

# Custodial health in Australia

Tips for providing healthcare to people in prison



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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

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# What is different about treating people in prison?

## Objectives of the document

Treating patients who are in prison poses some specific challenges for medical practitioners and takes place in a unique environment. It is necessary for practitioners to acquire the knowledge and skills which can assist with patient care in prisons. This document assists doctors and medical students by providing practical tips for providing healthcare in custodial settings.

## Custodial patients are a vulnerable population

- People frequently arrive in prison with existing physical and mental health problems. They have higher rates of
  complex mental and physical health problems than other members of the community. This can include anxiety,
  depression, schizophrenia, intellectual disability, fetal alcohol spectrum disorder (FASD), autism spectrum
  disorder (ASD), substance misuse, chronic disease (and its risk factors) and communicable diseases.
- Despite the significant health needs of people in contact with the criminal justice system, this population has commonly accessed healthcare poorly in the community and can fall between the cracks.
- Prison is frustrating and can challenge custodial patients' capacity to control anger and negotiate with prison fellows or staff.
- Prisons are places where exercise of free choice is very limited. Both prison authorities and prisoner hierarchies exert force on individuals to conform.
- · Custodial patients have little or no privacy.
- Custodial patients have little economic means and are reliant on the prison authorities for basic needs.
- Prison conditions can negatively affect people's health, including the risk of exposure to communicable diseases and violence.
- On release from prison, people face multiple social challenges including homelessness, disconnection from family and community, poverty, unemployment and stigma.
- When people leave prison they are at high risk of hospitalisation and death, immediately post-release and in the first year after their release.

These concepts have been recognised for some time and progressive generations of prison reformers have aimed to change the purpose of prisons to rehabilitation and support rather than a vessel for punishment. This is best summarised by Paterson: 'Men are sent to prison as a punishment, not for punishment'.

# People in prison have high rates of disease and high levels of social disadvantage

Research consistently demonstrates that people who are in prison have higher rates of social disadvantage, as shown in Table 1.

Table 1. Characteristics of the Australian prison population<sup>2</sup>

| Characteristic  | Indicators  | Percentage of prison population |  |
|---|---|---------------------------------|--|
| Cultural background                                     | Aboriginal and/or Torres Strait Islander  | 27%                             |  |
|   | Born overseas   | 19%                             |  |
| High level of indicators indicating social disadvantage | Unemployed in 30 days before prison   | 48%                             |  |
|   | One of parents have been in prison  | 17%                             |  |
|   | Homeless before incarceration   | 25%                             |  |
| Low levels of education                                 | Highest level of education below year 10  |                                 |  |
| Low engagement with health system                       | Proportion of prison entrants who, in the preceding 12 months, needed to consult a health professional in the community but did not |                                 |  |
| High levels of mental illness                           | Ever been told they have mental illness   | 49%                             |  |
|   | Taking medication for mental illness on entry to prison   | 27%                             |  |
|   | Ever intentionally harmed themselves  | 23%                             |  |
| High levels of  | Current smokers   | 74%                             |  |
| substance use   | High risk of alcohol-related harm prior to incarceration  | 58%                             |  |
|   | Illicit drug use in 12 months before incarceration  | 67%                             |  |
|   | Ever used intravenous drugs   | 45%                             |  |
| High levels of chronic disease                          | Ever been told they have a chronic disease  | 30%                             |  |
|   | Positive for hepatitis C  | 31%                             |  |

# People in prison reside in an environment that provides specific challenges to healthcare delivery

People in prison are housed in a unique and challenging environment. Health in prisons and forensic facilities is managed by state government facilities (either by the health or justice sector) or by private corporations. Correctional centres are dispersed and are sometimes remote. The prime objective is security, which means that working in a custodial environment is actually safer than working in a hospital environment.<sup>3</sup> However, there may be challenges in efficient delivery of care. These could include access to medical staff, access to investigations, examinations being undertaken while a person is restrained (eg in handcuffs in a hospital environment), maintenance of confidentiality and differences in medications provided by the formulary of the health service provider.

## People in prison themselves are, however, not greatly different to other patients

It is common to see people who are, or who have been, in custody. The number of people in custody in adult corrective services is increasing. According to the Australian Bureau of Statistics there were 38,845 adults in corrective services at 30 June 2016 – an increase of 8% from the previous year.<sup>4</sup> This equates to a national imprisonment rate of 196 people in prison per 100,000 of the adult population. Estimates have been made that about 2% of the population has been in prison at some time.<sup>5,6</sup> This means that, from time to time, all clinicians will see people who have been in custody.



# Understand the benefits of good healthcare for custodial patients

Treating custodial patients can be challenging and it is common to hear pejorative comments about the patients and the professionals who care for them. So, in the first instance, understand why you are treating patients who are in prison.

## It is right to provide good care for people in prison

Nelson Mandela said 'No one truly knows a nation until one has been inside its jails. A nation should not be judged by how it treats its highest citizens but its lowest ones'. From the earliest times, medical practitioners have had an ethical obligation to care for all people. The Australian Medical Association (AMA) in its position statement on the healthcare of people who are in prison or detained states: 'Prisoners and detainees have the same right of access, equity and quality of healthcare as the general population'.<sup>7</sup>

#### It offers the best chance for people in prison to rejoin the community

Custodial patients are at an increased risk of death after release from jail.<sup>8</sup> If people are well cared for in custody, this will ensure that they have the best chance of successful integration into the community. This has been demonstrated in the management of mental illness<sup>9</sup> and addictive behaviours.<sup>10</sup> Evidence shows people who are well managed are less likely to die or reoffend when released.<sup>11</sup>

#### It enables targeting of high risk groups

The concept of 'risk stratification' is now a high priority for health departments. This means targeting the sickest people for early intervention, then intervening to avoid hospital admissions and further costs down the track. When a working group at the 2010 Australasian Custodial Health Medical Officers Conference was asked, 'What are the opportunities for doctors working in correctional facilities?', one participant noted that in prisons 'all of society's most disadvantaged groups are concentrated in one place'.

## It provides benefit to the whole community

It can be argued that having a group of people with poor health in custody will adversely affect all of the community because of a pool of untreated mental, physical, addictive, infective and social morbidity.<sup>13</sup> This has been recognised by the New Zealand Ministry of Health, which states:

The problem of poor prisoner health extends well beyond the Department of Corrections and the criminal justice system in its effects ... There is a whole-of-society cost arising from poor prisoner health. This affects families in every town and city, threatens communities, damages child health and social outcomes, and creates challenges for numerous government agencies.<sup>14</sup>

# It is more efficient to provide prompt clinical care to all people

Frequently, patients in prison are challenging or uncooperative. A health practitioner may be tempted to avoid managing challenging patients, especially if there is a high patient workload. However, if patients are not managed well, their disease can progress and become more problematic for the next medical practitioner with whom they engage. If this occurs, their clinical care is likely to take more time and be more expensive, and there could be legal implications.

# It enables the justice system to function safely

If a proper health service is not provided for people in custody, people cannot be put into custody. So providing a good health service ensures that the justice system can operate. Access to appropriate healthcare is a basic human right as outlined by article 12 of the Australian Human Rights Commission. Without proper access to health services within the justice system, people may rightly argue that they cannot go to prison, or must leave prison, as they may be regarded as being too sick to be incarcerated. Services that are similar in quality to community services need to be provided in order to allow people to be given custodial sentences. Doctors frequently prepare reports and appear in court in relation to people seeking to avoid a prison sentence.



# Respect and advocate for the rights of access to healthcare

#### Access to a doctor

People in prison should have timely access to a healthcare practitioner on entering the prison system to ensure appropriate screening. While in custody, people need timely access to confidential primary, secondary and tertiary healthcare services.

#### Equivalence of care

A prison healthcare service should be able to provide services for medical treatment and nursing care, as well as nutrition, physiotherapy and rehabilitation services that are comparable in quality to those available to patients in the outside community.

#### Equity of health outcomes

A prison health service should aim to provide not only equivalence of service quality but also equity in health outcomes. This means that such services may require additional resourcing compared to those in the community setting.

#### Patient privacy and confidentiality

Freedom of consent and respect for confidentiality are fundamental rights of the individual. They are also essential for trust, which is a necessary part of the doctor-patient relationship. This applies especially in prisons, where patients cannot freely choose their own doctor. All efforts should be made to provide privacy, dignity and confidentiality during a consultation.

Custodial officers do not have a right to know a patient's health problems unless there is a risk to the patient, to other patients or to staff. Similarly, the treating practitioner does not have a right to know the cause and nature of the person's prison sentence. However, in some circumstances, it may be relevant to treatment – for example, in substance use discussions and psychiatric consultations. If the practitioner believes it could be relevant, they may ask the patient if they wish to disclose the offence. It may be better not to question patients about the nature of their offence; avoiding unnecessary questions may facilitate rapport and unprejudiced treatment.

In regard to patients' consent; the National Health and Medical Research Council lists custodial patients as a group where there are 'people in dependent or unequal relationships'. <sup>16</sup> Community standards for consent apply and particular care must be taken to ensure these patients are aware of their freedom of choice related to healthcare decisions, given their potential vulnerability. However, under exceptional circumstances, involuntary treatment may apply to some custodial patients. Enabling legislation for this will vary by jurisdiction, and in such exceptional cases practitioners would need to consult with senior management familiar with the legislation.

#### Preventive healthcare

The task of prison healthcare services should not be limited to treating sick patients. Health services should also be entrusted with responsibility for social and preventive medicine, such as lifestyle choices to prevent chronic diseases, hygiene, communicable diseases, suicide prevention, prevention of violence and promoting social and family ties. It should be noted that incarceration provides an excellent opportunity for people who may not access regular healthcare in the community to engage in preventive healthcare and screening.

# Professional independence

In order to ensure independence in healthcare matters, doctors should be aligned as closely as possible with the standard of healthcare provision in the community at large. Doctors' clinical decisions should be informed only by medical considerations and should not be affected by a patient's status as a person in prison.

# Professional competence

Prison doctors should have similar qualifications to their community-based colleagues in the discipline in which they practise. Prison doctors may need particular knowledge and special skills, and should work towards acquiring the specialised knowledge and skills that enable them to deal with the complex and particular health problems of people in prison.



# Keep safe – Physically and professionally

## Prisons are safe places in which to work

Security is the main priority for custodial centres. There is a suite of protocols to ensure security, such as security escorts, biometric scanning, the use of metal detectors, the need to wear duress alarms, random searches and sudden 'lock downs' for security purposes. This makes working in a custodial setting much safer than working in hospitals, because security is the priority.<sup>3</sup>

Security measures also affect healthcare providers coming to correctional centres. For example, phones or other equipment may not be allowed into the prison without permission, there may be a requirement to take only clear bags into centres, and bags may be scanned and searched. It can take time to proceed through to clinics due to these security measures, and this is unavoidable. You may be required to wear a belt in some centres so that a personal safety alarm can be easily carried.

#### Follow recommended physical and procedural safety measures

Local security measures have been refined over many years by experts in the field, so adhere to these measures. They could include sitting nearest to the door, wearing a duress alarm and only consulting within sight of a correctional officer. For some patients there may be a requirement to undertake consultations with a correctional officer in the consultation room. Know and understand the security procedures for the centre. Should you be searched by a correctional officer, possibly with a dog, remember that these practices are the means by which a high level of safety is maintained.

## Always work closely with custodial staff

Custodial staff have specific training for dealing with security, as well as knowledge of the individual's security circumstances that can be used to maximise safety. This specialised knowledge is used to keep staff safe. It is important, however, to be aware that medical staff have a responsibility to advocate and preserve the rights of the custodial patient if they feel the patient is not being treated appropriately or fairly by any staff member. Be mindful that unusual emotional relationships can develop between people in prison and their guards. Well known illustrations of this are the 'Stockholm syndrome' where a strong emotional tie can develop between captor and captive, 17 or the Stanford prison experiment behaviour where volunteers randomised as guards or people in prison developed behaviour that was abusive and accepting of abuse. 18

#### Manage challenging consultations and anticipate higher risk consultations

The most common expectation of custodial patients is that their healthcare providers are good communicators and have a patient-centred approach, much as would be expected in the community. However, consultations with some patients can be challenging due to histories of life trauma, addictive behaviours, high health needs, mental health problems, expectation that they will encounter stigma and the limitations and restrictions imposed by the custodial environment. Prior to a consultation, it may be possible to anticipate a conflict due to likelihood of mismatched expectation – for example, around prescription of pain medications. In some cases, it may be necessary to be extra vigilant and perhaps warn security staff about possible conflict, without breaking patient confidentiality as to medical reasons for your concern.<sup>19</sup>

## Be skilled in the management of people who have severe mental illness or are agitated

Many people in custody have severe mental illness. It is important to develop skills for managing the symptoms and behaviours associated with mental illnesses. Some useful resources on education in mental health are included in the reference section. It is also important to realise that, although most people become visibly agitated when they are mentally unwell or distressed, some people may behave unpredictably. If someone does become agitated, leave the room and alert custodial staff according to local procedures.

## Maintain personal privacy

Never tell the patient any personal details that could be used to identify you. Do not talk to custodial patients about where you live, your hobbies, your family and friends or personal activities. Do not make it easy to be found: consider having silent numbers, being a silent elector and having appropriate restrictions on social media.

#### Maintain indemnity insurance

When working for government organisations, medical staff may be covered by the organisation's indemnity provisions. However, it is useful to maintain personal medical indemnity cover, considering the complex legal circumstances of the custodial environment, and to provide protection in the scenario that there is a conflict of interest between the practitioner and the organisation.

# Be sure to debrief on a routine basis and always after critical events

It is important to attend to your personal wellbeing. Prisons are an environment where medical staff may be exposed to emotional events, critical incidents and unusual activity. It is also common for practitioners to work in isolation from other practitioners. Doctors need the opportunity to debrief and it is better for this to be by formal arrangement. It could be in groups, by arrangement with a peer, by formal 'clinical supervision' or through a mentoring arrangement.

It is also important to look after your own health generally. Some recommendations about ensuring doctors' health are listed in the Australian Health Practitioner Regulation Agency's Code of Conduct.



# Undertake a good clinical assessment

Assessment of custodial patients is not unlike any other medical consultation but may take more time for a variety of reasons. It is important to undertake good and thorough assessments as you may not get another chance to see the patient. Waiting lists for doctors can be long, patient expectations of consultations high, other staff reliant on your medical advice and further investigations difficult to arrange.

Effective management of custodial patient health needs involves multiple aspects of good practice. A list of skills that will assist in making a sound assessment may be found in the RACGP curriculum, Core skills unit – the centrepiece of the general practice curriculum (Appendix A).

## Use of interpreters

Given the nature of the population and sensitivities of the subject matter in the custodial setting, it is especially important to use professional interpreters for culturally and linguistically diverse (CALD) people and Aboriginal and Torres Strait Islander peoples as required.

## Rapport

Take time to establish a good rapport and show genuine interest in the custodial patient as a person. Such patients have often had bad experiences with service providers, often have poor health literacy and may have an intellectual disability or a mental illness. Listen to the patient, explain everything calmly, be respectful, be patient-centred and be professional. Like all people, custodial patients are appreciative when they believe someone is showing an interest in their situation and medical problems.

#### History

When taking a history, allow time as consultations will often take longer due to the complexity of health problems. Be informed by other sources, including medical history. Start from the beginning, confirm factors that are already on record and take extra care to ensure that communication is optimal by using appropriate language and avoiding medical jargon.

With the possible exception of psychiatric and addiction assessments, it is not customary to ask about offences committed. Otherwise, leave these to the patient to disclose as they see fit. However, it may be useful to ask how long patients have to serve in order to assess whether to initiate investigations while in custody or to organise pre-release planning. It will be necessary to arrange proper continuity of care on release.

#### Gaining information from community providers and previous prison healthcare

All patients appreciate good care but many patients have poor understanding of their current illnesses and appropriate management. Some patients may be deliberately misleading in order to attempt to solicit drugs of addiction. Many patients have experienced fragmented healthcare. A good understanding of care they have received in the community is important, including confirming diagnoses and prior management with community providers. Doctors should carefully review previous health management plans commenced in the community or in previous incarcerations, to ensure continuity of important investigations or treatments.

#### Examination

Good clinical assessment, including physical and mental state examination, is necessary as it can be more difficult to arrange tests and specialist appointments in a custodial environment than in the community. Challenging behaviours are part of the presentation and should be documented. Look for the presence of intellectual disability, ASD and FASD.<sup>20</sup>

## Investigations

Arranging investigations can be difficult and expensive in a custodial environment. For example, a test at a hospital may require two or more escort officers for many hours. These barriers to organising external investigations also mean that there are often substantial delays in getting tests done. This should be taken into account when developing a management plan. If circumstances are clinically urgent or semi-urgent, investigations may take too long, and transport to the emergency department of a local hospital may be required.

## Diagnosis

This should involve a description of all aspects of the presentation. It may involve a number of diagnostic dimensions, such as:

- diagnosis of the full range of health conditions including physical conditions, mental health conditions, personality disorders, substance use status and infectious disease status
- diagnosis of holistic and patient-centred factors, including environmental circumstances, family circumstances, social considerations and the patient's functioning.

## Aboriginal and Torres Strait Islander health

It is important that all doctors working in a custodial environment have the knowledge and skills to work effectively with Aboriginal and Torres Strait Islander patients. Aboriginal and Torres Strait Islander patients are over-represented in prisons, often coming from a background of historical and systemic disadvantage. Respectful attitudes and good communication and consultation skills need to be combined with knowledge of the historical, cultural, social, medical and even system factors that impact on healthcare delivery for Aboriginal and Torres Strait Islander patients. Self-reflection when working in this cross-cultural context, undertaking cultural awareness training and seeking support and advice from Aboriginal and Torres Strait Islander colleagues can assist the doctor to be more culturally competent.

#### Trauma-informed and violence-informed care

A high number of people who are in custody or are in contact with the criminal justice system have a history of adverse childhood experiences. It is also common for this group to have had multiple life experiences of trauma and violence, including physical and sexual abuse. This can affect the way they interact with healthcare providers and how they experience the care provided. When managing people in custody, doctors should practise trauma-informed and violence-informed care. This approach to patient care is through a paradigm of 'what has happened to you' rather than 'what is wrong with you'. Be sensitive to the risk of re-traumatising vulnerable patients when undertaking histories or physical examinations.

#### Management of pain in custodial settings

People in custody often present with chronic pain for management. This is jointly due to the high prevalence of significant physical trauma in this population, lesser access to ancillary care options in prison, and perceived benefits of pain medications such as stronger analgesics or gabapentinoids. A full history and examination is especially useful in developing a management plan for these patients. The management of chronic pain will be discussed later.



# Expect challenging behaviours

## Don't take it personally if people are angry with you or behave in challenging ways

It is important not to take challenging behaviours or consultations personally, or to become angry, but to recognise the dynamics of the situation. At times people may be responding to the difficult situation of being in prison, or their behaviour may be a symptom of their health problem, including addictive behaviours. Anger or challenging behaviours may also result from emotions such as fear, shame, loneliness, poor self-worth and fear of abandonment. These behaviours can result from disordered lives, including social isolation and past life trauma. Patients may unconsciously transfer negative emotions from past experiences of being let down to you (transference). In turn, doctors can have an emotional response to a patient's negative emotions (counter-transference). Professional and skilled communication and management is required.

## Diagnose and manage the behaviours

In dealing with these challenging consultations, remember the following.

- Step back and look at the bigger picture.
- Ask yourself what is the reason behind their attitude and behaviour.
- Remember that it is normal for people to have emotions and it is important to handle a patient who is emotional with compassion.
- If custodial patients become emotional, this may generate an emotional response in you. If this occurs, recognise your emotional response as it may be helpful in diagnosis and in management.
- It is important to maintain professional, objective management of the patient.
- Make an assessment of the current safety risk and put safeguards in place for support if concerned.
   Suitable safety procedures may be obtained from local security protocols or discussions with security staff.
- Attempt to make a clear diagnosis of the physical, mental and social context of the patient.
- Build rapport as far as possible.
- Maintain professional boundaries and set clear limits.
- · Be professional, consistent and fair.
- Manage the problem as well as you can while recognising that the result may not be ideal.
- Always work in a team and have multidisciplinary meetings to develop a comprehensive and clear plan.
- Document challenging consultations carefully it may be necessary to document the language used and if the consultation was terminated by the patient or other reasons.
- Flag any behavioural concerns as alerts for future consultations.

#### Work in a team

People in prison may have developed coping behaviours that are manipulative. Some patients' behaviours are divisive and cause splits between different healthcare providers involved in their care. Some may engage in grooming of their healthcare providers, which can encourage practitioners to cross boundaries and hence create disharmony in teams. These behaviours could be part of a personality disorder or mental illness. Ensure that 'splitting' or 'grooming' does not cloud judgement.

It is important for all relevant providers to communicate regularly and document management plans clearly. Case conferences on care plans can be helpful. Careful management plans that take into account various contingencies may support teamwork when working with patients with high-level needs and challenging behaviours.

#### Set and maintain professional boundaries

Set clear boundaries. Never accept unreasonable behaviour. Patients may ask for special exemptions on medical grounds, such as diet, shoes and bedding. It is important to use discretion, independence and a skilled approach. It is important that the patient's welfare is paramount. Do not grant or refuse a request under pressure from custodial staff but be fair and transparent. Also be mindful that it may not be in the patient's interest for a special favour to be granted as this could lead to victimisation. For example, a patient may inappropriately be given permission for better shoes and subsequently be assaulted for having them.

#### Drugs will not solve behavioural problems but may exacerbate them

It is tempting to over-prescribe drugs for people who behave poorly or who demand or request particular medicines. However, drugs do not solve social problems and often exacerbate them. The best approach is to assess the patient carefully and fully, then decide on the best management plan and explain the reasons for your decision. Further information is available in the RACGP publication, *Prescribing drugs of dependence in general practice*<sup>21</sup> and Public Health England publication, *Managing persistent pain in secure settings*.<sup>22</sup>

#### Confirming information and collaborating with other sources is important

Where possible, corroborate your information with information gathered from other sources. Patients are often unaware of their medical history or, on occasions, may be intentionally misleading. The custodial centre will have a process to enable corroboration of information.

#### Self-harm

It is common for people in prison to engage in self-harm. The percentage of people entering prison who report previous self-harm is about 23%.<sup>2</sup> There is a spectrum of self-harming behaviours and much has been written about it. A good resource for health professionals is *Understanding self-harm – For health professionals*.<sup>23</sup>

Self-harming behaviours include suicide attempts, which are often by hanging. They also include deliberate and chronic self-harm such as punching walls, banging their head against a wall, swallowing objects such as razor blades, inserting foreign bodies under their skin, into their urethra or wounds, or even dehiscing or sabotaging wounds.

Managing patients who chronically self-harm is challenging, and their care requires a team approach. While management of this type of behaviour is primarily the responsibility of the custodial staff, it requires the whole team to be involved. Teams may consist of psychologists, psychiatrists, social workers, mental health nurses and correctional officers. Strategies may include identifying people at risk, accommodation in special units, removing hazards, increased support, diversionary activities and video surveillance.<sup>24</sup> Medical staff will commonly be required to assist with acute injuries and will need to collaborate with other staff in contributing to and participating in management plans.

#### Suicide prevention

Suicide is a significant problem for custodial services. About 7% of people who enter prison are identified as being at risk of suicide.<sup>2</sup> According to the Australian Institute of Criminology, between 2004 and 2013 there was an average of 11.7 deaths per year in custody in Australia.<sup>25</sup> There are many reasons why people in prison are at higher risk of suicide than the community. These include a high rate of mental illness, substance use behaviours and sudden loss of freedom, which acts as an acute stressor. Note that after release, this population remains at higher risk of suicide when compared with the general community.<sup>26</sup>

Each custodial centre will have systems in place to screen for people deemed at risk of suicide and to place them on a program. This could involve isolation in a safe cell with no access to 'hanging points', mandatory placement in a cell with another person, constant video surveillance and prompt mental health assessments with pathways to enhanced management as required. Collaboration between mental health professionals and custodial officers is necessary.

## Hunger strikes

Hunger strikes are a variant of self-harming behaviours and do occur in prisons. The AMA, in its position statement 'Medical ethics in custodial settings',<sup>27</sup> reinforces the right of people in prison to enter into a hunger strike. Management of hunger strikers is complex and may involve legal and political factors. There will be local policies on management of hunger strikers and it is wise to seek advice from senior managers. It is also prudent to familiarise yourself with targeted medical management. Some features of management are outlined in *Medical management of hunger strikers*.<sup>28</sup>



# Take care when prescribing

### General approaches to prescribing for people in custody

This chapter is an adaptation of an article in *Australian Prescriber*.<sup>29</sup> Prescribing should occur after proper assessment, even in this challenging environment. It should be accompanied by the use of appropriate language and information on medications or disease states. The information provided must be easy to understand, must be culturally appropriate and may require the use of Aboriginal health workers or an interpreter service. Tailoring and simplifying the medication regime to patients' needs is also a practical consideration for many patients. All prescriptions should be time-limited, and therefore reviewed periodically or discontinued. As in community situations, the prescriber has a legal responsibility to prescribe medications only after an appropriate clinical review and establishing that there is an evidence-based need.

#### Issues related to addiction and abuse

Approximately 75% of people in custody have used illicit substances prior to incarceration.<sup>2</sup> In addition to medication being taken by individuals for non-medical needs, there is concern for the potential of prescribed medications to be used as currency in prison, either voluntarily or under duress.

In general, a doctor should approach prescribing in custody with the following concepts in mind.

- The basis for safe and effective treatment is a thorough assessment, which includes seeking information from treating community clinicians and health services, including general practitioners (GPs) and hospitals.
- The prescription of psychoactive medications needs to be informed by a formal diagnosis, due to the potential for abuse.
- It is important to be aware that psychological, social and many physical problems will not be improved by medication and prescription medications may complicate the management of many individuals.
- It is vital to work as a team because of the potential for individual clinicians to be played off against one another.
- Work should be carried out in a multidisciplinary team, with input from pharmacists, addiction medicine
  specialists, psychiatrists, pain management specialists, physicians and surgeons when required. This applies
  particularly when prescribing drugs with the potential for addiction to people with chronic disease, chronic pain
  or palliative care needs.
- Always be cognisant of potential drug-seeking behaviours. This includes requests for specific medications, aggressive and unreasonable behaviours, provision of information that is inconsistent with objective findings, and patients seeking multiple prescribers.
- Formal management plans must be in place for all custodial patients being treated.
- The RACGP has guidelines for managing the prescribing of drugs of dependence.<sup>21,30–32</sup>

## Caution with specific classes of medications

#### Benzodiazepines

Due to the potential for abuse and diversion, caution needs to be exercised when prescribing benzodiazepines in prison. Administration of benzodiazepines to custodial patients should always be supervised.

A higher percentage of people entering custody are taking benzodiazepines. Custodial patients often self-report that this is for epilepsy, but it is common for such patients to be abusing, and dependent on, these drugs. Benzodiazepines have a place in treatment; however, they are rarely indicated for long-term management of epilepsy inside or outside the prison environment.<sup>32</sup>

There are specific considerations of which practitioners should be aware.

- Clonazepam may be appropriate for the treatment of epilepsy, but a consultation with a neurologist should be made to ensure treatment is appropriate for the condition.
- Temazepam may be useful for custodial patients in rare acute situations for example, for management of insomnia when first arrested or incarcerated.
- When people first enter custody, diazepam (or oxazepam if severe liver disease is present) may be used
  for management of withdrawal from gamma-aminobutyric acid (GABA) agonists usually alcohol and
  benzodiazepines to prevent serious complications such as seizures.
- Alprazolam prescription is hazardous in a prison setting and should not be used.<sup>32</sup>

#### Opioids

Opioids present a particular challenge in custody. People with an established diagnosis of opioid use disorder may be assessed for possible commencement onto an opioid substitution treatment (OST) program as appropriate and where available. Others who are withdrawing from opioids should be managed using established protocols under the supervision of a practitioner experienced in the management of such withdrawals. It should be borne in mind some patients can be 'stood over' by prison fellows for medications including opioids.

The RACGP has recently released *Prescribing drugs of dependence in general practice, Part C1: Opioids.* It outlines key principles that should be followed:<sup>30</sup>

- As with any treatment, prescription of opioids should be based on a comprehensive biopsychosocial-based assessment; a diagnosis; thoughtful consideration of the likely benefits and risks of any medication, as well as of non-drug alternative interventions; and a management plan derived through shared decision making (SDM) and continual clinical monitoring.
- General practitioners (GPs) should be aware of the common concerns associated with opioids, such as potential dependence, withdrawal, problematic drug use (including diversion and misuse) and known harmful effects, including falls, potential cognitive effects and motor vehicle accidents. These risks should be discussed with patients.
- Opioid treatment seeks to maximise outcomes for health and social functioning of the patient while
  minimising risks. To minimise risks, opioids should be prescribed at the lowest effective dose for the
  shortest clinical timeframe.
- Avoid prescribing opioids to patients with comorbid alcohol or substance use disorders or polydrug use.
   GPs should consider seeking specialist opinion in the management of these patients. Patients who use two or more psychoactive drugs in combination (particularly benzodiazepines and opioids) and patients with a history of substance misuse may be more vulnerable to major harms.
- Opioids are generally regarded by clinical practice guidelines as a short-term therapeutic option. Long-term use should be uncommon, undertaken with caution and based on consideration of the likely risks and benefits of opioids.
- If alternatives to opioid treatment fail, have limited benefit or are inappropriate, then supervised opioid treatment may remain an acceptable long-term therapeutic option.
- Long-term opioid prescriptions should be at the lowest effective dose, and regular attempts at reduction should be scheduled. Continued professional monitoring of health outcomes is required.
- Opioids should be prescribed from one practice and preferably one GP and dispensed from one pharmacy.
- GPs may wish to use the diagnosis of substance use disorder (SUD) rather than dependence, addiction or abuse; this is based on the sedative, hypnotic or anxiolytic use disorder criteria in the Diagnostic and statistical manual of mental disorders (5th edition) (DSM-5). This is a more neutral term that may reduce stigmatisation of patients with problematic use of opioids, benzodiazepines and other drugs or alcohol.
- GPs should have communication strategies and safety processes in place to manage inappropriate requests for opioids by patients.
- All patients, including those who use opioids and other drugs or alcohol problematically, have the right to best practice care that is respectful and promotes their dignity, privacy and safety.

People who are incarcerated are frequently on oral opioids prescribed inappropriately for chronic pain. Careful consideration should be used when approaching cases where people in custody are using opioids for chronic pain.

The RACGP has recently released a guideline *Prescribing drugs of dependence in general practice, Part C2: The role of opioids in pain management.* Note that these guidelines have a specific section on the 'inherited patient'. A structured and multidisciplinary team approach is important. A small number of patients may be deemed to require opioids for chronic pain, but such medication needs to be supervised and regularly reviewed. The National Drug and Alcohol Research Centre has also produced useful resources for GPs on opioid prescribing.<sup>34</sup>

The RACGP guideline has a summary of opioid use in chronic non-cancer pain in general practice section, which states:31

Chronic pain has historically been defined as continuous or recurrent pain that persists for an extended period (generally more than three months). However, the biological mechanisms for chronic pain are quite different from those of acute nociception, and should not be considered as 'unhealed' acute pain. Chronic non-cancer pain (CNCP) is a collection of clinical conditions with involvement of single or multiple pathophysiological mechanisms leading to persistent pain. It is also an individual, multifactorial experience influenced by culture, previous pain events, beliefs, expectations, mood and resilience.

Due to methodological weaknesses of chronic pain studies, interpretation and translation of evidence into practice is difficult. There is limited evidence to determine long-term benefits of opioids (outside of end-of-life care); however, there is evidence of risk of harm that increases with dose. While guidelines suggest opioids in the management of some chronic pain conditions, they are not recommended for routine or first-line use.

For accountable prescribing in managing CNCP, GPs should:

- undertake a complete biopsychosocial assessment of the patient with pain
- optimise non-drug therapies, and optimise non-opioid therapies as the primary interventions of care.

Opioids for CNCP should be reserved for selected patients with moderate or severe pain who have not responded to other therapies and where the pain significantly affects function or quality of life. If primary interventions fail or are suboptimal, opioid therapies may be considered. GPs should share the decision-making process with the patient, and if opioid therapy is considered, there should be:

- a patient selection/exclusion process before a therapeutic opioid trial
- formal care planning based on specific goals and risks
- an opioid trial, which is undertaken to determine a patient's response to opioid therapy. This trial includes the selection of an appropriate opioid, formal measures of analgesia and functionality, a trial of dose reduction, and a drug cessation plan if the trial fails
- an ongoing assessment and evaluation by the accountable prescriber if the trial shows opioid benefit
- opioid tapering and cessation if suboptimal results or aberrant behaviour occurs.

Long-term use should be uncommon, undertaken with caution and based on consideration of the likely risks and benefits of opioids. Intermittent use is preferable.

GPs should also be aware of chronic pain conditions where there are known clinical complexities involving opioids. These complex clinical areas include the exacerbation of pain or new acute pain in patients on long-term opioid therapy, managing opioids after a non-fatal overdose, and managing the inherited patient.

Some patients on long-term treatment with opioids for CNCP may represent de facto maintenance treatment for iatrogenic opioid dependence. GPs should aim to taper patients taking >100 mg oral morphine equivalent (OME) per day.

It is rare for patients to be released on opioids unless they are on OST. Prescribers should be aware of local regulations relating to restricted drugs.

#### GABA (gamma-aminobutyric acid) analogues

GABA analogues such as pregabalin and gabapentin were originally developed for epilepsy. They have a role in the management of chronic neuropathic pain.<sup>35</sup> However, the benefits are limited. These medications are frequently subject to abuse as they have a high currency value in the custodial environment.<sup>36</sup> It is suggested that their use should be avoided except in exceptional circumstances.

#### Other medications subject to abuse

In the custodial environment, many medications are abused for real or perceived effects. While evidence for this is limited and is often anecdotal, reported examples include:

- · medications with anticholinergic effects like hyoscine being abused for a 'high' that occurs when smoked
- nicotine patches boiled up in water to release the nicotine, with the water consumed to obtain an immediate stimulant effect
- mirtazapine and quetiapine being used for their sedative effects.

# Psychiatric prescribing in custody

Many people in custody have mental health problems and unfortunately many of these people only receive treatment by entering custody. People should receive comprehensive team management for their mental health problems. It is important that protocols are followed for initiation and maintenance of antipsychotics. These protocols contain checks for evidence of cardiac and metabolic side effects. It is also important for antipsychotics to be continued only for the period that is necessary, and for a treatment that was intended for a limited period not to be continued indefinitely. Amphetamine stimulants (eg dexamphetamine and methylphenidate) should be prescribed only by someone authorised for this both under state regulations and credentialed to do so by the health organisation providing care for custodial patients in the relevant state or territory. Many people in custody are prescribed antidepressants for a variety of reasons. As a rule, tricyclics are less well tolerated and have a narrower safety margin than other classes of antidepressants,<sup>37</sup> which is a significant consideration in a population with a high incidence of self-harm. Some patients may apply pressure for antidepressants to be used for sedative purposes. This should be resisted.

#### Preparation for release

It is important that patients are prepared for release, as there is a higher mortality immediately after release. <sup>38,39</sup> This can be challenging at times because release dates may not be predictable. People with known opioid use disorder have better outcomes in the community when treated with OST prior to release. When released from custody, they need to be linked to a relevant community service for follow-up. People with severe mental illness similarly should be stabilised and linked to a community mental health service for follow-up. People undergoing treatments for blood-borne viruses, such as human immunodeficiency virus (HIV), need to be linked with a community provider who is authorised to continue these treatments.

All people should be linked to a GP for follow-up after release from prison. This can be difficult because many people in prison do not have a GP, they may not want their GP to know they were in prison or they may decide to live in a different location on release. <sup>40</sup> Aboriginal and Torres Strait Islander people can be referred to an Aboriginal medical service. Many people who are released into the community have complex medical histories and have had substantial healthcare in prison. <sup>41</sup> Therefore, all people in prison should be released with a discharge summary and arrangements for care for specific treatments such as OST. However, if for some reason a patient attends a community health service and has been released from prison without a discharge summary, the GP should contact the health provider at the correctional service in their state or territory for more information. Details of correctional service centres are shown in Table 2 on page 23.

Doctors should note that the Pharmaceutical Benefits Scheme (PBS) has certain requirements for prescriptions that may differ to those systems of prescription used within custodial centres. This should be borne in mind when preparing patients for release. Examples where this may occur include the off-label prescribing of mirtazapine and quetiapine.



# Develop special skills

If you intend to work with patients in custodial centres, high-quality clinical skills are necessary and certain specific skills are advantageous, including:

- mental health training
- skills in addiction medicine including management of opiate withdrawal, overdose and OST programs (processes and regulations for which vary between states and territories)
- skills in management of blood-borne viruses and sexually transmitted infections, including
  - HIV prescribing
  - hepatitis B prescribing
  - hepatitis C prescribing
- cultural awareness
  - awareness of Aboriginal and Torres Strait Islander culture and history, and of local Aboriginal and Torres Strait
     Islander communities and services
- trauma-informed care (for managing survivors of mental, physical and sexual trauma and abuse). 42

Links to resources that may assist in developing these skills are listed in the Resources section.



# Document, document, document

#### Medical records

It is always important to practise good record keeping, but this is especially true in custodial practice. There are a number of reasons for this. First, it is good practice. Second, all deaths in custody are Coroner's cases and the records may be needed in court. Third, patients often complain about their treatment or ask for medical reports in the hope that they may get released. Remember the dictum: 'Good documentation, good defence; poor documentation, poor defence; no documentation, no defence'.

#### Report writing

People dealing with patients in custody may be required to write reports for a variety of bodies such as courts and parole boards. It is essential that this be done with the permission of the organisation and in accordance with their policies. It is also important to obtain patient consent if consent is legally required. Experience shows that a doctor is less likely to be subpoenaed to give evidence in a court if a report is well written. A court appearance can be very time consuming, so it is better to invest time in writing a comprehensive report.

- · Ascertain full details of what information is required.
- Take time to fully assess the patient or the patient's record.
- Answer the questions systematically and logically and in plain English.

## Attending court

- Contact the lawyer who has subpoenaed you and ascertain full details of what information is required.
- Take time to fully assess the patient or the patient's record.
- · Research the relevant topics so that you can provide an informed opinion.
- Take your notes on the patient and their condition with you to court.
- Get advice from your own legal team or medical defence union if required.
- Answer questions objectively in simple language.

Excellent resources for court attendances and report writing have been published by the AMA43 and the RACGP.44



# Connect with external providers

If a person needs to receive treatment as an inpatient or an outpatient while in custody, the external treating practitioners involved can find the experience confronting and may not be aware of specific issues relating to managing custodial patients. It is helpful to communicate with external providers to allay any concerns and explain specifics of the prison environment – for example, that:

- you are a health professional, not a correctional officer
- it is safe to treat people in prison
- care may take longer but there is potential for great gain in health status
- Medicare is not generally available for custodial health
- there are limited services in prisons, especially allied health services
- follow-up investigations, appointments and referrals may take some time to arrange
- · access to a second opinion is not readily available
- in a custodial centre, doctors may not be available every day
- specific details of care are available in inpatient facilities in prisons
- the prison will use a formulary (like a hospital) with limited medication availability
- drugs with a potential for abuse should be avoided where possible
- the doctors and health staff in the custodial centre are happy to discuss the case.

# Support patients to connect with the community when released from prison

It is important to provide the best opportunity for people to continue to manage their own health on release from prison. <sup>45,46</sup> Different prisons have different systems for facilitating care on release, so be familiar with local systems.

There will be targeted programs for people who are on OST. There are also likely to be specific release support systems for young people and for people on treatment for blood-borne viruses. It is particularly important for people with severe mental illness to be connected to a community mental health provider.

It is useful to have a list of GPs with an interest in areas relevant to the individual being released. If the patient is an Aboriginal or Torres Strait Islander person, an Aboriginal medical service will be a good option.

Custodial patients should be provided with a discharge summary. This may be complemented with a verbal handover for complex patients. On release, advise the patient that every jurisdiction has a process for their doctors to access information (Table 2). Consider issues with off-label prescribing, as some medications available on the prison formulary may not be subsidised by the PBS and therefore may not be easily available for patients in the community.

| Table 2. Acc    | essing health information f                                  | or the post-custodial patient   |  |
|-----------------|--|---|--|
| State/territory | State/territory organisation/s                               | Contact   |  |
| ACT             | ACT Health   | Accessing your medical records, www.health.act.gov.au/about-our-health-system/accessing-your-medical-records  |  |
| NSW             | NSW Health   | Access to medical records, www.justicehealth.nsw.gov.au/patient-support/access-to-medical-records   |  |
| NT              | Northern Territory Government                                | Prisoners' rights, https://nt.gov.au/law/prisons/prisoners-rights   |  |
| Qld             | Queensland Government  | Prisons and detention centres: Prisoners' rights, www.qld.gov.au/law/sentencing-prisons-and-probation/prisons-and-detention-centres/prisoners-rights  |  |
| SA              | Department for<br>Correctional Services                      | Requests for information should be directed to the discharge site as per the discharge letter, otherwise sent to SA Prison Health Service.  Telephone: 08 7002 3100  Facsimile: 08 7002 3199  Email: HealthSAPHSCorporateTeam@sa.gov.au |  |
| Tas             | Department of Health and Human Services                      | Correctional Primary Health Service, www.dhhs.tas.gov.au/service_information/services_files/mental_health_services/correctional_primary_health_service  Telephone: 03 6166 1249  Facsimile: 03 6216 8239                                |  |
| Vic             | Corrections Victoria   | Prisoner health records, www.corrections.vic.gov.au/home/prison/health+care/prisoner+health+records   |  |
| WA              | Government of Western<br>Australia, Department<br>of Justice | Access to prisoner information, www.correctiveservices.wa.gov.au/about-us/access-prisoner-information/default.aspx Telephone: 1800 077 735  |  |

# Appendix A. Summary of RACGP curriculum 2016: Core skills

#### Domain 1: Communication and the patient-doctor relationship

- CS1.1 GPs communicate effectively and appropriately to provide quality care
- CS1.2 GPs use effective health education to promote health and wellbeing to empower patients

#### Domain 2: Applied professional knowledge and skills

- · CS2.1 GPs provide the primary contact for holistic and patient-centred care
- CS2.2 GPs diagnose and manage the full range of health conditions in a diverse range of patients across the lifespan through a therapeutic relationship
- · CS2.3 GPs are informed and innovative
- CS2.4 GPs collaborate and coordinate care

#### Domain 3: Population health and the context of general practice

- CS3.1 GPs make rational decisions based on the current and future health needs of the community and the Australian healthcare system
- CS3.2 GPs effectively lead to address the unique health needs of the community

#### Domain 4: Professional and ethical role

- CS4.1 GPs are ethical and professional
- CS4.2 GPs are self-aware
- · CS4.3 GPs mentor, teach and research to improve quality care

# Domain 5: Organisational and legal dimensions

- CS5.1 GPs use quality and effective practice management processes and systems to optimise safety
- CS5.2 GPs work within statutory and regulatory requirements and guidelines

# Resources

#### Aboriginal health services in prisons

Australian Indigenous HealthInfoNet, Justice, https://healthinfonet.ecu.edu.au/learn/determinants-of-health/community-capacity/justice

#### Blood-borne viruses and sexual health

Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine, www.ashm.org.au

#### Court appearances

AMA position statement: Ethical guidelines for doctors acting as medical witnesses, https://ama.com.au/system/tdf/documents/Doctors\_Acting\_as\_Medical\_Witnesses\_0.pdf?file=1&type=node&id=40673

#### Doctor's health

Good medical practice: A code of conduct for doctors in Australia, www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx

Doctors' Health Advisory Service, www.dhas.org.au

#### Drugs of dependence

RACGP, Prescribing drugs of dependence in general practice, www.racgp.org.au/your-practice/guidelines/drugs-of-dependence-c

#### Standards in prisons

RACGP, Standards for health services in Australian prisons, www.racgp.org.au/your-practice/standards/standardsprisons

#### Mental health

RACGP, General Practice Mental Health Standards Collaboration (GPMHSC), www.racgp.org.au/education/gps/gpmhsc

#### Trauma-informed care

Mental Health Coordinating Council, Trauma-informed care and practice (TICP), www.mhcc.org.au/project/trauma-informed-care-and-practice-ticp

National Council of Juvenile and Family Court Judges, Adverse Childhood Experience (ACE) Questionnaire: Finding your ACE score, www.ncjfcj.org/sites/default/files/Finding%20Your%20ACE%20Score.pdf

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