

'If they're your doctor, they should care about you': Women on release from prison and general practitioners

Penelope Abbott, Joyce Davison, Parker Magin, Wendy Hu

Background

Nearly half of the people leaving prison see a general practitioner (GP) within a month of release, which provides an opportunity to promote health for this vulnerable group.

Objective

The objective of this article is to examine the expectations and experiences of GP care of women leaving prison.

Method

Semi-structured interviews pre-release and post-release from prison were analysed using inductive thematic analysis.

Results

Sixty-nine interviews were conducted with 40 women while they were still in prison and 29 of these women after they were released. Women perceived GPs as lacking interest in their social support needs and believed GPs needed more skills in substance misuse management. Given the fear of stigma, women may not disclose recent incarceration, affecting the continuity of healthcare initiated in prison.

Discussion

GPs' acknowledgement of, and assistance with, the broad issues that have an impact on the health and wellbeing of women after release is valued. Whole-person care also requires GP accessibility, management of substance misuse, continuity of care and understanding of the stigma associated with incarceration.

General practice is an important healthcare access point for people who are released from prison. In a recent Australian study of healthcare use by people leaving prison, 46.5% saw a general practitioner (GP) within a month of release.¹ However, there has been little Australian or international research that has examined effective primary healthcare for people leaving prison.

Mental health disorders as well as previous life trauma and high levels of psychological distress are common in people in prison.² Substance misuse, bloodborne viral disease, and chronic disease and its risk factors are all more common in people in prison, compared with the general population.²⁻⁴ Health vulnerability is heightened immediately post-release and in the first year after release, including increased risk of hospitalisation and death.⁵⁻⁸ Most women who are in prison are on medications or have health problems that require follow-up after release.⁹ Homelessness,¹⁰ disconnection from family and community,¹¹ poverty, unemployment,^{12,13} and return to a criminogenic environment¹⁴ are all factors that increase health instability. Competing demands, often related to family wellbeing, are particularly important for women leaving prison.^{15,16}

Approximately 8% of the prison population in Australia are women.¹⁷ Aboriginal and Torres Strait Islander women are over-represented in prison, making up approximately 30% of those in New South Wales (NSW) prisons,¹⁸ compared with 3% of the NSW population.¹⁹

This research examined the perceived health needs and plans of women during the period of transition from prison to the community, with a focus on their expectations and experiences of GP care.

Methods

Women who were within six weeks of release from prison and able to be interviewed in English were invited to take part in semi-structured interviews prior to release and one to six

months after release. Recruitment took place in three metropolitan correctional centres in Sydney. The first author, who undertook all interviews, was a visiting GP in one of the correctional centres. Women who had received substantial medical care from the first author prior to the interview were excluded from the study. Participants were selected using purposive sampling for age, ethnicity, custodial history, health status, health service use and engagement in transitional support programs.

Pre-release interviews were conducted face to face in private rooms and post-release interviews were conducted by phone. Participants were offered a payment of \$10 into their in-prison account or a \$50 supermarket voucher if they were in the community. Interview questions covered health needs and expectations or experiences of accessing healthcare after release, including GP care. Interviews were audiotaped and transcribed verbatim and inductive thematic analysis^{20,21} was undertaken. The first author coded transcripts concurrently with data collection; sampling continued until saturation for key themes was reached. The second and fourth authors undertook parallel coding on one-third of the interviews. The second author acted as an Aboriginal cultural mentor throughout analysis. Themes were finalised in an iterative process through research team discussions.

Ethics approval was obtained from the ethics committees of Justice Health and Forensic Mental Health Network (G31-13), Western Sydney University (H10322), Corrective Services NSW (13/259026), and the Aboriginal Health and Medical Research Council of NSW (910-13).

Results

Sixty-nine interviews were undertaken with 40 women pre-release and 29 of these women post-release. The women's ages were 19–59 years and length of incarceration was two months to two years. Five women identified as

coming from a culturally and linguistically diverse (CALD) background, defined as speaking a language other than English at home. Sixteen participants identified as Aboriginal women and one as a Torres Strait Islander woman.

Nine women were released from prison with the support of formal prison–community linkage programs,^{22,23} two to residential rehabilitation and two to transitional release accommodation. Of the 29 post-release interviews, seven were with women who were back in prison. The pre-release interview duration averaged 28 minutes and the post-release interview averaged 22 minutes.

Pre-release and post-release interviews were analysed together, given many women reflected on their experiences of multiple incarcerations. The major themes are presented below.

Needs and vulnerability immediately after release

The enormity of the life challenges faced by women after their release from prison often overpowered their need to access healthcare. These challenges included finding housing, employment, transport, finances and reintegration into families. Accessing services could require considerable resourcefulness, such as determinedly seeking out charities that would provide practical support.

Women who had little or no support from family or friends faced the most difficulties and, often, had worse linkages to health services. Women vividly recalled the overwhelming impact of social isolation on their wellbeing after release, reporting they felt vulnerable and alone.

Someone just to talk to, you know what I mean, [be]cause it's depressing. It is depressing like having no-one. You're around so many girls here, you know, you've got so many people that talk to you and that here. Getting out there it's like, you know, no-one. – Participant 16

Some women contrasted their hopes for successful integration into the community with previous bad experiences and what they had observed in other women.

Several expressed fearfulness for their future, particularly those who had poor health prior to incarceration, usually because of substance misuse or mental health problems. This battle with addiction and life stressors came to a head in the immediate post-release period, and vulnerability after release was a common theme.

What they don't understand is there's only, like, even though I've been off it for so long now, anything could trigger it again and I could start up.

– Participant 38

However, this period was also identified as a time of increased motivation to maintain health. Some women saw the first few days or weeks after their release from prison as a time-limited window of opportunity to link with services to assist with their health and social support needs, and prevent relapse and recidivism. This was also a perceived advantage of transitional programs because they linked the women to healthcare when they were most receptive.

A plan, an appointment, set for a week after you're out ... I think if you make that appointment quickly, you've got that little bit of time where you can get them in. – Participant 35

Post-release continuity of healthcare

Continuity of care on leaving prison was seen as desirable, but the fear of differential treatment resulting from disclosure of incarceration led some to avoid GP follow-up of previously managed conditions. Some withheld their prison discharge summaries because of previous negative experiences.

I had to go to that doctor to get medication for when I got released, and I only had the release paper with me and it was just awkward ... The conversation just went dead real quick. You know what I mean. Then it wasn't about again what I needed, it was about, you know, just come out of jail and what are you trying to get.

– Participant 6

Geographical dislocation, due to a need to avoid previous associates through choice or as part of parole conditions, could mean women had to seek GPs and health agencies in unfamiliar areas. Women reported particular difficulties in rural locations where GPs had longer waiting lists. Delays in seeing a GP caused stress and resulted in discontinuing medication.

There were also facilitators of continuity of care. Aboriginal health services and sexual health services were considered to be more accessible and less likely to stigmatise ex-prisoners. The national network of Aboriginal medical services (AMSs) increased women's confidence that care would be available in the event of release to an unfamiliar location, although getting appointments could still be difficult. Pre-release and post-release programs that linked women with health services in the community were valued.

They [transitional case managers] help you, any help you need, they'll sometimes take you there and meet you there. If you're unsure and if you're not very good at speaking or whatever, to go to the doctors or communicating – or anywhere that you need to go, they'll help you with that. – Participant 21

Other individuals and services that supported healthcare access were parole officers, churches and charities. Continuity of care was easier for women with priority health conditions, such as human immunodeficiency virus (HIV) and schizophrenia. Those with priority health conditions reported they received more supportive and accessible care to ensure adequate management.

Because of my status, I'm more of a risk to the community ... so, they put me straight in. – Participant 37

Pre-existing relationships with GPs or other health services were helpful at release. Some women reported that, after release, their strong existing relationships with GPs would help to prevent relapse to substance misuse and previous behaviours that had led to their incarceration. However, themes in post-release interviews suggested that

this perception was sometimes idealised or impractical, and several women did not access care as planned.

I'm hoping that Dr X [however Dr X had retired] is gonna be sort of like a home base, you know, and once this healthcare plan is drawn up I just follow that guidance sort of thing. In here, where you're given directions every day, you know you get up at this time, you do this, you do that. So if I just take it like that ... it's got to be a day-to-day part of my routine to do whatever's on this healthcare plan then I'll be right.

– Participant 34

GP services: Expectations and experiences

Study participants expected their GP to have good communication skills, interest in the whole person and a non-judgemental and empathic approach; to be thorough, accessible and flexible with appointments; and to provide adequate consultation time. Many women reported that prior GP consultations did not adequately explore or address problems related to their incarceration and life challenges. Instead, they focused solely on their physical health, although they would have preferred a more holistic approach.

I've known him [my GP] for years, sometimes it's ... just like, yeah, I had the golden staph and then he'd obviously realised [my injecting drug use] by looking through the notes but it was never talked about. It was never like, 'Are you okay?', you know, like counsellors do. – Participant 9

If they're your doctor, they should care about you and not only your physical health, but your mental [health] as well.

– Participant 7

Several women had experienced being blocked from GP services and were anxious that this would happen again after release. At the most extreme level, some women had been previously barred from local GP surgeries because of their behaviours prior to incarceration and were not sure if there were any local practices where they would be welcome.

A professional approach, yep. Instead of judging you because you're a criminal or a drug-user ... With my track record, from when I used to be on the [oxycodone], I'm barred from a lot of doctors' surgeries. As soon as they type in my name, I'm asked to leave. That's also hard too, even though I'm not the same person anymore. – Participant 8

For some women, accessing GP care after release could be compromised by negative attitudes from GPs and practice staff.

My GP on the outside ... was quite discriminative towards the fact that I was in custody and I had my daughter in custody. It's like he looked down on me ... pretty much saying that I had to get my act together and that, even though I had my act together – I had my own house – I was always, like, my daughter was always well looked after. I was there getting an immunisation needle for her. – Participant 19

The stigma of imprisonment was seen as being linked with that of substance misuse, and poor interactions with GPs often revolved around this. In particular, prescription of medication that had potential for misuse could cause concern or conflict, either because they were being prescribed too freely by some GPs or because they were seen as being unfairly denied. Some GPs who did not ask about substance misuse or mental health were seen to lack skills or lack care, and thought to be ignoring what mattered the most. Other GPs were commended for their skills in managing prescription medicine abuse or for linking women to relevant services.

He's not really that good of a doctor anyway, because I'll go there and he makes me feel like he just wants me to leave. So I'll go there and he doesn't sit down and talk to me properly. He just gets it over and done with. Because I've got a drug problem, he thinks I'm there to look for drugs. But I'm not ... I just – sometimes I just want to talk.

– Participant 7

When I tried to get [alprazolam] from [my GP], he was, like, no chance. He's good. He cares about people ... I used

to just go from doctor to doctor and get them. And they would mess me up.

– Participant 23

Discussion

There has been little research into the role of GPs working with people leaving prison, despite people commonly seeking consultations with GPs after release,¹ and mental, physical or substance misuse problems at release increasing the risk of recidivism.²⁴ Women in this study believed that having a GP was important when leaving prison and GPs should be non-judgemental, skilled and good communicators, consistent with known expectations of high-quality healthcare.²⁵

In a large study of people leaving prison in the US, one of the main facilitators for engagement in community primary care was that 'health providers be pleasant'.²⁶ However, the challenges of providing effective healthcare for people leaving prison can extend beyond patient-centred consultations, given the complex disadvantage that often precedes incarceration, and the high health and social support needs at release.^{10,12,17}

Engagement in healthcare by women after their release from prison can be difficult, particularly when there are other priority needs such as accommodation. Yet, the participants in this study considered such engagement to be urgent to harness motivation and prevent relapse, which is consistent with previous research.²⁷ Furthermore, continuity of care can be poor when people leave prison because of a lack of release planning and discharge communications being provided to GPs.²⁸ Notably in this study, poor continuity of care on leaving prison appeared to be further exacerbated by women not disclosing their incarceration or in-prison healthcare to GPs because they feared differential treatment and stereotyping.

In the view of the women who took part in this research, care is more effective when, as part of whole-person care, GPs acknowledge and actively consider the broad difficulties that these women face. However, this did not usually occur in the

GP consultations they had experienced. Some participants perceived this to be because of stigma and a lack of empathy or skills on the part of the GPs. However, this perception may also arise because GPs themselves want to avoid differential treatment and stereotyping. Fear of appearing judgemental or of making inaccurate assumptions when consulting with patients from diverse backgrounds can inhibit healthcare providers from acknowledging difference, which can be perceived as ignoring important aspects of a patient's life.²⁹ The evidence from our study suggests women leaving prison value enquiry about the antecedents to their incarceration to facilitate access to care they needed. Examples of potential care include GP prescription of opioid substitution therapy or referral to psychologists, domestic violence or gambling services.

Skilled GP management can greatly assist people leaving prison who have a history of substance misuse. Prescription drug misuse is an important clinical problem that may cause relapse or death for those leaving prison. There is particular danger immediately after release, as medications perceived to be misused are commonly ceased in prison. Consequently, women are at greater risk of overdose because of lowered tolerance. Additionally, other medications with potential for adverse events may have been prescribed in prison, including psychotropic medication.⁹

In this study, women reported being permanently barred from GP practices because of behaviours linked to prescription drug misuse, exacerbating their lack of access to care on release. Such behaviours are challenging symptoms of addiction. One management approach may be to put a time limit on decisions to discontinue care because of unacceptable patient behaviour, thus allowing potential resumption of future care within agreed boundaries. Practice protocols for the management of people requesting drugs of addiction are available to assist the safe management of people with substance

misuse³⁰ and encourage the therapeutic relationships that the women reported as important.

This study has limitations. The primary researcher was known to some participants to be a GP who worked in both community and prison settings. This may have decreased the participants' confidence in expressing critical views about GPs. While participants were purposefully sampled to explore the views of women with a variety of backgrounds, our findings are not necessarily transferrable to other women leaving prison.

Conclusion

Women who are transitioning from prison to the community often have multiple health and social support needs. GPs' acknowledgement of, and assistance with, the broad issues that have an impact on the health and wellbeing after release are important. Skills in the management of substance misuse, promotion of continuity of care on exiting prison, good accessibility to GP care and understanding of the stigma of incarceration may assist women leaving prison to maintain and improve their health and wellbeing.

Implications for general practice

- Active consideration by GPs of the life challenges facing many women leaving prison, such as homelessness, poverty, social isolation, family disruption and risk of relapse to substance misuse, is valued by women leaving prison.
- The early post-release period is a time of increased vulnerability for many women, and healthcare and added support through the GP may assist at this crucial time.
- Holistic care for people on release from prison may require facilitation of links to relevant community social support and health services.
- Confidence in the management of substance misuse and mental health problems by GPs is needed, including good management of prescription drug misuse.

- Continuity of care across the prison – GP interface can be disrupted by women choosing not to disclose healthcare given in prison through fear of differential treatment.

Authors

Penelope Abbott MBBS, MPH, FRACGP, Senior Lecturer, Department of General Practice, University of Western Sydney, Penrith, NSW. p.abbott@westernsydney.edu.au

Joyce Davison, Cert III Aboriginal health worker, Aboriginal cultural mentor, Department of General Practice, University of Western Sydney, Penrith, NSW

Parker Magin MBBS, PhD, MFM (Clin), MGPP, DPD, DipPaed, GDipClinEpi, FACPSychMed, FRACGP, Conjoint Professor, Discipline of General Practice, University of Newcastle, Newcastle, NSW

Wendy Hu MBBS, DipPaed, MHA, PhD, FRACGP, Associate Dean, Chair of Medical Education, Medical Education Unit, University of Western Sydney, Penrith, NSW

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References

- Young JT, Arnold-Reed D, Preen D, Bulsara M, Lennox N, Kinner SA. Early primary care physician contact and health service utilisation in a large sample of recently released ex-prisoners in Australia: Prospective cohort study. *BMJ Open* 2015;5(6).
- Australian Institute of Health and Welfare. The health of Australia's prisoners 2015. Cat. no. PHE 207. Canberra: AIHW, 2015.
- Gilles M, Swingler E, Craven C, Larson A. Prison health and public health responses at a regional prison in Western Australia. *Aust N Z J Public Health* 2008;32(6):549–53.
- Binswanger IA, Krueger PM, Steiner JF. Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population. *J Epidemiol Community Health* 2009;63(11):912–19.
- Kinner SA, Preen DB, Kariminia A, et al. Counting the cost: Estimating the number of deaths among recently released prisoners in Australia. *Med J Aust* 2011;195(2):64–68.
- Andrews JY, Kinner S. Understanding drug-related mortality in released prisoners: A review of national coronial records. *BMC Public Health* 2012;12(1):270.
- Alan J, Burmas M, Preen D, Pfaff J. Inpatient hospital use in the first year after release from prison: A Western Australian population-based record linkage study. *A N Z J Public Health* 2011;35(3):264–69.
- Pratt D, Piper M, Appleby L, Webb R, Shaw J. Suicide in recently released prisoners: A population-based cohort study. *Lancet* 2006;368(9530):119–23.
- Abbott P, Magin P, Hu W. Health care delivery for women in prison – A medical record review. *Aust J Prim Health* 2016;http://dx.doi.org/10.1071/PY15110.
- Baldry E, McDonnell D, Maplestone P, Peeters M. Ex-prisoners, homelessness and the state in Australia. *Aust N Z J Criminol* 2006;39(1):20–33.
- National Indigenous Drug and Alcohol Committee. Bridges and barriers: Addressing Indigenous incarceration and health. Canberra: Australian National Council on Drugs, 2009.
- Weatherburn D, Snowball L, Hunter B. The economic and social factors underpinning Indigenous contact with the justice system: Results from the 2002 NATSISS survey. Sydney: NSW Bureau of Crime Statistics and Research, 2006.
- Martire K, Sunjic S, Topp L, Indig D. Financial sanctions and the justice system: Fine debts among New South Wales prisoners with a history of problematic substance use. *Aust N Z J Criminology* 2011;44:258–71.
- Borzycski M. Interventions for prisoners returning to the community. Canberra: Australian Institute of Criminology, 2005.
- Richie BE. Challenges incarcerated women face as they return to their communities: Findings from life history interviews. *Crime Delinq* 2001;47:368–89.
- World Health Organization for Regional Europe. Declaration on women's health in prison: Correcting gender inequity in prison health. Copenhagen and Vienna: World Health Organization Regional Office for Europe and United Nations Office on Drugs and Crime, 2009.
- Australian Bureau of Statistics. Prisoners in Australia, 2015. Cat. no. 45170. Canberra: ABS, 2015. Available at www.abs.gov.au/ausstats/abs@.nsf/mf/45170 [Accessed 29 June 2016].
- Corben S. NSW Inmate census 2012. Statistical publication no. 39. Sydney: Corrective Services NSW, 2013.
- Australian Bureau of Statistics. 2011 census counts – Aboriginal and Torres Strait Islander Peoples. Canberra: ABS, 2012. Available at www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/2075.0 [Accessed 29 June 2016].
- Pope C, Ziebland S, Mays N. Qualitative research in health care: Analysing qualitative data. *BMJ* 2000;320:114–16.
- Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;3(2):77–101.
- Martire KA, Howard MVA, Sayle MA, Sunjic SS. Connections Program patients: A descriptive analysis of the reintegration needs of incarcerated substance users. *J Alcoholism Drug Depend* 2013;1(133).
- Justice Health and Forensic Mental Health Network. 2014–2015 year in review. Sydney: NSW Health, 2015.
- Mallik-Kane K, Visher CA. Health and prisoner reentry: How physical, mental, and substance abuse conditions shape the process of reintegration. Washington, DC: The Urban Institute, 2008.
- Saha S, Beach MC, Cooper LA. Patient centeredness, cultural competence and healthcare quality. *J National Med Assoc* 2008;100(11):1275–85.
- Fontana L, Beckerman A. Recently released with HIV/AIDS: Primary care treatment needs and experiences. *J Health Care Poor Underserved* 2007;18(3):699–714.
- Wang EA, Hong CS, Samuels L, Shavit S, Sanders R, Kushel M. Transitions clinic: Creating a community-based model of health care for recently released California prisoners. *Public Health Reports* 2010;125(2):171–77.
- Abbott P, Magin P, Lujic S, Hu W. Supporting continuity of care between prison and the community for women in prison: A medical record review. *Australian Health Review* 2016 [Epub ahead of print].
- Baker K, Beagan B. Making assumptions, making space: An anthropological critique of cultural competency and its relevance to queer patients. *Med Anthropol Q* 2014;28(4):578–98.
- The Royal Australian College of General Practitioners. Prescribing drugs of dependence in general practice, Part A – Clinical governance framework. East Melbourne, Vic: RACGP, 2015.

correspondence afp@racgp.org.au