were currently taking psychotropic medication; 76% were daily tobacco smokers; 58% reported drinking alcohol at high risk levels; 66% had used illicit drugs during the previous 12 months; and 26% had at least one chronic health condition such as asthma, cardiovascular disease or diabetes.¹¹

A possible barrier to better health for prisoners in Australia is their effective exclusion from Medicare and the Pharmaceutical Benefits Scheme (PBS). The *Commonwealth Health Insurance Act 1973* precludes provision of services under Medicare or the PBS if these services are [purportedly] provided by state and territory government authorities. While the intention is to avoid 'double dipping', underinvestment in prison health services by some Australian jurisdictions means that prisoners miss out on some treatments and medications available to the wider community. These include the Aboriginal and Torres Strait Islander Health Check, bowel cancer screening for men aged over 50 years (there are currently over 3000 men aged over

50 in Australian prisons), some pharmaceuticals, second opinions (eg. from an Aboriginal medical service) and access to psychologists. The exclusion provides no financial incentive for community health service providers, such as Aboriginal community controlled health services, to enter prisons, particularly in rural and remote areas.

The Alexander Maconochie Centre

Over the past 4 years, a primary care model of service delivery has been developed at the community health centre operating at the Alexander Maconochie Centre, a Canberra (Australian Capital Territory) prison with maximum and minimum security units and housing both male and female prisoners. Contact with the health service is initiated through visits to residential areas within the prison by registered nurses, twice each day. A confidential (usually written) request for a health service is triaged by a nurse and allocated to a range of health services. Medical officers (most of whom are qualified general practitioners practising in the local community or are advanced trainees of The Royal Australian College of General Practitioners), play an important role in the provision of primary care. The prison runs specialist clinics to address important health priorities including the provision of pharmacotherapies, a specialist hepatitis treatment service and a mental health service. Other tertiary level services are referred to the community based health service, with prisoners being queue-equivalent to community counterparts. There is no inpatient service in this prison, so all surgical and postsurgical care is provided in the neighbouring teaching hospital. Women's health and Aboriginal health services are offered routinely.

Improving ex-prisoner access to primary care

Despite the touted policy of 'throughcare' for prisoners in Australia,¹⁵ health impairment in this population tends to continue from the community, into prison and back into the community.¹⁶ Ex-prisoners die at rates far higher than their community peers, particularly in the days and weeks immediately following release from custody and overwhelmingly due to drug overdose and suicide.^{17,18} Rates of hospitalisation for physical and mental health problems are similarly elevated in the immediate postrelease period.^{19–21}

After release from prison, a return to previous patterns of behaviours is common, as is the recurrence of health problems that may have been identified (and sometimes treated) in custody.^{16,20} Once released, the majority of ex-prisoners re-offend – typically within 2 years.^{2,22} Important predictors of recidivism include poor physical and mental health, substance misuse and social disadvantage.^{20,23–25} Given the well documented links between health impairment and criminal behaviour,^{20,23,25,26} improving health outcomes for ex-prisoners is important from both a criminal justice and a public health perspective.

Therapeutic relationship issues

Many prisoners have not sought the help of a medical professional for many years, and many have had negative experiences during previous encounters and feel disenchanted with the medical profession. The provision of nonjudgemental care in custody and on release has the potential to increase rates of follow up.

Patient disclosure of incarceration

For most ex-prisoners, their prison experience is a small part of their life story, and it does not define them or provide any real predictive value about their personality and actions in broader clinical and social contexts. Making judgements about a patient based on a history of incarceration is no more valid or useful than judging character by some other life experience or social attribute.

If a patient volunteers a history of incarceration, it is important to address this early on in the consultation process. They must be allowed to freely express their feelings about the period of incarceration without fear of judgement. Many ex-prisoners will openly discuss their time in prison; others never elaborate. Unless there are specific aspects of the incarceration that they wish to discuss, the details should have little ongoing impact in the provision of medical care.

Patient literacy and numeracy skills

Many ex-prisoners have had limited formal education, and their literacy skills may not be well developed. This is important to keep in mind if a patient is required to read and sign documents for

consent or receive written educational pamphlets. Many prisoners are self conscious of their limited literacy and numeracy skills, so being frank, direct and nonjudgemental is the best course of action.

Medicare eligibility

Medicare eligibility is interrupted while an individual is incarcerated and needs to be reinstated on release. Although this often occurs before release, it is important to confirm Medicare status during the first clinic visit and offer assistance if eligibility needs to be re-established.

Screening for health conditions and risk behaviours

Given the current nature of our justice and mental health systems, and the laws regarding prohibition of certain drugs, ex-prisoners tend to exhibit higher rates of certain medical conditions than other members of society. Therefore, if a patient discloses a history of incarceration it may be appropriate to screen for health conditions and risk behaviours that are highly prevalent in this population, including substance dependence, mental disorders and infectious diseases, especially hepatitis C.

Obtaining patient records

To ensure continuity of care, it is appropriate for GPs seeing an ex-prisoner for the first time to contact the previous treating doctor at the relevant prison facility (once consent has been obtained) to discuss the patient's health history and to obtain medical notes. Given that many ex-prisoners have a history of underutilising healthcare in the community, prison health records may contain unique and valuable information about the patient's health status and treatment history. Despite rapid progress in the development of electronic health records, most prison health systems in Australia still rely on paper medical records, complicating the process of information transfer from prison to community healthcare providers.

Follow up of pathology and continuation of treatment plans

An ex-prisoner may have test results that were not provided before leaving custody, or a discharge summary that was not taken or was discarded before coming to your practice. The patient may also have a pre-existing mental or dental healthcare plan. These issues are easily addressed (once consent has been obtained) by contacting the prison health service.

The role of prison health services in undergraduate medical training

Some graduate medical programs offer students the opportunity to attend clinics at local prisons, providing exposure to the management of complex patients in a primary care setting. This exposure enables students to consider a range of clinical and ethical challenges, which are often discussed in medical school but rarely encountered in hospital or general practice settings. The clinical environment encountered in prison health centres also allows students and residents to learn techniques to deal compassionately and patiently with people displaying complex drug seeking and behavioural issues.

Resources

- A 60 minute web based course for health-care personnel working in prisons from the Norwegian Medical Association: www.medekspert.az/en/chapter11/about.html
- Health in Prisons, a World Health Organization guide to the essentials in prison health: www.euro.who.int/document/e90174.pdf
- Master of Forensic Medicine (unit subject in custodial medicine), Monash University: www.monash.edu/study/coursefinder/course/3412/
- Master of Forensic Mental Health, University of New South Wales: <http://psych.med.unsw.edu.au/psychweb.nsf/page/FMHReferences>.

Authors

Stuart A Kinner PhD, is Head, Justice Health Research, Burnet Institute, Melbourne, Victoria. kinner@burnet.edu.au

Luke Streitberg MBBS, MFM, is medical officer, Alexander Maconochie Centre, Canberra, Australian Capital Territory

Tony Butler PhD, is Head, Justice Health Research Program, Kirby Institute, University of New South Wales, Sydney, New South Wales

Michael Levy MBBS(Hons), MPH, FAFPHM, is Director, ACT Justice Health Service, Canberra, Australian Capital Territory.

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correspondence afp@racgp.org.au